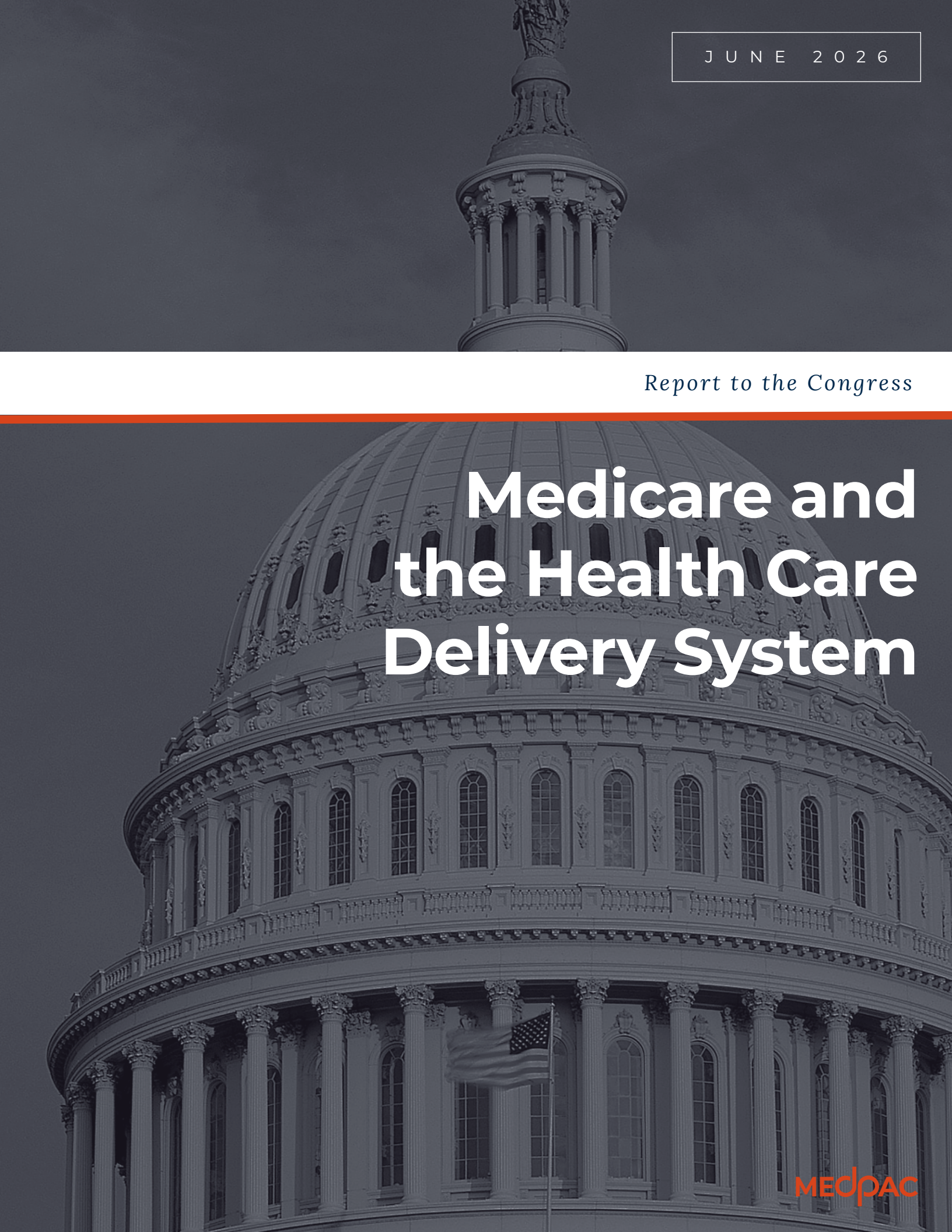




J U N E 2 0 2 6

Report to the Congress

Medicare and the Health Care Delivery System

MEDPAC



The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare’s traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

The Commission’s 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the Comptroller General and serve part time. Appointments are staggered; the terms of five or six Commissioners expire each year. The Commission is supported by an executive director and a staff of analysts, who typically have backgrounds in economics, health policy, and public health.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress. In the course of these meetings, Commissioners consider the results of staff research, presentations by policy experts, and comments from interested parties. (Meeting transcripts are available at www.medpac.gov.) Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the Centers for Medicare & Medicaid Services (CMS), health care researchers, health care providers, and beneficiary advocates.

Two reports—issued in March and June each year—are the primary outlets for Commission recommendations. In addition to annual reports and occasional reports on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

REPORT TO THE CONGRESS

Medicare and the
Health Care
Delivery System



*Medicare Payment
Advisory Commission*

425 I Street, NW • Suite 701 • Washington, DC 20001
(202) 220-3700 • www.medpac.gov



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Advisory Commission

425 I Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • www.medpac.gov

June 15, 2026

The Honorable JD Vance
President of the Senate
U.S. Capitol
Washington, DC 20510

The Honorable Mike Johnson
Speaker of the House
U.S. House of Representatives
U.S. Capitol
Washington, DC 20515

Dear Mister President and Mister Speaker:

I am pleased to submit the Medicare Payment Advisory Commission's June 2026 *Report to the Congress: Medicare and the Health Care Delivery System*. This report fulfills the Commission's legislative mandate to evaluate Medicare payment issues and report to the Congress. This report also satisfies the additional legislative mandate to report on the assessment of Medicare's Ground Ambulance Data Collection System.

The six chapters of the June 2026 report cover the following topics:

- Improving payment incentives in Medicare
- The complexity of Medicare enrollment decisions for beneficiaries
- Medicare payment operations and their role in identifying improper payments
- Estimated association between Medicare Advantage enrollment and hospitals' and post-acute care providers' finances
- Access to hospice and certain complex palliative services for beneficiaries with end-stage renal disease or cancer
- Mandated report: Assessment of the Medicare Ground Ambulance Data Collection System

I hope you find this report useful. As always, the Commission remains ready to assist the Congress and CMS as part of our mission to preserve beneficiaries' access to high-quality care, control Medicare spending growth, and provide sufficient payment for efficient providers.

Sincerely,

A handwritten signature in black ink, appearing to read "mchernew", with a long horizontal flourish extending to the right.

Michael E. Chernew, Ph.D.
Chair

Acknowledgments

This report was prepared with the assistance of many people. Their support was key as the Commission considered policy issues and worked toward consensus on its recommendations.

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Executive summary

Executive summary

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. ■

C H A P T E R

1

Improving payment incentives in Medicare

Improving payment incentives in Medicare

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).

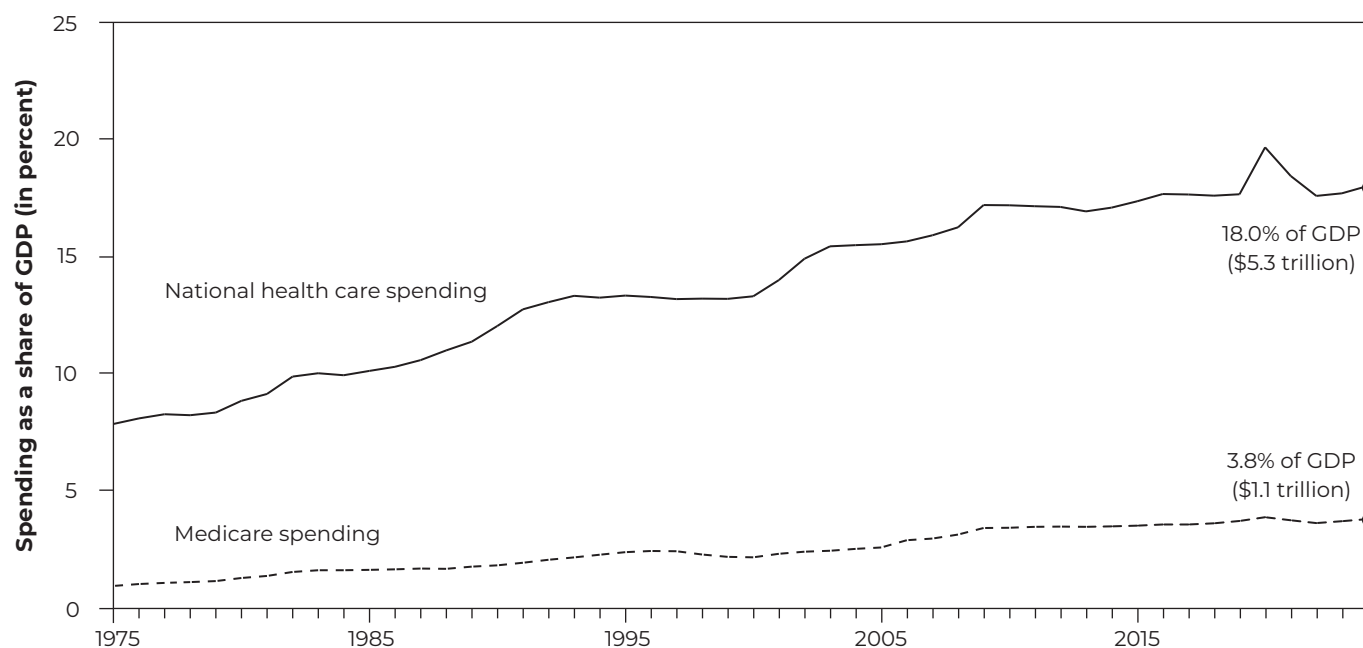
When developing recommendations, the Commission is guided by three principles:

- 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;

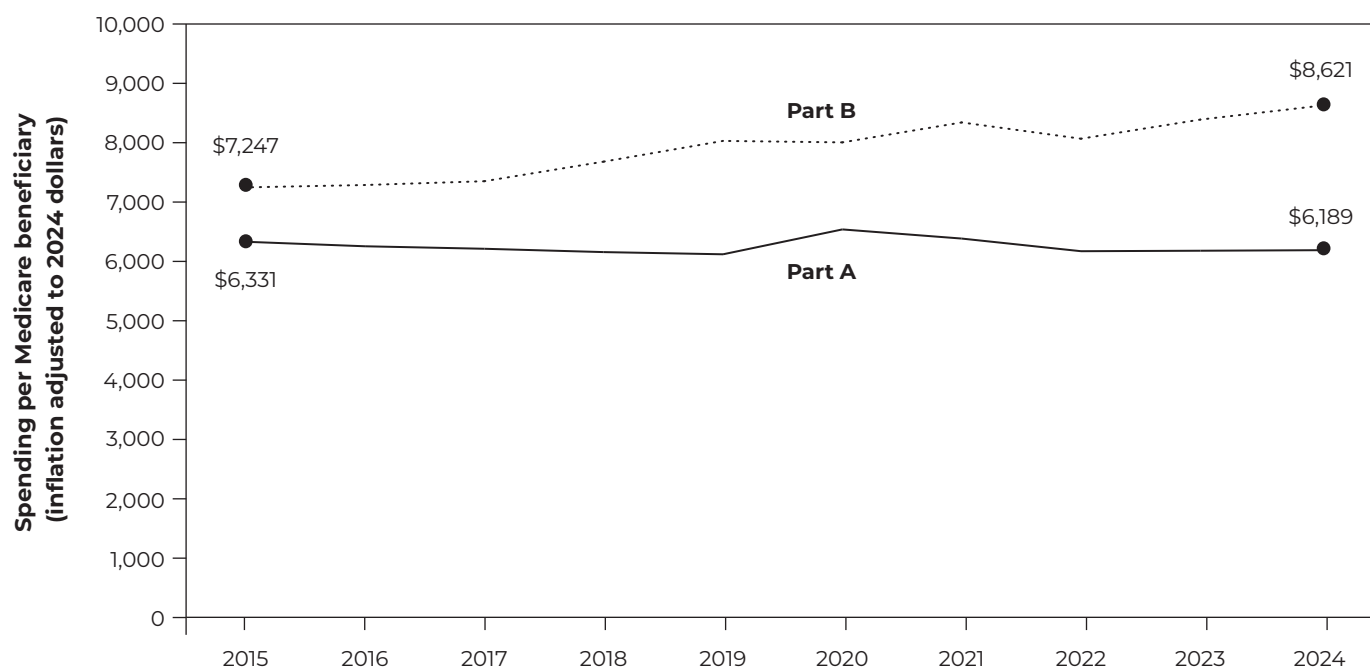
(2) the launch of new, higher-priced drugs; and (3) shifts in the mix of drugs (Medicare Payment Advisory Commission 2025a).² In general, Medicare pays for drugs in a very different way than it pays for other medical items and services.

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

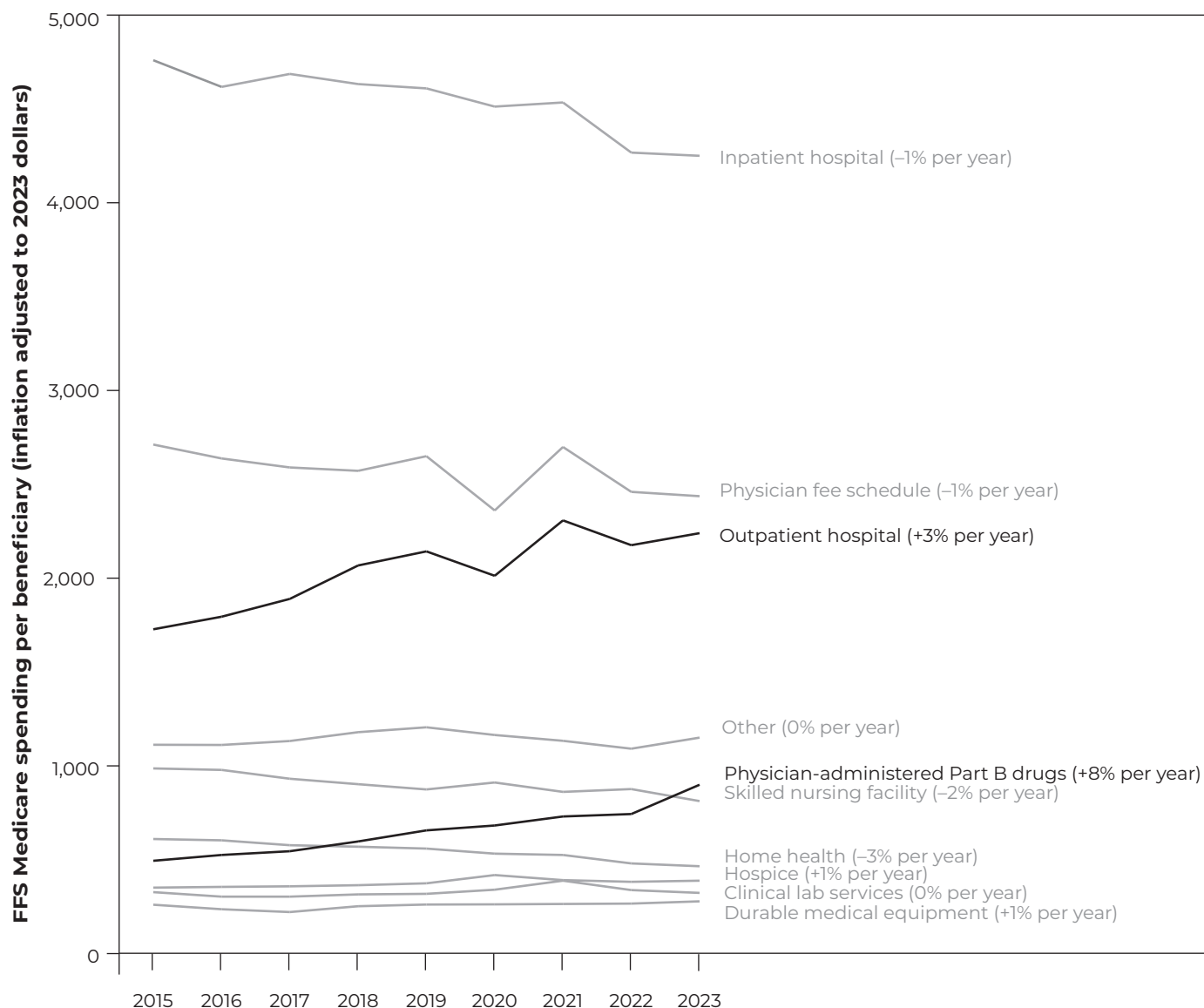
**FIGURE
1–2****Inflation-adjusted spending per beneficiary in FFS Medicare and MA grew faster for Part B than Part A, 2015–2024**

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).

Erratum: The printed version of the June 2026 report to the Congress contained an error in Figure 1-3. The "Inpatient hospital" and "Skilled nursing facility" lines were calculated incorrectly. The figure has been corrected in the online version of the report.

- **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).

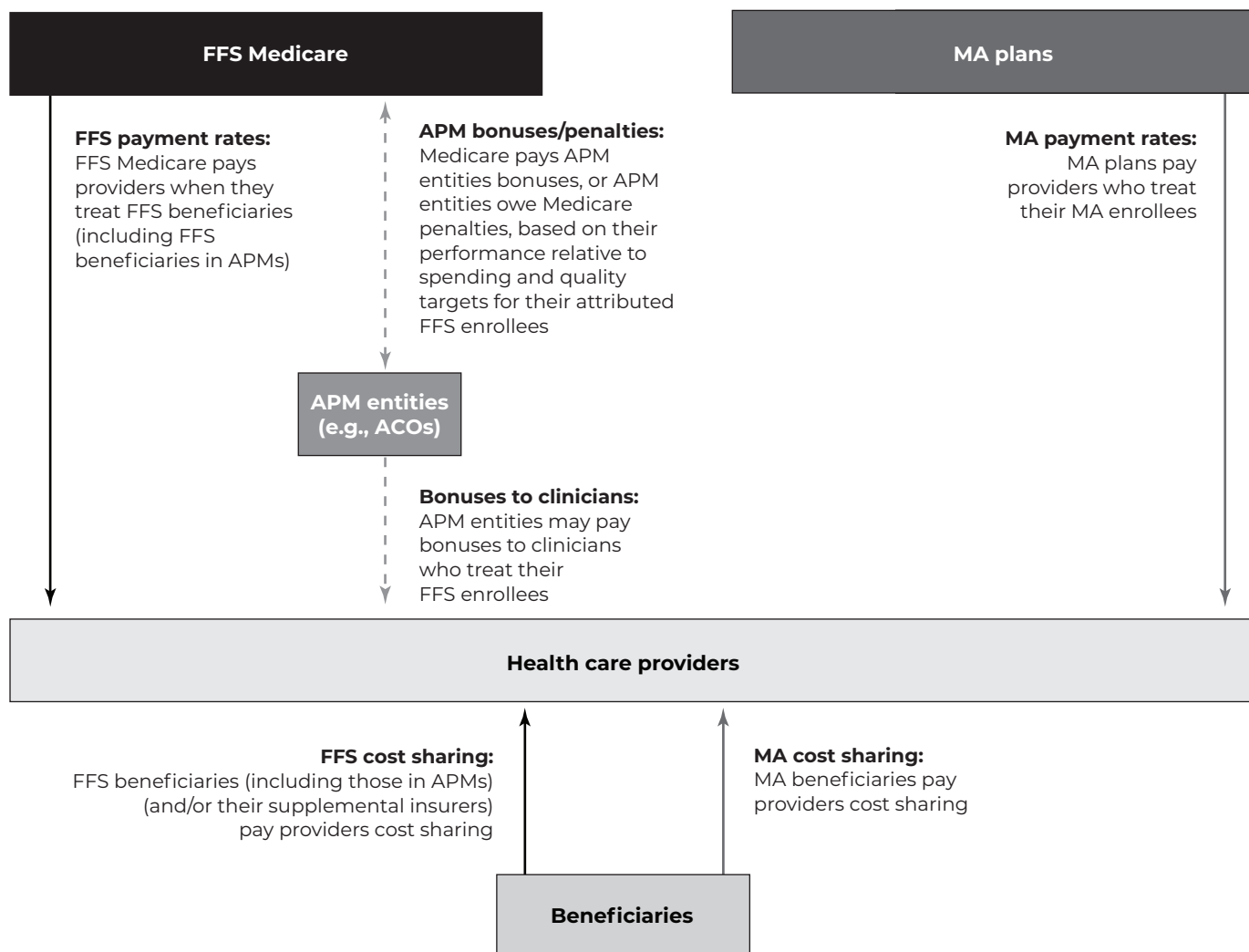
Basic design

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. ■

1-A

APPENDIX

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](https://www.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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C H A P T E R

2

**The complexity of
Medicare enrollment decisions
for beneficiaries**

The complexity of Medicare enrollment decisions for beneficiaries

Chapter summary

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. In our annual focus groups, beneficiaries often report confusion about enrolling in Medicare and their different coverage options. Some stakeholders have raised concerns that the growth in marketing by insurers and third-party marketing organizations has increased confusion for some beneficiaries. The complexity of the choices and numerous sources of information make it increasingly difficult for individuals to understand the requirements and relevant time frames so they can make the enrollment choice that is right for them. Some choices can have implications for as long as the individual has Medicare coverage. 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

In this chapter

- Medicare eligibility and enrollment options
- Complex enrollment environment with financial implications
- Factors affecting the choice to enroll in or switch between FFS Medicare and MA
- MA marketing may contribute to confusion
- Medicare information sources: CMS, SHIP, and insurance agents
- Appendix 2-A: Special enrollment periods and situations specific to Medigap
- Appendix 2-B: Beneficiaries' experiences assessing their coverage options, according to Medicare's annual survey

Security full retirement benefits generally began at age 65. However, as the age for full retirement benefits from Social Security has gradually increased, 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, prior to December 2021 when some individuals began receiving notice by email, they were not notified of their eligibility for coverage when they turned 65. Individuals who do not enroll in Medicare Part A (if applicable because they must pay a premium for Part A), Part B, or Part D during their initial enrollment period (i.e., the seven-month window around turning 65) will owe late-enrollment penalties, typically for the rest of their lives, after they eventually do enroll, unless certain circumstances (such as having delayed enrollment because they were covered by an employer's group health plan) make them eligible for a special enrollment period.

Once enrolled in Medicare, beneficiaries must choose between receiving benefits from the fee-for-service (FFS) Medicare program or from private plans through Medicare Advantage (MA). Beneficiaries who do not enroll in MA remain in FFS Medicare. Most MA plans include Part D prescription drug coverage, an out-of-pocket cap, and supplemental benefits including reduced cost sharing as part of their benefit package. Beneficiaries enrolling in FFS Medicare may select a stand-alone Part D plan for prescription drug coverage (known as a prescription drug plan, or PDP). Beneficiaries who enroll in FFS Medicare may also obtain secondary insurance through a retirement plan or, if eligible, through Medicaid; otherwise they may purchase a Medigap policy to protect themselves against cost-sharing liabilities (e.g., the 20 percent FFS coinsurance rate that applies to most Part B outpatient services). 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. Whether they opt for FFS Medicare with a Part D and a Medigap plan or MA, beneficiaries choose from a number of different plans. In 2026, beneficiaries with FFS Medicare can choose from 10 standardized Medigap plan types with numerous insurers offering each type and have an average of 11 PDPs from which to choose, each with differing premiums, formularies, and benefit structures. Beneficiaries who opt for MA in 2026 choose from an average of 39 plans (offered by an average of eight organizations) available in their area, with differing out-of-pocket costs, provider networks, and supplemental benefits.

Beneficiaries make enrollment and coverage decisions during different periods over their lifetime: the initial enrollment period, an MA initial coverage period, a Medigap enrollment period with federal guaranteed-issue rights, general enrollment period, annual enrollment period, the open enrollment period that applies to MA enrollees, and any special enrollment periods that may apply depending on the individual's circumstances. These enrollment periods can add to the complexity of a beneficiary's choices both because they occur at different times throughout the year and because the requirements for each period often differ by the part of Medicare. After their initial enrollment, beneficiaries selecting MA or Part D may join, switch, or drop their plans during certain times of the year unless a special enrollment period applies.

Beneficiaries in various focus groups and surveys conducted by MedPAC and other researchers report that they 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 such as prior authorization in exchange for lower premiums and a maximum out-of-pocket cap. 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 supplemental 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 help fill gaps in Medicare coverage and thus appeal to many beneficiaries. When making enrollment choices, 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 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. Some of those reasons could reflect changes in their personal circumstances or dissatisfaction with a current plan due to changes in their plan or plan performance. At the same time, Medicare has some features that make it harder for beneficiaries to switch MA plans or return to FFS Medicare, including limited enrollment periods, the out-of-pocket maximum resetting when switching MA plans during the year, a limited time period for

guaranteed issue of Medigap policies (depending on the beneficiary's state of residence), and lack of an out-of-pocket maximum in FFS Medicare. Many of those features, including limited enrollment periods, were designed to combat adverse selection both within MA and between MA and FFS (that is, to prevent beneficiaries from switching to certain types of coverage or plans when they have expensive health care needs).

To make Medicare enrollment decisions, beneficiaries rely on a variety of sources for information and advice, including:

- **CMS tools.** CMS has several tools that can be accessed by visiting Medicare.gov or calling the 1-800-MEDICARE help line. These tools are designed to provide free, accurate, and objective information to help navigate enrollment and coverage choices. Medicare.gov provides numerous 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, PDPs, and Medigap plans offered in their area. Beneficiaries can customize the results shown on Plan Finder in several ways (for example, they can use the tool to determine whether plans cover their prescription drugs, pharmacies, and clinicians), but the tool has some notable limitations (such as limited detail about MA supplemental benefits and Medigap premiums). In our analysis of Medicare Current Beneficiary Survey results, many respondents said they were satisfied with the availability of information about the Medicare program, and awareness of these CMS information sources was generally high.
- **The federally funded State Health Insurance Assistance Program (SHIP).** The SHIP is a federal program that provides grants to the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands to deliver objective Medicare counseling, information, and assistance at no cost to beneficiaries, and some grantees help enroll beneficiaries in Medicare plans. SHIP counselors can be especially helpful for 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 grantees depend on the availability of volunteer staff. In semistructured interviews with individuals involved with the SHIP, participants reported that SHIP counselors face capacity constraints as call volumes have risen and as the growing complexity of

Medicare enrollment decisions has led to longer counseling sessions that require special expertise. A Commonwealth Fund survey conducted in 2022 found that 4 percent of MA enrollees and 5 percent of FFS enrollees reported using the SHIP to guide their plan choice. Few beneficiaries in our annual focus groups were aware of their local SHIP grantee, but those who used it reported positive experiences.

- **Insurance agents.** Many beneficiaries rely on insurance agents to help navigate their Medicare options. (“Agents” and “brokers” are trained insurance professionals, and the terms are often used interchangeably; we use the term “agents” in this chapter.) Agents are 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 they are not required to contract with all available companies in their market. As a result, a single agent will not necessarily present every available plan to a beneficiary, something that may not be understood by the beneficiary even if agents disclose it in their communications. The ways in which agents are compensated for their services vary and can be complex. Commonly, agents contract with multiple insurance carriers that pay commissions tied to initial enrollment and retention of beneficiary enrollment 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 to determine the premiums and out-of-pocket costs of different plans. Beneficiaries described how their insurance agents tailored suggestions based on individual health needs, especially medication lists and clinician preferences. But some stakeholders have voiced concern that agents have financial incentives to steer beneficiary decision-making. These incentives could favor enrollment in MA plans over Medigap plans and PDPs, in higher-premium Medigap plans over lower-premium Medigap plans, and in plans that offer bonuses for reaching enrollment benchmarks.

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 such as an inability to obtain a Medigap policy on a guaranteed-issue basis when desired. There may be a need for additional updates to Plan Finder and greater support for the 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. ■

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. The complexity of the process makes it increasingly difficult for Medicare beneficiaries to understand the relevant requirements and time frames necessary to select the enrollment option that is right for them. Some enrollment decisions have lifelong implications; for example, failing to enroll in Medicare at the appropriate time can result in permanent late-enrollment penalties. Given both the complexity of these choices and the high stakes involved, access to clear and accurate information is especially important. Many beneficiaries report being satisfied with their information sources, though a substantial share say that it is difficult to understand their Medicare choices and to find good sources of information. Although beneficiaries have many potential sources of information, those sources, including advertising, can be overwhelming, influenced by financial incentives, or misleading.

In our annual focus groups, some beneficiaries have expressed confusion regarding enrolling in Medicare, including having insufficient information (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024).¹ These beneficiaries reported that they did not have a clear understanding of the different options for Medicare coverage as they approached enrollment, and some continued to express confusion about the different options. As one beneficiary said in 2024:

When I turned 65, I hadn't prepared myself to educate myself about these plans. As a matter of fact, I just went in thinking, Medicare, all this is going to be short. So . . . a Medicare agent came to my house and he kind of ran through it and I'm not comprehending all this stuff. He's just throwing all this information at you.

One beneficiary who was dually eligible for Medicare and Medicaid noted in 2025:

It was truly, truly confusing and I don't understand how people who are real seniors, and are beginning to lose touch . . . I don't understand how they do it because it's confusing for me, and I'm supposed to be relatively smart, I suppose.

Adding to the confusion regarding Medicare choices, many participants in our beneficiary focus groups described the amount of information they received about Medicare plans as overwhelming. These participants reported receiving “constant” phone calls and frequent mailings from insurance companies, especially during open enrollment. A beneficiary who eventually enrolled in a Medicare Advantage (MA) plan said, “Well, before turning 65, I was getting the mail. A little overwhelming at first. . . . So, I just signed up with that without, you know, thinking too much about it.” Other participants reported receiving many phone calls related to enrolling in Medicare plans, with one noting, “Why is it—it's like every day, somebody calling you about your insurance? I already did this for this year” and another estimating the number of calls: “I get five, six a day.”

Many beneficiaries described turning to formal resources for help making these decisions, including agents, plan representatives, health fairs, and Medicare.gov. Others described relying on guidance and recommendations from less formal sources, including family members and friends.

The experiences reported in our focus groups are consistent with other research. For example, in 2023, KFF also conducted focus groups with beneficiaries and reported that most participants found the process of selecting their coverage to be confusing, difficult, and overwhelming (Freed et al. 2023). A 2022 Commonwealth Fund survey found that more than half of beneficiaries used a variety of sources for information and advice on Medicare plan choice (e.g., insurance agents, Medicare.gov) (Leonard et al. 2022). Also, we examined results from the Medicare Current Beneficiary Survey (MCBS) and found that many respondents are generally satisfied with the information available to compare their insurance options; however, some beneficiaries also report that they do not have the information needed to make informed comparisons across coverage options (see Appendix 2-B, p. 86, on results from CMS's MCBS).

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 such as an inability to obtain

a Medigap policy on a guaranteed-issue basis when desired. There may be a need for additional updates to Plan Finder and greater support for the State Health Insurance Assistance Program (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.

In this chapter, we explain Medicare eligibility and enrollment options. We then discuss the complex beneficiary enrollment environment with financial implications, including the growing problem of beneficiary notification as the full retirement age for Social Security benefits has risen from age 65. Next, we review the factors that beneficiaries consider when choosing between fee-for-service (FFS) Medicare and MA, including feedback from beneficiary focus groups regarding how beneficiaries weigh these factors. We also discuss issues related to switching between MA, Part D, and Medigap plans. We then outline how marketing by MA plans and third-party marketing organizations may add to beneficiary confusion. Finally, we take a closer look at the information sources that beneficiaries use to make Medicare enrollment decisions, with a focus on CMS information sources, the SHIP, and insurance agents.

Medicare eligibility and enrollment options

Individuals are eligible for Medicare either because they have turned 65, they are disabled and have received Social Security disability insurance payments for two years, they have been diagnosed with end-stage renal disease (ESRD), or they have just begun to receive disability insurance payments and have a diagnosis of amyotrophic lateral sclerosis (ALS). In 2022, 88 percent of beneficiaries were eligible for Medicare because of their age, 11 percent because they were disabled, and 1 percent because of an ESRD diagnosis (Medicare Payment Advisory Commission 2025a).

Eligible individuals are entitled to Medicare Part A, which helps pay for inpatient hospital stays, post-acute care following those hospital stays, and hospice care. Part A is available to 99 percent of Medicare beneficiaries without a monthly premium because they

or their spouse or parent paid Medicare payroll taxes for at least 10 years (40 quarters) (Centers for Medicare & Medicaid Services 2025b).² Individuals entitled to Medicare Part A due to age, ESRD, or disability who do not meet the required years of payroll taxes must pay a monthly premium.³ In 2026, the full Medicare Part A premium is \$565 per month (Centers for Medicare & Medicaid Services 2025j).

Eligible individuals can also enroll in Medicare Part B, which helps pay for clinician and other outpatient services. For most beneficiaries (including those in an MA plan), the Part B premium is deducted from their monthly Social Security benefits.⁴ In 2026, the standard Part B premium is \$202.90 per month for beneficiaries with a modified adjusted gross annual income of up to \$109,000 (or \$218,000 for a married couple) (Centers for Medicare & Medicaid Services 2025b). Beneficiaries with higher incomes pay higher Part B premiums, known as the income-related monthly adjustment amount (IRMAA) (Table 2-1) (Centers for Medicare & Medicaid Services 2025b). The standard Part B premium amount is the same for individuals entitled to Medicare due to age, disability, or ESRD.⁵

Prescription drug coverage is available through Part D, either through stand-alone prescription drug plans (PDPs) or MA plans that include drug coverage. Part D enrollees with higher incomes are also required to pay higher premiums due to the Part D IRMAA, based on the same income thresholds used for Part B premiums. The average stand-alone PDP premium in 2026 was estimated at \$44 per month, while the average cost of the Part D portion of an MA premium was \$9 per month (Medicare Payment Advisory Commission 2026).

Once enrolled in Medicare, beneficiaries can choose to continue in FFS Medicare (Part A, Part B, and Part D) or enroll in MA plans (known as Part C, which bundles Part A, Part B, and usually Part D together). In addition to covering basic Part A and Part B services, MA plans may provide “supplemental” benefits to their enrollees, such as reduced cost sharing for Part A and Part B services, reduced Part B and Part D premiums, enhanced Part D benefits, and other benefits not covered under FFS Medicare such as dental, vision, or hearing services (Medicare Payment Advisory Commission 2025b). Beneficiaries who enroll in FFS Medicare may be eligible for Medicaid, purchase secondary insurance such as Medigap, or obtain

**TABLE
2-1**

Part B income-related monthly adjustment amounts, 2026

Beneficiaries who file individual tax returns with modified adjusted gross income of:	Beneficiaries who file joint tax returns with modified adjusted gross income of:	Income-related monthly adjustment amounts	Total monthly premium amounts
Less than or equal to \$109,000	Less than or equal to \$218,000	\$0.00	\$202.90
Greater than \$109,000 and less than or equal to \$137,000	Greater than \$218,000 and less than or equal to \$274,000	\$81.20	\$284.10
Greater than \$137,000 and less than or equal to \$171,000	Greater than \$274,000 and less than or equal to \$342,000	\$202.90	\$405.80
Greater than \$171,000 and less than or equal to \$205,000	Greater than \$342,000 and less than or equal to \$410,000	\$324.60	\$527.50
Greater than \$205,000 and less than \$500,000	Greater than \$410,000 and less than \$750,000	\$446.30	\$649.20
Greater than or equal to \$500,000	Greater than or equal to \$750,000	\$487.00	\$689.90

Note: The modified adjusted gross income is an individual's total (gross) income from all sources with certain adjustments from the most recent federal tax return, generally two years prior (Social Security Administration 2024a).

Source: Centers for Medicare & Medicaid Services 2025k.

employer- or union-sponsored insurance coverage that supplements the Medicare benefit package.

Beneficiaries who qualify for both Medicare and Medicaid are known as “dually eligible beneficiaries.” Medicaid is a joint federal and state program designed to help people with low incomes obtain the health care they need. For dually eligible beneficiaries, Medicare is the primary payer for acute and post-acute services and Medicaid provides varying levels of assistance with Medicare premiums and cost sharing. For many beneficiaries, Medicaid also covers services not included in the Medicare benefit, such as long-term services and supports (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2025). A total of 13.6 million individuals were dually eligible for Medicare and Medicaid benefits in at least one month of 2022 (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission

2025). Dually eligible beneficiaries are more likely than non-dually eligible beneficiaries to be enrolled in a Medicare managed care plan and less likely to have other secondary coverage, such as employer-sponsored coverage or Medigap (Medicare Payment Advisory Commission 2025a).

Under mandatory Medicaid eligibility pathways referred to as Medicare Savings Programs (MSPs), dually eligible beneficiaries qualify for assistance that is limited to payment of Medicare premiums and, in some cases, Medicare cost sharing. There are four MSPs with differing requirements: the Qualified Medicare Beneficiary Program, Specified Low-Income Medicare Beneficiary Program, Qualifying Individual Program, and Qualified Disabled and Working Individual Program. States have the authority to expand eligibility for MSP benefits by using less restrictive methodologies for counting income and assets. As of August 2025, 18 states and the District of Columbia

have expanded eligibility for MSPs (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2025).

Individuals may also qualify for Part D's low-income subsidy (LIS), also referred to as the Medicare Part D Extra Help program, which assists individuals with limited income and resources with payment for Part D premiums and cost sharing. Individuals receive the LIS automatically if they have full Medicaid coverage, have help from their state in paying their Part B premiums through an MSP, or are receiving Supplemental Security Income (SSI) payments from Social Security, while other individuals need to apply (Centers for Medicare & Medicaid Services 2025f). Individuals qualifying for the LIS will be automatically enrolled in a PDP if they do not have one already.

Seventeen states also have State Pharmaceutical Assistance Programs (SPAPs), which help pay prescription drug-related costs for certain populations with limited financial resources, including older adults (Centers for Medicare & Medicaid Services 2026b, McSpadden 2024). SPAPs typically pay for services that wrap around Part D coverage but vary by state. Individuals apply to their state to enroll in the MSPs and SPAPs.

Complex enrollment environment with financial implications

The Medicare eligibility notification process has been historically 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, as the age for full retirement benefits from Social Security has gradually increased, a growing number of individuals become eligible for Medicare before they begin to collect Social Security benefits. For these individuals, there is no automatic enrollment in Medicare and historically they were not notified of their eligibility for coverage when they turned 65. Individuals who do not enroll in Medicare Part A (if applicable because they must pay a premium for Part A), Part B, or Part D during their initial enrollment

period (IEP) (i.e., seven-month window around turning 65) will owe late-enrollment penalties, typically for the rest of their lives, after they eventually do enroll, unless certain circumstances (such as having delayed enrollment because they were covered by an employer's group health plan) make them eligible for a special enrollment period (SEP). After the IEP, beneficiaries may continue to face enrollment and coverage decisions during different periods over their lifetime, such as the MA initial coverage period; the Medigap enrollment period; general enrollment period (GEP); annual enrollment period (AEP); the open enrollment period (OEP) that applies to MA enrollees; and any SEPs that may apply depending on the individual's circumstances. These enrollment periods can add to the complexity of a beneficiary's choices both because they occur at different times throughout the year and because the requirements for each period often differ by the Medicare part. After their initial enrollment, beneficiaries selecting MA or Part D may join, switch, or drop their plans only during certain times of the year unless an SEP applies. Beneficiaries generally have few opportunities after their IEP to enroll in a Medigap plan without medical underwriting, meaning their initial decision of whether to enroll can have long-lasting implications.

A growing number of individuals need to take steps to enroll in Medicare

The Medicare automatic enrollment process has been historically tied to eligibility for Social Security.⁶ Individuals who are about to reach age 65 and receive Social Security benefits are notified of Medicare eligibility and automatically enrolled in Medicare Part A and Part B when they turn 65.⁷ Individuals who do not receive Social Security benefits at age 65 are not automatically enrolled in Medicare Part A and Part B and need to take steps to enroll, and historically, these individuals may not have been notified of the need to take action.

The Social Security Administration (SSA) is responsible for determining the Medicare eligibility of individuals and for notifying CMS of their enrollment. If individuals are receiving or have applied for Social Security benefits four months before they turn 65, the SSA will send their records to CMS four months before they turn 65. CMS notifies these individuals about their automatic enrollment in Part A and Part B and

sends the IEP package to the individual three months before the month the individual turns 65. This package includes the “Welcome to Medicare” letter, the *Welcome to Medicare* booklet that provides an overview of the Medicare program, the Medicare card, and a Part B refusal card and return envelope for those enrollees who do not wish to be enrolled in Part B (Social Security Administration 2024b). In a separate mailing, CMS also sends the *Medicare & You* handbook to these individuals. Only individuals who receive or have applied for Social Security benefits four months before turning 65 are automatically enrolled in Medicare when they first become eligible.

The Social Security Amendments of 1983 gradually raised the full retirement age for Social Security benefits, also known as the Old-Age, Survivors, and Disability Insurance (OASDI) Program, from 65 to 67. The age for full retirement benefits for individuals born in 1960 or later is 67, although individuals can retire early and collect reduced Social Security benefits beginning at age 62. Individuals receiving Social Security benefits four months before turning 65 will be notified of their Medicare eligibility and automatically enrolled in Medicare at age 65.

Historically, most individuals were receiving full retirement benefits from Social Security at age 65, which is the same age for Medicare eligibility, so the majority of eligible individuals were notified of Medicare eligibility and automatically enrolled. However, the share of 65-year-olds receiving Social Security has decreased over the last few decades, falling from 92 percent in 2002 to 60 percent in 2016 (Medicare Payment Advisory Commission 2019). The increase in the age for full Social Security benefits means that Medicare-eligible individuals not receiving Social Security benefits four months before turning 65 are not automatically enrolled in Medicare at age 65. This situation was not a problem historically because the eligibility age for the two programs was aligned. As the age of eligibility for full Social Security benefits has risen, many people are still working at age 65 and are delaying Social Security.

Individuals who are not automatically enrolled in Medicare at age 65 must take active steps to enroll. These individuals may use one of the following methods to enroll: apply on the SSA website, complete a form and mail or fax the form to the local Social

Security office, call the SSA to set up an appointment, or visit the local Social Security office (Centers for Medicare & Medicaid Services 2025o). Of the approximately 3.6 million individuals who turned 65 in 2012 (as projected by the Census Bureau), based on previous analysis, we estimate that 30 percent, or 1.1 million, were not receiving Social Security benefits and may not have been notified of the need to enroll in Medicare (Medicare Payment Advisory Commission 2019, Census Bureau 2012).

In December 2021, the SSA and CMS began collaborating on an outreach campaign to send emails to individuals approaching age 65 who are not yet receiving Social Security benefits to remind them of the need to enroll in Medicare. Originally the campaign was limited to individuals who had established an online “my Social Security account” with the SSA, but the campaign has since been broadened to include any individuals who have provided an email address to the SSA. Individuals who have an email address on file with the SSA and are approaching 65 years old receive monthly email reminders about the need to enroll in Medicare on time and avoid penalties.⁸

The disconnect between the applicable age for Medicare eligibility and the full retirement age for Social Security means that an increasing number of Medicare-eligible individuals will not be automatically enrolled in Medicare and may be unaware of their eligibility status because they did not take action to enroll. Some individuals who registered an email address with the SSA may not receive or see an email regarding the need to enroll. These individuals could be at risk for gaps in coverage and late-enrollment penalties that may be imposed for the rest of their lives.

In addition, some individuals find it confusing that they must enroll in Medicare through the SSA but that once they have enrolled, the relevant federal agency to contact is CMS. Individuals will also interact with private-insurance companies if they select Medicare Advantage, Part D, or Medigap, potentially leading to further confusion.

Multiple enrollment periods and potential late-enrollment penalties

Once an individual becomes eligible for Medicare, they must make many complex enrollment decisions

that may affect coverage and cost for the rest of their lives. Generally, individuals who do not enroll in Part B or Part D during their IEP will owe late-enrollment penalties if they eventually do enroll and are ineligible for a SEP. Beneficiaries selecting MA may join, switch, or drop their MA plan only during certain times of the year unless an SEP applies.

Beneficiaries generally have few opportunities, after their IEP, to enroll in a Medigap plan without medical underwriting, meaning their initial decision of whether to enroll can have long-lasting implications. There are guaranteed-issue protections during a one-time six-month Medigap enrollment period that begins when a person is 65 or older and newly enrolled in Medicare Part B, as well as during periods precipitated by certain events, including periods that may vary by state. Outside of these periods, a Medigap policy may not be available to purchase due to medical underwriting in states without additional guaranteed-issue protections.

In our June 2019 report to the Congress, we examined a cohort of 2.9 million beneficiaries we followed who turned 65 in 2012 and were enrolled in Medicare Part A and/or Part B sometime between 2012 and 2017 (Medicare Payment Advisory Commission 2019). By 2017, about 40,000 beneficiaries—roughly 1.5 percent of the 2012 cohort—were paying Part B late-enrollment penalties. We found that about 20 percent of those paying penalties in 2017 also delayed enrolling in Part A and may not have been notified of the potential penalties for delaying Part B when they turned 65 (Medicare Payment Advisory Commission 2019).

Enrollment periods

Beneficiaries make many complex enrollment decisions during different periods over their lifetime, both when they are first eligible for Medicare and later when they can change aspects of their coverage. The following enrollment periods are available to beneficiaries:

- the IEP for Part A, Part B, and Part D, the seven-month window around turning 65;
- an initial coverage period for MA (known as the initial coverage election period) once an individual enrolls in Part A and Part B;
- a GEP for Part A and Part B;

- the AEP for MA and Part D;
- the MA open enrollment period, an annual period for people already enrolled in MA to switch;
- a Medigap enrollment period when federal guaranteed-issue rights are available; and
- any SEPs or guaranteed-issue rights that may apply depending on the individual's circumstances.

These enrollment periods can add to the complexity of a beneficiary's choices because they occur at different times throughout the year and may depend on the beneficiary's circumstances.

Enrollment periods when an individual first becomes eligible for Medicare When an individual first becomes eligible for Medicare, they have different periods in which they can enroll in Part A, Part B, and Part D, select MA coverage, and purchase a Medigap policy with guaranteed issue (Table 2-2).

Initial enrollment period When aged individuals are first eligible for Medicare, they have a seven-month IEP to sign up for Part A, Part B, and Part D. The seven-month IEP begins three months before the month an individual turns 65, includes the month they turn 65, and ends three months after the month they turn 65. For aged individuals who enroll before the month they turn 65, Part A and Part B coverage begins the month when the individual turns 65. For aged individuals who enroll the month they turn 65 or during the six months after, Part A coverage will begin at age 65 and Part B coverage will begin the month after enrollment. Aged individuals who do not have to pay a premium for Part A and who miss the IEP may sign up for Part A anytime after they turn 65, and the Part A coverage starts six months before Part A enrollment or when they apply for benefits from Social Security (Centers for Medicare & Medicaid Services 2024f). For individuals who must pay a premium for Part A, coverage begins the next month after enrollment. Generally, Part D coverage is effective the first of the month following the plan's receipt of the enrollment request, assuming the individual is enrolled in Part A and/or Part B.

After the IEP, beneficiaries face penalties for late enrollment unless an SEP applies. Beneficiaries will pay a Part B late-enrollment penalty for each full 12-month period during which the individual could have been

**TABLE
2-2**

Medicare initial enrollment periods when turning 65

Enrollment period	Description	Length of time
Initial	First period for beneficiary to enroll in Part A, Part B, and Part D	7-month window around turning 65 (3 months before birth month, birth month, and 3 months following the birth month) or, for Part D, the 7-month window around initial Part A and/or Part B enrollment
MA initial coverage	First period to enroll in MA after initial Part A and Part B enrollment	Concurrent with the IEP unless the individual does not enroll in Part B during the IEP, then the 3-month period before enrolling in Part A and Part B for the first time through the 2-month period after eligibility for MA or the end of the IEP, whichever is later
Medigap	First period to purchase a Medigap policy with guaranteed issue	6-month window beginning after the individual is 65 and is also enrolled in Part B

Note: MA (Medicare Advantage), IEP (initial enrollment period). This table does not include relevant time frames that may apply for individuals with end-stage renal disease or disabilities.

Source: Centers for Medicare & Medicaid Services 2024e, Centers for Medicare & Medicaid Services 2024f.

enrolled in Part B (not including the IEP).⁹ Beneficiaries will pay a Part D late-enrollment penalty if they go without Part D or other creditable prescription drug coverage for any period of 63 or more days in a row during which the individual could have been enrolled in Part D (not including the IEP). Creditable prescription drug coverage is coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage (Centers for Medicare & Medicaid Services 2025q).

For example, an individual born on June 10, 1955, turned 65 on June 10, 2020, when the full retirement age is 66 years and two months. Assuming this individual does not receive Social Security benefits before the full retirement age, they will not be automatically enrolled and will need to initiate enrollment on their own. In this example, the individual does not have to pay a premium for Part A. Their IEP begins in March 2020 (three months before their birthday) and concludes at the end of September (three months after their birth month). If this individual enrolls in Part A and Part B and requests to enroll in a PDP in April 2020, then

Part A, Part B, and Part D coverage will begin in June 2020. If the individual enrolls in Part A and Part B and requests to enroll in a PDP on August 14, 2020, then the individual's Part A coverage will begin in June 2020, and the Part B and Part D coverage will begin in September 2020. This individual would not be subject to late-enrollment penalties.

Individuals entitled to Social Security benefits based on disability are automatically enrolled in Part A and Part B after receiving disability benefits for 24 months, except those with ALS, who are entitled to Part A and Part B the first month they are entitled to disability benefits and are automatically enrolled then.

Individuals entitled to Part A and Part B based on ESRD begin their Medicare coverage at different times, depending on whether the individual is on dialysis or getting a kidney transplant. If the individual is on dialysis, Medicare coverage usually starts on the first day of the fourth month of a regular course of dialysis (after a three-month waiting period) or the first month a regular course of dialysis begins if the individual engages in home dialysis training, the doctor

expects the individual to finish training and do dialysis treatments at home, and the individual maintains a regular course of dialysis (Centers for Medicare & Medicaid Services 2025e). In addition, if an individual has employer or union group health coverage and becomes eligible for Medicare because of permanent kidney failure, there is a coordination period of 30 months in which the employer or union coverage pays first and Medicare pays second (Centers for Medicare & Medicaid Services 2025e). If the individual is getting a kidney transplant, Medicare coverage can begin the month of kidney transplant or two months before the month of transplant if the individual was hospitalized during those months in preparation for the transplant (Centers for Medicare & Medicaid Services 2025e).

Beneficiaries who qualify for Medicaid or the MSPs or who are eligible for Medicare due to ESRD do not pay the Part A (applicable only to those paying a premium for Part A) or Part B late-enrollment penalties.¹⁰

Previously, individuals may have enrolled in a high-deductible health plan along with a health savings account (HSA), which is a tax-advantaged account that is used to pay for certain medical expenses not covered by insurance, such as deductibles and coinsurance (Congressional Research Service 2020). Once enrolled in Medicare, individuals can no longer contribute to an HSA, and any contributions made after Medicare enrollment are known as excess contributions and subject to a tax penalty (Internal Revenue Service 2025). Individuals can withdraw the excess contribution before their tax filing date for the year the contributions were made. Some individuals contributing to an HSA may not realize that when they enroll in Medicare Part A, the enrollment will be retroactive to the previous six months (or to the age of 65, whichever is shorter). If these individuals do not stop their HSA contributions before Medicare enrollment or withdraw their excess contributions by the applicable tax filing date, they will be subject to tax penalties.

MA initial coverage period for people who have just enrolled in both Part A and Part B Beneficiaries are eligible to enroll in an MA plan after having initially enrolled in both Part A and Part B. For beneficiaries who enrolled in Part A during their IEP but not Part B, there is an initial coverage period for MA enrollment for beneficiaries newly enrolled in Part B that begins three months before the beneficiary first has both

Part A and Part B and ends two months after the beneficiary first has both Part A and Part B or the last day of the Part B IEP, whichever is later. During this period, beneficiaries can enroll in an MA plan with or without drug coverage. Beneficiaries who desire MA coverage but missed their IEP to enroll in Part A and Part B or missed the MA initial coverage period after first enrolling in Part A and Part B, and are ineligible for an SEP, must generally wait for the AEP described below (October 15 through December 7) to enroll in MA, effective January 1. Individuals enrolling in a Medicare Advantage Prescription Drug plan (MA-PD) plan after going 63 days without Part D or creditable coverage may pay a late-enrollment penalty for Part D.

Individuals paying a late-enrollment penalty for Part B or Part D (or Part A if they are paying a premium for Part A) must continue to pay those late-enrollment penalties after they enroll in MA, as applicable. There are no MA late-enrollment penalties, so individuals enrolling in MA at any time after they were first eligible to enroll do not pay any additional penalties, beyond any late Part B or Part D (or Part A if they are paying a premium for Part A) enrollment penalties.

Part D initial coverage period for people who have just enrolled in either Part A or Part B A beneficiary must enroll in either Part A or Part B to be eligible to join a PDP. If the beneficiary does not enroll in a PDP during the seven months around turning 65, the individual may enroll in a PDP during the seven-month period around when the individual became eligible to enroll in a PDP because the individual enrolled in Part A and/or Part B. If the beneficiary remains in FFS Medicare and misses the IEP and is ineligible to enroll during an SEP, the beneficiary may next enroll during the AEP described below (October 15 through December 7). Beneficiaries who enroll in Part D 63 days or more after their IEP and do not have creditable coverage face late-enrollment penalties and a gap in coverage. Beneficiaries who qualify for the LIS do not pay the Part D late-enrollment penalty.

For example, an individual turning 65 on June 10, 2020, who was not notified of Medicare eligibility or automatically enrolled, learns that they are entitled to Part A after the IEP (March 2020 through the end of September 2020) has concluded. This individual enrolls in Part A in May 2022. They do not pay a premium for Part A and choose not to enroll in Part B or Part D at the same time because of the premiums. In October 2022,

they decide that they would like to enroll in a combined MA and prescription drug plan. However, they have not yet enrolled in Part B, which is required before MA enrollment. Unless an SEP applies, this individual will have to wait until the next GEP (January 1, 2023, through March 31, 2023) to enroll in Part B and will be subject to Part B late-enrollment penalties. If this individual enrolls in Part B in February 2023, Part B coverage starts on March 1, 2023. The MA initial coverage period after the individual first has Part A and Part B coverage begins in December 2022 and ends in April 2023. If this individual requests MA enrollment on March 15, 2023, MA coverage begins on April 1, 2023. If the individual, after starting Part B coverage on March 1, 2023, decides not to enroll in MA before April 30, 2023 (including a combined MA and prescription drug plan), and stays in FFS Medicare instead, the individual will have to wait until the AEP described below (October 15 through December 7, 2023) to enroll in a PDP for coverage effective on January 1, 2024, unless an SEP applies. This outcome results from missing the Part D initial coverage period after becoming eligible for Part D when they first obtained Part A in May 2022. In addition to Part B late-enrollment penalties, this individual will be subject to Part D late-enrollment penalties.

Medigap enrollment Individuals in FFS Medicare seeking insurance to cover any cost sharing may choose to enroll in Medigap. Federal law allows Medigap enrollment with guaranteed-issue protections during a one-time six-month Medigap enrollment period that begins with the first day of the first month on which an individual is 65 or older and is also enrolled in Medicare Part B. Generally, during the Medigap enrollment period, a beneficiary may buy any Medigap policy sold in the beneficiary's state from any insurer that is licensed in that state to sell one without medical underwriting (known as "guaranteed issue").

After Medigap enrollment, an insurer cannot make beneficiaries wait for coverage to start, except for coverage related to a preexisting condition. In some cases, the insurer can delay coverage of out-of-pocket costs for preexisting conditions for up to six months, called a "preexisting-condition waiting period." After six months, the Medigap policy will cover the out-of-pocket costs for services related to the beneficiary's preexisting condition. However, if a beneficiary is buying a Medigap policy to replace certain kinds

of health coverage that Medigap deems "creditable coverage," such as employer-sponsored insurance or a commercial plan, the beneficiary can avoid or shorten the preexisting-condition waiting period.

State law determines whether insurers must offer Medigap policies to individuals under age 65. Thirty-six states require insurers to offer at least one kind of Medigap policy without medical underwriting to Medicare beneficiaries under age 65 with disabilities during a Medigap enrollment period (CSG Actuarial 2025). Seven states (Hawaii, Kansas, New Jersey, Oklahoma, Oregon, Pennsylvania, Virginia) offer eligibility for at least one plan for beneficiaries under age 65 when they are first eligible for Part B, at the same Medigap premium as for beneficiaries ages 65 and older (CSG Actuarial 2025). Individuals under age 65 with disabilities will have guaranteed-issue rights when they turn 65 and may obtain a new Medigap policy at that time with a premium set at the state's rate for 65-year-olds.

Enrollment periods when Medicare beneficiaries can change their coverage There are periods of time throughout the year when beneficiaries can change some of their coverage: the GEP for Part A and Part B; the AEP for MA and Part D; the OEP for enrollees in MA; and the SEPs for Part A, Part B, Part D, and MA, and Medigap guaranteed-issue rights (Figure 2-1, p. 52).

Annual enrollment period for Medicare Advantage and prescription drug plans Each year during the AEP, which occurs from October 15 through December 7, all individuals enrolled in Part A and/or Part B may join or switch MA plans or PDPs or return to FFS Medicare. (Beneficiaries face some issues related to switching between MA and FFS, which are discussed later in the chapter.) Individuals may change their minds and switch plans multiple times during the AEP. The last selection made during the AEP is effective. This new coverage begins January 1 of the following year.

The Social Security Act requires the Part B premium for the following year to be announced in September; occasionally, however, the premium amount is announced in November, which leaves less time for beneficiaries to review their budget and plan options. MA plans or PDPs can make changes to their plans each year, such as changes to their cost-sharing amounts or to which providers and pharmacies are in their

**FIGURE
2-1**

Enrollment periods when Medicare beneficiaries can change their coverage

Enrollment period	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
Annual Annual period for all enrollees to join, switch, or drop MA or Part D plans										Oct. 15–Dec. 7		
General After missing the IEP, the next period to enroll in Part A and Part B	Jan. 1–Mar. 31											
MA Open Annual period for MA enrollees to switch or drop MA plans	Jan. 1–Mar. 31											
Special All programs have federal SEPs, and Medigap may have additional state enrollment periods	Varies depending on the individuals' circumstances											

Note: MA (Medicare Advantage), IEP (initial enrollment period), SEP (special enrollment period). The annual enrollment period is also commonly referred to as the "open enrollment period." This figure does not include relevant time frames that may apply for individuals with end-stage renal disease or disabilities.

Source: Centers for Medicare & Medicaid Services 2024f.

networks. Individuals currently enrolled in plans should review the materials their plans send them, like the "Evidence of Coverage" and "Annual Notice of Change" documents as well as the "Summary of Benefits" document. If their plans are changing, individuals should make sure their plans will still meet their needs for the following year. Those beneficiaries who are satisfied with their current plan do not need to do anything during the AEP to remain in their current plan.

General enrollment period for people who did not enroll in Part B (or Part A if they must pay a premium) during their IEP Individuals who are not automatically enrolled or did not enroll in Part A during their IEP can enroll in Part A at any time after they are first eligible for coverage if they do not have to pay a premium for Part A. Aged individuals who did not enroll in Part B (or

Part A if they must pay a premium for Part A) during their IEP and are not eligible for an SEP can enroll in Part A and/or Part B between January 1 and March 31, known as the GEP. Coverage for individuals enrolling during the GEP begins the first day of the month following the month of enrollment. These individuals may face lifelong Part B late-enrollment penalties for not enrolling when they were first eligible and may experience a gap in their coverage. Beneficiaries who qualify for Medicaid or the MSPs or are eligible for Medicare due to ESRD do not pay the Part A premium (if applicable) or Part B premium or penalties.

Open enrollment period for people enrolled in Medicare Advantage Individuals enrolled in an MA plan may switch their plan or return to FFS Medicare and join a PDP during the OEP, which occurs from January 1

**TABLE
2-3**

Medicare's late-enrollment penalties vary in amount and duration, 2026

Part of the Medicare program	Penalty description	Penalty amount per month after delayed enrollment for 12 months	Duration
Part A	10% of Part A premium (up to \$565 per month depending on the number of work credits)	\$56.50	Twice the number of uncovered years
Part B	10% of Part B premium (\$202.90 per month) for each full 12-month period of delayed enrollment	\$20.30	As long as the individual retains Part B coverage
Part C	See Part B and Part D (and Part A if paying a premium for Part A)*	See Part B and Part D (and Part A if paying a premium for Part A)*	See Part B and Part D (and Part A if paying a premium for Part A)*
Part D	1% of Part D national base beneficiary premium (\$38.99 per month) for each uncovered month	\$4.70	As long as the individual retains Part D coverage

Note: * Beneficiaries enrolled in a Medicare Advantage plan (Part C) continue to pay Part B and Part D (and Part A if paying a premium for Part A) premiums and any late-enrollment penalties associated with them. Penalties associated with late enrollment in Part A are not common because 99 percent of Medicare enrollees are eligible for premium-free Part A and face no late-enrollment penalties. The monthly penalty is always rounded to the nearest \$0.10. This table shows the amount of the penalty in 2026, but the amount of the penalty will increase each year as the premium increases.

Source: Centers for Medicare & Medicaid Services 2025a, Centers for Medicare & Medicaid Services 2025b.

through March 31 of each year. This coverage is effective the first of the month after the plan receives the request to enroll. This period is an opportunity for individuals enrolled in an MA plan who wish to change plans or return to FFS Medicare. Any individual enrolled in an MA plan, whether they recently enrolled during the previous AEP or have been enrolled in the plan for a long time, may use this period. Individuals may switch plans or return to FFS Medicare only one time during this period.

Special enrollment periods and situations specific to Medigap There are a variety of Medicare SEPs, which apply in certain situations when an individual may need to enroll or change their enrollment due to circumstances often beyond their control. Each SEP has detailed requirements that must be met to qualify. However, not every circumstance that may affect insurance coverage has an SEP. Circumstances that often qualify for an SEP include a coverage gain or

loss, an error made by a party advising the individual, changes in the individual's location, certain changes made to the MA or PDP plan, or other exceptional circumstances. We discuss three common situations in Appendix 2-A (p. 81): no longer being covered by an employer's group health plan, trial rights, and a significant change in a plan's provider network, as well as issues specific to Medigap.

Late-enrollment penalties

Late-enrollment penalties are different for Medicare Part A, Part B, and Part D (Table 2-3). Late-enrollment penalties only apply to Part A if an individual must pay a premium. Most individuals do not pay a premium for Part A and would not be subject to a late-enrollment penalty.

If an individual has to pay a premium for Part A but did not enroll in Part A when first eligible during their IEP, they may have to pay a higher monthly premium

if they decide to enroll later. The monthly premium for Part A may increase up to 10 percent. The individual will have to pay the higher premium for twice the number of years that the individual could have had Part A but did not enroll. SEPs may apply depending on the circumstances.

If an individual did not sign up for Part B when first eligible, the individual may have to pay a late-enrollment penalty for as long as the individual has Medicare. The individual's monthly premium for Part B will go up 10 percent for each full 12-month period that the individual could have had Part B but did not enroll. Penalties accrue only after a full 12-month window in which the individual was eligible but did not enroll. SEPs may apply depending on the circumstances. Beneficiaries who qualify for Medicaid or the MSPs or are eligible for Medicare due to ESRD do not pay the Part B penalty.

Beneficiaries can enroll in an MA plan after having enrolled in both Part A and Part B without incurring an additional late-enrollment penalty for delayed MA enrollment. However, individuals facing a Part B or Part D (or Part A if applicable) late-enrollment penalty must continue to pay those penalties after enrolling in an MA plan, as applicable.

A person may owe a late-enrollment penalty if, after their IEP (when they first enroll in Medicare Part A and/or Part B), they go without Part D or other creditable prescription drug coverage for any period of 63 or more days in a row. The penalty is calculated by multiplying 1 percent of the national base beneficiary premium (\$38.99 in 2026) by the number of full, uncovered months that the person did not have Part D or creditable coverage.¹¹ The monthly penalty is added to the monthly Part D premium. SEPs may apply depending on the circumstances. Beneficiaries who qualify for Part D's LIS do not pay the Part D penalty.

For those individuals who must pay a Part A premium, the penalty applies for only twice the number of uncovered years. In contrast, the Part B and Part D penalties are incurred for as long as the beneficiary maintains Medicare coverage (with certain exceptions described previously). In general, relatively few beneficiaries face late-enrollment penalties. In 2021, roughly 0.05 percent of Part A enrollees (30,000 people), 1.3 percent of Part B enrollees (779,000 people),

and 5 percent of Part D enrollees (2.5 million people) paid a penalty (Komisar and Lind 2024).

In 2021, for Part B enrollees, the average late-enrollment penalty equaled 27 percent of the standard premium (Congressional Research Service 2022). Assuming the average Part B penalty is also 27 percent in 2026, we estimate that the average Part B penalty this year is about \$55 per month. As for Part D, using Medicare enrollment data, we found that the average late-enrollment penalty in that program has grown over time, from 27 percent of the base beneficiary premium in 2014 to 36 percent in 2024. Assuming some continued growth, we estimate that the average Part D penalty in 2026 equals 37 percent of the base premium, or roughly \$14 per month.

Factors affecting the choice to enroll in or switch between FFS Medicare and MA

After a beneficiary has enrolled in Medicare, they must choose between receiving benefits from the FFS Medicare program or from private plans through the MA program. Within the FFS and MA coverage options, beneficiaries face additional decisions. Beneficiaries who enroll in FFS Medicare often buy Medigap insurance to protect themselves against cost-sharing liabilities. Beneficiaries selecting Medigap choose from 10 standardized Medigap plan types, and there are numerous insurers offering each plan type (see text box, pp. 56–57, on Medigap policies) (Centers for Medicare & Medicaid Services 2025d). Beneficiaries enrolling in FFS Medicare may also select a stand-alone PDP for prescription drug coverage. Beneficiaries choose from an average of 11 PDPs in their region with differing formularies and benefit structures (Medicare Payment Advisory Commission 2026). Within MA, beneficiaries choose from an average of 39 plans (offered by an average of eight insurers) available in their area. Beneficiaries mainly choose from health maintenance organizations (HMOs) or preferred provider organizations (PPOs), which can have differing cost-sharing and provider-network requirements (Medicare Payment Advisory Commission 2025c).¹² Most MA plans offer Part D and some supplemental benefits.

About 90 percent of people under the age of 65 have health care coverage either through employer-sponsored insurance, individual insurance, or Medicaid (Tolbert et al. 2026). Thus, beneficiaries may have some familiarity and experience with health insurance and utilization management, such as prior authorizations, when they enter the Medicare program. Even with this experience, selecting Medicare coverage and plans may be difficult because of differences in the financial protections, access, and extra benefits offered. As discussed below, researchers have found that individuals have more difficulty selecting coverage options when they have many choices.

Beneficiaries consider various factors when making a choice to enroll in or switch between FFS Medicare and MA, and when choosing among the plans within those options, including financial protection, access to care and specific providers, and extra benefits. Beneficiaries weigh these factors, considering their current health needs as well as future health needs that may not be evident at initial enrollment. There may also be financial implications, beyond the enrollment penalties described above, that can make it difficult for a beneficiary to switch from one MA plan to another or from MA to FFS Medicare.

Research on consumer decision-making has found that individuals have difficulty making optimal decisions about health coverage when they have many choices

Researchers have found that individuals have more difficulty selecting a health plan when they have many choices. Studies included in a review of the literature on consumer decision-making for health plans have found that, as the number of choices increases, individuals are less likely to correctly identify the lowest-cost plan, less likely to review all of their coverage options, and more likely to select a plan that is clearly inferior to another available plan (Taylor et al. 2016).¹³ Many of those studies found that individuals had difficulties when the number of choices increased. The same literature review found that many people have difficulty understanding concepts such as coinsurance and deductibles, tend to put more emphasis on premiums over cost sharing when picking plans, and are influenced by how plan choices are presented.

Studies have also found that people are prone to status quo bias, in that they remain enrolled in initial plan

choices even if prices change or if new, potentially better choices become available. One study found that, because of the difficulty associated with selecting a plan, beneficiaries feel little incentive to reevaluate their plan choice after achieving general satisfaction with their plan (Stults et al. 2018). Another study that analyzed MCBS and CMS Medicare Compare data found that MA beneficiaries have a strong preference for remaining with the same MA plan over time (Atherly et al. 2020). The same study also found that, when individuals did switch MA plans, they were more likely to switch between plans offered by the same insurer rather than switch between insurers.

One study that compared growth in MA enrollment with growth in the number of MA plans found that enrollment grew faster in areas where the increase in the number of plans was relatively small (fewer than 15 plans), suggesting that beneficiaries were more likely to enroll when they had a more manageable number of choices (McWilliams et al. 2011). The same study also found that beneficiaries with some degree of cognitive impairment did a poorer job of selecting plans that would minimize their out-of-pocket costs.

Since the literature described above was published, there has been an increase in the development and use of artificial intelligence (AI) and machine-learning technologies to support people's insurance-choice decisions. Researchers are beginning to study how AI-based decision support tools could affect plan choice. For example, one study found that when an AI-based machine-learning decision support tool was used by skilled agents in a private retiree Medicare insurance exchange selling MA plans, consumer costs went down on average (i.e., annual premium and predicted out-of-pocket costs) and heterogeneity across agents' performance was reduced (Gruber et al. 2020). While the decision tool is a complement to agents' skill on average, this study found that it is a substitute across the skill distribution; "lower-quality agents" provide better recommendations with an AI-based tool than the top agents did without it. The same study also found that individuals enrolled in plans not recommended by the AI-based decision support tool were more than twice as likely to switch plans the following year compared with individuals who enrolled in a recommended plan. As another example, a randomized controlled trial of digital expert advice

Medigap policies are standardized

Beneficiaries with fee-for-service (FFS) Medicare can obtain a Medigap policy to protect themselves against cost sharing (e.g., 20 percent of Part B outpatient services). Medigap policies are subject to federal and state law and regulation. Unlike many other insurance policies, all Medigap policies are standardized, but the premiums can vary. Federal law specifies 10 standardized policies (Table 2-4), and Medigap plans are names in most states by letters A-D, F, G, and K-N, with the same letter offering the same basic benefits. (In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized differently.) This standardization facilitates “apples-to-apples” comparisons among policies. Some Medigap policies also cover services that

FFS Medicare does not cover except in limited circumstances, like a portion of emergency medical care when traveling outside the U.S. In 2024, Medigap Plans F and G were the most popular plans, with about 41 percent of beneficiaries with Medigap in each of those plans.

Plan F, which is no longer available to new policyholders eligible for Medicare after January 1, 2020, covers all cost sharing. Plan G is the most comprehensive policy available to new policyholders, covering the Part A deductible and all cost sharing for Part A- and Part B-covered services but not the Part B deductible, which is \$283 in 2026. ■

(continued next page)

in the context of prescription drug insurance found that digital expert advice provided consumers with information but also altered how consumers value product features (Bundorf et al. 2024). With the digital expert advice, consumers were more likely to switch their plans and select a plan with lower expected costs. However, researchers found that individuals for whom they predicted the largest effects from exposure to expertise were the least likely to demand such expertise, which may signal that passively offering these tools is unlikely to reach those who need the most help navigating the selection of insurance.

Weighing financial protection, access to care, and extra benefits

Beneficiaries in various focus groups and surveys conducted by MedPAC and other researchers report considering various factors when making a choice of FFS or MA and the plans within those options, including financial protection, access to care and specific providers, and extra benefits (Freed et al. 2023, Leonard et al. 2022, NORC at the University of Chicago

2025). Beneficiaries who enroll in MA accept provider networks and utilization-management tools such as prior authorization in exchange for lower premiums and an out-of-pocket maximum, though they pay more if they seek care from out-of-network providers. By contrast, FFS offers broader choice of providers with limited utilization management but can expose beneficiaries to high out-of-pocket costs unless they purchase additional coverage. MA plans also typically offer a variety of extra benefits not available in FFS, such as dental, vision, and hearing benefits. While it can be challenging for beneficiaries to understand each plan's package of supplemental benefits, these extra benefits help fill gaps in Medicare coverage and appeal to beneficiaries. Beneficiaries weigh these factors, considering their current health needs as well as future health needs that may not be evident at initial enrollment.

Beneficiaries may want to switch their Medicare coverage or plan for a wide variety of reasons. Some of those reasons could reflect changes in their personal circumstances, such as a new diagnosis or a change in

Medigap policies are standardized (cont.)

**TABLE
2-4**

Covered benefits and out-of-pocket costs in standardized Medigap plans, 2024

	Medigap standardized plan type									
	A	B	C	D	F	G	K	L	M	N
Part A hospital coinsurance and costs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or cost sharing	✓	✓	✓	✓	✓	✓	50%	75%	✓	\$20/\$50
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice coinsurance or cost sharing	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
SNF coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible			✓		✓					
Part B excess charges					✓	✓				
Foreign-travel emergency			80%	80%	80%	80%			80%	80%
Out-of-pocket limit	N/A	N/A	N/A	N/A	N/A	N/A	\$7,220	\$3,610	N/A	N/A
Lives covered (in thousands)	109	134	405	146	5,084	5,109	69	28	1	1,321
Percentage enrolled	1	1	3	1	41	41	<1	<1	<1	11

Note: SNF (skilled nursing facility), N/A (not applicable). Three states (Massachusetts, Minnesota, and Wisconsin) have different plan types and are not included in this chart. The ✓ indicates that the plan covers all cost sharing for that benefit. Percentages indicate that the plan covers that share of the total cost sharing. The "\$20/\$50" indicates that the plan covers all but \$20 for physician office visits and all but \$50 for emergency room visits. Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, those eligible for Medicare before January 1, 2020, but who have not yet signed up may be able to buy Plan C or Plan F. Plans F and G offer a high-deductible plan in some states. Plans K and L show how much they will pay for approved services before a beneficiary meets their out-of-pocket yearly limit and Part B deductible. After a beneficiary meets their out-of-pocket yearly limit and Part B deductible, the plan pays 100 percent of the beneficiary's cost. The enrollment percentages do not sum to 100 percent due to rounding. The number of beneficiaries represented in this chart is 12.4 million.

Source: MedPAC analysis of National Association of Insurance Commissioners data 2024, Medicare Payment Advisory Commission 2025a.

financial circumstances. Beneficiaries may also want to switch their MA or Part D plans due to undesirable changes in their current plan or switch their Medigap policy if premiums increase. But financial implications,

beyond the enrollment penalties described above, can make it difficult for a beneficiary to switch from one MA plan to another or from MA to FFS Medicare.

Financial protection

Most MA plans have lower premiums compared with FFS with Medigap and PDP coverage. In 2026, more than three-quarters of MA enrollment is projected to be in “zero-premium” plans with drug coverage, while FFS enrollees may pay, on average, a premium of \$217 per month for a Medigap policy and \$44 per month for a Part D plan (Freed et al. 2024b, Medicare Payment Advisory Commission 2026, Medicare Payment Advisory Commission 2025c).^{14,15} In 2024, the average monthly MA-PD premium for all plan types was \$12 for HMO plans and \$16 for local PPO plans (Freed et al. 2024a).

MA plans may also attract some beneficiaries because they typically have a different cost-sharing structure than FFS. MA plans must have an annual cap on out-of-pocket spending for in-network Part A and Part B services, known as a maximum out-of-pocket (MOOP) limit, while FFS does not have an annual cap.¹⁶ In 2025, the MOOP limit for in-network services was \$9,350, but many plans used some of the rebates they receive under the MA payment system to offer a lower limit, and the average MOOP limit for MA enrollees was \$5,320 (Ochieng et al. 2025). Compared to FFS, many MA plans also use rebates to reduce cost sharing for certain services, such as primary care visits (where enrollees often pay no cost sharing) and inpatient care. These features provide some protection against high out-of-pocket costs and may be appealing to beneficiaries who either cannot or do not want to purchase a Medigap policy. However, for beneficiaries who use more medical services, the cost sharing in an MA plan may be higher, in aggregate, than the amount they would have spent on premiums for a Medigap policy.

Beneficiaries who purchase Medigap insurance exhibit a strong preference for Medigap plans that reduce or eliminate cost sharing: Over 80 percent of those beneficiaries are in Plans F and G, which have the most comprehensive coverage (see text box, pp. 56–57, on Medigap policies). Although comprehensive supplemental coverage available to new enrollees limits most out-of-pocket liability for beneficiaries, research has shown that secondary insurance coverage may induce service use (Direct Research 2014). Research also finds that even relatively small levels of cost sharing are associated with reduced use of care, including necessary services (Artiga et al. 2017).

In our annual focus groups, beneficiaries who chose MA plans mentioned cost as a driver of their decision to enroll (NORC at the University of Chicago 2025).¹⁷ Several beneficiaries mentioned low or no out-of-pocket expenses (including premiums) or cost sharing as their primary reason for choosing MA over FFS Medicare. One beneficiary enrolled in MA noted, “It was a good choice. It was basically zero deductible on most doctor visits, hospital stays, etc.” Another noted, “I retired on disability. . . . I didn’t want . . . out-of-pocket [costs].”

A 2022 Commonwealth Fund survey also found that 20 percent of MA enrollees surveyed reported that the limit on out-of-pocket costs was the main reason they chose their Medicare coverage and the second-highest reason for choosing MA, with more benefits being the most reported reason for choosing MA (Leonard et al. 2022). In contrast, only 4 percent of FFS beneficiaries surveyed reported lower cost as the main reason they chose their Medicare coverage (least commonly reported reason), with more provider choice being the most reported driver of the FFS choice.

Access to care

FFS enrollees have broader choice of providers and are largely not subject to utilization management. MA plans are required to provide the same set of benefits that are available under FFS Medicare. MA enrollees who are in an HMO plan often must select an in-network primary care provider (PCP) who manages referrals to specialists and, except for urgent or emergency care, they are generally liable for out-of-network provider charges (not to exceed 100 percent of the FFS amount). MA enrollees who are in PPO plans have more flexibility because they are not required to name a PCP and are allowed to see both in- and out-of-network specialists without a referral; however, they may pay higher cost sharing for out-of-network providers compared with in-network providers (which may include preferred and nonpreferred providers). MA plans can require enrollees to obtain prior authorization to access certain services, a practice that has limited use in FFS Medicare.¹⁸ Potential impacts of prior-authorization requirements on receiving care may not be fully apparent when beneficiaries first enroll in Medicare, especially if they are healthy and have not experienced the prior-authorization process with previous insurers.

MA plans negotiate payments with individual providers. MA plans can also use utilization-management tools to contain spending and prevent beneficiaries from receiving unnecessary or low-value services. On the one hand, provider networks and prior authorization have the potential to promote more efficient care, including better quality outcomes (Medicare Payment Advisory Commission 2024). On the other hand, misapplication of these tools could lead to delay or denial of beneficiary care. CMS currently regulates certain aspects of both tools, through network-adequacy standards and Medicare coverage requirements, but limitations persist in current data-collection and enforcement mechanisms. In 2024, nearly all MA enrollees were in plans that required prior authorization for some categories of services; those requirements varied across MA plans (Freed et al. 2024a). Because prior-authorization requirements vary by service type and by plan, they can affect beneficiaries with certain conditions and their ability to obtain services from some provider types and specialties more than others.

In our focus groups, many FFS beneficiaries described choosing FFS Medicare over MA because they wanted unrestricted access to clinicians or because their clinician recommended FFS Medicare. Participants with serious or chronic health conditions, as well as those who described themselves as relatively healthy, described choosing FFS Medicare because it allowed them to access a broader range of specialists without needing referrals or facing network restrictions. Several participants noted that their physicians steered them in the direction of FFS Medicare. One said, “My doctors, because I need a monthly treatment, wanted all the people who get this treatment to have traditional Medicare.” While we cannot verify the details and circumstances of beneficiary reports, several beneficiaries who chose FFS Medicare cited negative perceptions or experiences with MA. A few participants expressed distrust of or dissatisfaction with MA plans, especially regarding examples they had heard of denials of care. One mentioned:

An Advantage plan is fine as long as you don’t get sick. I just had a lady call me. Her husband had a stroke a few months ago. He needs a wheelchair. The plan she has with Advantage won’t give it to her. He needs therapy. They won’t give it to her.

A 2022 Commonwealth Fund survey also found that FFS beneficiaries made their coverage choice for more access to providers, with 40 percent of FFS beneficiaries surveyed citing more doctor, hospital, and health care provider choice as the main reason they chose to remain in FFS Medicare (Leonard et al. 2022).

Extra benefits

In addition to covering basic Part A and Part B services, MA plans may provide “supplemental” benefits to their enrollees, such as enhanced Part D benefits and other benefits not covered in FFS Medicare such as dental, vision, or hearing services (non-Medicare services) (Medicare Payment Advisory Commission 2025b). Nearly all plans now have dental, vision, and hearing benefits. Dental benefits account for about 40 percent of spending on supplemental benefits (Government Accountability Office 2023). MA plans have increasingly offered coverage of nonmedical benefits and use of “flex” cards. (Flex cards are prefunded debit cards through which plans can administer benefits that are offered.) It can be challenging for beneficiaries to understand each plan’s package of benefits.

A few beneficiaries in our focus groups were drawn to MA plans because of the additional benefits not typically included in traditional Medicare. They specifically cited their use of flex cards for over-the-counter items and plans that offered dental and vision coverage. One noted, “I used to get \$160 a month for frivolity stuff—toothpaste, aspirin, that kind of stuff.” Another reported, “[One MA plan] wasn’t offering dental care, eye care, or anything. . . . So I joined [another MA plan] and was able to get what I needed.”

Many dually eligible beneficiaries in our focus groups described the importance of extra benefits not typically included in FFS Medicare when choosing an MA plan. These participants frequently mentioned dental, vision, transportation, wellness incentives, and flex cards as key motivators. One participant noted, “My aunt had told me [her plan] gives a \$250 card that you can pay your bills or your gas with. So, I called them. They set me up.” Another explained, “Mine was offering dental, vision, and physical. . . . I have a lot of health issues, so [my priority] was to know what I was covered with.” A third said, “I can pay for cash bills, healthy food, and that \$250 comes [in] handy.”

A 2022 Commonwealth Fund survey also found that MA enrollees valued extra benefits in their coverage choice, with 24 percent of MA enrollees surveyed citing more benefits as the main reason they chose their Medicare coverage (Leonard et al. 2022).

Issues related to switching in MA, Part D, and Medigap

Beneficiaries may want to switch their Medicare coverage for a wide variety of reasons. Some of those reasons could reflect changes in their personal circumstances. For example, beneficiaries might have received a new cancer diagnosis or experienced a recent health-related event like an injury or a heart attack. Their financial situation may have changed, such as when they can no longer afford a Medigap plan's premium, or their preferences for how they receive health care may have changed (for example, the desire to switch to a new doctor or the need to see a specialist with experience treating their condition who may not be in their current plan's network).

Beneficiaries may also want to switch their MA or Part D plans due to undesirable changes in their current plan, such as increased premiums or cost sharing, the exclusion of a particular provider from the plan's network, expanded use of prior authorization or other forms of utilization management, changes in the coverage or cost of a beneficiary's medications, or changes to the plan's package of supplemental benefits. Beneficiaries may wish to switch their Medigap policy if premiums increase.

But Medicare has some features that beneficiaries must consider if they want to switch coverage and plans. First, as described above, beneficiaries are largely prohibited from enrolling or changing plans outside of certain limited enrollment periods, although there are a variety of SEPs that allow beneficiaries in certain situations to switch plans at other times. Second, in the MA market, if a beneficiary switches MA plans during eligible enrollment periods during a year, the annual maximum out-of-pocket resets, which may be a financial burden. For example, if in February a beneficiary in an MA plan has already reached half of their out-of-pocket limit amount due to the use of certain services with large cost sharing, if they use the OEP to switch MA plans in March, the new plan will not credit them with the spending incurred in the previous

plan toward their out-of-pocket limit. Instead, the plan will begin the new plan's annual out-of-pocket limit calculation at \$0 without giving the enrollee credit for their out-of-pocket spending under the previous plan. In contrast, in Part D, when a person switches PDPs during the year, the balance of the amount that counts toward a person's annual out-of-pocket threshold (known as the person's true out-of-pocket costs) transfers to the new drug plan. Third, in the Medigap market, beneficiaries who try to buy a policy outside of the Medigap enrollment period, a state-designated period, or an SEP may also be subject to medical underwriting, where the insurer may not sell the plan to the beneficiary due to the beneficiary's health conditions. These features are primarily intended to prevent or reduce adverse selection.

If beneficiaries want to switch plans, they must consider that FFS Medicare does not have an annual limit on out-of-pocket costs, while MA and Part D do (as described above). Beneficiaries who are accustomed to limited cost sharing (because they have been enrolled in private plans before age 65 and in Medicare have been enrolled only in MA) may not anticipate the impact that the lack of out-of-pocket maximum in FFS Medicare could have on their finances and therefore may underestimate the need for Medigap coverage. Some beneficiaries wishing to leave MA, such as after a new diagnosis, and return to FFS may find it difficult to do so because they cannot afford to incur FFS's higher out-of-pocket costs but also find Medigap premiums to be too expensive or may be unable to purchase a Medigap policy at all due to underwriting. A recent study found that the rate of switching from MA to FFS in the year after a cancer diagnosis was more than twice as high in states with Medigap guaranteed-issue protections (4.7 percent) than in those without (2.7 percent), underscoring the protective association of state Medigap regulations in facilitating a switch to FFS (Kwon et al. 2025). In our June 2012 report to the Congress, the Commission, noting that no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary in FFS can incur, recommended a redesign of Medicare's FFS benefit package including an out-of-pocket maximum (see text box on the Commission's recommendation to reform Medicare's benefit design) (Medicare Payment Advisory Commission 2012).

The Commission's 2012 recommendation to reform Medicare's benefit design

Under the current fee-for-service (FFS) benefit design, no upper limit exists on the amount of Medicare cost-sharing expenses that a beneficiary can incur. Without additional coverage, the FFS benefit design exposes Medicare beneficiaries to substantial financial risk. In June 2012, the Commission recommended that the Congress direct the Secretary to develop and implement a FFS benefit design that would replace the current design and would include:

- an out-of-pocket maximum;
- deductible(s) for Part A and Part B services;
- replacing coinsurance with copayments that may vary by type of service and provider;
- secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the out-of-pocket maximum;

- no change in beneficiaries' aggregate cost-sharing liability; and
- an additional charge on supplemental insurance.

The Commission's recommended redesign of Medicare's FFS benefit package provides better protection against high out-of-pocket spending and thus enhances the overall value of the FFS benefit, mitigating the need for beneficiaries to purchase supplemental insurance (Medicare Payment Advisory Commission 2012). It also creates clearer incentives for beneficiaries to make more informed decisions about their use of discretionary care while holding the aggregate beneficiary cost-sharing liability about the same as under current law. The redesign allows for ongoing adjustments and refinements in cost sharing as evidence of the value of services accumulates and evolves. An additional charge on supplemental insurance would recoup at least some of the additional costs imposed on the Medicare program due to the insurance effect of supplemental coverage. However, it would still allow beneficiaries to buy supplemental coverage if they wish to do so. ■

MA marketing may contribute to confusion

MA insurers and third-party marketing organizations (TPMOs) rely on marketing to attract and retain enrollees, such as TV ads, direct mailings, phone calls, and digital ads.¹⁹ In the 2022 Commonwealth Fund survey, 3 percent of respondents in FFS and 7 percent of MA respondents reported using advertisements on TV or somewhere else to guide their plan choice (Leonard et al. 2022). Though MA organizations must submit all marketing materials, all election forms, and certain designated communications materials for

CMS review, some stakeholders have raised concerns about an increase in marketing by plans and TPMOs, arguing that the volume of ads, mailings, and calls may be overwhelming to some beneficiaries and that some marketing materials may be misleading. CMS has noted an increase in the number of beneficiary complaints about MA insurers' marketing activities. Stakeholders have also raised concerns about the increasing role of lead generators and offshore entities in MA marketing. The increase in concerns about MA marketing may be associated with a finding that the number of MA beneficiaries who "rapidly disenroll" from their plan tripled from 2017 to 2022 (rising from 3.5 percent to 12.2 percent) (defined as switching to FFS Medicare or

a new MA plan within the OEP during the first three months of the year) (Balkan et al. 2026).

Beneficiaries receive lots of marketing about MA, and some marketing may be misleading

A KFF study found that beneficiaries are “flooded” with TV ads for MA plans, with nearly 650,000 airings (more than 9,500 per day) during the 2022 AEP on mainly local media markets (Fuglesten Biniek et al. 2023). Many participants in our annual beneficiary focus groups reported being overwhelmed by the amount of marketing information they received (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024). These participants reported receiving “constant” phone calls and frequent mailings from insurers, especially during the AEP. Other participants reported receiving many phone calls related to enrolling in MA plans, with one noting, “Why is it—it’s like every day, somebody calling you about your insurance? I already did this for this year already” and another estimating the number of calls: “I get five, six a day.”

Digital advertising, communication, and outreach by health plans and TPMOs are common sources of Medicare information for beneficiaries, and today these efforts compete with nonprofit and government sources for beneficiary attention (Commonwealth Fund 2021b). In 2021, the Commonwealth Fund conducted a series of online searches with Medicare keywords and found that agents’ and insurers’ Medicare resources are widely available online and are likely to be among the first information sources seen in online searches. Agents and health plans accounted for a third of the search results and 87 percent of all ads (paid placements); only 7 percent of ads were from the federal government.

Increasing beneficiary complaints about Medicare marketing

In 2022, CMS reported that it has “seen an increase in beneficiary complaints associated with TPMOs and has received feedback from beneficiary advocates and stakeholders concerned about the marketing practices of TPMOs who sell multiple MA and Part D products” (Centers for Medicare & Medicaid Services 2022b). In 2020, CMS received a total of 15,497 complaints related to marketing. In the first 11 months of 2021, there were

39,617 complaints. CMS stated that many of these complaints were related to TPMO marketing (Centers for Medicare & Medicaid Services 2022b).

CMS said its “experience in reviewing beneficiary complaints and listening to recorded calls between agents/brokers and beneficiaries revealed many instances during which agents/brokers failed to provide enough information” or “provided inaccurate information about plan benefits” (Centers for Medicare & Medicaid Services 2023a). CMS also identified instances where agents “led beneficiaries to believe the beneficiaries were calling Medicare rather than an insurance agent” (Centers for Medicare & Medicaid Services 2023a). According to CMS, in listening to hundreds of marketing and enrollment calls, the agency found “in the majority of the calls (over 80 percent), agents and brokers failed to ask pertinent questions to help a beneficiary enroll in a plan that best meets the individual’s needs” (Centers for Medicare & Medicaid Services 2023a). Examples included “beneficiaries being told that if their medication was not on the formulary, the doctor could tell the plan, and the plan would simply add it; or incorrectly stating that ‘nothing would change’ when beneficiaries asked if their current health coverage would stay the same” (Centers for Medicare & Medicaid Services 2022a).

CMS stated that these “complaints are typically filed by enrollees or their caregivers through 1-800-MEDICARE or CMS regional offices, and generally allege that a beneficiary was encouraged or pressured to join an MA plan, and that once enrolled, the plan was not what the enrollee expected or what was explained to them when they spoke to an agent or broker” (Centers for Medicare & Medicaid Services 2023b). CMS stated that “the rise in MA marketing complaints noted above suggests that agents and brokers are being influenced to engage in high pressure tactics, which may in turn cause beneficiary confusion about their enrollment choices, to meet enrollment targets or earn ‘administrative payments’ in excess of their compensation payment” (Centers for Medicare & Medicaid Services 2023b).

In 2022, the Senate Committee on Finance released a report on Medicare beneficiary complaints regarding the marketing of MA plans and PDPs by plans and TPMOs (U.S. Senate Committee on Finance 2022). The Committee found evidence of “aggressive or deceptive MA and Part D marketing practices” that

were “widespread, not isolated events.” The Committee said that “[a]gents were found to sign up beneficiaries for plans under false pretenses, such as telling a beneficiary that coverage networks include preferred providers even when they do not.”

Changes in third-party marketing organizations over time

CMS defines TPMOs as “organizations and individuals, including independent agents, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision)” (Centers for Medicare & Medicaid Services 2008a). In conversations with some agents and others in the industry, we commonly heard that the structures and roles of organizations and individuals involved in marketing MA plans and enrolling beneficiaries have changed over time. We heard that individual agents, field marketing organizations (FMOs), call centers, marketing firms, and lead generators are all lumped together under the current TPMO definition but serve different roles. In 2022 and 2025, the Senate Finance Committee majority and minority staff, respectively, reported on the growing, complex network of marketing organizations in MA (U.S. Senate Committee on Finance 2025, U.S. Senate Committee on Finance 2022). The committee reported that MA plan marketing efforts were initially handled by smaller, independent brokerages and agents. While some brokers still operate independently or in small brokerages, marketing activities are now largely overseen by FMOs that provide back-end administrative support for agents and brokers and serve as the primary contact for insurers (U.S. Senate Committee on Finance 2025). FMOs can be large national organizations or smaller regional organizations. The report highlighted questionable lead-generation techniques, the role of onshore and offshore call centers, and a “marketing and administrative payments arms race” (U.S. Senate Committee on Finance 2025). In recent proposed rules, CMS issued a request for information on ways to modify the current definition of TPMOs and to delineate the roles of and requirements applicable to the different kinds of TPMOs (Centers for Medicare & Medicaid Services 2025i).

Medicare information sources: CMS, SHIP, and insurance agents

In our annual beneficiary focus groups, many beneficiaries described turning to formal resources for help making Medicare enrollment decisions, including insurance agents, plan representatives, health fairs, and Medicare.gov (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024). Others described relying on guidance and recommendations from less formal sources, including family members and friends. In this section, we focus on three of these sources: CMS tools, the federally funded SHIP, and insurance agents.

CMS information sources include Medicare.gov, 1-800-MEDICARE, and Medicare Plan Finder

CMS has several tools available to individuals and their families or caregivers that can be accessed by visiting Medicare.gov or calling the 1-800-MEDICARE help line. These tools are designed to provide beneficiaries with unbiased information to help them navigate their enrollment and coverage choices.

Medicare.gov

Medicare.gov has numerous resources about Medicare enrollment and benefits, including the *Medicare & You* handbook, the *Choosing a Medigap Policy* guide, and the Medicare Plan Finder tool (discussed below). The annual *Medicare & You* handbook includes information about Medicare coverage, Medicare plan enrollment options, and what is new in Medicare for the current year. The annual *Choosing a Medigap Policy* guide explains what Medigap policies cover, when individuals have guaranteed-issue rights to Medigap policies, and the steps to buy a Medigap policy.

1-800-MEDICARE

The toll-free 1-800-MEDICARE line and a live chat on Medicare.gov are available 24 hours a day except for certain federal holidays. Customer inquiries are received through the telephone, mail, email, telecommunications device for the deaf/teletypewriter (TDD/TTY), fax, and webchat. Individuals call 1-800-MEDICARE to obtain information about MA, prescription drug plans, or Medigap policies available in their area; what services are covered by Medicare;

and the status of claims, among other topics. Calls placed to 1-800-MEDICARE are answered initially by an interactive voice-response system that routes a call to a customer service representative or provides other information, such as a recording. Customer service representatives rely on written scripts to answer callers' questions and may also consult other tools, such as information on Medicare.gov.

In 2025, 1-800-MEDICARE received 24.2 million calls, with the interactive voice-response system completely managing 30 percent of call volume (7.3 million calls) (Centers for Medicare & Medicaid Services 2026c). CMS targets a five-minute average speed of answer for calls to 1-800-MEDICARE, but we do not have current data on actual wait times (Centers for Medicare & Medicaid Services 2026c). In 2023, 49 percent of MCBS respondents reported that they were aware of 1-800-MEDICARE, and 33 percent reported calling the phone line (see Appendix 2-B, p. 86, on results from the MCBS).

Medicare Plan Finder

One key resource for Medicare beneficiaries seeking information about their coverage options is the Medicare Plan Finder, an online search tool available at Medicare.gov. CMS initially developed Plan Finder in 1998 and has made numerous modifications to it since then to incorporate newer technology and reflect changes in Medicare, such as the addition of the Part D drug benefit and the ability of MA plans to offer a broader range of supplemental benefits (Centers for Medicare & Medicaid Services 2019, Government Accountability Office 2019). Plan Finder can be found at www.medicare.gov/plan-compare.

To use Plan Finder, beneficiaries enter their ZIP code and indicate whether they want information about MA plans, stand-alone Part D prescription drug plans (PDPs), or Medigap plans. Beneficiaries who indicate interest in MA plans or PDPs are asked whether they receive assistance from Medicaid, the Medicare Savings Programs, or Part D's low-income subsidy. (When beneficiaries indicate that they receive one of these types of assistance, Plan Finder automatically adjusts the cost information for plans and the order in which plans are listed.) Plan Finder provides information for all conventional MA plans, MA special-needs plans, and PDPs offered in a beneficiary's county of residence,

including plan premiums, deductibles, cost-sharing amounts, and annual out-of-pocket limits. Beneficiaries can enter information about the prescription drugs and pharmacies they use and, for each PDP and MA plan with drug coverage, get a personalized estimate of their total annual spending for premiums and cost sharing. For MA plans, Plan Finder indicates whether the plan offers at least some coverage for approximately 25 distinct types of supplemental benefits. If a beneficiary selects an MA plan or PDP, they can enroll in the plan directly through the website.

For beneficiaries interested in traditional FFS Medicare, Plan Finder has some information on Medigap plans, such as the specific policies that are available (all Medigap plans use 1 of 10 standardized benefit packages, but insurers may not sell every type of policy), an estimated premium, and contact information for each insurer. Beneficiaries who want to select a Medigap plan must contact the insurer to determine their exact premium and enroll in the plan.

It is not clear how often beneficiaries use Plan Finder. According to a 2022 Commonwealth Fund survey that asked beneficiaries which sources of information they used to select a plan, 5 percent of beneficiaries in traditional FFS Medicare and 9 percent of beneficiaries in MA used the Medicare hotline or Medicare.gov (Leonard et al. 2022). In 2023, less than half of respondents (46 percent) in the MCBS reported visiting the Medicare.gov website for any purpose (see Appendix 2-B, p. 86, on results from the MCBS). However, those figures may significantly understate the use of Plan Finder because several other sources of information that beneficiaries rely on—such as insurance agents, friends and family, and SHIP counselors—may use Plan Finder themselves in assisting beneficiaries. In our beneficiary focus groups, several beneficiaries have reported using Plan Finder to review their coverage options, although relatively few said they relied on it as their only source of information in making a decision (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024).

In 2025, CMS made two significant changes to Plan Finder. First, information about the specific providers that participate in an MA plan's network was added, making it easier for beneficiaries to understand which plans have their providers in network. Previously,

beneficiaries needed to visit the websites for each individual plan to find this information. Second, more detail about each MA plan's coverage of various supplemental benefits was added, such as the in-network and out-of-network cost-sharing amounts and whether the plan limits its coverage in some way. Previously, for most types of benefits, Plan Finder simply indicated whether plans had “some coverage” or “no coverage.”

Although Plan Finder has improved over time, it still has some limitations. For example, with respect to MA supplemental benefits, Plan Finder provides relatively little information about issues such as potential limits on a plan's coverage, requirements to obtain services from specific providers, or the need to obtain prior authorization. Similarly, regarding Medigap, the premium information in Plan Finder may not be accurate for beneficiaries who are interested in buying a plan in situations where they might have to go through medical underwriting.²⁰ Both limitations are clearly noted in Plan Finder, and they are difficult to incorporate into a search tool given the substantial plan-level variation in MA supplemental benefits and the state- and insurer-level variation in policies that affect Medigap premiums.

The addition of information from plans' provider directories, in particular, addresses a key gap in Plan Finder's capabilities, but further improvements will be needed. The approach that CMS employed last year was an interim step that used provider data collected by a private company (SunFire Matrix) and did not have information for all plans. However, CMS has started requiring all plans to submit their provider directories to the agency and aims to incorporate these data into Plan Finder in time for the next AEP, which starts in October. The provider data now used in Plan Finder are also largely limited to individual clinicians, and beneficiaries can include only up to five providers in their search; future improvements could allow beneficiaries to enter information about more than five clinicians and see if plans cover other important providers such as specific hospitals or skilled nursing facilities. There are long-standing concerns that the information in MA provider directories can be inaccurate—for example, a provider's address may have changed or they may not be accepting new patients.²¹ (The provider directories for other types of health

insurance can have similar problems.) Inaccuracies in the underlying data from MA provider directories could make Plan Finder less useful and could result in some beneficiaries selecting plans that do not actually cover all of the providers they use.²²

CMS has expressed interest in incorporating artificial intelligence-based tools into its information sources

In February, CMS issued a request for information (RFI) about existing commercial products or services that use AI technology and “are capable of enhancing the Medicare experience for beneficiaries” (Centers for Medicare & Medicaid Services 2026f). The agency expressed interest in using AI tools in a variety of ways that would affect each of the information sources discussed in this section, such as:

- developing virtual assistants and chatbots to provide “real-time conversational support” to beneficiaries;
- automating routine inquiries to the 1-800-MEDICARE helpline;
- translating plan documents and other Medicare information into plain English; and
- developing personalized plan recommendations that incorporate data from a beneficiary's FFS claims, Part D claims, and MA-plan encounters to help them select plans that meet their needs.

In the RFI, CMS said that it anticipated issuing formal solicitations for AI-related tools in the future but did not discuss its plans in detail.

The State Health Insurance Assistance Program is a key federal source of Medicare counseling for beneficiaries

The SHIP is a federal program that provides grants to the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands to deliver objective information, outreach, and counseling at no cost to Medicare beneficiaries. Established in 1990, the SHIP is currently administered by the Administration for Community Living (ACL) within the Department of Health and Human Services. Local grantees deliver individual assistance through in-person, phone, online, and written communications

and are not compensated by insurers. Grantees rely heavily on the availability of volunteer staff to provide SHIP services. From April 2022 to March 2023, paid staff and volunteer SHIP counselors assisted nearly 4.3 million beneficiaries and their families or caregivers through counseling sessions or outreach events—about 6 percent of the Medicare population (Administration for Community Living 2025). From July 2025 to December 2025, 10,043 paid staff and volunteer SHIP counselors provided individual counseling to nearly 1.2 million beneficiaries.²³ The SHIP is funded through a combination of discretionary and mandatory federal funding from the Medicare trust funds and state and local funding. Federal funding over the past 17 years has not kept pace with growth in Medicare enrollment.

In our annual beneficiary focus groups, few beneficiaries were aware of their local SHIP grantees, but those who used them reported positive experiences (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024). A Commonwealth Fund survey conducted in 2022 found that 4 percent of MA enrollees and 5 percent of FFS enrollees reported using the SHIP to guide their plan choice (Leonard et al. 2022).

As part of our work examining the complexity of enrollment choices in Medicare, we conducted semistructured interviews with ACL staff that direct the SHIP, staff at the SHIP Technical Assistance (TA) Center, and counselors or staff from seven grantees. We focused on the interviewees' experiences working with beneficiaries to help them make Medicare enrollment decisions, as well as the functions and challenges of the SHIP. We selected SHIP grantees to interview in areas with varying MA penetration rates, shares of beneficiaries who are dually eligible for Medicare and Medicaid, and differing Medigap guaranteed-issue policies. As described below, all interviewees reported funding and capacity challenges as call volumes have risen, counseling sessions have lengthened, and more expertise is required of volunteers.

SHIP funding and operations

Local SHIPs are the primary federally funded source of community-based individualized counseling for beneficiaries navigating their enrollment and coverage decisions. SHIP grantees provide no-cost assistance to

beneficiaries about FFS Medicare (Part A and Part B), MA (Part C), the Medicare Prescription Drug Program (Part D), Medigap, and Medicaid (Congressional Research Service 2023). SHIP counselors provide one-on-one counseling to help beneficiaries make informed enrollment and benefit decisions. In addition to individual counseling, grantees conduct public education and outreach on a variety of topics related to Medicare, including plan comparison, enrollment periods, and understanding coverage and benefits. The SHIP also receives federal funding dedicated to outreach to hard-to-reach Medicare beneficiaries, such as those in rural areas.

The ACL provides grants to the states and territories to fund the infrastructure, training, and administration needed to support SHIP staff, nearly half of whom are volunteers, in over 2,200 community-based organizations. Nearly two-thirds of SHIP grantees are administered by state- or territory-level agencies that advocate for and provide assistance to older residents, their families, and adults with physical disabilities, known generally as state units on aging (Administration for Community Living 2024, Congressional Research Service 2023). The remaining one-third of grantees are administered by their respective state departments of insurance. At the local level, many grantees partner with a public or private nonprofit agency designated by the state to address the needs of older persons in the community, known generally as area agencies on aging. Some grantees are colocated with their local Senior Medicare Patrol offices, which are federal programs dedicated to the determent and prevention of Medicare fraud and abuse (Administration for Community Living 2025).

Beneficiaries can also visit Medicare.gov or call 1-800-MEDICARE with their Medicare enrollment questions. Beneficiaries who raise complicated issues during calls to 1-800-MEDICARE may be referred to their local SHIP grantee. Sometimes grantees require assistance from 1-800-MEDICARE to resolve beneficiary issues. SHIP counselors can contact 1-800-MEDICARE on behalf of a beneficiary using the counselor's unique identification number on a dedicated 1-800-MEDICARE line that allows them access to information to resolve beneficiary issues, a service some SHIP grantees we interviewed reported using several times a week.

Funding sources The SHIP is funded through a combination of discretionary and mandatory federal funding from the Medicare trust funds (with half of total funding drawn from the Hospital Insurance fund and half from the Supplementary Medical Insurance fund) and state and local funding. Discretionary federal funding supports SHIP operations that serve all Medicare beneficiaries, while mandatory federal funding supports additional individual counseling and outreach services targeted to hard-to-reach populations.

Each year, the Congress appropriates discretionary funding for the SHIP, which represents the primary source of SHIP funding. This funding supports grants to state and territory grantees (the amounts of which are determined based on regulatory formulas), the ACL's oversight of the program, and the operations of the SHIP TA Center that provides training and technical assistance to the 54 grantees and operates a telephone line and a website with a SHIP directory to aid beneficiaries in finding their local grantee (Administration for Community Living 2026, Congressional Research Service 2023).²⁴ For fiscal year 2026, \$55.2 million in discretionary funding was appropriated to the SHIP (U.S. House of Representatives 2026). This amount is consistent with recent years (Congressional Research Service 2023), but funding has not kept pace with inflation or growth in Medicare enrollment. From 2008 to 2025, the annual amount of discretionary funding appropriated to SHIP grantees, adjusted for inflation, has declined 26 percent, while Medicare enrollment has increased by about 53 percent (Figure 2-2, p. 68).

In addition to the discretionary funding, the SHIP also receives mandatory federal funding intended to support additional outreach and assistance for hard-to-reach Medicare beneficiaries, including beneficiaries living in rural communities, those with low incomes, and those with limited English proficiency.²⁵ Mandatory funding was first provided in the amount of \$7.5 million (or \$11.6 million as adjusted for inflation) in 2009 and has gradually increased over the years (Congressional Research Service 2023).²⁶ A total of \$16 million in mandatory federal funding was issued for SHIPs in 2026 (U.S. House of Representatives 2026, U.S. House of Representatives 2025). This change in mandatory federal funding from 2009 to 2026 represents about a 38 percent increase since

2009 when adjusted for inflation. With this funding, SHIPs educate beneficiaries about the LIS program for Medicare Part D, the MSPs, and the availability of Medicare preventive services like flu shots while also providing in-depth application assistance to help Medicare beneficiaries apply for benefit programs that would lower their health care costs.

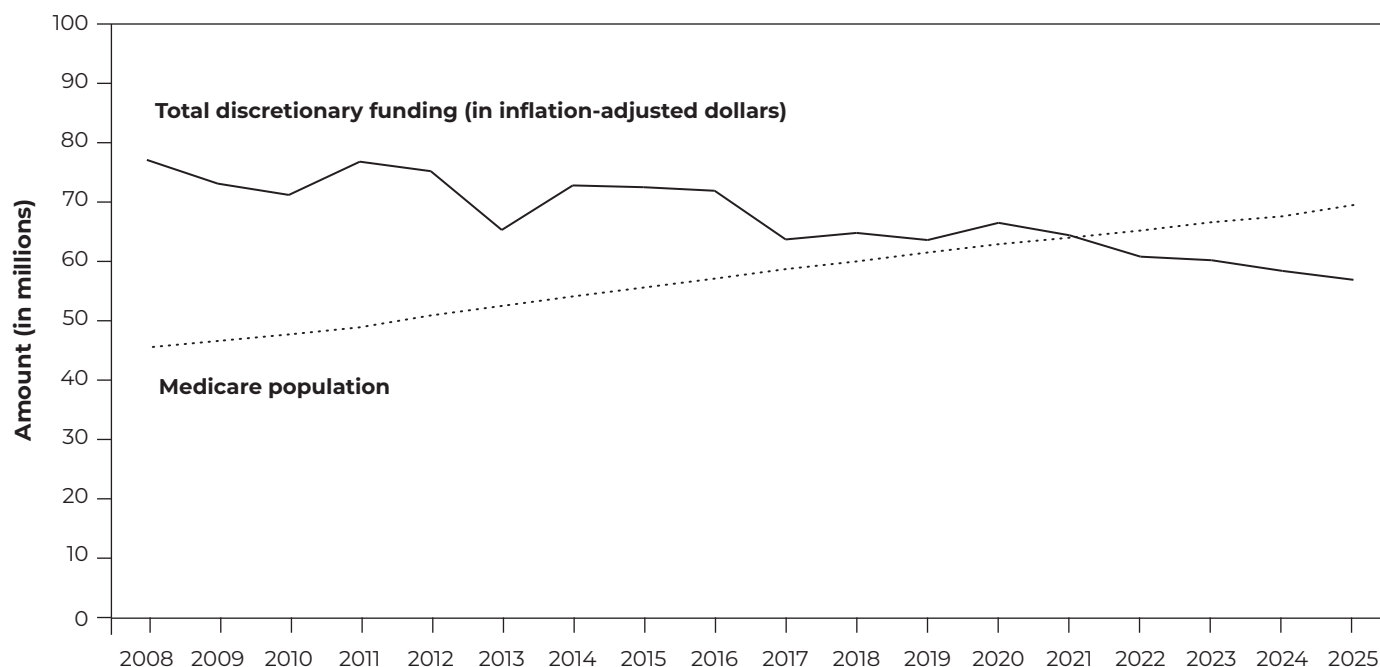
SHIP grantees may also receive funding or in-kind services (such as paid staff from other organizations or a telephone line or case-management system) from states, territories, or local governments. For example, some states have Medicaid funds specifically for outreach to individuals eligible for Medicaid. Grantees often use state and local funding to compensate full-time employees, who, apart from counseling beneficiaries, are responsible for handling administrative tasks (including reporting to the SHIP Tracking and Reporting System (STARS)), coordinating beneficiary outreach and enrollment events, and overseeing SHIP volunteers. Of the 10,043 SHIP staff and volunteers in place from July 2025 to December 2025, 20 percent were federally funded, 32 percent were funded by in-kind services such as paid staff from partner organizations or other state and local funding, and 48 percent were unpaid volunteer staff.²⁷

SHIP counselor training and certification All SHIP staff, both volunteer and paid, must complete training before assisting beneficiaries. On-the-job or “shadow” training with experienced counselors is an important complement to formal instruction. The SHIP TA Center has developed a 23-module training and certification program for SHIP grantees, which is currently used by 51 out of 54 grantees in some capacity. The SHIP TA Center regularly updates the curriculum to address emerging or complex topics, based on input from SHIP grantees and the ACL. Recent additions include Medicare interactions with employer coverage (e.g., the Federal Employee Health Benefits Program and TRICARE), ESRD benefits, and the needs of individuals with intellectual and developmental disabilities. The SHIP TA Center also responds to questions from SHIP grantees and generates beneficiary educational materials for use by SHIP counselors.

Grantees select which courses are required for their staff to complete; most require counselors to complete eight or nine courses as part of their training, along with additional program-specific training. In our

**FIGURE
2-2**

**Change over time in SHIP discretionary funding
and the size of the Medicare population, 2008–2025**



Note: SHIP (State Health Insurance Assistance Program). “SHIP discretionary funding” refers to the primary amount of funding appropriated to the SHIP by the Congress. Discretionary funding amounts have been adjusted for inflation to reflect 2026 dollars using historical values from the Congressional Budget Office Consumer Price Index for All Urban Consumers.

Source: MedPAC analysis of 2008 CMS newsroom press release; 2009 through 2025 Department of Health and Human Services, Administration for Community Living, and CMS budget justifications; the 2015, 2020, and 2025 Medicare Trustees’ reports; and 2026 Congressional Budget Office Historical Data and Economic Projections.

interviews with SHIP representatives, one explained that they conducted three types of annual training: summer sessions on MA and Part D issues, monthly counselor training webinars, and statewide continuing-education training in preparation for the AEP. Another grantee reported using a combination of SHIP TA Center training, experiential training, and CMS national training. SHIP counselors must be regularly recertified, either through the SHIP TA Center testing or grantee-specific testing.

A recent secret-shopper study evaluating the Medicare information provided by SHIP sites found that the percentage of accurate answers provided by SHIP grantees ranged from 26 percent to 94 percent,

depending on the Medicare-related topic (Dugan et al. 2025). The study found that SHIP counselors provided more accurate information on topics related to initial Medicare enrollment and evaluating coverage options and less accurate information related to discussions of special-needs plans for dually eligible beneficiaries (or D-SNPs) and questions on specific MA plans, highlighting the need for additional training resources on these subjects. This study did not investigate the accuracy of information provided to Medicare beneficiaries by insurance agents or by 1-800-MEDICARE, so it is unclear whether SHIP grantees perform better or worse than these other information sources. In line with Dugan et al.’s findings,

when surveyed, SHIP counselors have expressed the desire for more training related to Medicaid (Garrido et al. 2024).

To promote consistency in counselor certification and due to increasing complexities in Medicare, the ACL is developing a national SHIP counselor certification program. All SHIP team members will need to pass this certification before engaging with Medicare beneficiaries and the public. The program will likely be based on the existing SHIP TA Center training program and CMS's insurance agent training and testing guidelines (Centers for Medicare & Medicaid Services 2026a). All SHIP grantees would require their counselors to complete the national certification, though grantees could continue to offer additional testing.

SHIP activity reporting and performance measurement

SHIP grantees report their activities and beneficiary demographic information to the ACL through the STARS web-based data system (State Health Insurance Assistance Program 2017). Launched in 2018, STARS was designed to streamline the process of data entry for data reporting and performance measurement (e.g., beneficiary contacts, outreach contacts, under-65 contacts, “hard-to-reach” contacts, and enrollment contacts). Information from STARS is used for the five performance measures that evaluate the work of the SHIP grantees. The ACL includes the results of the measures at the grantee level in the annual report to the Congress posted on the ACL's website (Administration for Community Living 2021). STARS is also intended to streamline the data-reporting process across multiple federal grant programs (e.g., for the Senior Medicare Patrols). SHIP grantees report information to STARS at least monthly. In September 2025, the ACL contracted with a private entity to develop and implement a new, revised STARS over a five-year period, considering feedback on system improvements from the SHIP grantees. The new STARS will incorporate the national counselor certification program described above.

SHIP counselors use the Plan Finder tool to help beneficiaries compare and enroll in MA and PDP plans. SHIP counselors described using a SHIP TA Center tool called the Medigap Plan Finder to compare available Medigap plans. The Medigap Plan Finder uses proprietary data from the CSG Actuarial database to

display current and past premium amounts as well as data from the National Association of Insurance Commissioners (NAIC) to display Medigap plan enrollment amounts. This tool has more information about Medigap than may be found on CMS's Plan Finder. While beneficiaries cannot use the Medigap Plan Finder themselves to enroll in a Medigap plan, SHIP counselors use the tool as another information source to help clients select a plan.

Interviewees mentioned some technological constraints that affect their ability to effectively counsel beneficiaries. For example, some grantees do not have a unified telephone system that allows calls to be transferred between counselors or that allows caller identification so that a beneficiary knows that a SHIP counselor is calling.

Some SHIP grantees are using proprietary case-management systems that allow them to save information (with the beneficiary's knowledge and consent) about a beneficiary's concern or issue so that when the beneficiary calls again or if another counselor is needed to assist, the history of the concern or issue is available. Some of these systems are used by other state agencies, allowing more effective case management for beneficiaries with multiple enrollment issues. Some enrollment issues, such as assisting with an MSP, may require multiple counseling sessions, and interviewees without case-management systems noted that it can be frustrating for a beneficiary to have to explain their issues again each time they call.

Key themes from SHIP interviews

In our 2026 interviews with SHIP staff, we focused on their experiences working with beneficiaries to help them make Medicare enrollment decisions, as well as the functions and challenges of the SHIP. Interviewees reported on the following: (1) assisting beneficiaries with a wide range of Medicare needs and income levels, (2) providing in-person assistance and staying up-to-date on local market conditions, and (3) concerns about ongoing limited capacity.

Assisting beneficiaries with a wide range of Medicare needs and income levels The grantees we spoke with reported assisting beneficiaries with a wide range of Medicare decisions, reflecting substantial variation in beneficiaries' understanding of the program.

Interviewees explained that new beneficiaries typically contact SHIP grantees to gain a basic understanding of Medicare's structure and coverage options. Several interviewees highlighted the free "Medicare 101" information sessions as a key outreach tool they used in their communities. One interviewee said that every Medicare 101 session includes at least one individual who is surprised to learn that premiums are required for certain parts of Medicare. Interviewees also explained that some beneficiaries are unable to identify the MA, Part D, or Medicaid plan that they are enrolled in and often confuse Medicare and Medicaid plans, which can make counseling difficult.

Interviewees also described working with beneficiaries with varying income levels. One counselor noted that individuals contacting their SHIP seemed to be at the "extremes of income distribution." Beneficiaries with higher incomes often sought assistance understanding the effects of Medicare's income-related monthly adjustment amount (IRMAA) on their Part B and Part D premiums or requested validation that they had selected an appropriate Part D plan or Medigap policy.²⁸ All interviewees discussed helping beneficiaries navigate Medigap options, with common questions related to premiums, carriers, enrollment periods, and guaranteed-issue protections.

By contrast, beneficiaries with lower incomes typically required assistance applying for Medicaid or the MSPs. One counselor reported that most of the low-income individuals who contacted the grantee were eligible for those programs. All interviewees described assisting beneficiaries with completing MSP applications, a process that is particularly streamlined for SHIP counselors that have access to Medicaid eligibility and enrollment data. Interviewees also noted a high volume of interactions with dually eligible beneficiaries. One interviewee characterized these cases as the "most complicated" counseling sessions, due to the challenges associated with coordinating Medicare and Medicaid benefits. Consistent with these reports, a recent survey of SHIP counselors found that questions related to dual eligibility were among the most common topics raised by beneficiaries (Garrido et al. 2024). Interviewees further reported hearing from beneficiaries that they could only afford to enroll in MA plans with low or zero-dollar monthly premiums because they did not qualify for Medicaid or the MSPs.

Interviewees had varied access to state Medicaid eligibility and enrollment information. One SHIP with many dually eligible beneficiaries in their area reported having access to Medicaid eligibility and enrollment data, which they used to inform beneficiaries on Medicaid-related topics such as D-SNPs in MA and MSP applications. At other SHIP grantees, counselors must instruct the client to call or make an appointment with the Medicaid agency to confirm enrollment information. Another interviewee reported that, despite receiving approximately 1,000 referrals per month from their state's Medicaid program, their SHIP lacked access to Medicaid enrollment data.

Interviewees described SHIP counseling sessions as covering a broad range of topics beyond plan selection. While questions during the AEP typically focus on choosing coverage, SHIPs reported receiving non-Medicare enrollment-related questions outside of the AEP, pertaining to issues such as filing MA coverage appeals, navigating use of MA supplemental benefits, and midyear changes in Part D plan formularies. SHIPs also receive questions on late-enrollment penalties and Social Security retirement or disability benefits. Several interviewees also reported receiving finance-related calls, such as when beneficiaries with Part D plans have trouble paying for prescription drugs. Interviewees explained that such calls often become enrollment related as SHIP counselors provide information on options available to low-income beneficiaries, who may have more flexibility than other beneficiaries to change plans outside of the AEP.

Interviewees emphasized the increasing complexity of the Medicare program and its implications for SHIP operations. One interviewee stated that it is "unreasonable to expect a volunteer program to start picking up the slack on the growing complexity of the Medicare program." Although SHIP training materials are updated each year to prepare counselors for complex beneficiary cases, interviewees explained that some calls require referral to counselors with specialized expertise (for example, questions about how Medicare interacts with retiree health coverage offered by a local employer).

Providing in-person assistance and staying up-to-date on local market conditions All interviewees pointed to the value of the local nature of SHIP grantees because they can meet in person with beneficiaries, particularly

those with low health literacy or other circumstances that require enrollment assistance. Interviewees said that SHIP counselors possess knowledge of provider and pharmacy networks and available plans in the local area. The 1-800-MEDICARE customer service representatives have expertise in Medicare enrollment, coverage, and billing issues, but the call center is national and does not meet with beneficiaries in person or have specific expertise on local health care resources, such as knowing about recent local MA plan network changes (e.g., a local health system no longer in network for an insurance carrier) when counseling beneficiaries on their plan choices.

Interviewees also reported that SHIP counselors receive referrals directly from 1-800-MEDICARE. According to interviewees, 1-800-MEDICARE customer service representatives may refer beneficiaries to SHIP counselors when a greater level of in-person advocacy or more time-intensive assistance is needed, such as reviewing paperwork or providing extended counseling that may not be feasible for the national call center. Some interviewees noted that these referrals frequently involve questions related to Medicaid eligibility since SHIP counselors are familiar with state-specific eligibility requirements and can help guide beneficiaries through the application process for Medicaid-administered programs such as MSPs. One interviewee noted that beneficiaries may prefer contacting their local SHIP counselor instead of 1-800-MEDICARE because wait times are “significantly less.”

Interviewees reported that many beneficiaries commonly learn about the SHIP grantees through local marketing efforts, community outreach events, and word of mouth. Interviewees also noted that beneficiaries are referred to SHIP counselors by local Medicare insurance agents. Some described long-standing productive relationships with local agents to meet beneficiary needs when appropriate, as well as an increase in agent referrals to SHIP counselors when agents cannot earn a commission for enrolling the beneficiary in a plan. In contrast, one interviewee reported concerns about negative commentary from at least one local agent at public SHIP events and on SHIP website postings that may have been intended to steer beneficiaries to the local agent instead of the SHIP grantee.

Concerns about ongoing limited capacity Recent reports indicate that demand for SHIP counseling has increased alongside the continued growth of the Medicare population and the growing complexity of beneficiary coverage decisions (AARP 2025). The ACL reports that the average length of a one-on-one SHIP counseling session increased from 28 minutes in 2014 to 33 minutes in 2021, reflecting more complex counseling needs (Administration for Community Living 2021). The average SHIP session length is more than three times the average call time to the 1-800-MEDICARE call center (Administration for Community Living 2025). A recent survey of SHIP counselors found reports of capacity constraints, particularly during the AEP (Garrido et al. 2024). Furthermore, a recent secret-shopper study evaluating the Medicare information provided by SHIPs revealed challenges in reaching SHIP sites (Dugan et al. 2025). Nearly 47 percent of attempted phone calls to 131 unique SHIP sites could not be completed, with the most common reason for an incomplete phone call being that the secret shopper left a message and was not called back.

Our interviewees echoed these capacity challenges. Interviewees consistently expressed that they felt “inundated with calls” referred from 1-800-MEDICARE, insurance agents, and their local communities. One interviewee noted that the length of calls with beneficiaries can vary anywhere from five minutes to an hour, depending on beneficiary needs. We heard from all interviewees that existing SHIP capacity is insufficient to meet demand, particularly during the AEP. When surveyed, SHIP counselors have previously described capacity constraints, particularly during prior AEPs (Garrido et al. 2024). Even outside of the AEP, SHIP grantees are stretched thin, with one interviewee describing their counselors as “overburdened.”

Interviewees reported that the 2025 AEP presented a unique set of challenges, with one interviewee describing it as a “perfect storm” due to an increased volume of beneficiary contacts created by several contributing factors. Each SHIP grantee we spoke with noted that the volume of beneficiary contacts received during the 2025 AEP was substantially higher compared with previous years. One interviewee noted that they received four times as many calls per day during the

2025 AEP compared with the months before the 2025 AEP. Interviewees pointed to several contributing factors, including increased MA plan terminations in certain regions, providers exiting MA networks, increased referrals from Medicare agents following insurers' decisions to stop paying commissions for certain plans, expanded SHIP outreach and marketing efforts, and confusion about the continued operation of 1-800-MEDICARE during the 2025 federal government shutdown. Many beneficiaries called SHIP grantees for assistance switching to another MA plan or moving from MA to FFS Medicare, and an interviewee estimated that there was a "50/50 breakdown" between these two options. Other interviewees noted calls during the 2025 AEP for assistance with MA enrollment because of either high Medigap premiums or beneficiaries switching out of D-SNPs and into conventional MA plans.

Several interviewees noted that their local SHIP reached capacity (meaning that they could no longer accept any appointments to counsel beneficiaries for the remainder of the AEP (October 15 to December 7)) before Thanksgiving. One interviewee said their local SHIP was at capacity only three weeks into the 2025 AEP. Once at capacity, grantees are no longer able to help beneficiaries who do not already have an appointment through the rest of the AEP. When capacity is reached, local SHIPs notify 1-800-MEDICARE that they are at capacity and can no longer accept beneficiary referrals and inform the public through website postings, voicemail messages, and other outreach that the public needs to obtain assistance from 1-800-MEDICARE instead.

To extend their reach despite capacity constraints, interviewees described a range of process-improvement efforts. For example, the SHIP TA Center and SHIP grantees have developed more self-directed beneficiary education resources, such as videos, fact sheets, and other online materials that may help beneficiaries when counselors are unavailable. SHIP grantees also described implementing triage systems to assess the urgency of a particular inquiry and whether it can be handled with publicly available resources instead of individual counseling, determining which counselor has the requisite expertise to handle the issue in the event of complex matters, or redirecting inquiries to 1-800-MEDICARE due to capacity limits. One interviewee reported exploring the use of rule-based chatbots to handle routine questions.

Many beneficiaries work with insurance agents to navigate their Medicare options

Agents and brokers are trained insurance professionals who can help beneficiaries enroll in Medicare insurance plans. ("Agents" and "brokers" are often used interchangeably. In this chapter, we generally use "agents," who are appointed by insurance companies to sell their products.) There are two main types of insurance agents: independent agents, who are not employees of the insurance company and sell products from multiple insurance companies, and agents who are employed by or contracted with one insurance company (also referred to as a "captive agent"). A 2022 Commonwealth Fund survey found that, among Medicare beneficiaries ages 65 and older who received help with their plan choice, about 30 percent of FFS beneficiaries and 31 percent of MA enrollees turned to agents for help (Leonard et al. 2022).

In our annual focus groups, many beneficiaries report positive experiences working with agents to determine the premiums and out-of-pocket costs of different plans (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024). Beneficiaries described how their insurance agents tailored suggestions based on individual health needs, especially medication lists and clinician preferences. However, because agents are not required to contract with all available companies in their market, a single agent will not necessarily present every available plan to a beneficiary, something that may not be understood by the beneficiary even if agents disclose it in their communications.

Some agents contract with multiple insurance carriers that pay commissions tied to initial enrollment and retention of beneficiary enrollment 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—for instance, \$694 for initial enrollment in an MA plan (Centers for Medicare & Medicaid Services 2025m). In addition to commissions per enrollment, agents may receive supplemental administrative compensation such as a bonus for meeting enrollment benchmarks or payments for carrying out other activities for plans (e.g., beneficiary health risk assessments). There is no set cap for these payments, and CMS estimates that

administrative payments far exceed the compensation paid for enrollment (Centers for Medicare & Medicaid Services 2024c). These compensation arrangements have led some stakeholders to voice concern that agents have financial incentives to steer beneficiary decision-making. These incentives could favor enrollment in MA plans over Medigap plans and stand-alone prescription drug plans, in higher-premium Medigap plans over lower-premium Medigap plans, and in plans that offer bonuses for reaching enrollment benchmarks.

Beneficiaries report positive experiences working with insurance agents

In our annual focus groups, many beneficiaries said they had positive experiences working with agents to determine the out-of-pocket costs, premiums, and prescription costs of individual plans (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024). Most of these beneficiaries described wanting help understanding the different Medicare options, including traditional FFS Medicare versus MA, and more specific plan choices under each option. In general, beneficiaries in our focus groups found the agents they worked with to be helpful for navigating their choices and ultimately selected their plans after discussing options with their agent.

Beneficiaries described how their agents tailored suggestions based on individual health needs, especially medication lists and clinician preferences. These beneficiaries said that when they were establishing a relationship with an agent, they had comprehensive discussions about the medications they were taking, the specific clinicians they wanted to be certain were in a plan's provider network, and their preferences for specific hospitals or health systems.

Most of the beneficiaries in our focus groups who used insurance agents said they received information about multiple plans from different insurers. One beneficiary noted, "He presented five or six different companies. And we told him what we wanted." Another reported, "[My agent] looked through all the plans, then presented two or three different ones, and I really liked that." A subset of beneficiaries who described using an agent said the agent recommended a single plan. One participant noted, "[The agent] gave us options. But

then he said, 'Out of all these, this is the one I suggest because it fits you guys better.'"

In our focus groups, some beneficiaries questioned how agents are compensated by insurers, although most felt that their agents acted in their best interest. These beneficiaries questioned whether agents had financial incentives that might bias their recommendations and whether some plans pay agents more than others. One beneficiary noted: "How can you be assured that they have your best interest at heart? Because do they get the same amount of money from every company?" Although participants expressed awareness that agents are compensated by insurance companies, most felt that their agents still acted in their best interest. One beneficiary made this comment about their agent:

You know, you can't ask somebody to do something for free. But every year, as soon as the new Medicare stuff comes out, which I think is in October, I'm not 100 percent certain, but we always go and visit with her and she goes through everything and weighs it all.

Most beneficiaries in our focus groups reported checking in with their agent annually during the AEP to reassess their plan. A subset of beneficiaries used agents for additional services, such as finding travel insurance for cruises or answering questions about changes in their coverage, but most did not have interactions with their agent outside of the AEP.

Federal and state requirements to practice as an agent, including training

CMS requires that agents who represent MA and Part D insurers must be (1) licensed in the state in which they do business, (2) trained and annually tested on their knowledge of Medicare and health and prescription drug plans and achieve 85 percent or higher on all forms of testing, and (3) secure and document a scope of appointment before meeting with potential enrollees (Centers for Medicare & Medicaid Services 2026a, Centers for Medicare & Medicaid Services 2024a).²⁹ MA and Part D insurers must report to CMS all enrollments made by unlicensed agents and for-cause terminations of agents.

Each state's licensing requirements for agents vary. Generally, requirements involve specialized coursework and training, as well as passing a licensing exam. In

Michigan, for example, 40 hours of education are required before sitting for an exam covering principles pertaining to one's insurance field (Kaplan Financial Education 2025). However, not every state requires specialized coursework and training. For example, any Tennessee resident over the age of 18 may sit for the state's agent-licensing exam, regardless of whether they have completed any education courses. Some states also have annual continuing-education requirements for agents to keep their license in good standing. While state licensing exams generally cover the same health insurance topics across states, such as basic insurance product knowledge, they differ in their sections pertaining to state regulations that licensed agents must follow.

An agent also does not typically have to be a resident of the state in which they are applying for a state insurance license, which allows agents to serve clients in multiple states. States typically have a reciprocity provision in which an individual holding an active license in good standing from one state can apply for what is known as a nonresident state health insurance producer license in another state. Since these individuals are already licensed, they often do not have to complete the precensing requirements or pass a licensing exam in their nonresident state. Instead, they are often required to submit an insurance license application for that state and pay the applicable fee.

CMS requires that MA and Part D insurers provide training and testing to agents on Medicare rules and regulations, the plans that agents will sell (including any details specific to each plan), and relevant state and federal requirements. CMS annually provides MA insurers with training and testing guidelines (Centers for Medicare & Medicaid Services 2025p). In addition, the insurers themselves often require agents to complete product and sales training. Many insurers require agents to complete a training program developed by AHIP, a national association of health insurers, in order to sell MA products (AHIP 2025).

CMS requires that MA plans and PDPs put systems in place to ensure that agents appropriately communicate with beneficiaries, including that agents appropriately complete scope-of-appointment records for all personal marketing appointments (including telephonic and walk-in). The scope-of-appointment form specifies which Medicare plans and topics will be discussed

during the meeting and is intended to prevent unexpected sales pitches.

Agents typically sell plans from multiple insurers but are not required to sell all available plans in their market

Independent agents typically have contracts with multiple insurers but are not required to contract with every insurer that offers plans in their market. As a result, an agent will not necessarily represent every plan that is available to a beneficiary. In this way, agents filter plan options, which may not be apparent to the beneficiary even if the agents disclose it in their communications.

It is not clear what proportion of total available plans in a given geographic area a typical agent will represent, though some analysis suggests that it varies. The Commonwealth Fund compared the MA plans and PDPs listed on Plan Finder with the plans listed on three large online-agent tools for five metropolitan areas (Commonwealth Fund 2021b). They found that, on average, each online-agent tool included less than half (43 percent) of MA plans and less than two-thirds (65 percent) of PDPs listed on Plan Finder (Commonwealth Fund 2021b).

Agents are compensated by insurers, with compensation tied to initial enrollment and enrollment retention

Insurers must report to CMS if they use agents to sell MA and Part D plans. In our analysis of the information publicly reported by CMS for coverage year 2025, virtually all insurers (99 percent) reported that they were using independent agents to sell their plans (Centers for Medicare & Medicaid Services 2024a). (Ninety-six percent of MA and Part D insurers also use employed agents to sell their products, and those agents are exempt from compensation requirements (Centers for Medicare & Medicaid Services 2026a, Centers for Medicare & Medicaid Services 2024a).) A survey of Medigap insurers found that 85 percent used independent agents to sell their plans (Gen Re 2025, Gen Re 2024).

The ways in which agents are compensated for their services vary and can be complex. Commonly, agents contract with multiple insurers that pay commissions tied to initial enrollment and beneficiary retention in the MA, Part D, or Medigap plans they sell.³⁰ CMS

has established maximums on the compensation per enrollment that MA and Part D plans can pay agents. In addition to commissions per enrollment, agents may receive supplemental compensation, which does not have set federal maximums, such as a bonus for meeting enrollment benchmarks or payments for carrying out other activities for plans such as beneficiary health risk assessments.

Payments to agents for enrolling beneficiaries in MA or Part D Compensation caps reduce the variation in commissions across plans, which can limit the ability of insurers to incentivize agents to steer beneficiaries toward their plan by offering a larger commission. The Medicare statute requires that CMS develop guidelines to ensure that the use of agent compensation creates incentives to enroll individuals in the MA plan that is intended to best meet their health care needs (Centers for Medicare & Medicaid Services 2024b). CMS has also established that agent compensation is an administrative cost for insurers in the calculation of an MA plan's medical loss ratio (MLR) (Centers for Medicare & Medicaid Services 2025g).³¹ Based on insurer-reported information, spending on agent and broker fees and commissions increased from \$2.4 billion in 2018 to \$6.9 billion in 2023—a 19 percent compound average growth rate (U.S. Senate Committee on Finance 2025). Because of data limitations, this figure is likely an underestimate of spending.³²

For each initial year of enrollment, MA plans and PDPs may pay agent compensation up to a maximum amount known as the fair market value (FMV), which is updated annually (Centers for Medicare & Medicaid Services 2005). The FMV amounts are originally based on 2006 to 2007 commission data that plans submitted to CMS and have been adjusted since then by the national per capita MA growth percentage (Centers for Medicare & Medicaid Services 2012, Centers for Medicare & Medicaid Services 2008b). Agents receive initial enrollment payments from insurers during the first year of a beneficiary's enrollment or when there is an enrollment change to an “unlike plan type.”³³ Once a beneficiary has enrolled in an MA plan or PDP, agents can earn a renewal enrollment payment of up to 50 percent of the FMV when the beneficiary stays with their original plan or switches to a “like plan type.”³⁴

Insurers determine the exact compensation level they will pay agents for enrollment in a plan. There is no requirement for MA and Part D organizations to report the exact amounts they compensate agents. However, on an annual basis, organizations must report to CMS the minimum and maximum rates they will pay independent agents (Centers for Medicare & Medicaid Services 2024a). In our analysis of 2025 data that plans reported, we found that close to 85 percent of reporting MA plans and over 90 percent of reporting Part D plans use the FMV maximum initial and renewal commissions as their maximum reported rates and zero dollars as the minimum reported rates. We have heard from some agents that MA and Part D organizations typically pay the FMV maximum compensation amount.

For 2026, the FMV amount for most states is \$694 for an initial enrollment in an MA plan and \$347 for a renewal year (Table 2-5, p. 76) (Centers for Medicare & Medicaid Services 2025m). The FMV limits are higher in California, Connecticut, the District of Columbia, New Jersey, and Pennsylvania and lower in Puerto Rico and the U.S. Virgin Islands. The FMV amount for all states for initial PDP enrollment is \$114 and \$57 for renewal years. (When a beneficiary enrolls in an MA plan that has prescription drug coverage (an MA-PD), insurers pay only the MA compensation amount.) All FMVs are updated annually by adding the current year's FMV and the product of the current-year FMV and the national per capita MA growth percentage for combined aged and disabled beneficiaries, which is published each year in the annual MA rate notice (10.7 percent in 2026) (Centers for Medicare & Medicaid Services 2025c).

In addition to the compensation for enrollment, MA and Part D organizations can also pay agents for referrals of beneficiaries for enrollment in MA and Part D plans (also known as “finder's fees”) (Centers for Medicare & Medicaid Services 2005). CMS has stated that referral fees are not contingent on a beneficiary being enrolled in a plan and are essentially payments for sales leads (Centers for Medicare & Medicaid Services 2021). Plans may determine the circumstances as to when they pay referral fees. CMS sets a referral fee limit that “reflects an amount CMS determined is reasonably expected to provide financial incentive for an agent or broker to refer a beneficiary for an enrollment into a plan that is not the most appropriate

**TABLE
2-5**

**Maximum insurance-agent compensation per enrollment
in Medicare Advantage and Part D plans, 2026**

Compensation type	National	Connecticut, Pennsylvania, District of Columbia	California, New Jersey	Puerto Rico, U.S. Virgin Islands
MA				
Initial year	\$694	\$781	\$864	\$474
Renewal years	347	391	432	237
PDP				
Initial year	114	—	—	—
Renewal years	57	—	—	—

Note: MA (Medicare Advantage), PDP (prescription drug plan). CMS establishes maximum annual compensation amounts that an insurer can pay an independent agent for initial enrollment in MA and Section 1876 cost plans and PDP plans, as well as in renewal years. The compensation rate for an initial enrollment must be at or below the fair market value (FMV), and renewal compensation is limited to a maximum of 50 percent of the FMV. The FMV for MA plans is higher than the national rate in five states and lower in two U.S. territories. There is no variation by state/territory in the maximum compensation for PDP enrollment.

Source: Centers for Medicare & Medicaid Services 2025m.

to meet his or her needs” (Centers for Medicare & Medicaid Services 2021). These fees are one-time only and may not exceed \$100 for a referral into an MA plan and \$25 for a referral into a PDP.

Some insurers are willing to compensate agents beyond the enrollment and referral fees. MA and Part D organizations can also make administrative payments for services other than enrollment of beneficiaries (for example, training, customer service, agent recruitment, operational overhead, or assistance with completion of health risk assessments (HRAs)). As defined in regulation, the payments for these services must not exceed the value of those services in the marketplace (Centers for Medicare & Medicaid Services 2005). CMS does not set a maximum value for administrative payments as it does with enrollment-based compensation. CMS has said that “it is our understanding that the administrative fees paid per enrollee far exceed the compensation paid for that enrollment” (Centers for Medicare & Medicaid Services 2024c).³⁵

In focus groups convened by the Commonwealth Fund, agents said that they can earn extra income from

conducting beneficiary HRAs during the MA enrollment process (Commonwealth Fund 2023). All focus-group participants who sold MA plans said they were paid to complete HRAs when their clients enrolled in a new MA plan. Many characterized the assessments as an easy way to earn extra money because they take only around five minutes to complete. In 2023, CMS reported that some agents receive up to \$125 for completing an HRA of a new enrollee, an amount that was about 10 times higher than CMS’s estimate of the FMV for such an assessment when provided by nonmedical staff (Centers for Medicare & Medicaid Services 2023b). However, we heard from some agents that most MA plans have since changed their compensation policies to only provide HRA-related payments for SNP enrollees. One large MA insurer is offering agents a payment of \$35 to complete HRAs for SNP enrollees in 2026 (Humana 2026). It is not clear how plans use the HRA information collected by agents. Such information could help plans identify beneficiaries for follow-up, including documentation of diagnoses through clinician-conducted HRAs. (The diagnoses listed on HRAs can increase plan payments under the MA risk-adjustment system, but only if the HRAs are conducted by a clinician.)

Payments to agents for enrolling beneficiaries in

Medigap In general, the sale of Medigap plans is governed by state law and regulation, which are deemed to meet federal requirements if the state's law and regulation provide for standards at least as stringent as those contained in the NAIC model regulation (Centers for Medicare & Medicaid Services 2017). The NAIC model regulation permits compensation only if the first-year enrollment commission or other compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy in the second year. Renewal compensations must be the same amounts and are provided for no fewer than five renewal years (National Association of Insurance Commissioners 2025). The NAIC model regulation defines compensation as any kind of payment or nonmonetary item relating to the sale or renewal of the policy, including but not limited to bonuses, gifts, prizes, awards, and finder's fees (National Association of Insurance Commissioners 2025).

The agent's commission is typically a percentage of the annual plan premium; the insurer sets the percentage, and the commission is paid by the insurer (Commonwealth Fund 2021a). This structure can tend to provide an agent with a higher commission for enrolling beneficiaries in a higher-premium Medigap policy. A recent industry report indicates that first-year commissions for enrollments in Medigap are approximately 20 percent of annual premiums, but they can vary based on the state or plan type (Gurley 2025). The commission for subsequent years (i.e., the renewal or residual commission) is generally set at 10 percent of the premium (Commonwealth Fund 2021a). The renewal commissions can drop to 1 percent or 2 percent of the premium after 6 years and to zero percent after 10 years (Clark 2022). Agents have anecdotally reported that some insurers do not pay commissions (sometimes known as "zero-dollar commissions") for Medigap plans covered by guaranteed-issue requirements (Centers for Medicare & Medicaid Services 2024d).

The average monthly premium for Medigap plans was \$217 in 2023, or \$2,604 for a full year of coverage, according to a KFF analysis of data from the NAIC (Freed et al. 2024b). However, premiums vary by state and by policy type. For example, the average monthly premium for people enrolled in Plan G was \$164 (\$1,968

for 12 months), but this amount varied from a low of around \$140 in Hawaii, New Mexico, and the District of Columbia to a high of \$236 in New York. Based on the national average of \$2,604 and the industry reports cited above on the percentage of premiums used to determine agent compensation, an agent could be paid about \$521 for the first year and \$260 as a renewal commission. These are estimates of average premiums because premiums and rate adjustments for policies vary and commissions may shift based on beneficiary, type of policy sold, and location.

Agent compensation may create financial incentives to steer beneficiary decision-making

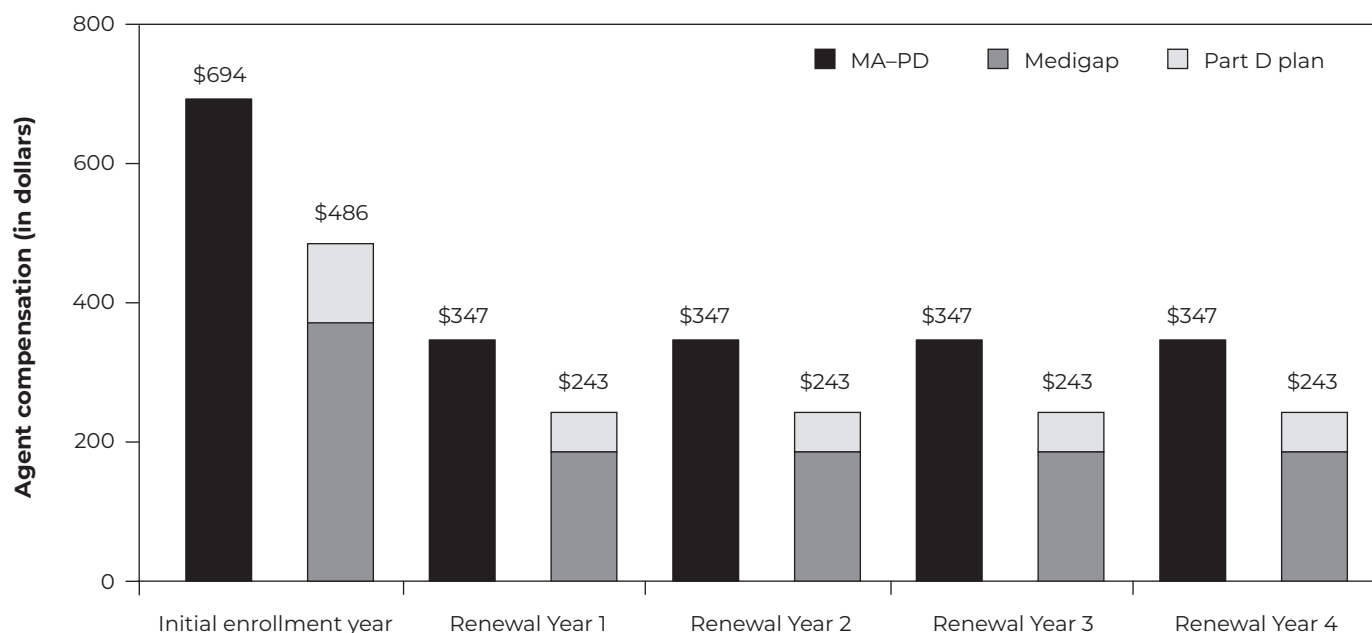
Beneficiaries choose their coverage by weighing the costs and financial protections, access to care, and extra benefits offered by different insurance options with their own needs and preferences. Insurance agents can help beneficiaries consider their enrollment options, saving beneficiaries significant time researching plan details. Their personalized guidance, which may include year-round support (e.g., helping beneficiaries with claims or answering coverage questions) comes at no cost to the beneficiary since agents are paid by insurance companies. The agents we spoke with reported that they assume a fiduciary role with their clients and want to get beneficiaries into the plan that is right for them, regardless of the financial incentives.

But some stakeholders have voiced concern that agents have financial incentives to steer beneficiary decision-making. These incentives could favor enrollment in MA plans over FFS Medicare with Medigap plans and PDPs, in higher-premium Medigap plans over lower-premium Medigap plans, and in plans that offer bonuses for reaching enrollment benchmarks.

Enrollment in MA-PDs over Medigap and PDPs In the Commonwealth Fund's agent focus groups, most agents recalled receiving higher commissions—sometimes much higher—for enrolling people in MA plans compared with Medigap plans, with some variation by geographic region and new enrollments versus renewals (Commonwealth Fund 2023). One agent in the Commonwealth Fund focus groups recalled getting paid three times more to sell an MA plan; even when the PDP and Medigap commissions were added together, most agents said that MA commissions were

**FIGURE
2-3**

Illustrative example of agent compensation providing financial incentives to enroll beneficiaries in an MA-PD plan over Medigap and a stand-alone Part D plan



Note: MA-PD (Medicare Advantage Prescription Drug [plan]). For the coverage year 2026, CMS established maximum agent compensation for initial enrollment in an MA plan at \$694 and a PDP at \$114. The maximum renewal-enrollment compensation for MA is \$347 and \$57 for PDPs. This example uses the median annual premium for a Plan G Medigap plan (\$1,860) based on Plan Finder results for a 65-year-old female with no tobacco use and no household discount in ZIP code 22206 (Arlington, VA). We assume that agent compensation for Medigap is 20 percent of the annual premium for initial enrollment and 10 percent of the annual premium for renewal enrollment. This illustrative example does not include administrative and bonus payments that insurers may pay agents.

Source: MedPAC analysis of CMS compensation amounts and Medicare Plan Finder tool.

much higher. The difference in commissions could create incentives for agents to steer beneficiaries to certain plans.

However, we spoke with some agents who reported that they think about their compensation over time rather than just the initial commission amount. These agents told us that their goal is to have a successful long-term relationship with the beneficiary and that the difference in commission payments between MA plans and Medigap policies would not induce them to steer the beneficiary to a plan that was not right for that beneficiary. We also heard from some agents that Medigap plans have more “plan persistency” than MA, meaning that Medigap plans are more likely to be consistent year after year and that beneficiaries tend to stay in the same Medigap plan over time. Thus,

writing a Medigap policy may have a more reliable renewal commission with less time spent consulting a beneficiary every year, compared with MA plans, which can change every year.

Using the information presented in the sections above, we now present an example that illustrates the financial incentives that an agent might have to encourage beneficiaries to enroll in an MA-PD over a Medigap plan and a PDP. This illustrative example is incomplete and may be a lower estimate because we do not have data on administrative and bonus payments that insurers pay agents. In our illustrative example, an agent selling an MA-PD to a new enrollee in Virginia could earn \$694 in compensation in 2026 (the FMV limit) (Figure 2-3). If the agent instead enrolled that beneficiary in a median-priced Medigap policy (Plan G)

and a PDP, they could earn an estimated \$372 (20 percent of the \$1,860 annual premium) for the Medigap plan plus \$114 for the PDP, for a total of \$486. Thus, for the initial year of enrollment, the agent would make \$208 more for enrolling the beneficiary in MA over Medigap and a PDP.

In the subsequent year, if that enrollee stayed in their initial MA plan or switched to a “like” MA plan, the agent could receive \$347 (Figure 2-3). If the enrollee stayed in their Medigap plan and PDP, the agent would receive \$186 (10 percent of the \$1,860 annual premium) and \$57 for the PDP, or \$243 in total, which is \$104 lower than the MA renewal fee. Over a five-year period, an agent could make \$624 more by enrolling a beneficiary in an MA plan versus a Medigap plan and PDP. (This example assumes that the beneficiary stays in the plan for five full years.)

Note that in our illustrative example, the compensation amounts for renewal remained the same over the period. However, in actuality, the financial incentives to enroll beneficiaries in MA instead of Medigap could be increasing over time. A Commonwealth Fund analysis that used 2016, 2018, and 2020 data found that MA plans had higher commissions in all three years and that the difference between MA and Medigap commissions increased over that period (Commonwealth Fund 2021a).

Enrollment in higher-premium Medigap plans over lower-premium Medigap plans Since the agent-compensation structure for Medigap is typically a percentage of the premium, agents have an incentive to enroll beneficiaries interested in Medigap in plans with higher premiums. Most beneficiaries with Medigap plans choose plan types that provide comprehensive coverage, such as Plan G, which covers all Part A and Part B cost sharing other than the Part B deductible (see Appendix 2-A, p. 81). The premium amount is the key difference between Medigap policies within the same plan letter sold by different companies, and there is variation in the premiums that different insurance companies charge for the same types of coverage (Freed et al. 2024b).³⁶

As an illustrative example, if an agent enrolled a beneficiary in Virginia in a median-priced Plan G Medigap plan, they could make \$372 (20 percent of the \$1,860 annual premium) (Figure 2-4, p. 80). If the

beneficiary instead enrolled in the median-priced Plan N policy, the agent would make \$278 (20 percent of the \$1,392 annual premium). Thus, on that initial enrollment, the agent would make \$94 more for enrolling the beneficiary in Plan G instead of Plan N. In the subsequent year, if that beneficiary remained enrolled in their Medigap plan, the agent could receive \$186 (10 percent of the \$1,860 annual premium) for the Plan G policy versus \$139 (10 percent of the \$1,392 annual premium) for the Plan N policy, a difference of \$47. Over a five-year period, an agent could make \$282 more for enrolling a beneficiary in the higher-premium Plan G Medigap policy.

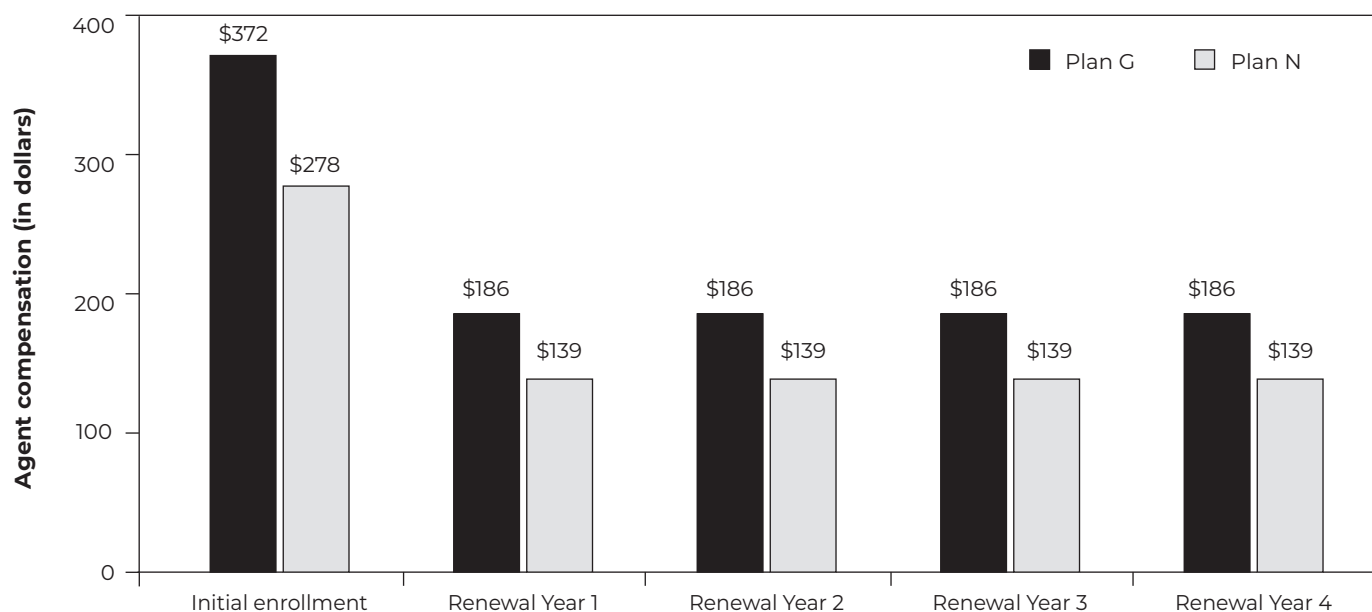
Bonuses for reaching enrollment benchmarks In the Commonwealth Fund’s agent focus groups, agents said that insurers commonly provide bonus payments for reaching enrollment benchmarks, with some payments described as “substantial” (Commonwealth Fund 2023). Describing one insurer’s bonus program, a focus-group participant said, “I think it was 20 policies within a three-month period. That bonus was actually a hundred bucks a policy.” The Department of Justice (DOJ) recently filed a complaint against three insurers and three large insurance brokers that allegedly directed Medicare beneficiaries to plans offered by insurers that paid the most in “kickbacks,” regardless of the plan’s suitability for the beneficiary (Department of Justice 2025).

Insurers may stop paying commissions for certain plans

Insurers do not have to pay commissions to agents for enrolling beneficiaries in MA plans. There are reports of some insurers halting commission payments for new enrollment in certain MA plans. For example, partway through the 2024 AEP, three insurers (Aetna, Cigna, and Elevance) stopped offering commissions to agents and third-party marketers for certain plans and in certain markets (Tepper 2024). Beginning in July 2025, UnitedHealth Group stopped paying commissions in all or part of 38 states and the District of Columbia for more than 180 plans (Young and Tepper 2025). The plans affected by this change were PPO products but included some HMO products and special-needs plans. Insurers may stop paying commissions for some plans because sales are higher than desired. Some insurers have also stopped paying agent commissions on PDPs, which may be an attempt to encourage agents to direct consumers into the insurer’s MA plans (Herman 2025, Herman 2024). As noted above, CMS has also heard that

**FIGURE
2-4**

Illustrative example of agent compensation providing financial incentives to enroll beneficiaries in a higher-premium Medigap plan over a lower one



Note: This example uses the median annual premiums for a Plan G Medigap plan (\$1,860) and Plan N Medigap plan (\$1,392) based on Plan Finder results for a 65-year-old female with no tobacco use and no household discount in ZIP code 22206 (Arlington, VA). We assume that agent compensation for Medigap is 20 percent of the annual premium for initial enrollment and 10 percent of the annual premium for renewal enrollment. This illustrative example does not include data on administrative and bonus payments that insurers may pay agents.

Source: MedPAC analysis of CMS compensation amounts and Medicare Plan Finder tool.

some Medigap insurers do not pay commissions for guaranteed-issue Medigap plans (Centers for Medicare & Medicaid Services 2024d).

In late 2025, roughly a dozen state departments of insurance warned insurers about the use of zero-dollar commissions under state laws because they hinder consumer access to plans (Tong 2025).³⁷ CMS then issued a memo to state insurance commissioners noting that federal law likely preempts state laws in regulating MA broker compensation (Centers for Medicare & Medicaid Services 2025n).

Agents told us that if they enroll beneficiaries in zero-dollar-commission plans, they will not be paid for their work. Some agents reported that they do enroll beneficiaries in zero-dollar-commission plans, particularly when there is a long-standing relationship

between the agent and the beneficiary and the agent believes the zero-dollar-commission plan is the right plan for the beneficiary. Some agents reported that they will refer beneficiaries to SHIP counselors or 1-800-MEDICARE when they think a zero-dollar-commission plan is best, because they prioritize enrollments with a commission. ■

2-A

APPENDIX

Special enrollment periods and situations specific to Medigap

We discuss three common special enrollment periods (SEPs) and situations specific to Medigap in this appendix: no longer covered by an employer's group health plan, trial rights, and a significant change in a plan's provider network, as well as issues specific to Medigap.

No longer covered under an employer's group health plan

Most individuals are eligible for Part A without a premium, so individuals who are still working and covered under their (or their spouse's or parent's, as applicable) employer-sponsored group health plan will typically enroll in Part A when eligible and do not need an SEP. However, individuals who are working and are covered by an employer-sponsored group health plan can postpone Part B (and Part A if they must pay a premium) enrollment without a penalty by using the SEP for employer group health plan coverage.³⁸ These individuals who postpone Part B enrollment also preserve their guaranteed-issue right to a Medigap plan when they are no longer covered by a group health plan sponsored by an employer. This SEP begins after the individual is no longer covered by a group health plan because they (or their spouse or parent, as applicable) are no longer actively employed or the employer-provided medical coverage ends, and the SEP concludes after eight months from the month the employment or employer-provided coverage ends. Individuals who use this SEP to enroll will avoid Part B (and Part A if they must pay a premium) late-enrollment penalties unless there is a gap after the end of the SEP before the individual enrolls.

However, individuals (or their spouse or parent, as applicable) who are no longer actively employed or whose employer-sponsored coverage ends may have insurance that is not an employer-sponsored group health plan. Having this insurance does not confer eligibility for the Part B SEP. Examples of insurance not considered an employer-sponsored group health plan for the purpose of the Part B SEP are Consolidated Omnibus Budget Reconciliation Act (COBRA) plans, retiree health plans with coverage for individuals (or their spouse or parent, as applicable) no longer actively

working, Veterans Affairs coverage, TRICARE, or individual health coverage (such as through the Health Insurance Marketplace).

In contrast to the Part B SEP requirements, the Part D SEP requirements allow consideration of whether the other insurance is creditable prescription drug coverage. Health plans that offer prescription drug coverage, like plans from employers or unions, are required to notify their Part D-eligible members if the coverage they offer is creditable coverage. However, a failure to notify members that they are eligible for Part D does not lead to an SEP. Individuals with creditable coverage will not be subject to the Part D late-enrollment penalty unless there is a gap of creditable prescription drug coverage for 63 or more days in a row. This situation means that an individual with COBRA coverage would not be eligible for a Part B SEP but may be eligible for a Part D SEP if the COBRA coverage includes creditable prescription drug coverage.

If an individual loses their employer group health plan because they are no longer actively employed or their employer-sponsored coverage ends, or when they elect into or out of employer-sponsored coverage, such as during an employer's "open season," there are also SEPs for Medicare Advantage (MA) and Part D. Individuals desiring to enroll in MA and/or Part D have two months after their group health plan coverage ends to enroll in a plan.

Once individuals enroll in Part B, they have six months to enroll in a Medigap plan to obtain a guaranteed-issue policy (some states may have additional guaranteed-issue rights). Individuals may have employer-sponsored coverage that would allow a Part B SEP if they enrolled in Part B after their employer coverage ends. Sometimes individuals will enroll in Part B when they turn 65, even if they have employer coverage. However, the six-month Medigap guaranteed-issue period starts when they are 65 or older and enroll in Part B. Individuals may not realize that they should wait to enroll in Part B or that they need to enroll in Medigap during that six-month period to preserve their guaranteed-issue rights if they do not qualify for the employer group health plan situation below.

Part B-enrolled individuals who are members of an employer group health plan offered by an employer

of a certain size (20 or more employees for aged beneficiaries or 100 or more employees for disabled beneficiaries) are eligible for Medigap guaranteed-issue rights when their employer coverage ends. This situation allows individuals 63 days from notice of the loss of employer coverage to buy certain Medigap plans sold in their state without medical underwriting.

The Medigap guaranteed-issue right is broader than the Part B SEP due to the consideration of the type of insurance that is ending. The Part B SEP applies only when employer group health plans are ending (or the beneficiary is choosing to leave the employer group health plan) and not when retiree or COBRA coverage is ending. In contrast, the Medigap guaranteed-issue right applies when employer group health plans as well as retiree or COBRA coverage is ending.

Trial rights

There are two SEPs that let individuals who have been in MA for less than 12 months exercise “trial rights” to buy a guaranteed-issue Medigap policy without medical underwriting after the Medigap enrollment period. The first SEP applies to beneficiaries joining an MA plan when they are first eligible for Part A and Part B at age 65 and within the first year of MA plan enrollment, decide to return to FFS Medicare and purchase a Medigap policy. The beneficiary may apply for certain Medigap policies sold in their state on a guaranteed-issue basis no more than 63 days after disenrolling from the MA plan.

The second trial-right period applies to beneficiaries who dropped a Medigap policy to join an MA plan for the first time and have been in the MA plan for less than a year. These beneficiaries may apply for a Medigap policy no more than 63 days after disenrolling from the MA plan unless other circumstances apply. The beneficiary can buy the same Medigap policy that they had before enrolling in the MA plan if it is still sold by the same insurer; otherwise the beneficiary may buy certain Medigap policies sold in their state on a guaranteed-issue basis no more than 63 days after disenrolling from the MA plan.

Significant change in provider or pharmacy network

There is an MA and Part D SEP for exceptional circumstances, including a significant change in the beneficiary’s provider network.³⁹ If a significant change in network has occurred, within two months of notice of the significant change, the affected enrollee has the option to stay enrolled in the plan, change MA plans, or return to fee-for-service (FFS) Medicare and purchase certain guaranteed-issue Medigap policies without medical underwriting. Enrollees affected by the significant change are those who are assigned to, are currently receiving care from, or have received care within the past three months from a provider or facility being terminated from the plan’s provider network.

Plans have considerable discretion to select the providers with whom to contract to build their provider networks, and providers have discretion about which plans to participate in. Plans can make changes to provider and pharmacy networks at any time during the contract year, after beneficiaries have already enrolled. CMS states that plans “may be in the best position to determine whether or not a provider termination without cause is significant,” regardless of the cause of the provider’s termination from the network (Centers for Medicare & Medicaid Services 2016a). CMS expects plans “to take a conservative approach in determining whether the no-cause provider termination represents a significant change to the network by notifying CMS if there is any doubt” as to whether the termination represents a significant change to the network (Centers for Medicare & Medicaid Services 2016a).

CMS considers significant changes to provider networks “to be those that go beyond individual or limited provider terminations that occur during the routine course of plan operations and affect, or have the potential to affect, a large number” of the plan’s enrollees (Centers for Medicare & Medicaid Services 2016a). CMS stated that it has “a rigorous internal review process that evaluates the totality of the unique circumstances around each termination to carefully determine whether that network change is ‘significant’ and requires an SEP” (Centers for Medicare & Medicaid Services 2024d). If a termination represents

a significant change in the plan's provider network, the plan is notified and must notify its enrollees of their eligibility for this SEP, including the right to Medigap guaranteed issue, and how to use the SEP (Centers for Medicare & Medicaid Services 2025h). CMS provides a model notice for MA plans to use to send to beneficiaries who disenroll from the plan and enroll in FFS Medicare about their temporary right to Medigap guaranteed issue.

CMS proposed a new rule for contract year 2027 to streamline the SEP and the change in provider-network plan notification by (1) replacing the current SEP for significant change in provider network with a new, broader SEP for provider terminations, thereby removing the need to make a determination on the significance of the change before enrollees are eligible for the SEP; and (2) requiring MA organizations to provide information about SEP eligibility as part of their notification to enrollees of an upcoming change in their provider's network status (Centers for Medicare & Medicaid Services 2025i). However, while acknowledging the broad interest in this topic, CMS ultimately decided not to finalize the proposal, stating that it will continue to consider the extent to which it may be appropriate to engage in future rulemaking in this area (Centers for Medicare & Medicaid Services 2026e).

Even if the determination is made that the change to a provider is not a significant change on a plan basis, SEP eligibility determinations may be made on an enrollee-by-enrollee basis, considering an enrollee's individual circumstances. Enrollees may contact 1-800-MEDICARE to request an SEP due to exceptional circumstances, such as situations in which access to services is compromised and adverse health consequences would result, including maintaining continuity of care for a chronic condition and to prevent interruptions in treatment (Centers for Medicare & Medicaid Services 2024d). The supporting details and documentation are reviewed to determine whether the enrollee is eligible for an SEP. If the enrollee is eligible, the SEP application is forwarded to the plan for processing, and the plan will send a notification to the enrollee. The enrollee may use that notification to enroll in another plan or, for MA enrollees, to return to FFS Medicare and enroll in a Medigap policy on a guaranteed-issue basis as part of the SEP.

Medigap guaranteed-issue rights and state variation

Regarding Medigap, individuals can obtain a guaranteed-issue Medigap policy at other times after the Medigap enrollment period in certain limited situations. As of 2024, 35 states require Medigap insurers to issue policies to Medicare beneficiaries ages 65 and older due to certain specified circumstances (Freed et al. 2024b). Outside of the federal and state enrollment periods, the right to purchase a Medigap policy is not guaranteed. Insurers may require medical underwriting before issuing a policy.

States have established requirements regarding the sale and pricing of Medigap plans. Individuals may be eligible for a guaranteed-issue Medigap policy during certain limited time periods precipitated by individual circumstances, depending on applicable state law. Some insurers may not sell a Medigap policy to an individual with certain medical conditions if the individual is subject to medical underwriting.

Four states (Connecticut, Maine, Massachusetts, and New York) require either continuous or annual guaranteed-issue protections for Medigap for all beneficiaries ages 65 and older, regardless of medical history (CSG Actuarial 2025). In Connecticut and New York, insurers are required to issue Medigap policies at any time during the year without medical underwriting to all individuals over age 65, while Massachusetts limits annual enrollment without medical underwriting from February 1 through March 31 (CSG Actuarial 2025). In Maine, each insurer must designate a one-month guaranteed-issue period each year when any applicant ages 65 to 70 will be accepted in Medigap Plan A without medical underwriting (CSG Actuarial 2025). Minnesota recently enacted legislation to institute annual guaranteed-issue protections, with an anticipated effective date of August 1, 2026. In these states, individuals who missed their initial Medigap enrollment period may obtain a Medigap policy without medical underwriting during the continuous or annual period, as applicable in the state. Individuals with a Medigap policy may also switch Medigap policies during the continuous or annual period, as applicable in the state.

After the initial Medigap enrollment period, there is no federally required annual enrollment period (AEP) that would allow beneficiaries to join or switch Medigap policies or insurers without medical underwriting unless a specific situation applies. In general, beneficiaries may drop their current Medigap policy and try to switch to another Medigap policy—or drop their MA plan, switch to FFS Medicare, and try to buy a Medigap policy—at any time. However, unless state law requires the sale of guaranteed-issue Medigap policies after the Medigap enrollment period or other federal situations apply, due to medical underwriting, individuals may not qualify for another Medigap policy. In contrast, federal rules allow beneficiaries to join, switch, or drop their MA plan or PDP annually during the AEP from October 15 through December 7. Enrollees may also switch or drop their MA plan annually during the open enrollment period (OEP) from January 1 through March 31.

For those with Medigap policies, state law may permit switching Medigap policies to other Medigap policies at certain times during the year. For example, in Maine, individuals with an existing Medigap policy may purchase another policy that provides equal or lesser benefits up to 60 days before the requested coverage effective date without medical underwriting (CSG Actuarial 2025). Washington allows individuals already enrolled in Medigap to switch to another plan or carrier at any time during the year, with some restrictions about which lettered plan the enrollee may switch to; for example, persons with Plan H, I, or J may move only to a less comprehensive Medigap plan (CSG Actuarial 2025). Minnesota's recently enacted Medigap legislation includes a guaranteed-issue AEP that will align with the dates of the MA OEP (January 1 through March 31), which may help reduce some of the enrollment complexity for enrollees in that state.

As of January 1, 2026, 12 states have a version of what is known as a “birthday rule” in place (CSG Actuarial 2025). The birthday rule is an annual application period around the Medigap beneficiary's date of birth that typically allows a beneficiary with a Medigap policy to change Medigap policies or carriers, usually only to

a policy with equal or lesser benefits, often without medical underwriting, as dependent on state law. For example, an individual with a Medigap policy issued in Maryland has 30 days from the individual's birthday each year to switch to another available Medigap policy with equal or lesser benefits than the individual's current Medigap policy (CSG Actuarial 2025). Because the individual in Maryland already has a Medigap policy, the individual may switch policies without medical underwriting (or without additional medical underwriting if the individual was subject to medical underwriting when they first purchased their Medigap policy).

Missouri has an “anniversary rule” in place in which Medigap enrollees who terminate their Medigap plan within 30 days of the Medigap policy's annual anniversary date in a year may obtain the same lettered plan from another insurer with no medical underwriting for a period of 63 days from the termination (CSG Actuarial 2025). For example, if an individual in Missouri purchased a Medigap policy on February 8, 2024, in order to take advantage of this rule in 2025, the individual would have had to terminate their existing policy within 30 days of their policy's anniversary date (February 8, 2025), which would have been by March 10, 2025. The individual could obtain the same lettered plan from another insurer within 63 days of the termination date of their policy. For example, if the individual terminated their existing policy on March 10, 2025, they would have had until May 12, 2025, to complete their purchase of a policy from another insurer. Because the individual in Missouri already has a Medigap policy, the individual may switch policies without medical underwriting (or additional medical underwriting if the individual was subject to medical underwriting when they first purchased their Medigap policy).

The birthday and anniversary rules apply only to individuals who currently have a Medigap policy. Individuals without a Medigap policy may try to obtain a policy at any time during the year, but due to medical underwriting, they may not qualify. ■

2-B

APPENDIX

Beneficiaries' experiences assessing their coverage options, according to Medicare's annual survey

Medicare beneficiaries face complex decisions about their coverage, and they often report confusion about their coverage options and say that they use various sources of information to make their coverage decisions. We examined results from CMS’s Medicare Current Beneficiary Survey (MCBS), a nationally representative survey that asks beneficiaries about a range of topics including their understanding of Medicare, satisfaction with the information available about the program, and how often they review their Medicare plan options. We analyzed changes in national-level responses over time (2019 to 2023) and variation in 2023 responses stratified across different beneficiary characteristics, such as enrollment in traditional fee-for-service (FFS) Medicare versus Medicare Advantage (MA), age, geography (rural/urban), dual eligibility for Medicare and Medicaid, race/ethnicity, and education level.⁴⁰

Our examination of the results from the MCBS adds to findings from our beneficiary focus groups and other surveys that beneficiaries use different information sources to navigate their decision-making and are generally satisfied with the availability of the information. Nevertheless, a sizable minority of beneficiaries between 2019 and 2023 found Medicare difficult to understand, although there has been a decline in the share of beneficiaries reporting that it is difficult to review and compare Medicare coverage options. This finding may signal opportunities to reduce program complexity and assist groups of beneficiaries who may need more guidance.

Understanding the Medicare program

When asked how easy it is to understand Medicare, 29 percent of respondents in both 2019 and 2023 said that the program was “very” or “somewhat” difficult to understand (Table 2-B1, p. 88). There were some differences across subgroups of beneficiaries, which may indicate the need for more targeted decision-making support. In 2023, full-benefit Medicare–Medicaid dually eligible beneficiaries were more likely to respond that the Medicare program was “very” or “somewhat” difficult to understand compared with non-dually eligible beneficiaries (33 percent compared with 28 percent; data not shown).⁴¹ When looking across race/ethnicity groups in 2023, Hispanic

beneficiaries were more likely than White and Black beneficiaries to say that the program was difficult to understand (38 percent compared with 28 percent and 24 percent, respectively). In 2023, beneficiaries with no high school diploma were also more likely to report that Medicare was difficult to understand (34 percent compared with 27 percent of beneficiaries with a college degree or more).

When asked how easy it is to review and compare Medicare coverage options, about a third of beneficiaries said it was “very” or “somewhat” difficult (Table 2-B1, p. 88). The share of beneficiaries reporting that it was difficult to compare Medicare plan options decreased from 2019 to 2023 (37 percent to 33 percent). In 2023, full-benefit dually eligible beneficiaries, Hispanic beneficiaries, and beneficiaries with no high school diploma were more likely to report that it was difficult to compare Medicare options (data not shown).

Experiences with information sources about the Medicare program

The vast majority of all respondents (92 percent) said they were satisfied with the availability of information about the Medicare program. There were no meaningful differences in the level of satisfaction with the availability of information across groups of beneficiaries we analyzed. About a quarter of beneficiaries reported trying to get information about the Medicare program in the past year. This share has increased from 23 percent of beneficiaries in 2019 to 27 percent in 2023 (Table 2-B1, p. 88). In 2023, 83 percent of respondents said that they “completely” or “somewhat” agree that they had the information needed to make informed comparisons across insurance options, an increase from 80 percent in 2019 (Table 2-B1).

The MCBS asks beneficiaries about their awareness of and experiences using three sources of information about Medicare: the *Medicare & You* handbook, the Medicare.gov website, and the 1-800-MEDICARE phone line. In 2023, 82 percent of all respondents reported that they either received the *Medicare & You* handbook in the mail or reviewed it online, and 64 percent said that they thoroughly read the handbook or read parts of it (the other 36 percent said they read none of

**TABLE
2-B1**

Changes in national-level MCBS responses over time, 2019–2023

MCBS question	2019	2023	Percentage point change
Understanding the Medicare program			
Medicare program is easy (very or somewhat) to understand	71%	71%	0%
Medicare program is difficult (very or somewhat) to understand	29	29	0
Easy (very or somewhat) to review and compare Medicare coverage options	63	67	4
Difficult (very or somewhat) to review and compare Medicare coverage options	37	33	–4
Experiences with information sources about the Medicare program			
Satisfied (very or satisfied) with availability of information about the Medicare program	90	92	2
Tried to get information in the past year about Medicare	23	27	4
Agree (completely or somewhat) that they have the information needed to make informed comparisons across insurance options	80	83	3
Received in mail or reviewed <i>Medicare & You</i> book online	86	82	–4
Thoroughly read through or read parts of <i>Medicare & You</i>	63	64	1
Read none of <i>Medicare & You</i>	38	36	–2
Visited Medicare.gov	47	46	–1
Aware of 1-800-MEDICARE before today	61	49	–12
Called 1-800-MEDICARE before today	37	33	–4
Reviewing Medicare plan options			
Review Medicare options at least once a year	46	52	6
Never review Medicare options	23	19	–4
During last open enrollment, compared insurance plans	29	32	3
During last open enrollment, reviewed changes in costs	47	53	6
During last open enrollment, reviewed changes in services	45	50	5

Note: MCBS (Medicare Current Beneficiary Survey). This analysis includes only community-dwelling beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in Part A or Part B throughout their Medicare enrollment in the year or who had Medicare as a secondary payer. The number of beneficiaries represented in this analysis is 56.7 million in 2023. The MCBS is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected. Response rates for initial interviews are approximately 60 percent; once the first interview is completed, participation in subsequent rounds is 80 percent or more. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2019–2023.

the book) (Table 2-B1). Less than half of beneficiaries (46 percent) reported visiting the Medicare.gov website. In 2023, 49 percent of beneficiaries reported that they were aware of 1-800-MEDICARE, and 33 percent reported calling the phone line. Awareness of 1-800-MEDICARE decreased by 12 percentage points from 2019 to 2023 (from 61 percent to 49 percent);

however, the share of beneficiaries who said they called the phone line only decreased by 4 percentage points (37 percent to 33 percent). Although respondents' awareness of these information sources was generally high, there could be opportunities to better promote the availability of the phone line and use of the Medicare.gov website.

Reviewing Medicare plan options

In 2023, 52 percent of beneficiaries reported that they review their Medicare plan options at least once a year, an increase from 46 percent in 2019 (Table 2-B1). In 2023, 19 percent of beneficiaries said they never review their Medicare plan options, a decrease from 23 percent in 2019.

In 2023, 32 percent of beneficiaries reported comparing insurance plans during the most recent annual enrollment period (AEP), which is the primary opportunity for beneficiaries to make changes to their coverage (Table 2-B1). Fifty-three percent of

respondents said they reviewed changes in the costs of their coverage during the last AEP, and 50 percent said they reviewed changes in covered services. Beneficiaries enrolled in MA were more likely to review their Medicare options annually compared with beneficiaries in traditional FFS Medicare (57 percent compared with 45 percent; data not shown). The cost-sharing rules and supplemental benefits for MA plans can change every year, which may lead to more MA enrollees reviewing changes in their plans annually. Non-dually eligible beneficiaries, Black beneficiaries, and beneficiaries with more education were more likely to report that they reviewed their Medicare options at least once a year (data not shown). ■

Endnotes

- 1 Understanding the experiences and perspectives of Medicare beneficiaries and providers is central to MedPAC's work. A benefit of the focus-group approach is that it allows us to ask questions with answers that cannot easily be put into numbers, for example, the "how" and "why" of experiences. The findings provide narratives and real-life examples that are useful as the Commission discusses issues affecting the Medicare program. Even with these benefits, we want to note that due to the nature of focus-group research, our sample size was limited, so findings cannot be generalized to the communities we studied or to the nation as a whole.
- 2 Individuals may be eligible for Medicare based on the work credits of the individual, the individual's spouse, or the individual's parents in the case of an adult with a disability that began before age 22 (Social Security Administration 2025). Individuals are also eligible for Medicare based on covered railroad service and creditable earnings (Railroad Retirement Board 2024). For simplicity, we refer only to "Social Security" in the remainder of this chapter.
- 3 Individuals pay the full Part A premium of \$565 per month in 2026 if they are eligible for Medicare but they did not pay Medicare payroll taxes for at least 7.5 years. Individuals pay a discounted Part A premium of \$311 per month if they paid Medicare payroll taxes for at least 7.5 years but less than 10 years (Centers for Medicare & Medicaid Services 2025j). The required credits for individuals entitled to Medicare due to disability or ESRD will vary according to the individual's age. Because so few beneficiaries pay the Part A premium, this chapter is limiting references to the premium for the Part A program.
- 4 MA plans can reduce the amount deducted from enrollees' benefits by "buying down" some or all of the standard Part B premium amount. Ninety-nine percent of beneficiaries have access to plans that offer some reduction in the Part B premium; in 2025, about 32 percent of enrollees in conventional plans (excluding enrollees in employer group and special-needs plans) were projected (in plan bids) to be in these premium-reduction plans, and the average monthly premium reduction was \$44 (the monthly Part B premium for 2025 was \$185) (Medicare Payment Advisory Commission 2025b).
- 5 Individuals who are under 65 and had a kidney transplant more than three years prior and therefore no longer qualify for Medicare due to ESRD can qualify for Medicare coverage of their immunosuppressive drugs under the Part B Immunosuppressive Drug Benefit (Part B-ID). Enrollees in Part B-ID with higher incomes are required to pay higher premiums, based on the same IRMAA thresholds used for Part B premiums. In 2026, the standard monthly Part B-ID premium is \$121.60 (Centers for Medicare & Medicaid Services 2025k). In 2023, approximately 155 enrollees with immunosuppressive drug coverage had roughly \$90,000 in Part B benefits (Boards of Trustees 2025).
- 6 Receiving benefits from the Railroad Retirement Board at age 65 will also lead to notification. To simplify for the purpose of this chapter, we refer to "Social Security."
- 7 Puerto Rico residents are automatically enrolled in Part A when they turn 65 but must actively enroll in Part B.
- 8 SSA staff email, April 2026.
- 9 Beneficiaries paying a premium for Part A will be subject to Part A late-enrollment penalties if they delayed enrollment 12 months or more.
- 10 Upon losing Medicaid eligibility, beneficiaries have a SEP of six months to sign up for Part B without a late-enrollment penalty.
- 11 The national base beneficiary premium is the starting point for calculating a plan-specific basic Part D premium. This value is calculated according to a statutory formula.
- 12 Among plan types, HMOs continued to enroll the most beneficiaries (57 percent) in 2025. Enrollment in HMOs grew by 5 percent between 2024 and 2025, outpacing growth of local PPOs (3 percent) (Medicare Payment Advisory Commission 2025c).
- 13 The literature review completed by Taylor et al. analyzed a total of nine studies published from 2009 to 2015. These included studies that relied on survey data asking consumers to evaluate different (mostly Medicare) health plans.
- 14 A zero-premium plan is a conventional (open to all MA-eligible beneficiaries) MA plan that includes Part D drug coverage and charges no Part C or Part D premium (enrollees may pay the Medicare Part B premium).
- 15 Using National Association of Insurance Commissioners data from Mark Farrah Associates, KFF found that the average monthly Medigap premium across all current Medigap policyholders in 2023 was \$217, ranging from \$191 in Alaska to \$267 in New York.

- 16 Plans that use a PPO model, which provide some coverage for services delivered by out-of-network providers, must also have a cap on total out-of-pocket costs for both in-network and non-network providers.
- 17 We annually conduct separate focus groups with beneficiaries enrolled in FFS Medicare and MA. We also conduct groups with dually eligible beneficiaries enrolled in either MA or FFS, and in 2025 all dually eligible beneficiaries in our groups were enrolled in MA. We organize findings by beneficiary source of coverage.
- 18 FFS Medicare has adopted prior authorization to reduce the unnecessary use of certain types of hospital outpatient department services and durable medical equipment (Medicare Payment Advisory Commission 2018). CMS has tested the use of prior authorization to reduce unnecessary use of hyperbaric oxygen therapy in FFS Medicare; however, it was not adopted by FFS Medicare as a permanent policy (Centers for Medicare & Medicaid Services 2016b). Prior authorization for repetitive, scheduled nonemergent ambulance transport (RSNAT) is voluntary; however, if an ambulance supplier elects to bypass prior authorization, applicable RSNAT claims are subject to prepayment medical review (Centers for Medicare & Medicaid Services 2023c). The Wasteful and Inappropriate Service Reduction (WiSeR) Model, launched in 2026, is using AI and data analytics to test new prior authorization for selected services in FFS Medicare in six states: New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington. Participating data companies will conduct medical reviews and be rewarded for reducing unnecessary spending (Centers for Medicare & Medicaid Services 2026g).
- 19 Insurers can contract with outside organizations and individuals, such as individual agents, to reach and enroll members; in return, these organizations and individuals earn compensation directly from insurers.
- 20 In the Medigap market, insurers must charge the same premium to beneficiaries who enroll in a given plan during a one-time enrollment period (which usually starts when a beneficiary turns 65) and in certain other situations (such as moving to another state or being enrolled in an MA plan that leaves the market). Outside of those situations, insurers in most states can engage in medical underwriting to guard against adverse selection.
- 21 Starting with the 2028 plan year, MA plans will be subject to several new requirements aimed at ensuring that their provider directories are accurate. Plans will be required to verify and update the information in their directory at least every 90 days and conduct an analysis that estimates the directory's accuracy for a sample of providers. In addition, if enrollees make an appointment with a provider that is incorrectly listed in the directory as an in-network provider, the plan must cover the service as an in-network service and charge enrollees the in-network amount for cost sharing.
- 22 For the 2026 plan year, CMS has created a temporary SEP for beneficiaries who use the provider information in Plan Finder, enroll in an MA plan, and then find that their preferred provider is not actually in the plan's network. The SEP can only be used during the first three months that a beneficiary is enrolled in the MA plan and is also limited to those who enrolled in a plan through Plan Finder (as opposed to enrolling through an insurer's website). Beneficiaries who qualify for the SEP can enroll in another MA plan or switch to traditional Medicare. We do not have any information about the number of beneficiaries who have used the SEP. CMS has not indicated whether a similar SEP will be available in future plan years.
- 23 Administration for Community Living, SHIP administrative data.
- 24 Grant allocations to states and territories are determined based on formulas that account for factors such as the share of the national Medicare population residing in the state, the proportion of the state's Medicare beneficiaries living in rural areas, and the percentage of Medicare beneficiaries in the state relative to the state's total population (Congressional Research Service 2023). Grant recipients and subrecipients and the funding amounts are available on the ACL's website.
- 25 In our March 2008 report, the Commission recommended that the Secretary increase SHIP funding for outreach to low-income Medicare beneficiaries to increase participation in the MSPs (Medicare Payment Advisory Commission 2008). The Commission explained that Medicare beneficiaries, particularly those who are hard to reach, get most of their information from personal contact and that increasing funding for SHIP grantees, which provide one-on-one counseling, would permit more beneficiaries to have access to programs for which they are eligible (Medicare Payment Advisory Commission 2008).
- 26 The mandatory-funding grant amounts are allocated to states based on the number of individuals who are not enrolled in, but who are eligible for, the LIS relative to the total number of individuals who meet the requirements for the LIS, as well as the number of Part D-eligible individuals residing in a rural area relative to the total number of such individuals in the state (Congressional Research Service 2023).
- 27 Administration for Community Living, SHIP administrative data.

- 28 The IRMAA is an amount added to the Medicare Part B and Part D prescription drug coverage premiums based on a beneficiary's modified adjusted gross income (see Table 2-1, p. 45, for Part B income-related monthly adjustment amounts).
- 29 These federal requirements for agents do not apply to the sale of Medigap plans. While agents who sell Medigap plans have to be licensed according to the requirements of the applicable state, state law may vary regarding any marketing or training requirements.
- 30 Medicare insurance agents' annual compensation can vary and is often higher for agents that have been selling insurance policies for several years and built a client base. The Bureau of Labor Statistics reports that the median annual wage for insurance sales agents was \$60,370 in May 2024, which gives a general sense of potential Medicare agent compensation (Bureau of Labor Statistics 2026). The lowest 10 percent earned less than \$36,390, and the highest 10 percent earned more than \$135,660. Some in the industry report that average annual compensation for a Medicare insurance agent was about \$87,000 (Seven Figure Medicare Agent Summit 2025).
- 31 MA plans are required to maintain an MLR of 85 percent (42 CFR Sec. 422.2410(b)). The MLR is the minimum percentage of revenue that an insurer is required to spend on benefits for their members. An MLR requirement of 85 percent means that the insurer is required to spend at least 85 percent of their revenue on care for their enrollees and can use no more than 15 percent of their revenue for administrative costs and profit. MLR requirements for MA organizations are monitored at the contract level. The numerator of the MLR includes incurred expenses for members' medical claims, including both Medicare and non-Medicare services (i.e., basic and supplemental benefits).
- 32 Not all MA plans report to the NAIC, data from California are limited, and those MA plans that do report may not include spending on marketing and administrative costs under "agent and broker," causing the data to potentially underestimate the total market spending.
- 33 A change to an "unlike plan type" is defined as changing from (1) an MA or MA Prescription Drug plan (MA-PD) to a PDP or Section 1876 cost plan, (2) a PDP to a Section 1876 cost plan or an MA or MA-PD, or (3) a Section 1876 cost plan to an MA or MA-PD or PDP.
- 34 A change to a "like plan type" is defined as changing from (1) a PDP to another PDP, (2) an MA or MA-PD to another MA or MA-PD, or (3) a cost plan to another cost plan.
- 35 For contract year 2025, CMS proposed eliminating the regulatory framework that allows for separate payment to agents for administrative services. Following the finalization of these regulations, the U.S. District Court for the Northern District of Texas issued preliminary injunctions in *Americans for Beneficiary Choice v. HHS*, No. 4:24-cv-00439, and *Council for Medicare Choice v. HHS*, No. 4:24-cv-00446, meaning that certain provisions cannot be implemented. In August 2025, the court held that CMS exceeded its statutory authority and vacated the administrative-payments portion of the rule.
- 36 Medigap policies may include benefits in addition to the required benefits.
- 37 The Idaho Department of Insurance filed emergency cease-and-desist orders against two insurers alleging that the insurers changed the commission structure as an attempt to discourage enrollment in their MA plans. The insurers sued the state, saying that federal MA law preempts state law in this area, and the district judge agreed that the insurers were likely to succeed in their lawsuit (*UnitedHealthcare of the Rockies and Care Improvement Plus South Central Insurance Company v. Dean Cameron, Director of the Idaho Department of Insurance*, U.S. District Court, December 2025).
- 38 However, in the case of aged individuals or their spouses in group health plans offered by employers with fewer than 20 employees (or in the case of disabled individuals or their parents, by employers with fewer than 100 employees), Medicare coverage is considered primary to the group health plan. These individuals are not eligible for this SEP. Based on data from the Survey of Income and Program Participation, which is administered by the Census Bureau, in 2023 about 40 percent of people 65 years and older who were employed worked for an employer with fewer than 25 employees (or about 7 percent of all people 65 years and older) (Census Bureau 2025). Although not an exact comparison because of differences in employer size, these points illustrate that a portion of Medicare beneficiaries are affected by this policy.
- 39 MA plans and providers are allowed to terminate their network agreements at any point in the year. Plans are required to notify affected enrollees of a termination of a contracted provider. When a primary care or behavioral health provider leaves a network, only enrollees currently assigned to that primary care provider and to enrollees who have been patients of the primary care or behavioral health provider within the past three years are required to be notified, and the notice period is at least 45 calendar days before the termination effective date. When other providers leave the network, the notice must be sent to enrollees who are assigned to or currently received care from or received

care in the past three months from the provider. These enrollees must be notified at least 30 calendar days before the termination date.

- 40 This analysis includes only community-dwelling beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in Part A and Part B throughout their Medicare enrollment in the year or who had Medicare as a secondary payer. The number of beneficiaries represented in this analysis was 56.7 million in 2023.

Response rates for initial interviews are approximately 60 percent; once the first interview is completed, participation in subsequent rounds is 80 percent or more (Centers for Medicare & Medicaid Services 2026d). The MCBS is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected.

- 41 All comparisons of responses across groups of beneficiaries are statistically significant at $p < 0.05$.

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C H A P T E R

3

**Medicare payment operations
and their role in identifying
improper payments**

Medicare payment operations and their role in identifying improper payments

Chapter summary

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 fee-for-service (FFS) Medicare, \$23.7 billion from Medicare Advantage (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 and duplicate detection and edits for applicable coverage policies. Claims are verified, removing identified duplicate claims and using national correct-coding-initiative edits, which include procedure-to-procedure, medically unlikely, and add-on code edits. Claims may be screened for medical necessity and other statutory and regulatory requirements using applicable national and local coverage determinations. MACs must

In this chapter

- How FFS Medicare pays for items and services under Part A and Part B
- Identifying and reducing improper FFS Medicare payments
- Assessing and reducing improper payments in Medicare Advantage and Part D
- Fraud prevention, detection, and prosecution

pay clean claims within 30 days of receipt. After payment, MACs conduct postpayment reviews to identify improper payments and initiate recovery efforts. (Other contractors may also perform postpayment audits.)

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. These tools target services with high risk for unnecessary utilization, such as cosmetic procedures, spinal surgeries, and nonemergency ambulance transports. 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. Among other goals, the demonstrations aim to reduce the number of provider and beneficiary appeals and improve provider compliance with Medicare program requirements. 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. Most errors stem from insufficient documentation, especially in skilled nursing facilities and outpatient settings.

Medicare makes capitated monthly payments to MA plans for their Medicare enrollees. Those payments are risk adjusted using demographic and diagnostic information 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. That estimate was based on a review of diagnosis codes that plans submitted for enrollees. CMS's primary corrective action for MA improper payments is 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 \$4.2 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. ■

Improper payments are payments that should not have been made or were made in the incorrect amount. The term generally includes overpayments or underpayments such as payments to an ineligible recipient, payments for an ineligible good or service, duplicate payments, payment for a good or service not received, and payments that do not account for credit for applicable discounts (Government Accountability Office 2025). Improper payments are payments for items and services that do not conform to Medicare policies or payments when the information is insufficient to determine whether a payment was proper. Not all improper payments represent fraud or abuse. 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 that year, including \$28.8 billion from fee-for-service (FFS) Medicare, \$23.7 billion from Medicare Advantage (MA), and \$4.2 billion from Medicare Part D (Department of Health and Human Services 2026).

In this chapter, we review how CMS pays for items and services under the FFS Medicare program and the roles of different entities in making those payments, including the various contractors that are responsible for certain payment operations. We then provide an overview of CMS’s program-integrity efforts, including those related to improper payments in FFS Medicare, MA, and Part D.

How FFS Medicare pays for items and services under Part A and Part B

To be paid by FFS Medicare, a provider must first enroll in Medicare by completing an application process that may include requirements for accreditation. The enrollment process and requirements vary by type of provider. Most providers that are enrolled in Medicare bill FFS Medicare directly for the items and services they provide and agree to accept Medicare payments as payment in full, billing beneficiaries for the statutorily allowed deductibles and copayments (referred to as “accepting assignment”). The share of physicians who accept assignment varies by specialty.

FFS Medicare payments are generated from claims submitted by enrolled providers. To pay FFS claims, CMS relies on Medicare administrative contractors (MACs)—private entities that have been awarded a contract to process Medicare Part A and Part B medical or durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims submitted by providers or entities in a specified geographic jurisdiction for services or items delivered to FFS beneficiaries. In FY 2023, CMS reported that the 16 MACs processed more than 1.1 billion FFS claims and paid out approximately \$431.5 billion (Centers for Medicare & Medicaid Services 2024i). By law, MACs must pay “clean” claims within 30 days of receipt. MACs use a multitiered process to verify claims before making payment. Claims first undergo “front-end” edits to verify the basic accuracy and completeness of information on the claim and then undergo a second stage of review to ensure against duplicate claims. Claims are then screened to check for items or services that should not be billed together and, when applicable, evaluated for compliance with Medicare coverage and payment policies.

Provider enrollment in Medicare

To enroll in Medicare, all providers (including institutions like hospitals, individual clinicians, and suppliers) must provide a national provider identifier (NPI) from the National Plan and Provider Enumeration System (NPPES) and complete an enrollment application on the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).¹ The PECOS application requests information about any adverse actions (e.g., suspensions or revocation of license, conviction of felonies, or revocation of privileges from billing Medicare or other federal or state health care programs) and electronic fund transfer documentation. MACs review applications for practitioners and suppliers (applications from suppliers of DMEPOS are reviewed by the DME-MAC) and have the authority to approve enrollment (Centers for Medicare & Medicaid Services 2024f).

DMEPOS suppliers are required to obtain accreditation from a CMS-approved organization before they can enroll in Medicare using PECOS. One of the DME-MACs reviews the application information, but before completing enrollment, the provider is required to post a surety bond (Centers for Medicare & Medicaid Services 2025d).

For Part A providers (such as hospitals and skilled nursing facilities) seeking to enroll in Medicare, applications are first reviewed by MACs and then are referred to the appropriate state survey agency to check the facility's licensure and conduct a survey to assess the facility's compliance with the applicable Medicare conditions or requirements of participation. Part A providers can opt to substitute certification from a CMS-approved accrediting organization rather than use the state survey agency. Once accreditation is achieved, a provider's application is reviewed again by the designated MAC and then by CMS, which assigns a certification number and effective date, executes the provider agreement, and updates the national database. The designated MAC then issues the final approval notification (Centers for Medicare & Medicaid Services 2025e).

Once enrolled in Medicare, any providers (whether paid under Part A or Part B) that experience a change in their ownership structure are required to notify CMS of the identity of the old and new owners, how the new entity will be organized, and when the change will take place (Centers for Medicare & Medicaid Services 2025h). They are also required to report any adverse legal actions or a change in practice location.

Not all providers that are enrolled in Medicare bill FFS Medicare directly for the items and services they provide, but most do. In Medicare Part B, participating providers agree to accept Medicare payments as payment in full and can bill beneficiaries for the statutorily allowed deductibles and copayments, an arrangement referred to as "accepting assignment." These providers bill Medicare and receive the payment directly from Medicare. Nonparticipating providers do not agree to accept Medicare payment as payment in full. Instead, a nonparticipating provider can charge up to 115 percent of the Medicare payment amount, referred to as the "limiting charge." Medicare pays nonparticipating providers 5 percent less than the amount allowed for participating providers, and the beneficiary is responsible for paying the balance, which may be up to 35 percent of the amount that the nonparticipating provider charges (Centers for Medicare & Medicaid Services 2025c, First Coast Service Options Inc. 2026).² Nonparticipating providers may bill Medicare directly, though some require beneficiaries to submit the claim to Medicare

themselves (Centers for Medicare & Medicaid Services 2025c, Medicare Rights Center 2025).

Providers who choose not to enroll in Medicare are considered to have opted out. Opt-out providers bill the beneficiary directly without any restriction on the fee, and the service is considered by all participants not covered by Medicare.³ Providers can change their status every two years.

Ninety-eight percent of nonpediatric physicians are enrolled in and participate in the Medicare program (that is, accept assignment), and 1.3 percent have opted out, but these shares vary by specialty and location. As of November 2024, 8.1 percent of psychiatrists, 4.5 percent of plastic and reconstructive surgeons, and 3.2 percent of neurologists had opted out of Medicare. In contrast, less than 0.1 percent of emergency medicine physicians, oncologists, radiologists, and pathologists had opted out (Cottrill et al. 2025). Some practitioners, such as physician assistants, nurse practitioners, and clinical psychologists, are required to accept assignment for their services (Centers for Medicare & Medicaid Services 2025h, Novitas Solutions 2024).

Providers bill FFS Medicare using standardized claims formats

In FFS Medicare, payments are generated from claims submitted by the providers.^{4,5} Claims are designed to provide the information a payer needs to know—what the beneficiary received and how much to pay. In addition to information about the beneficiary and the provider, claims contain dates of service or delivery of the item, description of the item or service, and the reason for the service (diagnosis) using standardized medical code sets.⁶ Other information about the service is conveyed in modifier codes, type-of-bill codes, condition codes, occurrence codes, and revenue codes (Noridian Healthcare Solutions 2025c).^{7,8} Claims forms started as paper forms and continue to be known colloquially by their paper-form names.^{9,10} Claims are now transmitted electronically, and the formats are dictated by the relevant standard for the electronic transaction.¹¹ Some providers use clearinghouses or billing services to facilitate their claims submissions to check the information on claims and ensure that it is complete before submission to Medicare and other payers or plans.

The structure of claims is not determined by CMS. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established an administrative process for developing consensus among stakeholders for health care transactions, including claims forms. The same basic claims format is used by all insurers and payers. In addition, some Medicare payment systems require additional information to be submitted on patient-assessment forms.¹²

Medicare administrative contractors process FFS claims

Providers send almost all Part A and Part B claims to a MAC using electronic data interchange (EDI) software.¹³ MACs are private entities that have been awarded a contract to process Medicare Part A and Part B medical or DMEPOS claims for FFS beneficiaries in specified jurisdictions.

CMS relies on MACs as the primary operational contacts between Medicare's FFS program and the health care providers enrolled in the program. Currently, there are 12 A/B MACs (4 of which function as the home health and hospice MACs) and 4 DME-MACs. In FY 2023, CMS reported that MACs collectively served more than 1.2 million health care providers enrolled in FFS Medicare, processed more than 1.1 billion FFS claims (including approximately 192 million Part A claims and 950 million Part B claims), and paid out approximately \$431.5 billion (Centers for Medicare & Medicaid Services 2024i). Beyond paying claims, MACs have additional responsibilities. They enroll providers (as discussed above), audit cost reports, develop local coverage determinations, educate providers on Medicare policies, respond to provider inquiries, and handle first-level claims appeals. Figure 3-1 (p. 110), Figure 3-2 (p. 111), and Figure 3-3 (p. 112) show the MAC jurisdiction regions (Centers for Medicare & Medicaid Services 2024i).

To process a FFS Medicare claim, a MAC must receive it within one year after the item or service has been furnished. By law, if the claim is “clean,” it must be paid within 30 days of receipt, or the MAC must pay interest to the provider. A clean claim is one that complies with all Medicare policies, without errors, omissions, or discrepancies, and requires no additional investigation by the MAC.

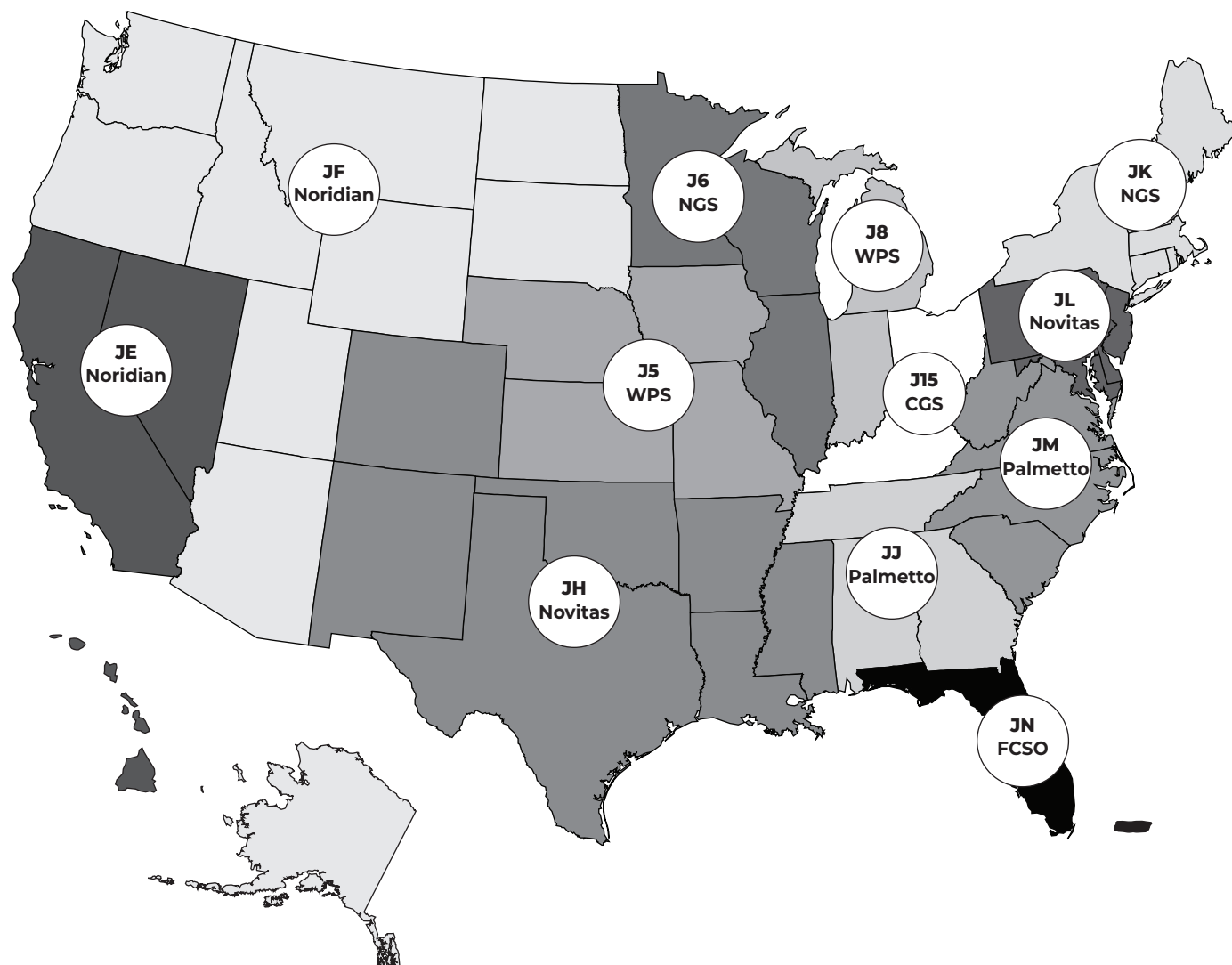
Verifying FFS claims for payment

MACs depend upon a multitiered process to verify claims before making payments. The beneficiaries' enrollment is verified, and claims undergo front-end edits, which check that the information on the claim is complete and verify basic information such as provider and beneficiary information and claim dates.

The second stage of review includes “implementation guide” edits, a more detailed and situation-specific examination of the elements on the submitted claim. At this stage, the claim is checked for duplicate claims or for a prior-authorization number, if one is required. To detect duplicate claims, comparisons are made with prior paid or pending claims. All exact duplicate claims or claim lines are rejected or may be auto-denied by the programmed edits.^{14,15} Suspected duplicate claims (or claim lines) are matched on beneficiary information, provider identification, and approximate dates. Suspected duplicates are then submitted to more complex edits and/or manual review by a MAC to determine whether to pay or deny the claim(s). Some claims that appear to be duplicates on initial check may have additional information that on closer examination identifies them as separate items or services. For example, a claim may have matching beneficiary, date, providers, and service, but another claim element called a modifier could be used to provide additional information that distinguishes the services, such as that the same procedure was performed on the right and left sides of the patient, as shown by the modifiers “RT” and “LT.”¹⁶ Claims are also checked for other elements such as bill type or condition codes that could distinguish a service from another service with similar claim elements. For example, an institutional claim may contain a bill-type code showing that the claim is a correction of an earlier claim, thereby indicating that the claims-processing software should replace the claim rather than pay it as a duplicate.

In the third stage of review, claims are evaluated for Medicare coverage and payment policies. Claims for practitioner and outpatient services and DMEPOS are screened using over 4.5 million National Correct Coding Initiative (NCCI) edits. NCCI edits check for items or services that should not be billed together. There are three main categories of these code-to-code edits, which are updated quarterly: procedure-to-procedure edits, medically unlikely edits, and add-on-code edits. A procedure-to-procedure edit might

Part A/B MACs, by jurisdiction

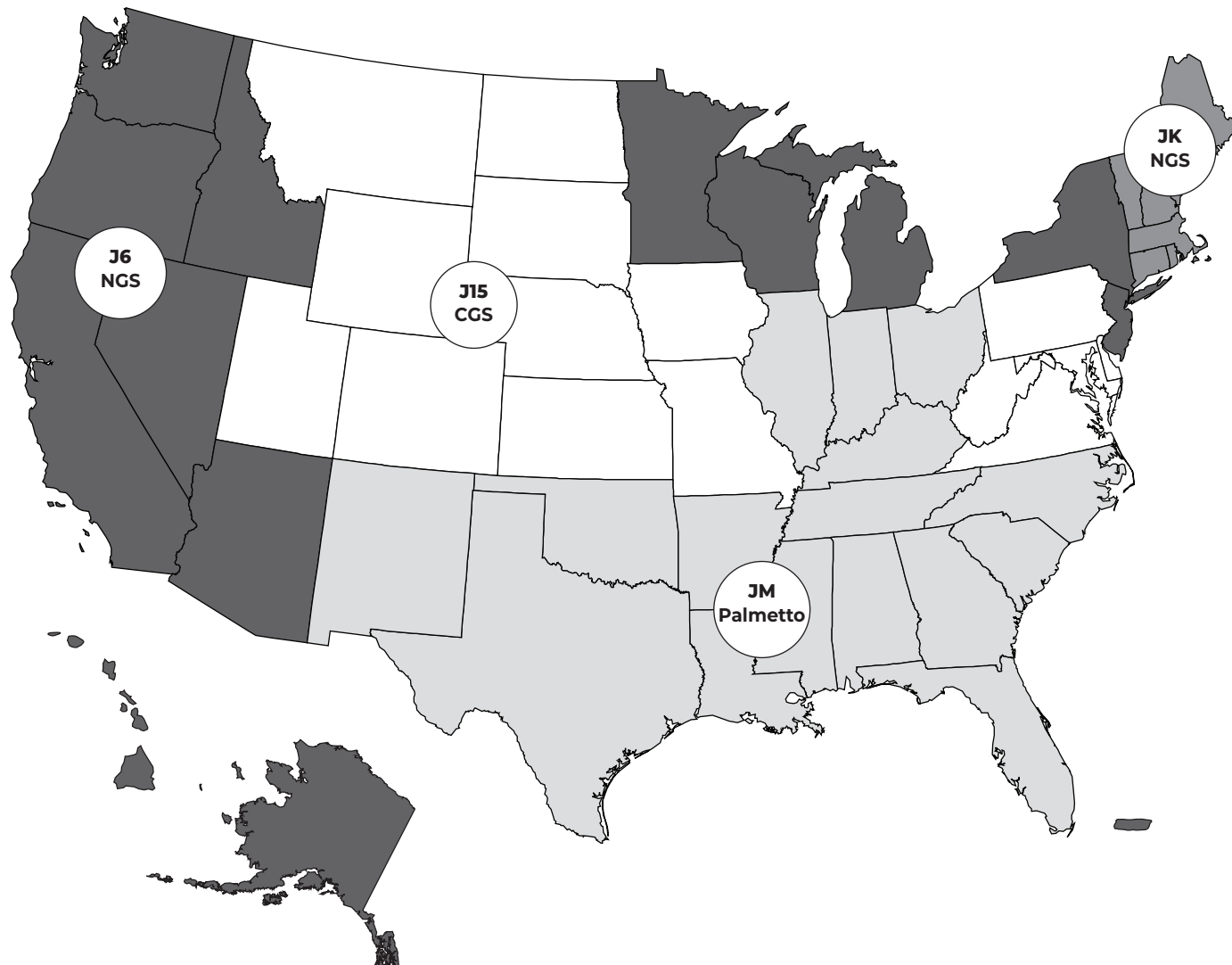


Source: <https://www.cms.gov/files/document/ab-jurisdiction-map03282023pdf.pdf>.

check whether any add-on codes are accompanied by the correct primary codes: For example, this type of edit might screen out a claim for spine surgery that has a primary code for a disc removal in the lower spine and an add-on code that is intended to be used with a procedure on the vertebra rather than on the disc.

**FIGURE
3-2**

Home health and hospice MACs, by jurisdiction



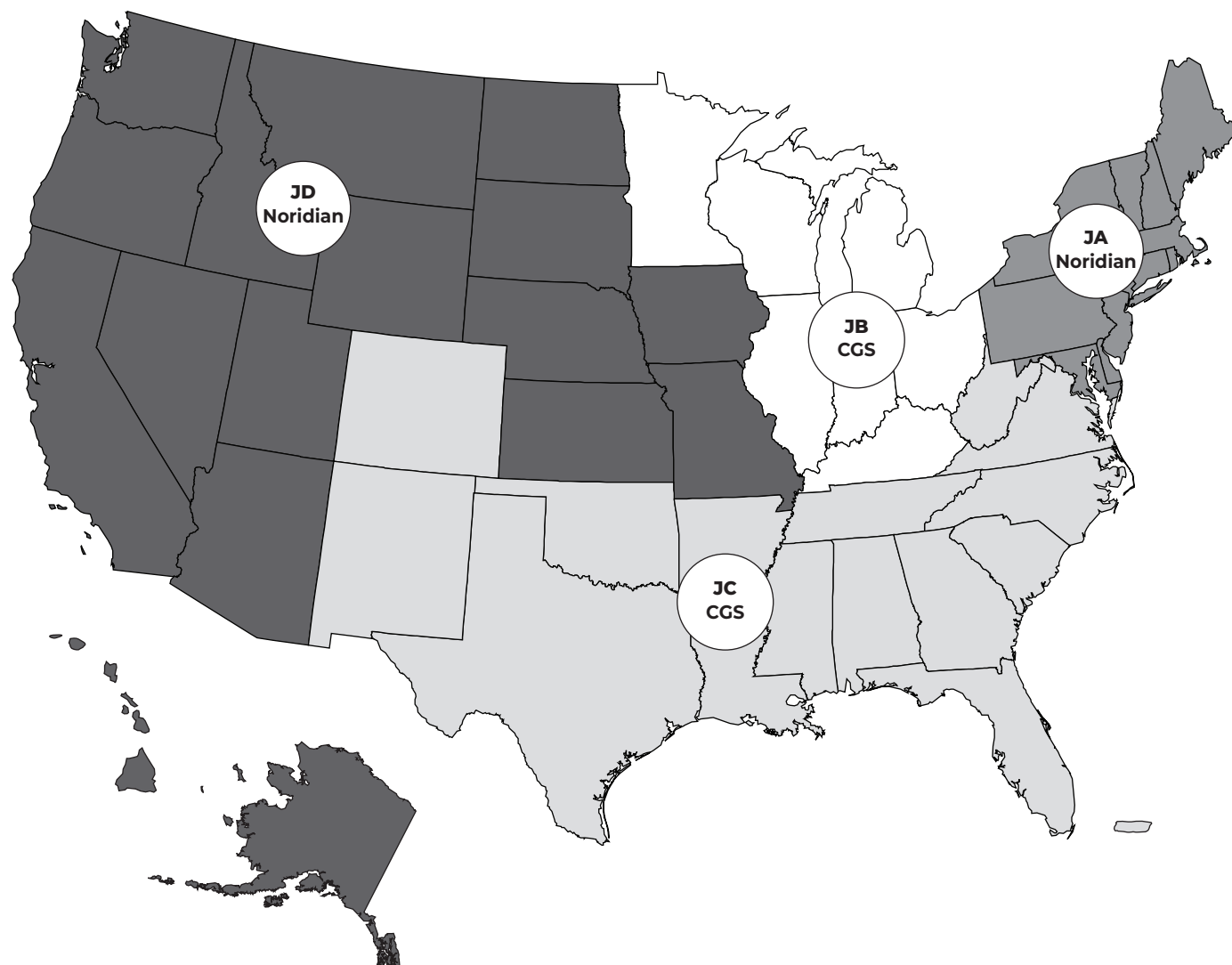
Note: MAC (Medicare administrative contractor). MACs are private entities that have been awarded a contract to process Medicare claims for fee-for-service beneficiaries in specified jurisdictions. There are four home health/hospice MAC jurisdictions, denoted by number or letter such as J6 or JK. Jurisdictions may include noncontiguous areas. As this report went to press, the following MACs were under contract to process home health and hospice claims: CGS Administrators, National Government Services (NGS), and Palmetto GBA.

Source: <https://www.cms.gov/files/document/hhh-jurisdiction-map03282023pdf.pdf>.

Claims can be checked to determine whether the item or service is reasonable and necessary for the treatment of illness or injury and therefore is covered by Medicare. Coverage determinations are made through national coverage determinations (NCDs) by CMS, local coverage determinations (LCDs) by MACs,

or on a case-by-case basis by a MAC. The claims-processing software checks for compliance with NCDs and LCDs. If there is an NCD or LCD, the claims system will typically include an edit to flag whether specific diagnoses and other procedures meet the coverage requirements. MACs can also develop other

DME MACs, by jurisdiction



Source: <https://www.cms.gov/files/document/dme-jurisdiction-map03282023pdf.pdf-0>.

MACs identify some claims for postpayment review, the traditional method of identifying whether a claim should not have been paid. These postpayment reviews examine whether an item or service should not have been covered (was not medically necessary) or was billed incorrectly (for coding, setting, or duplicate services). If the review identifies an

improper payment, the MAC must try to recoup the overpayment from the provider; this process is often referred to as “pay and chase.”

If a claim is denied, providers and beneficiaries have the right to appeal. In 2024, the FFS claims initial-denial rates for Part A, Part B, and DMEPOS were 8 percent, 10 percent, and 14 percent, respectively (Centers for Medicare & Medicaid Services 2026m). FFS Medicare beneficiaries and providers wishing to appeal a claims denial have five escalating levels of appeal open to them (Centers for Medicare & Medicaid Services 2026e).

Identifying and reducing improper FFS Medicare payments

CMS has developed new tools to decrease improper payment of FFS claims. To identify and reduce improper payments before they are made, MACs now perform limited prior authorization and preclaims reviews, focusing on services that are less likely to be medically necessary. Prior authorization and preclaim review are similar but differ in the timing of the review and when services can begin. Under prior authorization, the provider submits the prior-authorization request and receives the coverage decision before services are rendered. Under preclaim review, the provider or supplier submits the preclaim review request and receives the decision before claim submission; however, the provider or supplier can render services before submitting the request.

Recently, CMS has begun receiving FFS claims early in the reviewing process, which provide information before MACs pay the claim. CMS uses the Fraud Prevention System (FPS) edits on these claims, described later, to identify suspicious billing patterns and potentially fraudulent activities before payment is made (Centers for Medicare & Medicaid Services 2026f).

CMS has established nationwide prior-authorization requirements for certain services and items. In addition, CMS recently launched a new initiative, the Wasteful and Inappropriate Service Reduction (WISeR) Model, in selected states to test a new prior-authorization process using artificial intelligence and machine learning for specified services. Other CMS demonstrations in specified states are testing preclaim and postpayment review for services provided by home

health agencies (HHAs) and inpatient rehabilitation facilities (IRFs). CMS has also expanded prepayment review of newly enrolled hospices' claims.

Finally, beyond the immediate payment process, CMS engages several contractors other than MACs to analyze paid claims data to further identify and recover improper payments. In FY 2025, the improper-payment rate in FFS Medicare was estimated at 6.6 percent (equivalent to about \$29 billion in improper payments) (Centers for Medicare & Medicaid Services 2026n).

Prior authorization review for certain services

CMS has established nationwide prior-authorization requirements for certain hospital outpatient department (HOPD) services, certain DMEPOS items, and repetitive, scheduled nonemergent ambulance transport. Prior authorization in FFS Medicare has been used:

- For services that are often cosmetic (and therefore not covered), including eyelid surgery (blepharoplasty), botulinum toxin injections, removal of excess skin from the lower abdomen (panniculectomy), nose reshaping (rhinoplasty), and treatment of varicose veins (vein ablation), beginning in 2020. CMS estimated that requiring prior authorization resulted in a 21 percent decrease in payments for these services between 2020 and 2024 (Centers for Medicare & Medicaid Services 2025m).
- For selected services that have experienced large increases in volume. In 2021, CMS required prior authorization for implanted spinal neurostimulators (for the treatment of back and leg pain) and for cervical fusion with disc removal (for the treatment of neck and arm pain); in 2023, prior authorization was required for facet-joint injections (for the treatment of neck and back pain). Between 2021 and 2024, payments for implanted spinal neurostimulators and cervical fusions decreased by 29 percent; between 2023 and 2024, facet-joint injections decreased 18 percent (Centers for Medicare & Medicaid Services 2025m).
- For many DMEPOS items that have frequently been subject to unnecessary utilization. For these items, a face-to-face encounter and a clinician's written order are now required for 62 Healthcare

Common Procedure Coding System codes, including pressure-reducing support systems, power wheelchairs, lumbar-sacral orthoses, knee orthoses, and other arm and leg orthoses (braces). Preauthorization began in 2017 with a limited number of items and has been expanded and modified. Payments for orthoses decreased 85 percent between 2021 and 2024 (Centers for Medicare & Medicaid Services 2025m, Centers for Medicare & Medicaid Services 2016).

- For ambulance providers for repetitive, scheduled nonemergent transports. CMS has implemented “voluntary” prior authorization for such services, which are often used to transport patients to dialysis treatments. If the ambulance supplier opts not to seek prior authorization, claims for these services are subject to prepayment medical review. Payments for these services decreased 79 percent between 2014 and 2024 (Centers for Medicare & Medicaid Services 2025m).

Under the new WISer Model, data companies with expertise in artificial intelligence and machine learning will conduct medical reviews and validate coverage determinations to test whether using enhanced technology provides an improved and expedited prior-authorization process for FFS Medicare. CMS believes this model could help reduce inappropriate utilization, lower spending in FFS Medicare, expedite decision-making, and ease provider administrative burden (Centers for Medicare & Medicaid Services 2025i).

Data companies participating in WISer were chosen to operate in selected regions in Arizona, New Jersey, Ohio, Oklahoma, Texas, and Washington.¹⁷ FFS Medicare providers in those areas are given the option to submit a prior-authorization request for the model’s selected items and services or go through a postservice review before payment to ensure that the delivered item/service met Medicare coverage, coding, and payment criteria (Centers for Medicare & Medicaid Services 2025i). The model focuses on items and services that (1) may pose concerns related to patient safety if delivered inappropriately; (2) have existing publicly available coverage criteria; and (3) may involve prior reports of fraud, waste, and abuse. Examples of such services are skin and tissue substitutes, electrical nerve-stimulator implants for a variety of indications, epidural steroid injections for pain management,

percutaneous vertebral augmentation for vertebral compression fractures, cervical fusions, diagnosis and treatment of impotence, knee arthroscopy for knee osteoarthritis, and potentially other items and services as well. The model excludes services provided only to inpatients, emergency services, and services that would pose a substantial risk to patients if significantly delayed. Participating data companies will receive a percentage of the expenditures associated with averted wasteful, inappropriate care as a result of their reviews. The percentage will be adjusted based on the participant’s performance on measures related to the process, including provider experience. The model is expected to end on December 31, 2031 (Centers for Medicare & Medicaid Services 2025i).

Preclaim and prepayment review

Currently, MACs are testing preclaim reviews in two limited demonstrations in specified states, one for HHAs and another for IRFs. The HHA Review Choice Demonstration began in 2016 in Illinois and has expanded to Florida, North Carolina, Ohio, Oklahoma, and Texas. Initially, HHAs in the specified states choose between 100 percent preclaim review or 100 percent postpayment review; the majority have chosen preclaim review. After six months, if HHAs demonstrate compliance with the Medicare rules through either preclaim review or postpayment review, compliant HHAs can choose from continued preclaim review, “spot checks” on 5 percent of prepayment review, or selective postpayment review of a random sample of claims (Centers for Medicare & Medicaid Services 2025k). If an HHA choosing preclaim reviews does not submit the preclaim review and the claim is payable, it will be paid with a 25 percent reduction of the full claim amount. The demonstration’s goal is to reduce the number of Medicare appeals and improve provider compliance with Medicare program requirements without delaying care to beneficiaries or altering the home health benefit (Centers for Medicare & Medicaid Services 2025k). Although payments for home health services have declined during the demonstration, other changes have occurred in the home health payment system, so the decrease cannot be attributed to the demonstration.

The IRF Review Choice Demonstration began in 2023 in Alabama and was expanded to Pennsylvania in 2024, with plans to extend the demonstration to California

and Texas. As with the HHA demonstration, initially IRFs in the specified states choose between 100 percent preclaim review or 100 percent postpayment review; 94 percent have chosen preclaim review. After six months, if IRFs demonstrate compliance with the Medicare rules through either the preclaim review or postpayment review, compliant IRFs can choose from continued preclaim review, “spot checks” on 5 percent of prepayment review, or selective postpayment review of a random sample of claims. The goal is to test improved methods for the identification, investigation, and prosecution of potentially medically unnecessary admissions and to decrease appeals. From 2023 to 2024, only a 4 percent change in the amount paid to IRFs in the two states has been observed (Centers for Medicare & Medicaid Services 2025m).

Because of concerns about the rapid growth in new hospices, CMS began expanded prepayment review of newly enrolled hospices’ claims in September 2024 in Arizona, California, Georgia, Nevada, Ohio, and Texas (Centers for Medicare & Medicaid Services 2026b). CMS authorized this review as a provisional period of enhanced oversight of new providers, which can last between 30 days and one year.¹⁸ As of June 2025, 668 hospices have been subjected to medical review, and CMS has revoked the enrollment of 122 of these hospices (Centers for Medicare & Medicaid Services 2025j).

Unified program-integrity contractors conduct postpayment review of suspicious FFS claims

MACs refer claims suspected of representing improper payments to the unified program-integrity contractors (UPICs). The five UPICs are responsible for detecting and deterring improper Medicare and Medicaid payments in specific geographic areas. The UPICs investigate Part A, Part B, and DMEPOS claims and identify improper payments that MACs can recoup. They conduct medical-record reviews, data analysis, and investigations (including onsite visits and interviews with beneficiaries, complainants, or providers). The goal is to identify postpay overpayments, as well as the need for payment suspensions, prepayment or auto-denial edits, and enrollment revocations. Many of the UPIC investigations focus on improper payments related to credible allegations of fraud, which are referred to

law enforcement for consideration of civil or criminal prosecution. UPICs also support victims of Medicare identity theft (Centers for Medicare & Medicaid Services 2024i).

Many of the UPICs’ investigations are initiated by referrals from the Fraud Prevention System (FPS), developed in 2011 and run by CMS’s Center for Program Integrity (CPI). The FPS is designed to detect and prevent improper payments, using predictive analytics and data-analysis techniques. The FPS identifies suspicious billing patterns and potentially fraudulent activities. FPS models search for aberrant billing patterns in claims data. When FPS models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for further review and investigation. The FPS leads are referred to CMS’s contractors for investigation, and FPS identifies edits that can be added to the claims-processing systems to reject and deny claims before they are paid (Centers for Medicare & Medicaid Services 2026k).

Recovery audit contractors (RACs) perform targeted postpayment reviews to identify improper payments for recoupment. Four RACs identify and correct improper payments made under Medicare Part A and Part B, and a fifth RAC reviews DMEPOS, home health, and hospice claims. The RACs receive contingent fees from a portion of their overpayment recoveries to fund their activities, though they also identify underpayments. CMS specifies the audit topics addressed by the RACs. Current audit topics are well defined, including nonphysicians billing without a correct assistant-at-surgery modifier, drugs and biologics in multidose vials, and hip orthoses within the reasonable useful lifetime or excessive units (Centers for Medicare & Medicaid Services 2024b). The RACs request documentation from providers to support their audit efforts and conduct postpayment audits to identify a wide variety of improper payments. In FY 2024, RACs identified \$227.8 million in savings (Centers for Medicare & Medicaid Services 2025p).

The supplemental medical review contractor conducts medical records review

The supplemental medical review contractor (SMRC) conducts record reviews for CMS, as well as for the Department of Health and Human Services (HHS)

Office of Inspector General (OIG) and the Government Accountability Office (GAO) (Noridian Healthcare Solutions 2024). The SMRC conducts nationwide medical reviews of Medicaid, FFS Medicare Part A and Part B, and DMEPOS claims to determine whether claims follow coverage, coding, payment, and billing requirements. The SMRC reviews medical records and related documents from providers. The medical reviews may be prepayment or postpayment (Centers for Medicare & Medicaid Services 2024h). Some examples of prior projects are nonemergency ambulance transport, spinal-cord stimulators, outpatient hyperbaric oxygen, and therapeutic shoes for diabetics (Noridian Healthcare Solutions 2025a). Current projects include reviews of hyperbaric oxygen, vertebral kyphoplasty, and total knee arthroplasty (Noridian Healthcare Solutions 2025b, Noridian Healthcare Solutions 2024).

Comprehensive Error Rate Testing measures improper payments

Each year, CMS is required by law to report the magnitude of improper payments.¹⁹ To measure the improper-payment rate in FFS Medicare, CMS conducts Comprehensive Error Rate Testing (CERT). The CERT Program reviews a random sample of FFS Medicare claims—in 2025, approximately 37,500 claims—to determine whether the claims were properly paid (Centers for Medicare & Medicaid Services 2024c). In FY 2025, the FFS Medicare improper-payment rate was 6.6 percent (equivalent to \$28.8 billion in federal payments), down from a high of 12.7 percent in FY 2012 (reported in 2014) (Centers for Medicare & Medicaid Services 2026a). While the improper-payment rate for FFS Medicare has generally declined, the expenditures on improper payments have increased because Medicare spending has increased over this period. The error rate is higher for DMEPOS suppliers (24.2 percent) and Part B providers (8.4 percent) and lower for inpatient prospective payment systems hospital providers (3.2 percent). In FFS Medicare, insufficient or missing documentation was the most common reason for improper payments, accounting for 68 percent of improper payments. Services in skilled nursing facilities were associated with the largest share of improper payments, followed by payments in hospital outpatient departments, IRFs, and hospices (Centers for Medicare & Medicaid Services 2025a).²⁰

Assessing and reducing improper payments in Medicare Advantage and Part D

In Medicare Part C and Part D, CMS makes payment to MA and Part D plans rather than to providers; plans are then responsible for paying providers. As a result, the processes for determining whether MA and Part D payments are improper differ from the processes used in FFS Medicare. CMS generally does not assess specific items or services in MA but examines the inputs used to determine the payments to the plans. In Part D, CMS assesses the accuracy of prescription drug event (PDE) data.

Assessing improper payments in MA

The MA program (Medicare Part C) gives Medicare beneficiaries the option of receiving benefits from private plans rather than from traditional FFS Medicare. Medicare pays insurers offering MA plans a monthly capitated amount that is risk adjusted using demographic and diagnostic information to account for differences in MA enrollees' expected spending. The demographics for each enrollee are gathered by CMS, while the diagnostic information flows from diagnosis codes included in encounter data that are submitted by plans. (Diagnostic information can also flow from MA plan-initiated "chart reviews" that identify diagnoses not captured through encounter data.²¹) Those diagnosis codes are aggregated into CMS hierarchical condition categories (CMS-HCCs) by the risk-adjustment model. (For more information on Medicare's payments to MA plans, see MedPAC's *Medicare Advantage Payment Basics*.)

The Medicare Part C improper-payment measurement (IPM) measures the improper-payment rate in MA by assessing whether diagnosis codes submitted by MA plans for a random sample of enrollees are supported by medical-record documentation. Based on a sample of 930 beneficiaries, CMS estimated a 6.1 percent error rate in Medicare payments to MA plans in payment year 2023, representing \$23.7 billion in improper federal payments (Centers for Medicare & Medicaid Services 2026c).²²

These estimates of improper payments in MA are conceptually different from estimates of the effects of higher coding intensity in MA, but there is likely overlap

between the two estimates. Higher coding intensity in MA is driven by several factors, including MA plans documenting diagnoses more comprehensively than providers in FFS Medicare do, submitting incorrect or fraudulent diagnostic data, applying different clinical discretion to diagnostic coding, and other reasons (Medicare Payment Advisory Commission 2026).²³ The diagnosis codes that contribute to higher coding intensity in MA may or may not be supported by medical-record documentation. Only the diagnosis codes that are not supported by medical-record documentation are considered improper. Although there is some overlap between improper payments and coding intensity, the two concepts are sufficiently different that we do not expect estimates of improper payments in MA to match estimates of higher MA coding intensity.

CMS also conducts risk-adjustment data-validation (RADV) audits, which are conceptually similar to the estimates of improper payments but have some important differences in their purpose and implementation. Similar to the IPM, the RADV audit program addresses the diagnostic data underlying the CMS-HCC component of a risk score and does not address the data underlying the demographic components within selected MA contracts (Medicare Payment Advisory Commission 2019).

RADV audits of MA contracts have been limited, and reporting of results from audits that have occurred has been delayed. CMS initiated RADV audits of MA contracts in payment years 2011 to 2015, 2018, and 2019, and it plans to continue audits on an expedited basis until all remaining audits after payment year 2018 are completed. For RADV audits through payment year 2017, CMS used a protocol that audited roughly 5 percent of MA contracts per year; used a sample of 201 enrollees in each contract across three strata of beneficiaries with low, medium, and high risk scores; calculated an error rate for the sample population; and then calculated the overpayment amount for the sample of audited beneficiaries (that is, findings were not extrapolated to a larger population). Audits of 2007 risk-adjustment data identified diagnoses that did not meet risk-adjustment criteria and determined that average overpayment rates were well over 10 percent for most contracts under audit (Schulte 2016). CMS recovered \$13.7 million in overpayments from

audits of 37 contracts, based on overpayments for only the 7,437 beneficiaries included in the audit sample (Medicare Payment Advisory Commission 2019). No audits were conducted for payment years 2008, 2009, or 2010. For 2011, 2012, and 2013 payment years, CMS audited 30 contracts in each year and identified annual overpayments of between \$3.3 million and \$5.7 million (Centers for Medicare & Medicaid Services 2026h). For 2014 and 2015 payment years, CMS audited about 200 contracts and identified annual overpayments of \$13.5 million and \$11.2 million, respectively (Centers for Medicare & Medicaid Services 2026h). Recent audit results indicated that medical-record discrepancies, including documentation not submitted, accounted for 85 percent of all improper payments in MA (Centers for Medicare & Medicaid Services 2025n).

For audits that will be conducted for payment years 2018 and later, CMS finalized an audit method that would allow CMS to recover overpayments by extrapolating the error rate of the sampled enrollees to a larger population of audit-eligible enrollees in the contract. The majority of MA enrollees would be eligible for audit since nearly 70 percent of MA enrollees had at least one HCC in 2022, and only a small fraction of these enrollees would be excluded from the audit sample for other reasons (Medicare Payment Advisory Commission 2025b). However, in November 2024, CMS released a guidance document restricting the audit-eligible population to a much narrower set of enrollees in a given contract. Audits of 2018 data will focus on only two sets of beneficiaries: beneficiaries in the top decile of a contract's enrollees based on the greatest expected reduction in their risk score resulting from a RADV audit (based on CMS's improper-payment prediction model) or contract enrollees who had all their HCCs supported only by chart reviews. The first group of beneficiaries is roughly one-tenth of the beneficiaries who would have been audit eligible under methods applied to pre-2018 data. For the second group, between 2 percent and 3 percent of all MA enrollees (or between 3 percent and 4 percent of MA enrollees with at least one HCC) had all of their HCCs supported by only chart reviews,²⁴ and those enrollees had an average of 1.5 HCCs (Medicare Payment Advisory Commission 2025b).²⁵

While progress has been made initiating audits for more recent years, recoveries had not yet been made

by FY 2024 (Office of Inspector General 2025b). On May 21, 2025, CMS announced plans to increase both the speed and the scale of the RADV audits “to obtain more reliable findings that can be appropriately extrapolated.” CMS further specified that all plans will be audited annually, reviewing between 35 and 200 beneficiaries per contract, and audits of payment years 2018 to 2024 would be completed by early 2026 (Centers for Medicare & Medicaid Services 2025b). For audits of 2019 and 2020 data, CMS published methods that will focus on a contract’s enrollees based on the greatest expected reduction in their risk score resulting from a RADV audit. Audits will include the top decile of such beneficiaries for 2019 data and the top quartile of such beneficiaries for 2020 data (Centers for Medicare & Medicaid Services 2026h). CMS also published a schedule for initiating audits of 2020 through 2025 data by April 2027, which would essentially eliminate the backlog of RADV audits (Centers for Medicare & Medicaid Services 2026h).

Assessing improper payments in Medicare Part D

Under Part D, Medicare pays monthly capitated payments as well as cost-based reimbursements to private plans to administer the outpatient prescription drug benefit. (For more information on Medicare’s payments to Part D, see MedPAC’s *Part D Payment Basics* (Medicare Payment Advisory Commission 2025a).)

The monthly capitated amounts are calculated based on plan bids that reflect plans’ expected costs and are risk adjusted using demographic and diagnostic information to account for differences in Part D enrollees’ expected spending. Similar to the CMS–HCC model used under the MA program, the demographics for each enrollee are gathered by CMS, while the diagnostic information flows from physician, inpatient hospital, and outpatient hospital records in FFS claims data or MA encounter data; that is, the sources of diagnostic information used in Part D’s prescription drug HCC model and the CMS–HCC model are the same, and there is substantial overlap in the diagnoses used in the two models.

Part D differs from MA in that Medicare bears some of the risk of enrollees’ spending by making (and receiving) additional payments to plans in addition to the risk-adjusted monthly

capitated amounts. There are two types of risk-sharing arrangements: individual cost-based reinsurance and risk-corridor protection. Through reinsurance, Medicare shares the insurance risk for individuals with very high spending by paying a portion of those enrollees’ spending over a threshold amount. Using risk corridors, Medicare shares the risk that plans bear for drug spending. When the actual drug spending amount differs from the drug spending that plans anticipated when they submitted their bids (and that is reflected in their capitated payments), risk corridors limit plans’ losses and profits (above and beyond those assumed in their bids).

CMS makes interim monthly capitated and cost-based payments to Part D plans and then reconciles those payments with plans’ actual spending after the end of the benefit year.²⁶ For the capitated payments, the reconciliation process may result in risk-corridor payments from Medicare to plans (for a portion of losses incurred by plans) or from plans to Medicare (for a portion of profits earned by plans) when losses or profits exceed risk-corridor thresholds. For the cost-based reinsurance payments, the reconciliation process allows Medicare to make payment adjustments to ensure that the interim payments align with actual spending; those adjustments result in payments from Medicare to plans or vice versa.

Because the reconciliation payments are based on costs computed from PDE records, inaccurate information in those records can affect Medicare spending. The Part D IPM estimates improper Medicare payments to Part D plans due to inaccurate PDE records, such as inconsistencies between information reported in PDEs and medication orders submitted by plans as supported documentation (Centers for Medicare & Medicaid Services 2026i). HHS reviews sampled PDEs to determine drug cost errors and uses that information to simulate improper payments for a representative sample of beneficiaries; the estimate of Part D improper payments was based on a randomly selected 5 percent sample of the Part D beneficiaries. These simulated improper payments are extrapolated to the entire Part D population to produce the overall Part D improper-payment estimate (Centers for Medicare & Medicaid Services 2026g).

In payment year 2023, the error rate on Part D program payments was estimated to be 4.0 percent of

program outlays, representing \$4.2 billion in improper payments (Centers for Medicare & Medicaid Services 2026d, Centers for Medicare & Medicaid Services 2026l). Insufficient or missing documentation was the most common reason for Medicare Part D improper payments, at 75 percent in payment year 2023 (Centers for Medicare & Medicaid Services 2026l).

Medicare Part D is also reviewed by the Medicare Drug Integrity Contractors (MEDICs), which are entities contracted by CMS to detect and prevent fraud, waste, and abuse in Medicare Part C and Part D. Currently, the MEDICs consist of two contracts—the Investigations (I)–MEDIC and the Plan Program Integrity (PPI)–MEDIC. For example, the I–MEDIC may conduct investigative activities and referrals to law enforcement and analyze data to identify fraud and abuse among high-risk prescribers or pharmacies. In FY 2024, the I–MEDIC generated 989 investigations of complaints submitted to the I–MEDIC about alleged fraud, waste, and abuse in Part C and Part D and 132 law enforcement referrals (Centers for Medicare & Medicaid Services 2025g).²⁷ The PPI–MEDIC, on the other hand, is primarily focused on regulatory compliance and audits of Part C and Part D plans (Centers for Medicare & Medicaid Services 2025g). MEDICs thus differ from RADV contractors, who are focused on ensuring the accuracy of diagnosis codes submitted by MA organizations to determine the appropriateness of risk-adjusted payments under Part C.

Part D payments could also be affected by improper diagnosis codes. However, unlike in MA, where improper diagnoses can increase Medicare spending, any impact of improper diagnoses in Part D is expected to be budget neutral. In Part D, risk scores affect the relative payments to different plans but not the overall level of Medicare’s payments. CMS’s estimate of improper payments for Part D does not measure the effect of diagnosis codes.

Fraud prevention, detection, and prosecution

Improper payments have many sources. Many are due to lack of documentation or other errors. However, some improper payments result from intentional

deception or misrepresentation of the information submitted on claims; these actions are termed “fraud.” Several organizations focus on fraud because fraud prevention and detection are critical to reducing the overall amount of improper payments. Within CMS, CPI has the lead in preventing and detecting fraudulent activities. CPI is responsible for the various contractors described above who investigate improper payment. The HHS–OIG has responsibility for investigating and detecting fraud and excluding providers from billing Medicare. OIG and CPI also work with the Department of Justice (DOJ), which prosecutes fraud, at times with the assistance of the investigative capacity of the Federal Bureau of Investigation (FBI). The Health Care Fraud and Abuse Control (HCFAC) Program coordinates antifraud activities across agencies. Two groups also support the antifraud activities, the Health Care Fraud Prevention Partnership and the Senior Medicare Patrol.

CPI administers the contractors and programs described in the previous section (pp. 115–116) and is responsible for preventing, detecting, and combating fraud, waste, and abuse, which may include improper payments. CPI has a broad range of responsibilities for both Medicare and Medicaid, including provider-enrollment policy, data analysis, developing the FPS, managing contractors, and coordinating partnerships. CPI recommends modifications to programs and operations as necessary and cooperates with OIG, the DOJ, and law enforcement (Centers for Medicare & Medicaid Services 2024a).

OIG performs broad investigations and evaluations as well as targeted ones. OIG also has the authority to issue provider exclusions, which can last three to five years, barring an individual or entity from participating in any federally funded health care program, and can impose a civil penalty on anyone hiring an excluded individual or entity. In FY 2025, OIG excluded 2,839 individuals and entities from participation in Medicare, Medicaid, and other federal health care programs. Among these were exclusions based on criminal convictions for crimes related to Medicare, Medicaid, or other health care programs, for beneficiary abuse or neglect, and for state health care licensure revocations (Office of Inspector General 2025c, Office of Inspector General 2025d). CMS can issue payment suspensions to providers to block them from receiving Medicare payments after consulting with OIG and, if appropriate,

the DOJ, when there is a credible allegation of fraud. OIG also reviews and approves “safe harbor” relationships that are designated not to violate the anti-kickback statute.²⁸ OIG has reported that, in FY 2025, its investigations resulted in 701 criminal actions against individuals or entities that engaged in crimes related to Medicare and Medicaid and 876 civil actions, which include false claims, unjust-enrichment lawsuits filed in federal district court, and civil money penalty settlements. During FY 2025, OIG reported that its activities resulted in more than \$19 billion in expected recoveries and receivables, \$5.7 billion in investigative receivables, and \$533 million in audit receivables (Office of Inspector General 2025c, Office of Inspector General 2025d).

The DOJ’s main statutory authorities with respect to Medicare are the False Claims Acts (civil and criminal false-claims statutes), the anti-kickback statute, and the physician self-referral law. Some investigations are initiated by the organizations described above, but others come from whistleblower (or *qui tam*) complaints. The DOJ has reported that, in FY 2025, its activities recovered more than \$6.7 billion from the health care industry, including managed care providers, hospitals and other medical facilities, pharmacies, pharmaceutical companies, laboratories, and physicians (Department of Justice 2026b). There were 641 new health care-related false-claims cases in FY 2025; that same year, 194 persons were charged with criminal health care fraud (Department of Justice 2025b). The FBI often participates in health care fraud investigations by the Criminal Division of the DOJ (Department of Justice 2025c).

The Health Care Fraud and Abuse Control (HCFAC) Program, established by HIPAA, is a comprehensive cross-agency program to combat fraud against all public and private health plans. Jointly directed by the Attorney General and the Secretary of Health and Human Services (HHS) (acting through the HHS OIG), it is designed to coordinate federal, state, and local activities. HCFAC has dedicated funding that is used to support fraud activities in the various agencies, and it produces an annual report showing expenditures on health care fraud activities and reports the accomplishments and activities of the participant organizations (Department of Justice 2025c, Office of Inspector General 2024).

Two other groups contribute to identifying and combating fraud. The Health Care Fraud Prevention Partnership, sponsored by CMS, is a national partnership of about 310 members, including private payers; federal, state, and local agencies (Medicare, Medicaid, and other programs); law enforcement agencies; and health care fraud associations (Centers for Medicare & Medicaid Services 2024a). The members share data, analytics, and discussions of results and strategies to identify potential vulnerabilities. They combine analyses of clinician, institutional, and pharmacy claims from public and private payers, which are shared through a portal and in public white papers (Centers for Medicare & Medicaid Services 2024a).

The Senior Medicare Patrol (SMP) is a program that provides funding to groups to identify fraud. There are 54 projects funded by grants from the Administration for Community Living in HHS. SMP projects use outreach and education to train older adults and other community members to prevent; recognize; and report health care fraud, waste, and abuse (Office of Inspector General 2025a).

In addition to financial implications for patients and the Medicare program, fraudulent activities could directly cause harm. Some recent convictions have included:

- A very-high-billing Michigan oncologist who provided cancer medications, including chemotherapy, to Medicare beneficiaries who did not have cancer. Patients suffered from the adverse effects of the medications as well as psychological trauma (Schechter et al. 2015, Tycko & Zavareei Whistleblower Practice Group 2022).
- A portable X-ray supplier in Maryland that prepared and billed for X-ray interpretations for patients in nursing homes by an unlicensed and unqualified reviewer. The supplier billed using identifiers of physicians not involved in the care or interpretation. These false reports resulted in two patient deaths due to missed diagnoses of conditions that could have been treated (Federal Bureau of Investigation 2016).
- An Alaska rheumatologist who administered and billed for injectable treatments that were expired, marked “not for administration,” or did not contain the active medication. Records showed the physician purchased 369 units of medications but

billed for 4,829 units, resulting in patients being undertreated (Department of Justice 2026a, Erb 2026, Kuhn 2026).

- Practitioners in Arizona and Nevada who applied and billed for unnecessary expensive amniotic allografts for wounds without proper treatment for infections (Department of Justice 2025c).
- Cardiologists who performed invasive coronary and peripheral vascular procedures in patients who did not require that treatment (Carlson 2013, Carlson 2011, Department of Justice 2021, Department of Justice 2016, Department of Justice 2015, Department of Justice 2014a, Department of Justice 2014b, Newett 2025, U.S. Attorney's Office 2011).
- A manufacturer of knee prosthetic implants used in total knee arthroplasties that continued to sell implants that it knew were defective (Department of Justice 2025a).

In a paper published in 2020, researchers used Medicare data to compare beneficiaries who received medical treatment by providers who were later excluded from Medicare for fraud, patient harm, or a revoked license, referred to as fraud and abuse perpetrators (FAPs), with a large, random selection of FFS beneficiaries not treated by a FAP. All FAP-treated beneficiaries experienced higher mortality and emergency-hospitalization rates, even after risk adjustment and propensity-score weighting. The FAP-treated beneficiaries were more likely to be dually eligible for Medicare and Medicaid and disabled (Nicholas et al. 2020). ■

Endnotes

- 1 Applications are submitted either online or on paper mailed to the MAC.
- 2 Some Medigap plans and other secondary payers may cover the additional coinsurance and additional charges.
- 3 This arrangement is also referred to as “private contracting.” Medicare will pay in emergency situations as described in the *Medicare Benefit Policy Manual*, Chapter 15, Sec. 40.28.
- 4 Technically, providers who submit Part B claims are called “suppliers,” but for this chapter, the term “provider” will include both providers and suppliers. The word “provider” in this chapter refers to physicians and other practitioners, suppliers of DMEPOS, laboratories, and others providing Part B services as well as hospitals, nursing homes, home health agencies, and hospices, which provide Part A services.
- 5 Rarely, claims are submitted by beneficiaries that are still paper claims but are processed by the MACs by the same process as electronic claims after the information is entered into the claims-processing system.
- 6 For Part B claims, the procedure code sets are the Healthcare Common Procedure Coding System (HCPCS) developed by CMS and Current Procedural Terminology (CPT) developed and owned by the American Medical Association. Initially developed by the World Health Organization, the diagnosis code set is the International Classification of Diseases (ICD)-10-Clinical Modification (CM) as modified by the Centers for Disease Control and Prevention (CDC) for use in the U.S., and the Part A procedure code set is the ICD-10-Procedure Coding System (PCS) as developed by CMS and the CDC. Medicare payment systems may pay for items and services on a “bundled” basis; for example, most hospitals are paid on the basis of a diagnosis-related group that includes most items and services furnished by the hospital during an inpatient stay.
- 7 There are 382 modifiers that are two characters; four modifiers can be listed on each claim line. They specify information such as which side of the body or which finger or toe, if an assistant at surgery is billing, or if the service is not related to hospice diagnosis. Type-of-bill codes have four characters and describe the type of facility (e.g., hospital, skilled nursing facility, ambulatory surgery center), type of care (e.g., rural health center, comprehensive outpatient rehabilitation facility), and frequency (e.g., interim first claim, late-charge only, replacement of prior claim). Condition codes are two characters (e.g., to identify a second or subsequent interim claim by inpatient prospective payment systems hospitals, when a from or through date is changed, or other characteristics, such as the patient being homeless or treatment for a nonterminal condition for a hospice patient). Occurrence codes are two characters (e.g., to identify accident/medical coverage, date of hospice certification or recertification, date that cost-outlier status begins). Revenue codes are four-character codes that describe the type of care or resources used (e.g., semiprivate psychiatric bed, surgical intensive care, chest X-ray diagnostic radiology, pharmacy generic drugs).
- 8 Claims also include information about whether another payer should have responsibility for the payment.
- 9 For example, Form 1500 for clinician claims and the UB-04 for institutional claims.
- 10 Separate formats exist for certain types of claims, such as pharmacy and dental claims.
- 11 For example, the Health Care Claim Transaction Set (837).
- 12 Until 2023, CMS also required certificates of medical necessity for certain types of medical equipment.
- 13 Providers use EDI software to submit claims to the MAC portals or their clearinghouse. Some versions of this software are free. Some electronic health records seamlessly integrate with claims-submission software. Many providers use clearinghouses, which are private firms, to check that the information on their claims is complete and in the proper format to facilitate claims processing and avoid denials.
- 14 These claims have matching beneficiary identification, provider identification, procedure code, dates of service (or range of dates), type of service, procedure code or code for item, place of service, and billed amount.
- 15 Denied claims are not paid; rejected claims are returned to the provider for correction or added information and can be resubmitted and paid.
- 16 Modifiers are used on the 1500 claim form, but not all services have relevant modifiers.
- 17 The firms selected for WISer are Cohere Health (Texas), Genseon Corporation (New Jersey), Humata Health (Oklahoma), Innovaccer (Ohio), Virtix Health (Washington), and Zyter (Arizona).
- 18 New hospices include those that are newly enrolled in Medicare, undergoing a change in ownership, or reactivating their enrollment after being in a deactivated status.

- 19 The Congress recently revised the requirements for improper-payment reporting in the Payment Integrity Information Act of 2019 (P.L. 116–117).
- 20 In skilled nursing facilities, hospital outpatient departments, and hospices, insufficient or missing documentation was the major reason, but in IRFs the reason was medically unnecessary care (p. 209, HHS FY 2024 Financial Report).
- 21 Chart reviews are a plan-initiated assessment of information in a patient’s medical record, or chart. They allow MA plans to capture diagnoses that are not reported on claims or encounter data (for example, diagnoses made during an encounter in which the plan did not submit a record of the encounter to CMS or when the total number of diagnoses from the encounter exceeds the number of diagnosis fields on the encounter record). Chart reviews that document the diagnoses made during hospital and physician encounters in which medical services were provided are allowable for risk adjustment.
- 22 The total comprised \$21.4 billion in overpayments and \$2.2 billion in underpayments as reported in the FY 2025 Payment Error Results in the Part C IPM.
- 23 “Coding intensity” refers to the tendency for more diagnosis codes to be recorded for MA enrollees than for FFS beneficiaries, which causes payments for the same beneficiaries to be higher when they are enrolled in MA than the payments would be if they were enrolled in FFS Medicare. The Commission estimates that, due to higher coding intensity in MA, Medicare will spend \$22 billion more for MA enrollees in 2026 than it would spend if those beneficiaries were enrolled in FFS Medicare. For more information on the effects of higher coding intensity in MA, see the Commission’s status report on MA in our March 2026 report to the Congress.
- 24 Diagnoses that are identified only through chart review (i.e., are not recorded on encounter data) may include conditions that are no longer active or are not under active management. The Commission has found that MA plans’ use of chart reviews is a major source of higher coding intensity—and higher payments—in MA. Some MA plans devote significant effort to conducting chart reviews to increase their payments from Medicare. For more information on MA plans’ use of chart reviews to increase diagnosis coding, see the Commission’s status report on MA in our March 2026 report to the Congress.
- 25 The number of HCCs and the weight of each HCC determine the payment to the MA plan.
- 26 Medicare also pays most cost-sharing liabilities for beneficiaries who receive the low-income subsidy (LIS). These payments to plans that are made on behalf of LIS beneficiaries are also paid on a monthly basis and are reconciled at the end of the benefit year.
- 27 The I-MEDIC has a form on its website for submission of complaints: https://www.qlarant.com/wp-content/uploads/2024/01/Qlarant_I-MEDIC_Complaint_Form_2024_01_03.pdf.
- 28 Anti-kickback laws prohibit offering, paying, soliciting, or receiving anything of value in exchange for referrals or business involving items or services covered by Medicare or Medicaid.

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C H A P T E R

4

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

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

Chapter summary

Medicare's capitated payments to Medicare Advantage (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, on average, MA plans spend less on medical care compared with fee-for-service (FFS) Medicare while maintaining broadly similar levels of access to and satisfaction with care. That evidence suggests that, though heterogeneity across plans exists, 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. Broadly, MA plans' flexibility and use of enhanced tools may alter providers' patient volume, the revenues that providers receive per patient, and providers' costs of furnishing care. While plans' actions may be consistent with efficient care, providers have raised concerns about detrimental effects of these activities on their finances and potential

In this chapter

- Potential effects of MA on providers' finances
- MA enrollment and hospital finances
- MA enrollment and PAC providers' finances
- Appendix 4-A: Constructing the hospital study sample and regression variables
- Appendix 4-B: Calculating post-acute care providers' finances using Medicare cost reports

impacts on patient care. These concerns have intensified as enrollment in MA has grown such that MA enrollees now 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, skilled nursing facilities (SNFs), and home health agencies (HHAs), along with descriptive analyses of inpatient rehabilitation facility (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 providers located in markets that experienced smaller increases in MA enrollment over the study period.

There could be several reasons for the lack of association between MA penetration 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, because MA has been growing consistently for a long time and most provider costs are variable, providers might have responded to financial pressures from MA by reducing staffing or other costs (and therefore maintaining margin levels). Third, while MA plans might reduce revenues to providers, 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 for meeting certain quality benchmarks. Finally, there may be other factors that affect providers' finances that are correlated with (but not caused by) changes in MA penetration but that we were not able to measure in our analysis.

MA enrollment and hospital finances

In interviews conducted by MedPAC staff, hospital representatives reported that increases in MA enrollment have negatively affected their hospitals' finances. Concerns frequently raised during these interviews included 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 paid lower effective rates than FFS and/or did not match certain FFS

payments in the prices they paid hospitals (e.g., FFS Medicare's UC payments that are made to certain hospitals in the form of dollar add-ons to payments for inpatient hospital services provided to FFS beneficiaries). 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 FFS payment rates on average; and MA plans often make payments above and beyond FFS rates for activities including increased diagnostic coding and meeting certain quality metrics.

Our empirical analyses focused on comparing MA and FFS beneficiaries' average hospital length of stay, the implications of MA enrollment growth on Medicare's UC payments, and the association between MA enrollment and hospitals' all-payer operating margins, revenues, and costs. We found that:

- MA enrollees had a longer average hospital length of stay compared with FFS beneficiaries. After controlling for the hospital used, services received, comorbidities, and intended discharge destination, we found that MA enrollees had an average length of stay in fiscal year 2024 that was 11.2 percent longer than that of FFS beneficiaries. The difference in the average length of stay between MA and FFS beneficiaries was similar at hospitals paid under the inpatient prospective payment systems (IPPS) and at critical access hospitals (CAHs) but varied by intended discharge destination. For example, the difference in the average length of stay was 4.9 percent for beneficiaries who were intended to be discharged home (under self-care) but was 19.6 percent for those seeking care at a SNF and 32.3 percent for those seeking care at an IRF. Longer lengths of stay can increase costs for hospitals and cost sharing for beneficiaries and have other effects.
- The structure of FFS Medicare's UC payments may benefit hospitals with more MA patients, leading to mistargeted UC payments to the extent that MA plans match FFS UC add-ons. 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. UC payments become mistargeted when UC dollars are shifted to hospitals with a higher share of their Medicare patients from MA (and away from those with lower shares from MA patients) rather than being targeted to hospitals on the basis of furnishing UC.
- We did not estimate a statistically significant association, on average, between market-level MA penetration and all-payer operating margins, revenues, and costs for IPPS hospitals or CAHs, using data from 2013

to 2024 (excluding 2020 and 2021 due to the coronavirus pandemic). Our estimates are consistent with aggregate trends that show that IPPS hospitals' and CAHs' all-payer operating margins have remained relatively flat or increased slightly from 2013 to 2024, a period during which MA penetration increased substantially. The overall effects are an average over many different types of hospitals, but MA may affect some types of hospitals differently. Although we attempted to control for potential confounding factors, this analytic framework cannot isolate causal effects, and estimates should therefore be interpreted as associations. In addition, our analysis uses all-payer hospital financial metrics in part because current hospital cost reports do not allow us to directly examine the extent to which treating MA patients is profitable.

MA enrollment and post-acute care providers' finances

PAC representatives we interviewed identified similar channels in which MA enrollment may affect providers' finances as noted by acute care hospital representatives. Interviewees told us that MA plans' use of prior authorization to initiate and extend PAC services can reduce PAC volume relative to FFS Medicare. IRF representatives stated that prior authorization is the most significant MA-related challenge they face. SNF and HHA interviewees noted that MA plans typically had lower payment rates than FFS, whereas IRF providers told us that they received payments comparable to 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 such as IRFs where there is wide variation in use and that they tend to pay FFS prices (or more), though they may pay for a different unit of service (e.g., payments per visit for home health care instead of payment per 30-day period as in FFS Medicare).

Increases in MA enrollment might have different effects on PAC providers' finances compared with acute care hospitals for a number of reasons. For example, there is potential substitutability across PAC settings for some patients, which may enable plans to shift some PAC use 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 lower-than-FFS payment rates with PAC providers. 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 using the same regression-based approach applied to acute care hospitals. We 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. These results do not rule out meaningful effects of increases in MA penetration on the finances of specific providers.
- Changes in MA penetration may affect subgroups of SNFs and HHAs differently. We found differences in the estimates by size and time period and weaker evidence of differences by the extent to which providers were vertically integrated with MA plans (either by MA plans purchasing providers or by providers initiating MA plans). Further research is needed to better understand the underlying mechanisms for these differences, especially for smaller versus larger providers.

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

We note that lower PAC provider 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 a 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.

Appropriate caution in attributing estimates using changes in MA penetration to the causal effects of MA

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. Our regression approach compared providers in markets with larger changes in MA penetration to providers in markets with smaller changes in MA penetration to estimate the associations between MA enrollment and providers' finances. Some of the associations estimated in this analysis may reflect factors other than MA that were changing over the study period but that we were unable to control for. A particular concern for our analysis is that there may be different underlying trends in providers' revenues or costs in markets with larger changes in MA penetration relative to other markets. We conducted several analyses that suggest that this concern may be material both for our study and other analyses that use market-level changes in MA penetration to estimate the effect of MA enrollment. For example, markets with larger changes in MA penetration over the study period had higher baseline levels of hospital utilization, suggesting that those markets may have been on different spending trajectories for reasons unrelated to MA.

Concerns about differential trends confounding the interpretation of our results were less salient for the estimated associations between MA penetration and margins, meaning that it may be appropriate to place more weight on estimates for margins than on estimates of revenues, costs, and volume. Because both the revenue and cost components of the calculation of margins would be affected by concerns about differential trends in utilization, any effect of those trends may largely balance out when estimating associations between changes in MA penetration and margins. The estimated association of MA penetration and all-payer margin was consistently small and not statistically distinguishable from zero over many alternative specifications and sensitivity analyses. By contrast, associations of MA penetration with revenues, costs, and volume varied in their size over different specifications. ■

The Medicare Advantage (MA) program allows Medicare beneficiaries enrolled in both Part A and Part B to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. Medicare's capitated payments to MA plans create incentives for plans to find lower-cost ways to provide care. Indeed, research shows that, on average, MA plans spend less on medical care compared with FFS Medicare while maintaining broadly similar levels of access to and satisfaction with care. That evidence suggests that, though heterogeneity across plans exists, 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 (Medicare Payment Advisory Commission 2026, Medicare Payment Advisory Commission 2023b).

MA plans typically have flexibility to use alternative payment approaches, 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. When used appropriately, these practices have the potential to promote more efficient care that reduces costs for MA plans and their enrollees. Some of those tools (such as alternative payment models) may provide an opportunity for providers to share in the financial gains from enhanced diagnostic coding and share in any efficiencies from care management that MA plans generate, while other tools (such as prior authorization) could financially disadvantage providers. Broadly, MA plans' activities may alter providers' patient volume, the revenues that providers receive per patient, and providers' costs of furnishing care. While plans' actions may be consistent with efficient care that maintains quality, providers have raised concerns about detrimental effects on their finances and on beneficiaries.

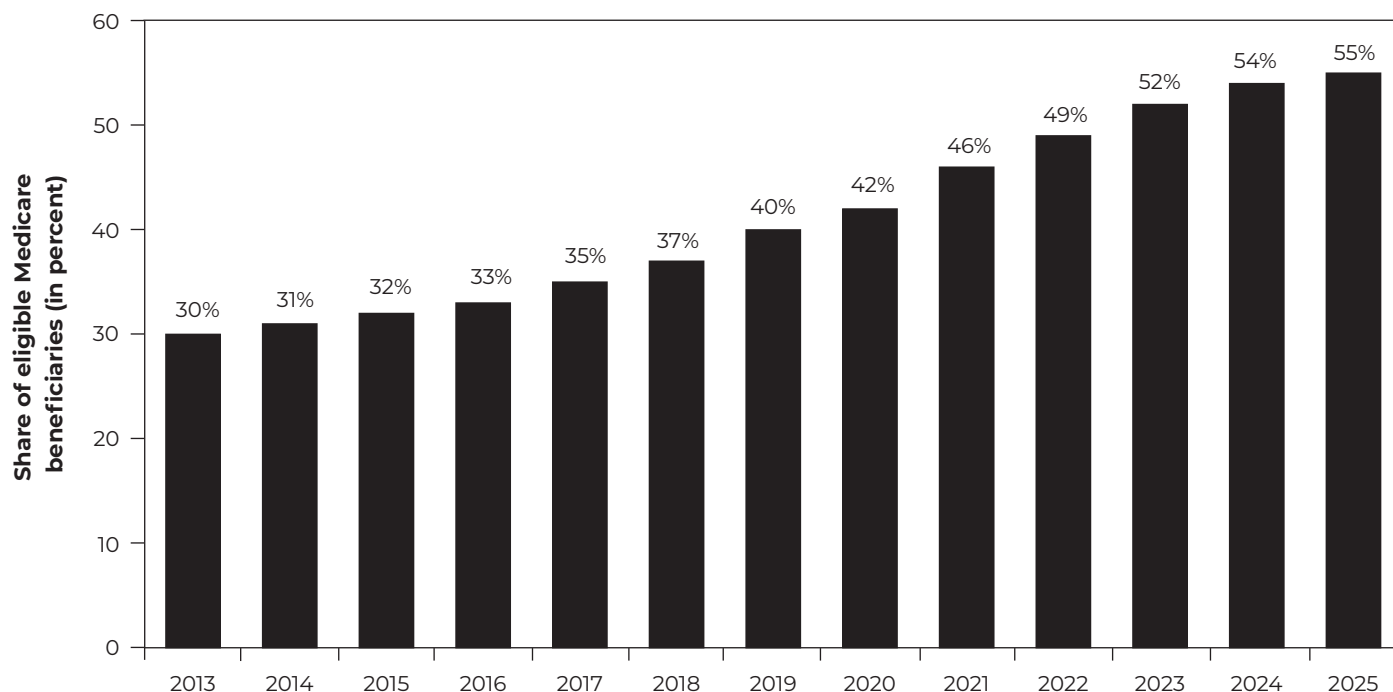
Providers' concerns have intensified as enrollment in MA has grown. From 2013 to 2025, the share of all beneficiaries with Part A and Part B coverage who were enrolled in MA rose from 30 percent to 55 percent (Figure 4-1, p. 138). Both the Boards of Trustees of the Medicare program and the Congressional Budget Office project that MA's share of overall Medicare enrollment will grow in the future. Understanding the effects of MA on providers (and the beneficiaries they serve) is

thus critical (Boards of Trustees 2025, Congressional Budget Office 2026).

In this chapter, we first review the theoretical ways in which MA plans could impact providers' finances. Next, we analyze differences in average hospital lengths of stay between MA and FFS beneficiaries, the implications of MA enrollment growth on Medicare's uncompensated care (UC) payments, and the association between MA enrollment and hospitals' all-payer operating margins, revenues, and costs. We then examine the association between MA enrollment and these all-payer financial metrics for skilled nursing facilities (SNFs) and home health agencies (HHAs). Finally, because we could not calculate these all-payer financial metrics for hospital-based inpatient rehabilitation facilities (IRFs) (which represent the majority of IRFs), we present descriptive information on IRF MA volume that is available for both freestanding and hospital-based IRFs and compare the clinical conditions of FFS and MA enrollees. We focus in this chapter on the effects of MA on providers, but the Commission also continues to explore the effects of MA on beneficiaries (including the impact of provider networks on MA enrollees' access to care and enrollees' use of MA supplemental benefits).

Potential effects of MA on providers' finances

As MA enrollment increases, providers are treating growing shares of MA patients. The implications of this growth for providers' finances may vary depending on the sector (e.g., hospitals, SNFs, dialysis providers), and providers can be affected through multiple channels. In theory, higher MA enrollment could affect providers' patient volume, the revenues that providers receive per patient, and providers' costs of furnishing care to Medicare beneficiaries. The impacts on providers may differ by the type of MA plan. For example, HMOs may have a greater ability to affect volume compared with preferred provider organizations, and issues such as prior authorization or claims denials (which can affect provider volume, revenues, and costs) may be of greater financial concern when the MA plan (the payer) is not vertically integrated with the provider (the payee).

**FIGURE
4-1****Share of Medicare-eligible beneficiaries enrolled in Medicare Advantage grew rapidly, 2013–2025**

Note: Beneficiaries must have both Part A and Part B coverage to enroll in a Medicare Advantage plan; therefore, beneficiaries who have Part A only or Part B only are not included in this figure.

Source: MedPAC analysis of CMS enrollment files.

Potential effects of MA on providers' patient volume

Although MA enrollment now makes up over half of eligible Medicare beneficiaries, the share of providers' Medicare volume attributable to MA enrollees can vary widely for multiple reasons. In general, relative to FFS Medicare, MA plans may reduce overall patient volume or shift the volume of care, both within a sector (e.g., shifting volume from one hospital to another hospital) or across sectors (e.g., shifting SNF volume to HHAs).

MA plans may shift or reduce volume using a variety of tools, including prior authorization, benefit design, and certain network strategies. When used appropriately, utilization-management tools have the potential to promote more efficient care, including better quality outcomes. However, misapplication of

these tools could lead to beneficiaries struggling with delays or denials of needed care (Medicare Payment Advisory Commission 2024b).

Plans' utilization-management tools may be applied more for some types of services than for others, and the exact mechanisms that MA plans employ may vary. For example, a study of prior authorization and utilization management in HHAs found that MA plans used mixed approaches—whether prior authorization was required for the initial start of care, only to extend the length of coverage, or for the number of visits approved (Thomas et al. 2025). Some plans contract with a company to manage their enrollees' post-acute care (PAC), and these companies may use algorithms to speed up the approval process and otherwise ease the burdens associated with prior authorization.

Those algorithms may present their own challenges to beneficiaries' access to care.

Plans may shift patient volume within or across provider sectors for multiple reasons. For example, plans' strategies to limit their provider networks may affect the volume and MA share of any given provider in that market. MA plans may limit the inclusion of IRFs or SNFs in their networks to those that agree to receive rates below a certain level or to those that meet certain levels of performance on measures that plans find desirable. Not only may limited networks result in shifts in volume toward certain providers or lower-cost sites of care, they may also have effects on MA volume in the other sectors (e.g., limited SNF networks may delay hospital discharge, increasing the lengths of stay for some MA enrollees).

Plans may also shift volume to certain providers based on ownership relationships. Plans that are vertically integrated with providers (e.g., an MA plan that owns physician practices or HHAs) have an incentive to direct patients to their vertically integrated providers for clinical reasons (e.g., improved care coordination or quality) and financial reasons (e.g., enhanced diagnostic coding, increasing their providers' profits). For example, a recent study found that an MA plan's acquisition of physician practices led to a substantial increase in diagnostic coding (Marr et al. 2026b).

Potential effects of MA on providers' revenues per patient

MA could affect providers' revenues per patient through the prices that plans negotiate with providers for a given service; additional revenues received from MA plans that are not tied to a particular service (e.g., incentive bonuses); the ways in which plans classify patients or services (e.g., classifying a hospital patient's stay as an observation stay rather than an inpatient admission); and the extent to which plans deny payments for services rendered to their enrollees.

MA plans negotiate prices with providers with whom they contract; those prices can be higher or lower than FFS prices. However, FFS prices tend to act as an important reference point in price negotiations between MA plans and providers (Berenson et al. 2015, Mackleby et al. 2025, Maeda and Nelson 2017, Medicare Payment Advisory Commission 2023b, Xu and Polsky 2023). The importance of FFS prices is partly

attributable to the fact that, when establishing MA, the Congress stipulated that when MA enrollees receive care from providers outside of a plan's network (i.e., a provider that does not have a contract with the plan), the provider is required to accept FFS rates. These statutes protect MA plans—and MA enrollees—from being charged high rates by providers in emergency situations.¹ CMS provided the following guidance in interpreting the FFS price cap from which MA plans and beneficiaries benefit:

Non-contract providers must accept as payment in full payment amounts applicable in Original Medicare. Thus, this provision of law imposes a cap on payment to non-contract providers of provider payment amounts plus beneficiary cost-sharing amounts applicable in Original Medicare, and ensures that non-contract providers not balance bill MA plan enrollees for other than MA plan cost-sharing amounts. (Centers for Medicare & Medicaid Services 2025b)

While the statute provides support for using FFS prices in out-of-network situations, negotiations between MA plans and providers can differ substantially when discussing in-network prices, but FFS prices still remain important when negotiating in-network prices. For example, if providers in a sector are substantially consolidated or an MA plan needs a particular provider to meet its network-adequacy requirements, providers may have leverage to negotiate higher-than-FFS prices. The Commission has found that the dialysis sector is highly consolidated, and MA plans paid rates that were, on average, 22 percent above FFS rates in 2022 (Medicare Payment Advisory Commission 2026). However, if providers negotiate rates that are too high, MA plans may struggle to offer supplemental benefits and remain competitive with FFS, beneficiaries might choose to enroll in FFS rather than MA, and providers would not receive the higher-than-FFS rates. In that way, FFS payment rates continue to act as an important reference point even for in-network providers. In contrast, if FFS prices are well above providers' costs and the supply of providers is not concentrated (as is the case for SNFs in some markets), MA plans may be able to negotiate prices below FFS rates.

Differences in Medicare network-adequacy policies may also play a role in MA price negotiations. MA plans are required to demonstrate the adequacy of their contracted networks for each of 29 clinician specialty types (e.g., primary care physicians, dermatologists)

and 14 facility types (e.g., acute care hospitals, SNFs), for every county in which they operate (Medicare Payment Advisory Commission 2024b).² Network adequacy must be demonstrated in terms of both a minimum number of providers per 1,000 beneficiaries and a maximum time and/or distance that a beneficiary must travel to reach a provider of each type. The thresholds to meet network adequacy are less strict in rural areas. For instance, the maximum time and distance can be up to 155 minutes/140 miles in counties with extreme access considerations for some facilities, compared with a maximum of 20 to 30 minutes/10 to 15 miles in large metropolitan counties.³ However, these network-adequacy thresholds do not need to be met for some providers such as IRFs and HHAs. The lack of network-adequacy standards may provide MA plans with greater leverage in negotiating rates with certain types of providers, especially when they can substitute alternative providers in their network.

Factors beyond negotiated prices can also affect revenues per patient. For example, MA may be more likely than FFS Medicare to deny claims for lack of medical necessity (or other reasons) or downgrade claims to lower-paid services. In these cases, a provider may receive less than 100 percent of FFS prices, on a realized basis, even if the contract between the MA plan and the provider stipulates payment at FFS rates. In contrast, MA plans may pay providers additional revenues that are not tied to a particular service. For example, as part of plans' overall investment in patient care, plans may give clinicians additional payments for meeting certain quality benchmarks that are important to the plan quality rating.

Potential effects of MA on providers' costs per patient

Providers' cost per patient may also vary across MA and FFS patients. Hospitals might incur higher costs to treat MA patients because of longer lengths of stay before initiating PAC and because of administrative costs associated with obtaining prior authorization approvals, following various billing requirements, and appealing claims denials. Providers' cost per patient may also be higher (or lower) to the extent that MA alters volume (either overall or at a particular provider), resulting in fixed costs being spread over fewer (or more) patients.

Over time, providers might also adapt to the different patient volume and revenue from their MA patients by modifying their cost structures to reduce the costs they incur. For example, providers may reduce their staffing hours to align with lower patient volume or reduce the intensity of treatment for particular types of patients (e.g., fewer visits per home health episode). While the ability to reduce their costs may be limited over very short periods, the fact that MA enrollment has been increasing consistently for two decades suggests that providers likely have had time to change their cost structures to adapt to the expansion of MA.

MA enrollment and hospital finances

To provide evidence on the relationship between MA and hospital finances, the Commission conducted several complementary analyses, including a series of site visits and interviews; analyses of MA and FFS beneficiaries' lengths of stay and UC payments; and an analysis of the association between changes in MA penetration and hospitals' all-payer operating revenues, all-payer costs, and all-payer operating margin.⁴

Hospital representatives reported that the growth of MA has negatively affected their hospitals' finances. We estimate that MA patients had longer average lengths of stay than FFS beneficiaries, driven by patients intended to be discharged to PAC. We found that the structure of UC payments benefits hospitals with a higher share of their Medicare stays for MA patients, leading to mistargeted UC payments to the extent that MA plans match FFS UC add-ons. On average, we found that changes in MA penetration were not associated with changes in hospitals' profit margins, although different effects were noted for certain hospital subgroups.

Hospital representatives expressed their perspective that MA growth has negatively affected hospital finances

To obtain hospitals' perspectives on the extent to which increases in MA enrollment have affected them, we spoke with representatives of the hospital industry and conducted multiple site visits across different regions of the country. For context, we also spoke with MA plan representatives and other MA plan stakeholders. These interviews were not intended to be representative of all providers' or MA plans' experiences.

Hospital representatives expressed their perspective that the growth of MA has negatively affected their hospitals' finances. Several key themes that were commonly raised by hospital representatives included:

- **Higher rates of denied claims relative to FFS:** Hospital stakeholders reported that, compared with FFS, MA plans denied payment for more claims after a service had already been provided. Acute hospital inpatient claims were reportedly targeted more frequently for denials, and a lack of medical necessity was often the stated reason. Hospital representatives said that a high percentage of denials were eventually overturned, often citing 80 percent or 90 percent overturn rates. (Similar to what we heard on our site visits, one recent paper found that 17 percent of inpatient claims were initially denied but that 60 percent of those denials were later overturned (Vabson et al. 2025).) Nevertheless, the process of challenging denials reportedly increased administrative spending, detracted from patient care, and increased clinician burnout since physicians working in hospitals are often tasked with liaising with MA plans to overturn denials. Hospital representatives expressed frustration that, in their opinion, MA plans often failed to provide clear, prospective guidelines that would allow them to determine medical necessity, did not clearly detail why certain claims were denied as medically unnecessary, and did not adhere to FFS guidelines for medical necessity.
- **Greater difficulty discharging MA enrollees to PAC:** Hospital representatives we interviewed said that MA plans often delayed beneficiaries from being discharged to PAC in a timely manner. Hospital representatives said that PAC providers were less likely to accept MA patients and that the process of receiving a prior authorization from MA plans for a PAC stay can take multiple days. These reports are consistent with some academic and industry research suggesting that MA enrollees have longer hospital stays compared with FFS beneficiaries when beneficiaries are discharged to PAC settings, such as SNFs (McGarry et al. 2025, NORC at the University of Chicago 2025).⁵ MA plan representatives said that delays in discharging beneficiaries to PAC can often be due to issues related to PAC capacity. For example, they noted

that securing a SNF bed in certain markets can be difficult regardless of the type of insurance the patient has.

- **Higher rates of downgraded claims:** Hospital representatives said MA plans frequently downgrade claims, resulting in lower payments to hospitals. Interviewees noted several types of downgrades—reclassifying a hospital inpatient stay as a hospital outpatient observation stay, changing the Medicare severity diagnosis-related group (MS-DRG) on the claim to a lower-paying one, and changing the level of emergency department (ED) visit (e.g., a hospital submits a claim with a Level 5 ED evaluation and management code and the MA plan pays it as a Level 4). Consistent with these reports, one recent study found that, for ambulatory care-sensitive conditions, MA enrollees had slightly lower hospitalization rates but much higher rates of observation stays and direct discharges from the ED (Beckman et al. 2023). From MA plans' perspective, providers may be inappropriately billing higher-level visits than warranted or billing for short hospital inpatient stays when an observation stay is more appropriate. For example, an HHS Office of Inspector General (OIG) report identified 2.5 million short inpatient stays from 2016 to 2020 and recommended a series of reforms to better monitor the extent to which such stays comply with Medicare policy (Office of Inspector General 2024).
- **Increased administrative burden:** Hospital representatives said that MA plans impose substantial administrative burdens on hospitals, which raises their costs. These extra burdens are a result of multiple factors, including the difficulty of contracting with multiple payers (each with their own set of distinct policies and procedures); prior authorizations; additional approvals (e.g., multiple approvals for one swing-bed stay); and managing denials and downgrades. (A recent KFF analysis found that, in 2024, there were about 1.7 prior-authorization requests per MA beneficiary compared with 0.02 per FFS Medicare beneficiary (Fuglesten Biniek et al. 2026).) In response to this administrative burden, hospitals reported hiring additional staff and asking existing staff (e.g., clinicians) to take on additional duties.

Representatives from MA plans we spoke with acknowledged that tools such as prior authorization can create administrative burden but can also be useful to prevent inappropriate, wasteful, or fraudulent care from being delivered and/or billed. One MA plan said their prior-authorization program was designed by their employed clinicians and was focused on preventing inappropriate clinical care from being delivered. Another plan noted that their prior-authorization program was focused on services such as high-cost imaging, where conservative management might be more appropriate in certain circumstances, and Part D specialty drugs, where less expensive therapeutic equivalents might exist and beneficiaries are not price sensitive (because of a \$2,000 out-of-pocket cap that was introduced in 2025).

- **Did not match certain FFS payments:** Hospital representatives we spoke with generally said that MA plans matched FFS rates for hospital inpatient and outpatient services, with some receiving slightly less than FFS and some receiving slightly more. While not necessarily true for other services (e.g., SNF, dialysis) or for particular hospitals, research suggests that MA payment rates for hospital inpatient and outpatient services tend to be, on average, similar to FFS rates (Mackleby et al. 2025, Maeda and Nelson 2017, Xu and Polsky 2023). However, in addition to the reasons discussed above (e.g., denials and downgrades), hospital representatives said that effective payment rates were often lower than FFS because MA plans are less likely to match non-claims-based payments and other add-ons. For example, FFS Medicare pays 65 percent of bad debts—deductible and coinsurance amounts from FFS beneficiaries that hospitals could not collect—while hospitals reported that MA plans generally had no payments for bad debts. Multiple hospital representatives also noted that MA plans do not pay health professional shortage area bonuses to their employed physicians, whereas FFS Medicare makes 10 percent lump-sum payments on a quarterly basis. Some hospital representatives also noted that MA plans might not match UC add-on payments per discharge if the add-ons are too high. In contrast, some hospital representatives also mentioned

receiving additional sources of revenue from MA plans, including payments for increased diagnostic coding and meeting certain quality metrics. In addition, MA plan representatives noted that, while they do not directly match all FFS add-ons or non-claims-based payments, the goal of their plan is to approximate the magnitude of those special payments and pay providers an equivalent rate. They said that doing so reduces administrative expenses for the plan (e.g., not going through cost-report reconciliation) while still paying providers roughly 100 percent of FFS rates.

MA patients had longer average hospital lengths of stay than FFS beneficiaries

In this chapter, we expand on our previous work to further explore two issues raised by hospital representatives—the differences in hospital inpatient lengths of stay for MA enrollees versus FFS beneficiaries and UC payments.⁶

We examine the extent to which MA enrollees had longer lengths of stay compared with FFS beneficiaries at IPPS hospitals and critical access hospitals (CAHs) using fiscal year (FY) 2024 Medicare Provider Analysis and Review data. We first examined the unadjusted differences in lengths of stay between MA and FFS beneficiaries. Then, because of potential differences between the MA and FFS populations, we ran claim-level regressions to control for the fact that MA enrollees might visit different hospitals, receive different services, have different comorbidities, or have different discharge destinations.

Consistent with our previous work on the topic and other research, we found that MA enrollees had a longer average length of stay compared with FFS beneficiaries in FY 2024 (Medicare Payment Advisory Commission 2024a, NORC at the University of Chicago 2025). Across all hospitals in our analysis (hospitals paid through the IPPS and CAHs), we found that MA enrollees had an average length of stay of about 5.7 days compared with 5.2 days for FFS beneficiaries, a difference of about 0.4 days or 8.6 percent (Table 4-1). After controlling for hospital and beneficiary differences in our regression analyses, we found that the difference in the average length of stay between MA and FFS beneficiaries increased to 11.2 percent (Table 4-1).

**TABLE
4-1**

MA enrollees had a longer average hospital length of stay than FFS beneficiaries, driven by patients who were referred to post-acute care, FY 2024

Category	Unadjusted averages				Regression-based estimates	
	MA LOS (days)	FFS LOS (days)	Difference (days)	Difference (percent)	Difference (days)	Difference (percent)
All	5.7	5.2	0.4	8.6%	0.6***	11.2%
Type of hospital						
IPPS	5.7	5.3	0.4	8.1	0.6***	11.2
CAH	3.8	3.5	0.3	9.7	0.4***	11.8
Discharge destination						
Home	3.8	3.5	0.3	7.6	0.2***	4.9
HHA	5.8	5.3	0.5	9.5	0.4***	8.4
SNF	8.9	7.2	1.6	22.3	1.4***	19.6
IRF	9.9	7.0	2.9	40.9	2.3***	32.3

Note: MA (Medicare Advantage), FFS (fee-for-service), FY (fiscal year), LOS (length of stay), IPPS (inpatient prospective payment systems), CAH (critical access hospital), HHA (home health agency), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility). "Discharge destination" reflects the intended discharge destination (and may not reflect the actual destination); not all discharge destinations are shown. The "home" category reflects patients with an intended discharge location that was home under self-care. We estimated stay-level regressions of length of stay on the following variables: an indicator for whether the stay was for a FFS or MA patient; fixed effects for the hospital; the patient's Medicare severity diagnosis-related group (MS-DRG); the discharge destination; and an interaction of MS-DRG and destination. (The latter two controls were omitted in the regressions limited to a single destination.) Standard errors were clustered at the hospital level. Differences are calculated from unrounded data. Statistical significance is shown for *p*-values less than the 10 percent (*), 5 percent (**), and 1 percent (***) significance levels.

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

The difference in the average length of stay between MA and FFS beneficiaries occurred at both IPPS hospitals and CAHs, despite differences in payment systems. In our regression analyses, MA enrollees had an average length of stay that was 11.2 percent longer than FFS beneficiaries' stays at IPPS hospitals and 11.8 percent longer at CAHs (Table 4-1).⁷

The longer average length of stay for MA enrollees compared with FFS beneficiaries was primarily driven by patients with intended discharge destinations to certain PAC settings. In our regression analyses, MA enrollees' average length of stay for patients who were discharged home (under self-care) was 4.9 percent longer than that of FFS beneficiaries. However, the difference in lengths of stay between MA and FFS

beneficiaries increased substantially for patients with an intended discharge to certain PAC settings: 8.4 percent longer for MA enrollees discharged to home health, 19.6 percent longer for MA beneficiaries discharged to a SNF, and 32.3 percent longer for MA enrollees discharged to an IRF (Table 4-1). The greater difference in lengths of stay among beneficiaries who were discharged to these PAC settings suggests that MA plans, through activities such as prior authorizations, could slow beneficiary discharges to PAC and therefore increase the average amount of time that beneficiaries stay in hospitals.

Comprehensively examining the financial effects of longer lengths of stays on hospitals and beneficiaries is difficult due to limited data on costs and payments

from MA plans (for more information, see the text box on calculating MA margins, pp. 148–149). However, we believe that a longer average length of stay increases hospitals’ costs.⁸

While longer lengths of stay may increase costs for all hospitals, the effect on hospitals’ profitability depends on whether revenues from MA plans increase proportionately to costs. MA plans commonly pay IPPS hospitals in the same way that FFS Medicare does—on a per stay basis, using MS–DRGs. As a result, longer lengths of stay do not typically result in extra payments from MA plans to IPPS hospitals. Therefore, longer lengths of stay for MA enrollees likely reduce profit margins for IPPS hospitals since costs increase without a concomitant increase in revenues. In contrast, MA plans commonly pay CAHs a per diem amount for acute inpatient hospital stays based on the previous year’s Medicare cost report.⁹ Thus, longer lengths of stay may result in higher revenues for CAHs, making it unclear the extent to which longer lengths of stays financially harm CAHs.

Regardless of the effect on hospital finances, longer lengths of stay can also increase costs for beneficiaries depending on the cost sharing charged by their MA plans for hospital and PAC providers. MA plans commonly employ per diem copayments for acute hospital inpatient stays (e.g., \$200 per day) (Medicare Payment Advisory Commission 2023a). Therefore, longer lengths of stay can increase beneficiary cost sharing (as beneficiaries pay more per diem copayments) and reduce costs for MA plans (because the fixed MS–DRG payment made to the hospital does not change but the share paid by the MA plan is reduced as beneficiaries pay more).

Longer lengths of stay can also create issues related to capacity. For example, if patients are delayed in being discharged from the hospital, that could affect the ability of hospitals to accept new patients, such as those in the ED waiting for an inpatient bed.

Structure of UC payments may benefit hospitals with more MA patients, leading to mistargeted UC payments

Our second analysis reviews the effect of changes in MA enrollment on UC payments. Certain hospitals (known as disproportionate share, or DSH, hospitals)

receive FFS UC payments in the form of a fixed dollar add-on to their FFS Medicare payment per stay.

To compute the amount that each hospital is owed in total FFS UC payments in a year, CMS first has hospitals report their UC costs (bad debt and charity care) related to all patients on cost reports. Then, CMS aggregates UC costs across all DSH hospitals. It then computes each hospital’s share of UC costs among all DSH hospitals.¹⁰ Each hospital then receives its share of the pool of FFS UC payments (which totals \$7.713 billion in FY 2026). (For more information on how the pool of UC payments is calculated, see the Commission’s June 2022 report to the Congress.)

To calculate the per stay add-on, CMS takes the hospital’s total FFS UC payments and divides it by an average of the hospital’s historical three-year average FFS inpatient stays. This calculation yields a per stay add-on payment for FFS stays. Through cost-report reconciliation at the end of the year, CMS makes a one-time payment adjustment if the interim add-on payments summed up across all FFS stays result in payments being higher or lower than the UC payment that CMS is obligated to pay the hospital for that year. Because reconciliation ensures that each hospital gets its full FFS UC payment, the formula for FFS patients’ aggregate UC payments is as follows:

Formula for FFS UC payments for a DSH hospital:

$$\frac{\text{UC costs at the DSH hospital}}{\text{Sum of UC costs at all DSH hospitals}} \times \text{Total dollars in the national UC pool}$$

Medicare does not make UC payments directly to hospitals for their MA patients. Instead, CMS includes FFS UC payments in the calculation of MA plan benchmarks. While MA plans have the ability to negotiate payment rates that deviate from FFS rates, they often set prices at or near FFS payment rates (using the IPPS pricer) and include the FFS UC add-on per stay in the MA price. MA plans using the IPPS pricer to set MA payment rates would compute the amount of UC payments as follows:

Formula for MA UC payments for a DSH hospital, if MA plans use the IPPS pricer:

$$\text{MA stays} \times \frac{\text{FFS UC payments}}{\text{Historical average of FFS stays}}$$

As a result of this process, hospitals that have a higher share of their Medicare inpatient stays from MA patients rather than FFS patients benefit financially relative to other hospitals. All else equal, a hospital with a higher share of their Medicare stays from MA patients has fewer FFS stays. Therefore, the FFS UC add-on per stay is higher (because the same pool of dollars is divided by a smaller number of stays). The higher FFS UC add-on does not affect total FFS UC payments (because of the cost-report reconciliation process described above). However, total MA UC payments are higher because MA plans are paying a larger UC add-on for a higher volume of cases.

Large increases in MA penetration over time do not necessarily result in higher UC payments going to hospitals (on a national aggregate basis) because the national UC pool is reduced to account for the fact that there are fewer FFS stays. Rather, hospitals that have a higher mix of MA stays (among their Medicare inpatients) relative to other hospitals disproportionately benefit, while those with a lower mix of MA stays are disadvantaged.

To demonstrate this concept, Table 4-2 (p. 146) shows an illustrative example of two hospitals that are identical except that 25 percent of Hospital A's Medicare inpatient stays are for MA patients and 75 percent of Hospital B's Medicare inpatient stays are for MA patients. As Table 4-2 shows, assuming that MA plans match the FFS UC add-on per stay, Hospital A ("low MA") receives \$4 million less (\$2.0 million vs. \$6.0 million) in total UC payments compared with Hospital B ("high MA"), and the difference is entirely due to higher UC payments for MA patients (\$0.5 million vs. \$4.5 million).

In practice, the level of UC add-on payments per inpatient stay varies widely across hospitals. Hospitals can have very large add-ons if they furnish a very large amount of UC (across all their patients), have very few FFS IPPS stays (e.g., because most of their

Medicare patients have MA or their hospital does not treat many Medicare patients), or both. For example, in FY 2026, about three-quarters of the roughly 3,100 IPPS hospitals were eligible to receive UC payments. Of the eligible hospitals, the median UC add-on per FFS stay was about \$1,000 in FY 2026 but with substantial variation across hospitals (Table 4-3, p. 147). At the high end, about 30 hospitals had an add-on per stay over \$20,000, up to a maximum of over \$300,000 (data not shown). Large variations in prices (due to differences in UC add-ons) for the same service across hospitals could create an incentive for MA plans to shift volume away from hospitals with high UC add-ons.

To empirically analyze the effect of MA growth on interim FFS UC add-ons, we ran a hospital-level regression that estimated the relationship between the share of a hospital's Medicare inpatient stays that were for MA patients and FFS UC add-ons per stay. We found that a 10 percentage point higher share of a hospital's Medicare inpatient stays that were for MA patients in FY 2024 was associated with a 15 percent higher FY 2026 estimated FFS UC add-on per stay, after accounting for each hospital's share of UC costs.¹¹ Similar to the illustrative example above, our regression results suggest that hospitals with a higher share of their Medicare inpatient stays for MA patients may benefit financially under the current UC formula (and, inversely, hospitals with lower shares of MA patients may be disadvantaged). Our results also suggest that the targeting of current UC payments could be improved because the mix of FFS and MA patients affects the amount of UC payments hospitals receive instead of that funding being solely determined by more appropriate factors, such as the amount of care furnished to individuals who cannot afford it.

The implications of both our illustrative table and regression analysis depend on the extent to which MA plans match hospitals' FFS UC add-ons per stay. We spoke with multiple stakeholders (including hospitals and organizations representing groups of hospitals) to qualitatively assess the manner in which MA plans address UC add-ons.

Consistent with research suggesting that MA plans set their hospital inpatient rates at or near FFS payment rates, our interviews suggest that MA plans typically match FFS UC add-ons per stay. However, for hospitals with extremely high UC add-ons, hospital

**TABLE
4-2****Illustrative example of how hospitals with a higher share of their Medicare inpatient stays from MA may benefit from the current uncompensated-care structure**

	Hospital A (low MA)	Hospital B (high MA)
Factors used to calculate the FFS UC add-on (before the payment year)		
FFS UC payments (calculated by CMS based on estimated DSH payments, uninsured rate, and UC costs reported by hospitals)	\$1.5 million	\$1.5 million
Historical average FFS stays (used to calculate interim FFS add-on)	1,500	500
FFS add-on per stay (FFS UC payments / historical average FFS stays)	\$1,000	\$3,000
Number of stays and UC payments (from the payment year)		
Medicare stays (FFS + MA)	2,000	2,000
FFS stays	1,500	500
MA stays	500	1,500
FFS UC payments (FFS stays × FFS add-on per stay) (with reconciliation, as needed)	\$1.5 million	\$1.5 million
MA UC payments (MA stays × FFS UC add-on per stay)	\$0.5 million	\$4.5 million
Total UC payments (FFS + MA)	\$2.0 million	\$6.0 million

Note: MA (Medicare Advantage), FFS (fee-for-service), UC (uncompensated care), DSH (disproportionate share). In this example, we assume that MA plans match FFS UC add-ons per stay. For simplicity, we assume that the number of FFS stays in the payment year was the same as the historical average number of stays used to calculate the FFS add-on payment. In practice, those numbers vary, and hospitals would go through reconciliation to ensure they receive an appropriate amount of total UC payments, which is \$1.5 million in this example.

Source: MedPAC analysis of inpatient prospective payment systems final-rule files.

representatives expressed concerns that MA plans have sought to exclude such hospitals from their networks, negotiate lower UC add-ons per stay, and/or shift volume to hospitals with lower UC add-ons. For example, one hospital with an extremely high FFS UC add-on per stay said that nearly all MA plans have excluded the hospital from their networks due to their high UC add-on.

The intent of UC payments is to direct additional funding toward hospitals that disproportionately provide care to individuals who cannot afford it.

However, the interaction of the growth of MA and the current structure of UC payments partially undermines that goal for a few key reasons:¹²

- UC payments become mistargeted when UC dollars are shifted to hospitals on the basis of their shares of Medicare patients in MA or FFS rather than being targeted to hospitals on the basis of furnishing UC; and
- MA plans have an incentive to reduce medical spending by paying less than the FFS UC add-on amounts and/or shifting care from hospitals with

**TABLE
4-3**

FFS uncompensated-care payments per stay varied substantially across hospitals, FY 2024–2026

Interim FFS uncompensated-care payments per stay	FY 2024	FY 2025	FY 2026
1st percentile	\$90	\$80	\$50
10th percentile	290	280	360
25th percentile	460	450	580
50th percentile	770	770	1,010
75th percentile	1,440	1,480	2,010
90th percentile	2,580	2,780	3,710
99th percentile	14,670	16,730	22,030

Note: FFS (fee-for-service), FY (fiscal year). Data limited to hospitals that are projected to receive FFS uncompensated-care payments in the year, exclusive of sole community hospitals projected to be paid their hospital-specific rate and inclusive of Puerto Rico and Indian Health Services hospitals that receive supplemental FFS uncompensated-care payments. Results are rounded to the nearest \$10. Dollars are nominal, not adjusted for inflation.

Source: MedPAC analysis of inpatient prospective payment systems final-rule files.

high UC add-ons to those with lower ones, which may have a negative effect on hospitals that furnish a high amount of UC. MA plans' reducing medical spending by shifting care to a clinically appropriate, lower-cost setting can often be valuable. However, in this case, the payment differentials across hospitals do not represent underlying differences in cost or quality but rather reflect the fact that the Congress has explicitly directed supplemental funding to certain hospitals based on their role in the health care system (i.e., providing a high amount of UC).

Multiple approaches are available to reform UC payments. One possible approach would be to remove UC payments from MA plan benchmarks and require CMS to make payments directly from Medicare to hospitals for both FFS and MA patients, which is similar to the way Medicare currently pays for indirect medical education (IME).¹³ Such an approach would address the adverse incentives MA plans currently have to avoid hospitals with high FFS UC add-ons per stay, but by itself such an approach would not address the mistargeting of UC payments. One approach to address that issue as well (in a budget-neutral manner) would be to increase the UC pool to account for the fact that it would now represent UC payments for

both FFS and MA patients. UC payments could then be paid directly to hospitals via a per stay add-on calculated using a combination of FFS and MA inpatient stays (rather than only FFS stays, as is currently the case). Under such a process, CMS could reconcile total interim UC payments (FFS + MA) through the cost-reporting process rather than only FFS UC payments, as is currently done. The Commission has also recommended removing UC payments from MA benchmarks and paying hospitals directly for all Medicare patients (FFS and MA) as part of a larger reform of hospital safety-net payments in the Medicare Safety-Net Index (Medicare Payment Advisory Commission 2023b).

Data limitations undermine policymakers' ability to understand MA's effect on hospital finances

Our analyses of beneficiary length of stay and UC payments suggest that increases in MA penetration may affect hospitals' finances. While these analyses may be useful to inform policymakers about potential issues, they capture only a few limited impacts. To better understand the effect of MA on hospital finances, one possible next step would be to calculate hospitals' MA margin, similar to the way the Commission calculates hospitals' FFS margin. While

Requiring better cost-report data for services furnished to Medicare Advantage enrollees would facilitate calculation of hospitals' Medicare Advantage margins

Medicare's hospital cost reports currently allow researchers to calculate hospitals' fee-for-service (FFS) Medicare margin (with some limitations), but they do not currently contain parallel data that would allow for a similar estimate of hospitals' Medicare Advantage (MA) margin. Policymakers could require additional information to be reported on hospital cost reports in order to calculate hospitals' MA margin, although such data collection would create additional administrative burden. Policymakers should weigh that burden carefully against the benefits of the information collected.

How hospital cost reports enable the calculation of hospitals' FFS Medicare margin

Hospital cost reports have worksheets that estimate a hospital's costs of providing FFS Medicare services and the hospital's revenues from the FFS Medicare program and its beneficiaries for providing these services. Using these data, researchers can calculate hospitals' FFS Medicare margin.

FFS Medicare costs

One set of worksheets (the D series) estimates hospitals' FFS Medicare costs by service line. Each service line contains a range of possible cost centers, and the hospital's FFS costs for each cost center are estimated through one of two methods:

- *FFS days multiplied by a cost per diem.* To estimate a hospital's FFS Medicare costs for a cost center using this method, the worksheet multiplies the hospital's FFS Medicare days by a per diem calculated as (the hospital's all-payer costs in that cost center) / (all-payer days in that cost center). Examples of cost centers using this method are inpatient routine costs (e.g., room and board) for general adult inpatient beds and routine costs for beds in intensive care units (ICUs).

- *FFS charges multiplied by a cost-to-charge ratio.* To estimate a hospital's FFS Medicare costs for a cost center using this method, the worksheet multiplies the hospital's FFS Medicare charges for the cost center by a cost-to-charge ratio calculated as (the hospital's all-payer costs in that cost center) / (all-payer charges in that cost center). Examples of cost centers using this method are drugs, labs, and operating rooms.

To facilitate hospitals' completion of these worksheets, CMS and its contractors produce a Provider Statistical & Reimbursement (PS&R) report that summarizes FFS Medicare claims data (and, where appropriate, shadow claims for MA enrollees) over the hospital's cost-reporting period, including volume and charge breakouts by cost center.

FFS Medicare revenues

Another set of worksheets (the E series) captures hospitals' FFS Medicare revenues by service line. Most of these lines can be filled out using the same PS&R report, which includes FFS revenues broken out by different types of payments (e.g., base payments, disproportionate share hospital payments, interim uncompensated-care payments). However, some lines that reflect a hospital's postclaim experience need to be supplied by the hospital (e.g., bad debt from uncollected beneficiary cost-sharing requirements).

Modifying hospital cost reports to enable a calculation of hospitals' MA margin

More complete encounter data and sources of postclaim payments would enable a parallel calculation of hospitals' MA margin. In another sector (skilled nursing facilities), CMS has begun to implement some changes to collect more data on MA volume and revenues (but not costs).

MA Medicare costs

A new set of worksheets could be added to hospital cost reports to calculate MA costs using the same

(continued next page)

Requiring better cost-report data for services furnished to Medicare Advantage enrollees would facilitate calculation of hospitals' Medicare Advantage margins (cont.)

hospital cost-reporting principles as used for FFS (in the D series). Following the same cost-reporting principles, some cost centers would use existing all-payer per diems and others all-payer cost-to-charge ratios. What would be needed are:

- MA inpatient days over the cost-reporting period, by type of day (e.g., general, ICU, rehabilitation unit). These data are already partially reported on the S-3 series but not by type of day.
- MA charges by cost center over the cost-reporting period. This information is at least partially reported in current MA encounter data, but there are questions about its completeness, reliability, and consistency.

These data points could be compiled by CMS and its contractors (such as by using encounter data to create parallel MA PS&R reports) and/or calculated directly by hospitals.

MA Medicare revenues

Similarly, a new set of worksheets could be added to hospital cost reports to capture the revenues hospitals receive for furnishing hospital care to MA enrollees. These data would reflect actual payments received by hospitals, including beneficiary cost sharing, claims-based payments, and any non-claims-based payments. The claims-based component of MA payments could be derived from encounter data and/or calculated directly by hospitals. The hospitals would need to directly report other components of revenues, such as those

not tied to a specific service (e.g., partial capitation, payments for diagnostic coding, or year-end bonus payments), and what portion of beneficiary cost-sharing liabilities hospitals actually collected in a given time period.

Limitations

Creating additional cost-report worksheets for MA costs and revenues would allow researchers to calculate hospitals' MA margin and compare it with their FFS Medicare margin. However, hospital cost-reporting principles have limitations, which would confound the comparison of hospitals' FFS Medicare and MA margins.

One key limitation of Medicare cost-reporting principles is the use of all-payer per diems and cost-to-charge ratios to estimate costs. For example, to the extent that hospitals incur higher administrative costs for MA patients than FFS patients, that would not be captured. A second limitation in comparing these FFS Medicare and MA margins is that the two populations differ. Therefore, cost reports would not capture the counterfactual of what a hospital's margin would have been if an MA patient had instead had FFS Medicare. A third limitation is that MA data sources (most notably encounter data) are currently incomplete, and even complete encounter data would not be sufficient to capture MA revenues that are not tied to a specific service. It would therefore take time and additional administrative burden (on some combination of hospitals, MA plans, and CMS) to collect and ensure the accuracy of these new hospital cost-report worksheets. ■

hospitals already separately track and report some information on MA enrollees (e.g., shadow claims), all the data needed to calculate MA-specific profit margins are not currently available.

One key data source that policymakers and researchers use to calculate hospitals' FFS Medicare margin is Medicare hospital cost-report data; requiring hospitals

to complete similar information on their MA revenues and costs would facilitate a comparable calculation of hospitals' MA margin but would still have limitations (see text box on the data that would be needed). Any additional information on cost reports would not replace data that MA plans are already required to report, such as MA encounter records.

Prior research on the effects of MA enrollment on hospital finances is limited and mixed

Researchers have examined MA's effects on providers by comparing FFS with MA prices and differences in volume trends and by examining the effect of MA on all-payer hospital margins.

The literature on the extent to which MA affects hospitals' financial performance is limited and mixed. Hospital industry research suggests that MA plans pay hospitals slightly less than FFS rates, while the peer-reviewed literature suggests that MA plans usually pay close to FFS rates. The research that examines MA's effects on hospitals' overall profitability is limited, mostly focused on rural hospitals, and finds that MA growth has had a statistically insignificant, slightly positive effect or slightly negative effect, depending on the specific metric used and methodology employed. The effect of MA may also vary by hospitals' characteristics, such as the extent to which a hospital is vertically integrated with an MA plan, but even less research has been done on this topic.

The American Hospital Association (AHA) released a report that compared payment-to-cost ratios for MA and FFS patients at rural hospitals. The report found that, from 2019 to 2023, rural hospitals' average MA payment-to-cost ratios were between 89 percent and 94 percent of their FFS payment-to-cost ratios (American Hospital Association 2025). According to the report, the ratio of MA-to-FFS rates was higher for certain types of hospitals and lower for others; for example, the ratio for CAHs was 95 percent, while the ratio for Medicare-dependent hospitals and low-volume hospitals was 85 percent. In contrast, one academic study using 2013 data for hospitals in urban areas found that MA prices for hospital inpatient services were, on average, roughly equal to FFS Medicare prices (Maeda and Nelson 2018). A more recent paper that used 2024 national price-transparency data found that MA prices for three common DRGs at the average hospital were 97 percent of FFS rates, with an interquartile range of 90 percent to 104 percent (Mackleby et al. 2025). Another study using the price-transparency data found that median MA prices were equal to FFS payment rates for ED visits and medicine and surgery, but the median MA price for radiology was slightly higher (4 percent) than FFS payment rates (Xu and Polsky 2023).

Two recent descriptive analyses from the University of North Carolina's Rural Health Research Program found that an increasing share of Medicare inpatient days attributable to MA patients was associated with no change in hospital financial performance or slightly improved financial performance. In one study, the authors found that a higher share of MA inpatient days relative to FFS days was negatively associated with their measure of hospital financial distress (i.e., hospitals with more MA patients performed better financially), but the effect was not significant (Malone et al. 2025). A second study, using data from 2022 to 2023, concluded that rural hospitals with a higher share of MA patients for Medicare inpatient days tended to have slightly higher operating margins, but there was no correlation for urban hospitals. For their rural analyses, the authors cautioned that the positive correlation could partially be attributed to the fact that rural hospitals with higher MA shares had characteristics that could independently be associated with better financial performance. For example, rural hospitals with higher shares of MA patients for their Medicare inpatient days tended to be substantially larger in terms of beds, net patient revenues, and average daily census (Kim et al. 2025).

Two recent academic papers used regression analyses to examine the effect of MA after controlling for some potentially confounding factors. One study examined 2008 to 2019 Healthcare Cost and Utilization Project data from 14 states and concluded that increasing MA penetration was associated with improved financial conditions for rural hospitals and reduced risks of closure (Henke et al. 2023). The second study, using AHA survey data and Medicare cost-report data, examined changes in county-level MA penetration and hospitals' Medicare inpatient days and all-payer inpatient revenues (Cataife and Liu 2025). That study concluded that increasing MA penetration from 2014 to 2020 was associated with a decrease in rural hospitals' Medicare inpatient days and all-payer inpatient revenues but an increase in urban hospitals' Medicare inpatient days and all-payer inpatient revenues.

While there has generally been limited research on the effects of MA growth on hospitals' finances, there has been even less research on MA's effect on specific types of hospitals, which may be of interest to policymakers. For example, we are not aware of any published studies that attempt to understand whether the effect of MA

on hospital financial performance varies by whether a hospital and MA plan are vertically integrated. Vertically integrated hospitals and MA plans likely face a different set of incentives, and some research suggests that vertically integrated hospitals perform better on certain clinical and patient-satisfaction measures (Bejarano et al. 2025, Bejarano et al. 2024). In addition, related research suggests that MA plans pay their vertically integrated physician groups substantially higher prices, suggesting that MA plans could face different incentives to reduce spending for vertically integrated and non-vertically integrated providers (Arnold and Fulton 2025).

Methods for analyzing the association between changes in MA penetration and changes in all-payer hospital finances

Given the lack of conclusive evidence on this topic, we added to the empirical literature by conducting a regression analysis to estimate the association between changes in market-level MA penetration and changes in hospital finances from 2013 to 2024 (excluding 2020 and 2021 due to the coronavirus pandemic). We separately examined IPPS hospitals and CAHs because the financial incentives for MA plans may differ for the two types of hospitals.¹⁴ CAHs also tend to be more financially vulnerable because of their smaller size and greater dependence on Medicare, so additional scrutiny on how MA penetration affects them is warranted.

Empirical strategy relies on comparing providers in markets with larger changes in MA penetration to providers in markets with smaller changes in MA penetration

We used linear regression models with hospital and year fixed effects to estimate the association between changes in MA enrollment and changes in hospitals' all-payer profit margins, revenues, and costs. Our main explanatory variable of interest is the share of Medicare beneficiaries in the hospital's market who are enrolled in MA in the year (referred to as "MA penetration").

This empirical strategy has been used in previous studies and has several advantages. First, estimating the association between MA and hospitals' all-payer margins allows us to capture the net effect of MA penetration on hospital finances from all the potential mechanisms discussed earlier. Second, the use of

hospital fixed effects controls for all hospital and market-level factors that are constant over the study period. For example, some hospitals may be located in areas with more intensive practice patterns or consistently have patient populations with more complex health care needs. Third, this approach also allows us to control for some factors that were changing over the study period using year fixed effects (controls for national changes common to all hospitals), state-level time trends (controls for state-level changes common to hospitals in a state over time), and variables that control for market-level population characteristics in each year.

However, interpreting the estimated associations of changes in market-level MA penetration and changes in hospital finances as causal requires a key assumption: that without differential changes in MA penetration, changes in hospital finances would be similar across markets, after adjusting for observable factors. To help assess that assumption, we compared the baseline characteristics of markets with different changes in MA penetration over the study period.

Markets with larger and smaller changes in MA penetration appear different in some ways, even in the first year of our study, which raises the concern that underlying differences in the markets themselves, rather than changes in MA penetration, could account for some of the estimated associations with changes in MA penetration and in hospital finances. For example, the quartile of markets that experienced the largest percentage point increase in MA penetration from 2013 to 2024 had the highest median per capita rate of all-payer inpatient stays in hospitals in 2013 (Table 4-4, p. 153). This quartile also experienced the largest decline in all-payer inpatient stays from 2013 to 2024. While this pattern may reflect a partially causal relationship, it is also possible that both inpatient stays declined and MA penetration increased more rapidly in these areas for a different, unobserved reason. In that case, our model would identify an association between decreases in inpatient stays (and lower costs and revenues associated with those stays) and increases in MA penetration even though the relationship is not entirely causal.

In addition, the population size, uninsured rate, unemployment rate, median income, and Medicare population demographics also differed for markets

that experienced smaller changes in MA penetration compared with markets that experienced larger changes (Table 4-4). Our analysis controlled for those and other observable factors; however, we cannot be sure that we controlled for all factors that impact hospital finances and are correlated with changes in MA penetration. Therefore, our estimates should be interpreted as associations that may reflect a combination of effects due to MA and other factors.

Data and main specification used to estimate regression models

We calculated all-payer operating revenues, all-payer costs, and all-payer operating margins from 2013 to 2024 for both IPPS hospitals and CAHs using Medicare cost reports (see Appendix 4-A, p. 176, for more details). We regressed these three outcome variables on market-level MA penetration (i.e., the share of Medicare beneficiaries in a health service area (HSA) with Part A and Part B coverage who were enrolled in MA) as the main variable of interest. We defined markets using HSAs, which are clusters of counties representing relatively self-contained hospital areas (National Cancer Institute 2023).¹⁵ There are approximately 945 HSAs with Medicare beneficiaries nationwide. We included provider fixed effects to control for non-time-variant characteristics of the provider (such as geographic location); year fixed effects to control for factors that affect all providers nationally; state-level time trends to control for differential state policies that change over time; and a set of market-level time-varying characteristics to control for changes in population and other factors that could affect the outcomes of interest.^{16,17} The inclusion of provider fixed effects means that the estimates reflect the association between changes in MA penetration and changes in finances within hospitals over time.

We report the estimated coefficient on market-level MA share as the association between a 10 percentage point increase in MA penetration and the outcomes of interest. The all-payer revenue and cost variables were logged, so the coefficients can be interpreted as the percentage change in each of the outcomes from a 10 percentage point increase in MA penetration. We also show the outcome variables' median values over the 2013 to 2024 period to provide context on the size of the estimate.

We estimated the following linear regression model:

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

where:

Y_{ht} is all-payer revenues, all-payer costs, or all-payer profit margins for hospital h in year t .

β is the coefficient of interest—the association between changes in MA penetration and the outcome.

MA_{mt} is MA penetration in market m (of hospital h) and year t .

X_{mt} is a vector of time-varying, market-level controls, and γ is the vector of coefficients.

α_h are provider fixed effects.

δ_t are year fixed effects.

$\lambda_s \cdot t$ is a linear state-specific time trend where λ_s is the state, s , where the hospital is located, and t is set to 0 to 9 for the year 2013 to the year 2024, excluding 2020 and 2021.¹⁸

ε_{ht} is the error term.

To determine how the relationship differs for subgroups of hospitals (such as size groups and system-affiliation groups), we ran the same regression model shown above with an interaction for MA_{mt} and the subgroup. The coefficients on each of the interacted subgroups then represent the association between changes in MA penetration and the outcome of interest for the hospitals within the subgroup.

We used a weighted least-squares linear regression, in which hospitals were weighted by the number of beds they reported in their first cost report in the sample. Standard errors were clustered at the market level.

Changes in MA penetration not found to be associated with changes in IPPS hospitals' profit margin on average, 2013–2024

To provide context for our regression analyses, we first report descriptive statistics for the IPPS hospitals included in our analysis. Consistent with the overall national trend, the median MA penetration rate increased from 26 percent to 55 percent in the markets for the IPPS hospitals in our analysis from 2013 to 2024 (Table 4-5, p. 154). Over the same period, hospitals'

**TABLE
4-4****Markets with smaller changes in MA penetration differed in some ways from markets with larger changes, 2013–2024**

Median characteristic, 2013 (unless otherwise noted)	Quartiles of HSA-level MA penetration change between 2013 and 2024			
	1st quartile N = 236	2nd quartile N = 236	3rd quartile N = 236	4th quartile N = 237
MA penetration change, 2013–2024 (percentage point)	13	23	30	38
MA penetration	12%	21%	18%	17%
Population characteristics				
Population (thousands)	51	157	137	107
Share unemployed	6%	7%	7%	8%
Share uninsured	15%	15%	18%	18%
Share enrolled in Medicare	18%	18%	18%	19%
Median income (thousands)	\$81	\$80	\$73	\$68
Medicare population characteristics				
Share under age 65	14%	17%	20%	22%
Share ages 85 and over	12%	11%	10%	9%
Share dually eligible or LIS	14%	15%	18%	22%
Share of FFS beneficiaries enrolled in MSSP	1%	4%	2%	2%
Share of FFS beneficiaries enrolled in MSSP (2024)	30%	38%	41%	39%
Total all-payer inpatient stays per thousand residents				
2013	69	82	81	91
2024	54	72	71	71
Percent change	–18%	–12%	–15%	–21%
Market characteristics				
MAO HHI (hundreds)	47	38	39	43
Health-system HHI (hundreds)	50	47	51	52
State-level Medicaid MCO penetration	67%	62%	63%	52%

Note: MA (Medicare Advantage), HSA (health service area), LIS (low-income subsidy), MSSP (Medicare Shared Savings Program), MAO (Medicare Advantage organization), HHI (Herfindahl–Hirschman Index), MCO (managed care organization). HSAs were divided into quartiles based on MA-penetration changes. Values are median market-level characteristics in each HSA subgroup in 2013 unless otherwise noted. Median income was inflated to 2024 dollars using the Consumer Price Index for All Urban Consumers. Because the MSSP was relatively new in 2013, we provide MSSP penetration in 2013 and 2024 for additional context. The change in total all-payer inpatient stays per thousand residents represents the median percent change from 2013 to 2024 for each quartile. Our analysis includes 945 HSAs. The table values were very similar when we included the roughly 900 HSAs with hospitals in them. All differences were statistically significant at the 0.01 level, except the percentage of the populations enrolled in Medicare, the health-system HHIs, and the Medicaid MCO penetration, according to Kruskal–Wallis rank sum tests.

Source: MedPAC analysis of CMS Medicare enrollment, American Community Survey, Bureau of Labor Statistics unemployment, Small Area Health Insurance Estimates, hospital cost-report, American Hospital Association survey, Medicaid and Children's Health Insurance Payment and Access Commission MCO, and National Cancer Institute HSA data.

all-payer operating margin remained relatively flat except for variations during the coronavirus pandemic. This aggregate view suggests little correlation at the national level between growth in MA penetration and

hospitals' all-payer operating margin, but it does not control for possible confounding factors or examine subgroups, which our regression analysis seeks to do.

**TABLE
4-5****Limited correlation at the national level between IPPS hospitals' all-payer margin and changes in MA penetration rates, FY 2013–2024**

Fiscal year	Number of hospitals	MA penetration in market	IPPS median			
			All-payer operating revenues (millions)	All-payer costs (millions)	All-payer operating margin	Aggregate all-payer operating margin
2013	3,150	26%	\$184.4	\$172.1	3.6%	6.1%
2014	3,180	28	185.4	174.7	3.8	6.1
2015	3,120	30	194.4	182.0	4.4	6.5
2016	3,110	31	197.1	183.7	4.0	6.1
2017	3,070	33	197.1	188.2	3.5	6.1
2018	3,020	36	203.3	192.5	3.6	6.0
2019	2,980	39	210.5	197.8	4.3	6.7
2020	2,930	43	203.4	197.6	0.9	2.1
2021	2,920	46	218.0	206.1	4.5	7.3
2022	2,900	50	216.0	211.7	0.3	1.7
2023	2,880	53	224.7	215.5	2.5	4.8
2024	2,760	55	239.1	226.4	4.1	6.3

Note: IPPS (inpatient prospective payment systems), MA (Medicare Advantage), FY (fiscal year). "Number of hospitals" is rounded to the nearest 10. See Appendix 4-A (p. 176) for hospitals included in our sample. "MA penetration in market" refers to the share of Medicare beneficiaries in a health service area (HSA) with Part A and Part B coverage who were enrolled in MA and is rounded to the nearest percent. Revenues and costs are inflated to 2024 dollars using the hospital market basket and rounded to the nearest hundred thousand. "All-payer operating margin" excludes reported investment and donation income, is reported exclusive of federal or other coronavirus relief funds, and is rounded to the nearest 0.1 percent. Despite differences in the hospitals included, the aggregate all-payer operating margin for hospitals in our analysis is similar to the one we reported in our March 2026 report to the Congress (Medicare Payment Advisory Commission 2026).

Source: MedPAC analysis of hospital cost-report, CMS market basket, Medicare enrollment, provider of services file, and National Cancer Institute HSA data.

In our regression analysis, we did not estimate a statistically significant association between market-level MA penetration and all-payer operating revenues, all-payer costs, or all-payer operating margins for IPPS hospitals (Table 4-6, p. 156).

Estimated associations varied for some subgroups of hospitals

While we estimated no statistically significant relationship between changes in MA penetration and IPPS hospitals' finances overall, our analyses of the underlying costs and revenues for subgroups of hospitals suggest that MA may differentially affect different types of hospitals. The growth of different types of MA plans (e.g., HMO vs. preferred provider

organization and provider sponsored or not) may also affect hospitals differently, but examining this issue is beyond the scope of this chapter.

To examine whether the results differed by type of hospital, we estimated four additional specifications, in which the coefficient of interest is the interaction term between market-level MA penetration and an indicator for each type of subgroup. Specifically, we examined the extent to which changes in MA penetration affected hospitals: of various sizes (based on bed counts), with different system membership, in markets with different levels of 2013 market MA penetration, or in different study periods. For one of these study periods, we also examined how the extent of vertical integration between hospitals and MA plans affected our analysis.

First, for small hospitals (1–100 beds) and medium hospitals (101–250 beds), an increase in MA penetration was negatively associated with all-payer revenues and all-payer costs. For example, for small IPPS hospitals, a 10 percentage point increase in market-level MA penetration was associated with a 1.7 percent decrease in all-payer operating revenues and a 2.3 percent decrease in costs (Table 4–6, p. 156). In contrast, for large hospitals (more than 250 beds), an increase in MA was positively associated with all-payer revenues, and we did not estimate a statistically significant association with all-payer costs. An increase in MA penetration was not associated with hospitals' margins for medium and large hospitals but was positively associated with small hospitals' margins.

Second, we estimated the association between market-level MA penetration changes and hospital finances for hospitals that were part of a system for at least one year in the study period and those that were not. Because the vast majority of hospitals (97 percent) were classified as part of a system, the estimated associations for system-affiliated hospitals were very similar to the overall estimates.¹⁹ For the small share of hospitals that were not part of a system, we found that a 10 percentage point increase in market-level MA penetration was associated with a 3.1 percent decline in all-payer operating revenues and a 3.0 percent decline in costs.

These analyses suggest that smaller hospitals and the small share of hospitals that were never part of a system experienced larger associations between changes in MA penetration and revenues and costs. There are multiple possible explanations for such differences. For example, larger hospitals or those that are part of a system could have greater negotiating leverage with MA plans, which could result in securing better contract terms with regard to prices, non-claims-based payments, or utilization-management practices.

Third, we stratified hospitals by 2013 market MA penetration quartiles (less than 9.3 percent, 9.3 percent to 17.6 percent, 17.6 percent to 26.2 percent, and more than 26.2 percent). IPPS hospitals in markets with a lower baseline MA penetration generally showed a more negative association between MA penetration and revenues and costs compared with hospitals in markets with higher baseline penetration, although results varied in their statistical significance (data not shown). The margin associations ranged between not statistically significant to positive across baseline MA

penetration groups, with no clear relationship between baseline MA penetration group and margin outcomes.

Fourth, we estimated the association between MA penetration changes and hospital finances for different study periods. We did not find a statistically significant association between MA penetration changes and IPPS hospitals' all-payer operating revenues or all-payer costs in any of the split study periods. For hospitals in the 2022 to 2024 study period, we found that a 10 percentage point increase in MA penetration was associated with a 0.70 percentage point increase in all-payer operating margins.

We further analyzed the hospitals in the 2022 to 2024 study period, stratifying by the extent to which they were vertically integrated with an MA plan in 2021. Hospitals were grouped into four categories: no MA inpatient encounter volume from an affiliated MA plan, less than 5 percent, 5 percent to 20 percent, and more than 20 percent.

For hospitals with higher levels of vertical integration, a 10 percentage point increase in market-level MA penetration was more commonly associated with increases in all-payer revenues, costs, and margin. In contrast, we did not find a statistically significant association for hospitals with no volume coming from a vertically integrated plan.

Our results suggest that MA's effects on providers could vary based on the extent to which they are vertically integrated with an MA plan. This finding is consistent with the theoretical incentives and the limited research on the topic to date. MA plans have less incentive to implement utilization-management practices (e.g., denials, downgrades, prior authorization) on their own providers. Vertically integrated hospitals also have an incentive to act in a manner that increases overall revenues for the hospital plus the MA plan (e.g., increased diagnostic coding) or reduce overall costs (e.g., better coordination) rather than only hospital-specific revenues and costs.

Estimated associations of MA penetration and margins were consistently near zero under multiple sensitivity analyses, while estimates with revenues and costs varied in size

We estimated several additional model specifications to assess the sensitivity of our results to alternative specifications for hospitals paid under the IPPS. The

**TABLE
4-6****No statistically significant association found between MA penetration changes and all-payer margin for IPPS hospitals on average, FY 2013–2024****Change estimated from a 10 percentage point increase in market-level MA penetration**

Group	Share of sample	All-payer operating revenues	All-payer costs	All-payer operating margin (in percentage points)
Overall	100%	–0.5%	–0.9%	0.39
Bed size				
1–100 beds	10	–1.7**	–2.3***	0.62*
101–250 beds	30	–2.3***	–2.7***	0.39
>250 beds	60	1.3**	1.0	0.32
System				
In a system	97	–0.3	–0.8	0.42
Never in a system	3	–3.1***	–3.0***	–0.17
Years				
2013–2016	41	–0.5	–0.9	0.38
2017–2019	30	–0.3	–0.8	0.46
2022–2024	29	0.1	–0.6	0.70**
Median outcome value		\$489.3 million	\$460.4 million	4.3%

Note: MA (Medicare Advantage), IPPS (inpatient prospective payment systems), FY (fiscal year). See p. 152 describing how the regression was defined and Appendix 4-A (p. 176) describing how the study sample was defined. Revenues and costs were inflated to 2024 dollars using the hospital market basket. "All-payer operating margin" excludes reported investment and donation income. All-payer revenues and margin exclude federal or other coronavirus relief funds. All-payer revenues and all-payer costs were logged in the regression analysis, and results represent the percentage change in the outcome associated with a 10 percentage point increase in the MA penetration of the hospital's health service area. Median outcomes and shares of sample were weighted by the number of beds the hospital had in the first year they were in the sample. The number of hospital-year records in our sample was 30,246. Statistical significance is shown for *p*-values less than the 10 percent (*), 5 percent (**), and 1 percent (***) significance levels.

Source: MedPAC analysis of hospital cost-report, market basket, and Medicare enrollment data from CMS, as well as supplemental data sources (see Appendix 4-A, p. 176).

results of these supplemental analyses show that the associations between market-level MA penetration and all-payer hospital margins are not sensitive to the particular specification that we used. In general, associations between MA penetration and all-payer hospital operating revenues and costs were directionally consistent with our main specification, but they were more variable in that the magnitude of the parameter results and the extent to which they were statistically significant were more prone to change compared with our analysis of margins.

First, we conducted several analyses that were motivated by the concern that the estimated associations may in part reflect preexisting differences in markets with lower relative to higher changes in MA penetration. When we excluded hospitals in the lowest quartile of HSAs in terms of changes in MA penetration over the study period and then subsequently hospitals in the lowest or highest quartile of HSAs, we did not find a statistically significant association between changes in MA penetration and hospital margins

(similar to our base model); revenues and costs, however, did have a significant negative association with increases in MA enrollment (data not shown). When we excluded hospitals in the highest quartile of HSAs, we did not find a statistically significant association between changes in MA penetration and any of our outcomes of interest. Because base-period inpatient hospital use appeared different across quartiles of HSAs with different levels of changes in MA penetration (see Table 4-4, p. 153), we also reran our regression three times: after dropping hospitals in the lowest quartile, after dropping those in the highest quartile, and after dropping both those in the lowest and those in the highest quartile of HSAs in terms of all-payer inpatient hospital stays per capita in 2013. We again found no statistically significant association between changes in MA penetration and hospital margins, and we found a limited number of significant associations between MA penetration and all-payer costs and all-payer revenues.

Second, we assessed the importance of adjusting for state time trends. In our interviews with hospital representatives, we consistently heard that state-level policies (such as trends in Medicaid managed care penetration, Medicaid payment rates, and state-directed payments) can have a material impact on hospital finances. Therefore, in our main model, we use state-specific linear time trends to control for differential state policies that change over time and to partially adjust for underlying trends in factors that we were unable to include as separate control variables. To assess the importance of state time trends, we estimated a specification that did not include those adjustments. We found that increases in MA penetration had a statistically significant and positive relationship with hospitals' all-payer margins but no significant relationship with all-payer costs or all-payer revenues. This specification is the only one that we ran in which an increase in MA penetration had a statically significant positive association with all-payer margins across our entire study period and sample of IPPS hospitals, which highlights the importance of accounting for state trends. We therefore also conducted a sensitivity analysis that more precisely controls for state time trends by replacing the state-specific linear time trends with state-by-year fixed effects. State-by-year fixed effects are a more precise way of accounting for trends because they can capture

trends that are not linear. However, state-by-year fixed effects can lead to imprecisely estimated associations when there are a small number of markets in a state. Nonetheless, our overall results did not materially change with state-by-year fixed effects.

Third, we also tested the association between hospital finances and county-level MA penetration (rather than HSA-level MA penetration). In this specification, we did not find a statistically significant association between changes in MA penetration and hospitals' all-payer margins. We did, however, find a statistically significant and negative association between MA penetration and all-payer revenues and all-payer costs.

Fourth, we conducted multiple sensitivity analyses regarding how we weighted our regressions. We weighted our base regressions by the number of beds the hospital had in the first year it appeared in our study sample. To assess the extent to which hospitals with a large number of beds were driving the results, we conducted a sensitivity analysis that excluded the 50 largest hospitals. Excluding these hospitals did not materially change most of our results. However, small hospitals and large hospitals exhibited different associations between MA penetration and revenues and costs (Table 4-6). Therefore, to assess a specification that placed more weight on smaller hospitals, we ran our regression weighted by the natural logarithm of the number of beds in the hospital in the first year it entered the study sample. In this specification, we did not find a statistically significant association between changes in MA penetration and hospitals' margins. However, we did find a significant and negative association between MA penetration and all-payer revenues and all-payer costs.

In addition to these four tests, we also conducted other, more minor sensitivity analyses that did not have material effects on our findings.²⁰

Limitations of this analysis indicate caution is warranted when interpreting estimated associations between MA penetration and hospitals' finances

The key limitation of our analysis is that markets that experienced larger changes in MA penetration during the study period may systematically differ from markets that experienced smaller changes. Although

**TABLE
4-7****Limited correlation at the national level between CAHs' all-payer margin and changes in MA penetration, FY 2013-2024**

Fiscal year	Number of hospitals	MA penetration in market	CAH median			
			All-payer operating revenues (millions)	All-payer costs (millions)	All-payer operating margin	Aggregate all-payer operating margin
2013	1,290	16%	\$24.9	\$24.0	1.6%	2.8%
2014	1,300	17	25.0	24.4	1.1	2.4
2015	1,300	18	26.3	25.7	2.2	3.5
2016	1,290	18	26.8	26.3	1.7	3.2
2017	1,300	20	27.2	26.8	0.9	2.6
2018	1,280	21	27.0	26.9	0.6	2.0
2019	1,290	26	28.2	27.7	1.4	2.6
2020	1,280	30	27.4	27.8	-0.6	0.5
2021	1,280	34	30.0	29.0	3.8	5.9
2022	1,300	38	29.8	29.6	0.6	2.2
2023	1,300	42	30.7	30.0	1.2	3.6
2024	1,270	45	32.2	30.7	2.8	5.3

Note: CAH (critical access hospital), MA (Medicare Advantage), FY (fiscal year). Number of hospitals was rounded to the nearest 10. See Appendix 4-A (p. 176) for hospitals included in our sample. "MA penetration in market" refers to the share of Medicare beneficiaries in a health service area (HSA) with Part A and Part B coverage who were enrolled in MA and is rounded to the nearest percent. Revenues and costs are inflated to 2024 dollars using the hospital market basket and rounded to the nearest hundred thousand. "All-payer operating margin" excludes reported investment and donation income, is reported exclusive of federal or other coronavirus relief funds, and is rounded to the nearest 0.1 percent. Despite our exclusions, the aggregate all-payer operating margin for hospitals in our analysis (rounded to the nearest 0.1 percent) is similar to the one we reported in our July 2025 data book.

Source: MedPAC analysis of hospital cost-report, CMS market basket, Medicare enrollment, provider of services file, and National Cancer Institute HSA data.

we controlled for some market-level factors that were changing over the study period, there are other factors we did not control for or were unable to measure. If those factors are associated with both changes in a market's MA penetration and hospital finances, that could result in changes in MA enrollment being associated with changes in hospital finances in ways that do not reflect the underlying causal relationship. In addition, if MA plans disproportionately entered markets because of their different spending trajectories, a portion of our estimates could reflect a reverse causality bias.

An analysis we conducted suggests that this concern may be material both for our study and other analyses that use market-level changes in MA penetration.

When we applied our fixed-effect regression models to estimate the relationship between changes in MA penetration and hospital inpatient stays, we estimated a negative and implausibly large association between MA penetration and total Medicare (MA and FFS) inpatient stays. Furthermore, we estimated a negative and implausibly large association between MA penetration and all-payer (Medicare and non-Medicare) stays. These analyses of volume suggest that markets that experienced greater changes in MA penetration were likely experiencing different trends in volume that were at least in part unrelated to MA. Since volume affects both hospitals' revenues and their costs, differential trends in volume would create a directionally similar bias in interpreting the

estimated associations of MA penetration with both revenues and costs. (Previous analyses indicate that roughly 75 percent to 85 percent of hospitals' costs are variable as hospitals adjust to different levels of volume from year to year) (Medicare Payment Advisory Commission 2025c). Table 4-4 (p. 153), which shows substantially different rates of hospital inpatient use in the beginning of our study period across areas that experienced different changes in MA enrollment from 2013 to 2024, reinforces the concern that changes in MA enrollment were systematically associated with certain characteristics.

Concerns about differential trends confounding the interpretation of our results were less salient for the estimated associations between MA penetration and margins, meaning it may be appropriate to place more weight on estimates of profit margins than for estimates of revenues and costs. Because both the revenue and cost components of the calculation of margins would be affected by concerns of differential trends in utilization, any effect of those trends may largely balance out when estimating associations between changes in MA penetration and margins. The estimated association of MA penetration and all-payer margins was consistently small and not statistically distinguishable from zero over many alternative specifications and sensitivity analyses, indicating the robustness of those results. By contrast, associations of MA penetration with revenues, costs, and volume varied in their size over different specifications. While these analyses indicate fewer concerns about the interpretation of the estimated associations of MA penetration with margins relative to revenues and costs, the estimates for margins should still be viewed as associations rather than precisely estimated causal effects.²¹

Changes in MA penetration not associated with changes in CAHs' profit margin on average, 2013 to 2024

As in our analysis of IPPS hospitals, we first report descriptive statistics for CAHs included in our analysis. The median MA penetration rate increased from 16 percent to 45 percent in the markets for CAHs in our analysis from 2013 to 2024 (Table 4-7). Over the same period, our CAHs' all-payer operating margin showed no clear correlation with MA penetration trends. This

aggregate view suggests little correlation between increases in MA penetration and CAHs' all-payer operating margin at the national level but does not control for possible confounding factors, which our regression analysis sought to do.

Our regression analysis did not estimate a statistically significant association between market-level MA penetration changes and all-payer operating revenues, all-payer costs, or all-payer operating margins for CAHs on average (Table 4-8, p. 160). However, when we estimated the association between MA penetration changes and hospital finances for different study periods, we found that a 10 percentage point increase in MA penetration was associated with a 1.8 percent increase in all-payer operating revenues from 2013 to 2016 and a 0.56 percentage point increase in all-payer operating margin from 2022 to 2024. Otherwise, we did not find a statistically significant association between MA penetration changes and CAH finances during the different study periods.

Lack of associations could reflect several factors, including some that may not be related to MA enrollment

Taken together, our analyses provide little support for the argument that increases in MA enrollment have had a substantial negative (or positive) net effect on hospitals' profitability. One possible explanation is that the lack of any substantial relationship reflects the reality of the situation on average. For example, hospitals could have responded to revenue reductions associated with increases in MA penetration by lowering their cost structures such that overall profitability remained largely unchanged. Such behavior would be consistent with the Commission's longtime observation that hospitals under fiscal pressure tend to have higher FFS Medicare margins and the academic literature, which suggests that hospitals tend to lower their costs in response to lower payments (Baker 2025). Alternatively, some of the reductions in revenues that hospitals reported experiencing could have been partially offset by other payments, such as higher UC payments or additional payments from MA plans to hospitals (such as additional payments to increase diagnostic coding, especially among hospitals that employ clinicians, or incentive payments for performance on certain quality

**TABLE
4-8**

No statistically significant association found between MA penetration changes and all-payer margin for CAHs on average, FY 2013–2024

Change estimated from a 10 percentage point increase in market-level MA penetration

Group	Share of sample	All-payer operating revenues	All-payer costs	All-payer operating margin (in percentage points)
Overall	100%	0.7%	0.3%	0.38
Years				
2013–2016	40	1.8*	1.5	0.29
2017–2019	30	0.7	0.5	0.10
2022–2024	30	0.53	–0.1	0.56*
Median outcome value		\$29.5 million	\$28.8 million	1.5%

Note: MA (Medicare Advantage), CAH (critical access hospital), FY (fiscal year). See p. 152 describing how the regression was defined and Appendix 4-A (p. 176) describing how the study sample was defined. Revenues and costs are inflated to 2024 dollars using the hospital market basket. All-payer revenues and margin exclude federal or other coronavirus relief funds. All-payer revenues and all-payer costs were logged in the regression analysis, and results represent the percentage change in the outcome associated with a 10 percentage point increase in the MA penetration of the hospital's health service area. Median outcomes and shares of sample are weighted by the number of beds that the hospital had in the first year they were in the sample. The number of hospital-year records in our sample is 12,945. Statistical significance is shown for p-values less than the 10 percent (*), 5 percent (**), and 1 percent (***) significance levels.

Source: MedPAC analysis of hospital cost-report, market basket, and Medicare enrollment data from CMS, as well as supplemental data sources (see Appendix 4-A, p. 176).

metrics). While our work on UC and our interviews with hospitals suggest some offsetting effects are likely, quantifying the precise mechanisms that led to no association between MA penetration and hospital profitability (and how that may affect beneficiaries) is beyond the scope of this chapter. Alternatively, as discussed above, the estimates could in part reflect unrelated factors that were changing in markets that experienced more changes in MA penetration that we were unable to control for in our analysis.

Our analysis of the relationship between MA penetration and hospitals' finances (and other similar work) also has a number of limitations. We therefore caution against overinterpreting the results. Instead, the estimates in this report should be interpreted as associations rather than estimates of causal effects of how MA penetration affects hospital finances.

MA enrollment and PAC providers' finances

Similar to our methods for examining MA and hospital finances, to provide evidence on the relationship between MA and PAC providers' finances, we conducted interviews with skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and home health agencies (HHAs) and with MA plans, and we analyzed the association between changes in MA penetration and PAC providers' all-payer operating revenues, all-payer costs, all-payer operating margin, and volume when data were available.²²

PAC provider interviewees reported that the growth of MA has negatively affected their finances. IRFs emphasized that MA plans' use of prior authorization to initiate services reduced PAC volume relative to FFS Medicare, while several SNF and HHA interviewees noted

that MA plans typically had lower payment rates than FFS. Across the three PAC settings, providers that we interviewed consistently reported higher administrative costs associated with obtaining authorization to start or extend care and to appeal denials.

For freestanding SNFs and HHAs, we estimated the association between changes in market-level MA penetration and providers' finances using the same regression-based approach we applied to acute care hospitals. We found that increases in MA penetration were associated with small declines in all-payer revenue and costs among SNFs and HHAs, on average. However, we did not find statistically significant effects on their all-payer margins, on average. These results do not rule out meaningful effects of increases in MA penetration on the finances of specific providers. Moreover, changes in MA penetration had different effects on subgroups of SNFs and HHAs. Since only about a third of IRFs are freestanding and we were able to calculate all-payer margins only 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.

MA penetration could have different effects on PAC providers' finances than on hospitals'

PAC providers deliver recuperative care generally (but not always) after a patient leaves the acute care hospital. The goal is to help patients recover or regain function, prevent patients' loss of function, or safely transition back to the community after illness, surgery, or hospitalization. SNFs, HHAs, and IRFs all provide rehabilitation, skilled nursing, and personal care, but the level of care varies, with each having distinct features.²³ HHAs care for beneficiaries who can be safely treated at home and do not require facility-based care. SNFs provide facility-based care to beneficiaries who require daily skilled care but do not need the intensity of rehabilitation care offered in IRFs or cannot meet IRF admission criteria.²⁴ IRFs offer the most intensive rehabilitation services, and care must be supervised by a rehabilitation physician. The Commission has discussed the overlap in some of the types of patients treated in the different PAC settings (Medicare Payment Advisory Commission 2026).

MA enrollment may have larger effects on PAC providers' finances compared with acute care hospitals for several reasons. First, given the potential substitutability across PAC settings for some patients and the large price differences among the settings, MA plans have a financial incentive to seek lower-cost settings for PAC placement when possible.²⁵ Shifting use would affect providers' revenues and costs (though the effects on costs would depend on the extent to which they are variable vs. fixed). In contrast, acute hospital care is generally less substitutable with care delivered in other settings.

Second, FFS payments to PAC providers tend to be high, and the Commission has for years recommended reducing the levels of payments in these sectors to achieve greater value for the program.²⁶ Given the high payments relative to costs, some MA plans may be able to negotiate lower payment rates with PAC providers. Higher FFS payments relative to MA for SNF care have been reported by the National Investment Center for Seniors Housing & Care and by some publicly traded nursing home companies (Medicare Payment Advisory Commission 2025b, Medicare Payment Advisory Commission 2023b). Depending on the source, the ratio of FFS to MA payments ranged from 1.21 to 1.38, though these differences did not account for differences in service intensity and were available for only a subset of SNFs; we do not know whether they are representative of other SNFs.

Third, Medicare revenues likely account for a relatively large share of all-payer revenues for HHAs and IRFs, given their high share of Medicare volume (90 percent and 67 percent, respectively).²⁷ If MA payment rates differ from those for FFS Medicare, expanded MA enrollment may have material implications for these providers' overall financial performances.

Last, FFS incentives may encourage unnecessary volume—either longer stays in SNFs, additional 30-day periods in HHAs, or admissions to IRFs that could have been treated in a lower-cost setting (Medicare Payment Advisory Commission 2026). Cost-sharing rules may also shape utilization. For example, as long as beneficiaries continue to require skilled care, home health stays may be extended because there is no cost sharing. In contrast, studies have found patterns suggesting that some SNF stays extend to Day 21, the day that beneficiary cost sharing begins (Chatterjee

et al. 2019, McGarry et al. 2021). Studies by CMS and OIG raise questions about IRF use. In 2025, CMS found that the improper-payment rate for IRF FFS claims was over three times the average (21.5 percent compared with 6.55 percent) and that the vast majority of the randomly selected FFS claims it reviewed (362 from freestanding IRFs and 172 from IRF units) did not support medical necessity (Centers for Medicare & Medicaid Services 2025a). OIG found that the documentation for the majority of the 220 randomly selected FFS IRF stays it reviewed did not support that the IRF care was reasonable and necessary (Office of Inspector General 2018). Thus, we might expect growth in MA penetration to be associated with lower Medicare volume if MA plans employ management tools to curb overutilization. However, it is not clear whether a lower level of services indicates more appropriate use or unmet needs among some enrollees. CMS is currently conducting a demonstration aimed at reducing improper payments to IRFs in states with high rates of such payments. The demonstration began in 2023 in Alabama and extended to Pennsylvania in 2024; CMS plans to expand the program in 2026 to Texas and California. Of the 15 participating IRFs in Alabama and 52 IRFs in Pennsylvania, CMS reported high rates of compliance with Medicare documentation standards (over 80 percent) for the first six months of 2025 (Centers for Medicare & Medicaid Services 2025d).

Most PAC providers we interviewed reported that increases in MA penetration have negatively affected their finances

We conducted semistructured interviews with representatives from several SNFs, IRFs, and HHAs to hear their perspectives on payment rates, differences in patient characteristics by payer, and cost implications associated with growth in Medicare beneficiaries enrolled in MA. We sought to include providers that were independent and those that were part of a chain and those located in various geographical areas. However, these interviews were not intended to be representative of all providers in their industries. Interviews focused on providers' perspectives on how growth in MA enrollment has affected volume, patient case mix, and services offered, as well as beneficiaries' access to care and providers' payments and financial performance. Our HHA interviews took place in late 2024 and early 2025 and included interviews with both providers and plans (Medicare Payment Advisory Commission 2025b). Our SNF and IRF interviews took

place in early 2026. We also spoke with several MA plans regarding their perspectives on providing PAC benefits and working with PAC providers. In earlier work, we interviewed hospital discharge planners' decisions to place beneficiaries in IRFs and SNFs (L & M Policy Research 2024). In a separate set of interviews, we talked with a variety of stakeholders about institutional special-needs plans (I-SNPs) (Medicare Payment Advisory Commission 2025b).

The interviews yielded several common themes, including:

- **MA plans denied claims, delayed care, and shortened stays:** IRF representatives said that MA plans' use of prior authorization reduced enrollees' access to IRF care. They reported that MA plans tended to use the 13 compliance conditions as admission criteria (even though IRFs may admit patients with other conditions as long as they meet coverage rules).²⁸ Some hospital-discharge planners we spoke with reported that while some MA plans limited IRF admissions, others rarely or never authorized IRF admissions. One interviewee told us that some MA plans told her that IRF care was not part of the benefit (L & M Policy Research 2024). Because plans often took longer to approve IRF care or to work through the denial and appeal process, the delays could mean that some beneficiaries' functional status deteriorated such that they no longer qualified for care in IRFs (beneficiaries must be able to actively participate in intensive therapy, typically defined as three hours a day). To expedite PAC placement, some hospital-discharge planners had concurrently sought prior authorization for SNF and IRF care, but when they realized that this approach generally resulted in IRF care being denied, they dropped pursuing SNF placements to improve the chances of an IRF placement. One MA plan told us that IRFs are eager to admit more of their enrollees; however, after evaluation, some of these patients are determined to be more appropriately treated in SNFs.

SNF representatives said that some MA plans denied care outright or shortened stays by authorizing care for 7 to 14 days at a time. Some interviewees worried that MA enrollees were prematurely discharged from the SNF, when the patients and their families were not ready to manage the care at home, and that some MA

enrollees ended up being readmitted to the hospital. One SNF representative mentioned changes to MA rules that might ease enrollees' access to SNF care by clarifying standards for denials and appeals.²⁹ SNF interviewees also told us that beneficiaries tend to switch out of MA and into traditional FFS Medicare when they get sick. On the other hand, one SNF reported that MA plans send letters to beneficiaries encouraging them to switch from FFS to MA.

One large HHA chain's interviewees said that their MA patients likely received fewer visits than FFS patients with similar conditions. Although they noted variation in how MA plans structured the home health benefit for their enrollees, generally, the plans they contracted with tended to require prior authorization for home health care up to a certain number of visits and require additional authorization for more visits. They noted that the prior authorization for more visits could be difficult to obtain even if the clinician assessed that the patient needed more visits.

- **Increased administrative burden:** IRFs and SNFs reported that MA plans were difficult to work with. Requests for prior authorization to admit enrollees and to extend stays were burdensome and costly to administer. SNF interviewees told us that even if the MA payment rates were close to FFS rates, they found the process of authorization for longer stays for enrollees to be challenging and administratively costly. One SNF told us that it used to avoid MA given the administrative hassles and low rates (see discussion below) but that the growth in MA made this approach less tenable.
- **Mixed approaches to managing beneficiaries' care.** In addition to approving prior authorizations for admission and continued stays in PAC settings, some SNFs reported that MA plans contract with care-management companies that assist with discharge planning and ordering durable medical equipment for patients going home. Another SNF said that some plans are not involved in care once the beneficiary is admitted except to review progress notes to estimate when a beneficiary will be discharged. An MA plan we interviewed noted that it waives the three-day hospital stay for SNF coverage (which is a requirement under FFS) and felt that plans and providers seem to be working

better together more recently. The plan noted that their value-based contracts with SNFs (through I-SNPs) better align plan and provider incentives.

- **Enrollees steered to in-network providers:** Some IRFs we spoke with told us that they struggle to be included in plans' networks, possibly because the plan has already contracted with other IRFs or because CMS's network-adequacy requirements do not set standards for the numbers of IRFs and time/distance to IRFs. Some IRFs also mentioned that it is difficult to get plans to cover out-of-network IRF care. One SNF representative said that plans steer enrollees to in-network providers. Another said that plans did not consider provider quality when selecting providers to be included in-network.
- **MA payment rates were lower than FFS's for SNFs and HHAs but not IRFs:** Unlike what we heard from acute care hospitals, the SNFs and HHAs we interviewed reported often receiving rates from MA plans that were lower than FFS. For example, HHAs receive a bundled prospective payment system (PPS) payment for an episode of care for FFS beneficiaries, while HHA interviewees reported that MA plans tend to pay per visit at lower rates than FFS Medicare (Medicare Payment Advisory Commission 2025b). On the other hand, some HHAs said they were able to obtain an episodic rate, and some plans told us that they pay 100 percent or more of FFS rates for home health visits.³⁰ Qualitative interviews reported by another study also noted the lower visit rates for MA patients compared with FFS beneficiaries (Zuckerman et al. 2020).

SNF interviewees stated that MA per diem payments tended to be lower than FFS rates, though there was variation among the interviewees. One SNF mentioned that rates were about 85 percent to 90 percent of FFS per diem rates, depending on the MA plan, and that some plans paid considerably less than FFS per diem rates—sometimes less than the cost of care. Another SNF told us they received close to 99 percent of SNF PPS per diem rates. We were told that some plans assign MA enrollees' stays to tiers (a version of a case-mix group) and that the plans try to assign the stays to the lowest tier to further lower their payments. Some interviewees noted that they need to be careful when admitting MA enrollees

since the payment can be quite low. Interviewees noted that payment rates for in-network and out-of-network use varied considerably by plan. One SNF told us that some of its MA contracts were old and their payment rates had not been updated and that it had no leverage with the plans to increase their payment rates. We were told that negotiating with new plans was especially difficult: The rates that were offered were low, and plans seemed less interested in securing contracts with higher-quality providers.

IRF representatives told us that they received payment rates from MA plans that were comparable with FFS. One MA plan emphasized that it paid 100 percent of the FFS rates for IRF, SNF, and HHA services. IRF representatives also told us that even though payment rates were comparable, they incurred higher administrative costs.

SNF interviewees mentioned another way revenues could be affected by growth in MA enrollment: inability to collect bad debt from MA plans. For example, when Medicaid does not cover the cost sharing for dually eligible patients (which varies depending on state Medicaid policy), they noted that there is no recourse for the SNF to recover any portion of the cost sharing associated with MA enrollees because there is no bad-debt policy for MA (the FFS bad-debt policy pays 65 percent of the amount owed). One SNF told us that they attempt to build the cost of any bad debt into their negotiated rate with some MA plans. In addition, when MA audits take back payments, providers cannot write off the lost revenues (as they can with audit-related reductions to FFS payments).

Prior research on MA and PAC finances is limited

There have been few studies that have examined the relationship between MA penetration and PAC providers' finances. Marr and Shen found that increased MA enrollment in a market decreased SNFs' financial performance during the 2012 to 2019 period (Marr and Shen 2024). A study by Geng and colleagues found that increased MA penetration in a market was associated with less PAC use by FFS enrollees with three conditions (stroke, hip fracture, and congestive heart failure), suggesting that MA may affect PAC providers' finances by reducing FFS volume (Geng

et al. 2023). A study examining the association of MA and the supply of HHAs between 2012 and 2022 found that counties with greater growth in MA penetration saw larger declines in the number of HHAs (Marr et al. 2026a). A larger number of studies have focused on comparing MA and FFS use of PAC, with some also examining differences in quality. Other work has analyzed the use of prior authorization and service denials by MA plans.

MA and FFS use of PAC

Many studies have examined differences in PAC volume between MA and FFS beneficiaries. A study comparing SNF, IRF, and HHA use for three common conditions (lower-extremity joint replacement, stroke, and heart failure) found that MA enrollees were less likely to use PAC (in any setting), and those who used institutional PAC (SNFs and IRFs) had shorter stays compared with FFS beneficiaries, with mixed differences in outcomes (see discussion below) (Skopec et al. 2020). The authors concluded that MA plans were not substituting HHA for institutional care but reducing PAC overall.

A study comparing SNF and HHA use found that, compared with FFS beneficiaries, MA enrollees were more likely to use SNF services but that home health use was comparable (Roy et al. 2025). In addition, MA enrollees had shorter SNF and HHA stays compared with FFS beneficiaries, yet outcomes were better. The authors concluded that some FFS beneficiaries may overuse services. Another study found that slightly lower shares of MA than FFS beneficiaries used HHAs and SNFs, with larger differences in days of care, though these analyses were not adjusted for differences in beneficiary characteristics (Burke et al. 2024). The study also found that MA used fewer providers of care.

Huckfeldt and colleagues compared MA and FFS enrollees' use of SNFs and IRFs and found MA enrollees had less intensive use of PAC: They were less likely to be admitted to an IRF compared with FFS beneficiaries and had shorter stays in SNFs (Huckfeldt et al. 2017). The lower use did not worsen the patient outcomes examined. The study also found that, compared with FFS beneficiaries, MA enrollees were concentrated in fewer SNFs. A recent paper by Lake and colleagues found that MA enrollment was associated with lower IRF use but higher mortality among patients with hip fracture and stroke, particularly in markets with high

IRF utilization (Lake et al. 2026). The authors suggested that in these markets, where IRFs tend to treat patients with more complex rehabilitation needs, MA plans may be diverting high-acuity patients to SNFs that may lack the capacity and experience to manage the patients' clinical complexity.

Studies comparing MA and FFS use of home health care have drawn mixed conclusions, in part because they used different data sources and not all studies adjusted for the characteristics of MA and FFS beneficiaries. A review of 30 studies had mixed findings regarding use, intensity of services, and outcomes, though more recent studies have generally found lower rates among MA enrollees (Ma et al. 2024). Our prior work found that the rates of home health use among MA enrollees and FFS beneficiaries were similar (Medicare Payment Advisory Commission 2025b). We also found that, conditional on using home health care, MA enrollment was associated with fewer visits received per beneficiary per year compared with FFS beneficiaries, consistent with the findings of a study conducted by Mroz and colleagues (Medicare Payment Advisory Commission 2025b, Mroz et al. 2025). A study using data from a large nonprofit HHA chain assessed whether the approaches that MA plans used to pay for home health care—per visit or per episode—affected utilization and outcomes (Prusynski et al. 2025). The study found that, compared with FFS Medicare, both MA approaches had shorter lengths of stay and higher odds of transferring patients back to an acute care hospital, though the per visit approach had the shortest home health care length of stay (and a greater share of visits from physical and occupational therapists compared with episodic MA patients). A study conducted by NORC at the University of Chicago found that, compared with FFS beneficiaries, MA enrollees were less likely to be discharged from the acute care hospital to SNFs and IRFs but more likely to be discharged to HHAs, though its analysis did not adjust for differences in patient case mix (NORC at the University of Chicago 2025). Xu et al. found that home health lengths of stay were shorter in MA than in FFS, but they also did not adjust for differences in patient case mix (Xu et al. 2026).

It is important to note that there has been an overall trend of fewer visits per home health stay among FFS home health care users. The introduction of the Patient-Driven Groupings Model payment system for FFS

home health care implemented in 2020 was associated with fewer visits per stay, particularly therapy visits (Medicare Payment Advisory Commission 2026).

Several studies have compared the quality of providers used by MA and FFS beneficiaries and found that MA enrollees tended to use slightly lower-rated SNFs and HHAs than FFS beneficiaries. One study compared outcomes for beneficiaries recovering from strokes and found that MA enrollees were less likely to be treated in high-quality HHAs and SNFs but equally likely to use high-quality IRFs (Skopec et al. 2020). Looking at all conditions, a study of SNF and HHA use found that MA enrollees used slightly lower-rated SNFs and HHAs than FFS beneficiaries (Burke et al. 2024). Two studies found that MA enrollees were less likely to enter high-quality SNFs compared with FFS beneficiaries (Meyers et al. 2018, Wang et al. 2025). A study of the quality of HHAs used by MA and FFS enrollees found that MA enrollees were less likely to use high-quality HHAs and that the likelihood was lower for those enrolled in low-quality MA plans (Schwartz et al. 2019).

Studies have examined MA plans' use of prior authorization. OIG and the Senate Permanent Subcommittee on Investigations have examined MA denials of services, with implications for beneficiaries' access to needed services. OIG found that SNF and IRF services were among the most frequently denied prior-authorization and payment requests that met Medicare coverage rules (Office of Inspector General 2022). OIG noted that the denials could delay or prevent beneficiaries from getting medically necessary care. Our previous analysis of prior-authorization appeals that were reviewed by a CMS-contracted independent review entity (IRE) found that the IRE upheld MA plans' coverage decisions in most cases; among these upheld decisions, about half involved requests to preapprove IRF admissions (Medicare Payment Advisory Commission 2024b).

A Senate investigation of three large MA plans found that, between 2019 and 2022, the use of prior authorization for PAC services increased and the denial rates for the requests were higher than for other services (U.S. Senate Permanent Subcommittee on Investigations 2024). The Senate committee reported that the companies' use of algorithms to review requests increased. In a class-action lawsuit against one large plan, plaintiffs alleged that the use of an artificial intelligence model wrongfully denied PAC by

overriding physicians' determinations about medically necessary care (U.S. District Court for the Western District of Kentucky 2023). As of February 2026, the lawsuit had not been settled. A study of a large MA plan's use of predictive algorithms resulted in shorter SNF lengths of stay without changes in outcomes (Marr 2025). An industry-sponsored survey of 441 nursing homes found that two-thirds of the respondents had experienced delays or denials of care or shortened stays associated with MA enrollees (American Health Care Association 2024).

Methods for analyzing the association between changes in MA penetration and PAC providers' finances

We applied the same regression models used for hospitals to estimate how changes in MA penetration within providers' markets over time are associated with changes in PAC providers' overall financial performance. We note that data are not currently available to directly calculate PAC providers' revenues, costs, and margins exclusively for their MA enrollees (see the text box on the data needed to better understand providers' finances related to MA, pp. 148–149). We applied this modeling approach to SNFs and HHAs.

Similar to the analysis for acute care hospitals, we used Medicare cost reports to calculate all-payer revenues, all-payer costs, all-payer margin, and volume from 2013 to 2024 (see Appendix 4-B, p. 179, on our methods for using cost reports to calculate providers' all-payer finances and volume). We regressed these outcomes on MA penetration of the provider's market as the main variable of interest. We included the same set of fixed effects and other control variables as described on p. 152, plus the number of total acute care hospitalizations per total population, which affects demand for PAC services and could help control for market-level trends in health care use.³¹ As in our analysis of acute care hospitals, we tried to control for variation in state Medicaid policies over this period (such as eligibility rules, supplemental and other targeted payments, provider taxes, payment rates, and cost-sharing and bad-debt policies) by including state-level linear time trends. Allowing for trends to vary by state is especially important for SNFs because Medicaid is the majority payer in most SNFs. We also ran the regression with state-by-year fixed effects

and reported when these results differ from our main findings.

We report the estimated coefficient on market-level MA penetration as the association between a 10 percentage point increase in MA penetration and the outcome of interest. The revenue, cost, and volume measures were logged, so the coefficient can be interpreted as the percent change in each of the outcomes from a 10 percentage point increase in MA share. Regressions for SNFs were weighted by the number of available beds in the provider's first year in the study sample, which serves as a proxy for provider size. For HHAs, size was proxied using the number of all-payer patients. Because HHA patient counts are more fluid than bed counts for SNFs and hospitals, we used the average number of all-payer patients observed over the study period to approximate HHA size.

Even with our extensive market, provider, year, and state time-trend controls, there may be unobserved factors that are correlated with changes in both MA penetration and providers' finances, which could confound the interpretation of our results. Indeed, as shown in Table 4-4 (p. 153), markets that experienced larger changes in MA penetration over the study period differed at baseline in some important ways from markets that experienced smaller changes in MA penetration. That difference suggests that the associations estimated in this analysis may in part reflect differences in underlying trends in markets with different changes in MA penetration. In addition, the inclusion of provider and year fixed effects and state-specific trends may limit our ability to detect smaller effects of MA penetration. See pp. 159–160 for further discussion of limitations in interpreting these findings.

Our regression analyses were limited to freestanding providers because their Medicare cost reports allow for the calculation of all-payer revenues, costs, and some measures of all-payer volume. Freestanding facilities account for the vast majority of SNFs (97 percent) and HHAs (93 percent). Hospital-based providers were excluded because we cannot calculate an all-payer margin from information in the hospital cost report. Only one-third of IRFs are freestanding (though they tend to be larger and account for a larger share of stays). The remaining IRFs operate as distinct part units of acute care hospitals. Lacking margin information for the majority of the IRF industry, we did

**TABLE
4-9**

MA penetration and SNF all-payer finances and volume for SNFs in our study sample, 2013–2024

SNF median values

Year	Number of SNFs	MA penetration in market	All-payer revenues (millions)	All-payer cost (millions)	All-payer margin	All-payer resident days	FFS share of all-payer revenue	FFS share of facility days
2013	12,720	25%	\$11.1	\$10.9	1.9%	31,250	22%	12%
2014	12,580	28	11.1	11.0	1.9	30,960	21	12
2015	12,550	29	11.1	11.0	1.7	30,540	21	12
2016	12,940	30	10.9	11.0	1.0	30,110	20	11
2017	13,050	32	10.8	10.9	0.6	29,770	19	11
2018	13,190	35	10.7	10.8	0.3	29,520	18	10
2019	13,060	38	10.7	10.8	0.7	29,680	17	9
2020	13,100	41	10.6	10.7	–1.3	27,230	19	11
2021	12,820	45	9.9	10.3	–2.8	25,220	18	10
2022	12,690	48	10.0	10.4	–3.3	26,350	17	10
2023	12,380	52	10.3	10.4	–0.3	27,560	14	9
2024	12,050	54	10.8	10.6	2.1	28,510	13	8

Note: MA (Medicare Advantage), SNF (skilled nursing facility), FFS (fee-for-service). Includes only nursing facilities that provide SNF care (see Appendix 4-B (p. 179) describing how our study sample was defined). We show values for 2020 and 2021 for SNFs in our study sample in this table, but these years are excluded from the analysis in Table 4-10 (p. 169). SNF all-payer revenues and costs are inflated to 2024 dollars using the SNF market basket. “MA penetration in market” refers to the share of Medicare beneficiaries in a health service area with Part A and Part B coverage who were enrolled in MA. “All-payer revenues” and “all-payer margin” exclude federal or other coronavirus relief funds. “Facility days” includes those for short-term posthospital care and long-term care.

Source: MedPAC analysis of Medicare cost reports for freestanding SNFs, CMS market basket, Medicare enrollment, and health service area data.

not conduct the analysis of MA market penetration and financial performance. Instead, we present descriptive information on IRF MA volume that is available for all IRFs and discuss additional analyses using IRF patient-assessment data, which are collected for all Medicare patients.

Changes in MA penetration not estimated to be associated with changes in SNFs’ profit margin on average from 2013 to 2024

Consistent with the overall national trend, from 2013 to 2024, the median market-level MA penetration for SNFs in our study sample steadily increased from 25 percent to 54 percent (Table 4-9) (see Appendix 4-B, p. 179, for how our SNF study sample is defined). Over this period, the number of SNFs decreased from 12,720 to 12,050

(or by about 5 percent). Median all-payer revenues declined slightly while costs remained steady over the period (both in 2024 dollars). Median all-payer margin declined over most of this period, especially during the coronavirus pandemic, but was 2.1 percent in 2024 (compared with 1.9 percent in 2013). Median total days (including short-term post-acute and long-term care days) decreased by about 9 percent. Resident days plummeted during the coronavirus pandemic but have steadily grown since then, though they remain below prepandemic levels. FFS Medicare days composed a small share of total facility days (8 percent in 2024) but a higher share of SNFs’ payments (13 percent) because of the higher FFS Medicare payments for short-stay rehabilitative care (Medicare Payment Advisory Commission 2026).

Over this period, median SNF all-payer revenues slightly declined (by about 3 percent after adjusting for inflation), with larger changes during the coronavirus pandemic, when hospital admissions were down (a prior three-day hospital stay is required for Medicare coverage, though this requirement was waived during the coronavirus pandemic, but many potential patients avoided SNFs) (Table 4-9, p. 167). Because total margins include Medicaid-funded long-term care, state policies regarding the level of Medicaid payments significantly affect the overall financial performance of this setting. In 2024, 45 states raised their Medicaid payment rates to nursing homes for long-term care (Hinton et al. 2025). The higher Medicaid rates in 2024 help explain the relatively large increase in the median all-payer margin.

We estimated that a 10 percentage point increase in MA penetration was associated with small declines in all-payer revenues and costs (–0.6 percent and –0.5 percent, respectively) and resident days (–0.6 percent) (Table 4-10). Because the revenue reduction was larger than the cost reduction, there was a small estimated reduction in the all-payer margin, but it was not statistically different from zero at the standard levels of significance. While the estimates for revenues, costs, and facility days are small, they translate to a somewhat larger decline when considering that Medicare is only a minority of SNFs’ revenues. For example, if we assume that Medicare accounts for about 20 percent of SNFs’ all-payer revenues and that all of the estimated decline in all-payer revenues was from Medicare, then a 0.6 percent estimated decline would translate to an approximately 3 percent decline in Medicare revenues associated with a 10 percentage point increase in the market-level MA penetration (0.6 divided by 0.2). The results were directionally the same when we included state-year fixed effects instead of state linear time trends, though in general the point estimates were slightly larger for the overall results.

Generally, the findings were similar for urban and rural facilities and for different time periods. The point estimates were larger during the most recent, 2022 to 2024, period. It is not clear whether this difference is due to larger impacts of MA penetration or other unrelated factors that affected markets with larger changes in MA penetration during this period. We also observed differences by SNF size. We estimated large increases in revenues, costs, and facility days associated with an increase in market MA penetration

among the smallest SNFs (those in the bottom quartile based on bed size) (Table 4-10). In contrast, among the largest SNFs, we estimated large decreases in revenues, costs, and facility days associated with an increase in MA penetration. These size-stratified patterns warrant further analysis to better understand the underlying mechanisms driving the differential findings.

We ran several alternative specifications to examine the sensitivity of our findings. These include defining smaller markets by using counties instead of HSAs, stratifying market MA penetration by quartile of initial penetration (to test for differences between areas that had low vs. high penetration in 2013), and stratifying market MA penetration by initial quartile of hospital discharge rates. Our findings were similar across these specifications: MA penetration was associated with lower all-payer margins, but the estimates were not statistically significant.

Our overall results are directionally consistent with a study of the impact of MA on SNFs conducted by Marr and Shen (Marr and Shen 2024). During the period 2012 through 2019, they found that a 10 percentage point increase in MA penetration in a county was associated with large reductions in all-payer revenues, costs, and total margins. Although both studies analyzed all-payer finance and volume information from the Medicare cost reports and used similar regression frameworks, there were some differences in specifications that might have resulted in our study finding smaller associations during the 2013 to 2019 period.³²

A growing number of nursing homes participate in I-SNPs, a type of MA plan designed for long-stay nursing home residents (Medicare Payment Advisory Commission 2025b). Medicare beneficiaries who are long-stay residents at participating nursing homes can enroll in these plans. The I-SNP model is based on the premise that plans can improve the quality of care for long-stay residents by delivering more care in the nursing home and reducing unnecessary inpatient care and emergency room visits (which benefit the plan and the beneficiary). Changes in MA penetration among these SNFs may have different impacts on their finances than on SNFs not affiliated with I-SNPs. This difference may be especially true if the I-SNP is owned and run by the SNF (referred to as “provider-led” I-SNPs). In 2024, about 30 percent of the SNFs in our analytic sample participated in an I-SNP plan. Among

**TABLE
4-10****Increases in MA penetration were associated with declines in SNF all-payer revenues, costs, and volume but not in all-payer margin, FY 2013–2024**

Change estimated from a 10 percentage point increase in market-level MA penetration

Group	Share of sample	All-payer revenue	All-payer costs	All-payer margin (in percentage points)	Total facility days
Overall	100%	–0.6%*	–0.5%*	–0.10	–0.6%**
Geography					
Urban	73	–0.7**	–0.7**	–0.03	–0.3
Rural	27	–0.4	–0.3	–0.19	–1.2***
Years					
2013–2016	40	–0.8**	–0.7**	–0.13	–0.7**
2017–2019	31	–0.5	–0.4	–0.08	–0.6**
2022–2024	29	–1.4***	–1.0***	–0.47**	–0.7**
Bed size					
Small	25	2.5***	2.6***	–0.06	2.2***
Medium	50	–0.2	–0.2	–0.00	–0.1
Large	25	–2.7***	–2.5***	–0.26	–2.8***
Median outcome value	—	\$12.6 million	\$12.6 million	0.83	34,570

Note: MA (Medicare Advantage), SNF (skilled nursing facility), FY (fiscal year). The study cohort includes nursing facilities that provided SNF care (see Appendix 4-B (p. 179) describing how the study sample was defined). “All-payer revenue” and “all-payer costs” are inflated to 2024 dollars using the SNF market basket. “All-payer revenue” and “all-payer margin” exclude federal or other coronavirus relief funds. All-payer revenues, all-payer costs, and total resident days were logged in the regression analysis, and results represent the percentage change in the outcome associated with a 10 percentage point increase in MA share of Medicare in the SNF’s health service area. Bed-size categories were determined using the <25th (small), 25th to 75th (medium), >75th (large) percentiles of SNFs’ bed counts in the first year the SNF is in the sample. The years 2020 to 2021 were excluded from the analysis because of the coronavirus pandemic. The number of SNF-year records in our sample was 127,220. Statistical significance is shown for *p*-values less than the 10 percent (*), 5 percent (**), and 1 percent (***) significance levels.

Source: MedPAC analysis of Medicare cost reports for SNFs, enrollment and cost-report data from CMS, as well as supplemental data sources (see Appendix 4-B, p. 179).

the participating SNFs, the median share of the SNFs’ long-term residents who were enrolled in an I-SNP plan was 36 percent (ranging from 1 percent to 80 percent at the 1st and 99th percentiles, respectively).

Using available data on SNFs with long-stay patients enrolled in I-SNPs from 2018 to 2024, we examined how participation in an I-SNP affected the association between MA market share and all-payer margin using the regression model described above. We defined

participation as SNFs with more than 10 percent of their long-stay patients enrolled in an I-SNP in the year (20 percent of SNFs in the sample). SNFs with an I-SNP had a lower all-payer margin in aggregate than other SNFs, consistent with our previous findings (Medicare Payment Advisory Commission 2025b). When we regressed an interaction term between MA penetration change and I-SNP participation, the point estimates showed that SNFs with I-SNPs had a smaller decline

**TABLE
4-11****MA market penetration and HHA all-payer finances
and volume for HHAs in our study sample, 2013–2024**

Year	Number of HHAs	HHA median						
		MA penetration in market	All-payer revenues (millions)	All-payer cost (millions)	All-payer margin	All-payer patients	All-payer visits	FFS share of patients
2013	6,690	29%	\$2.0	\$1.9	3.2%	260	9,380	84%
2014	7,760	32	2.1	2.0	2.9	280	9,810	82
2015	7,590	33	2.2	2.1	3.1	290	10,120	79
2016	7,380	33	2.3	2.2	2.5	310	10,480	78
2017	7,160	35	2.3	2.2	2.7	330	10,670	76
2018	6,910	39	2.4	2.3	3.1	350	11,300	74
2019	6,780	42	2.5	2.4	3.9	370	11,680	73
2020	6,570	44	2.4	2.3	4.6	380	10,480	70
2021	6,410	49	2.5	2.3	6.0	400	10,460	66
2022	6,440	52	2.4	2.2	4.3	390	9,850	65
2023	6,370	56	2.3	2.2	4.8	380	10,030	61
2024	6,050	58	2.4	2.3	4.9	400	10,750	58

Note: MA (Medicare Advantage), HHA (home health agency), FFS (fee-for-service). Includes freestanding HHAs with valid Medicare cost-report fields that treated at least 20 patients during the year. We show values for 2020 and 2021 for HHAs in our study sample in this table, but these years are excluded from the analysis in Table 4-12. "All-payer revenues" and "all-payer costs" are inflated to 2024 dollars using the HHA market basket. "MA penetration in market" refers to the share of Medicare beneficiaries in a health service area with Part A and Part B coverage who were enrolled in MA. "All-payer revenues" and "all-payer margin" exclude federal or other coronavirus relief funds.

Source: MedPAC analysis of Medicare cost reports for freestanding HHAs, CMS market basket, Medicare enrollment, and health service area data.

in margin associated with an increase in MA market penetration compared with those without I-SNPs, but the point estimates were not statistically significantly different from zero at the 10 percent significance level.

Changes in MA penetration not estimated to be associated with changes in HHAs' profit margin on average from 2013 to 2024

From 2013 to 2024, the median MA penetration in HHA markets increased from 29 percent to 58 percent (Table 4-11). During this time, median HHA all-payer revenues and costs (inflated to 2024 dollars) grew slightly (median revenues increased from \$2.0 million to \$2.4 million). Between 2013 and 2024, the median all-payer margin grew from 3.2 percent to 4.9 percent. From 2013 to 2024, as MA penetration grew, the FFS share of HHAs' all-payer patients dropped from 84 percent to 58 percent.

During the study period, the number of HHAs in our study sample declined from 6,690 HHAs to 6,050 HHAs (Table 4-11).³³ At the same time, volume (patients and visits) increased, indicating that the median HHA got bigger. From 2013 to 2024, the median HHA's number of patients increased from 260 to 400. We did not examine whether growth in MA penetration was associated with HHA closures or mergers, though our analysis would capture worsening margins that might have preceded them. Any consolidation of HHAs may have yielded economies of scale for the remaining HHAs in the market that could have increased profits, all else equal.

As shown in Table 4-12, our regression analysis estimated declines in revenues and costs associated with increases in MA penetration of 2.7 percent that

**TABLE
4-12****Increases in MA penetration associated with decreases in HHA all-payer revenues and costs but not all-payer margin or volume, 2013-2024**

Change estimated from a 10 percentage point increase in market-level MA share

Group	Share of sample	All-payer revenue	All-payer costs	All-payer margin (in percentage points)	Total visits	Total patients
Overall	100%	-2.7%*	-2.7%*	-0.12	-1.3%	-1.8%
Geography						
Urban	86	-2.7*	-2.6*	-0.23	-1.0	-1.8
Rural	14	-2.7*	-2.9*	-0.08	-2.0	-1.9
Years						
2013-2016	35	-3.8**	-3.6**	-0.27	-2.0	-2.6
2017-2019	26	-2.7*	-2.4*	-0.32	-0.9	-2.0
2022-2024	23	-4.5**	-3.2	-1.24***	-0.6	-4.1*
Size						
Small	25	-8.8***	-8.1***	-0.82**	-14.4***	-18.2***
Medium	50	-2.5*	-2.2	-0.41	-0.9	-0.9
Large	25	-1.2	-1.8	-0.51	2.2	2.0
Median outcome value	—	\$2.7 million	\$2.6 million	3.6	12,650	420

Note: MA (Medicare Advantage), HHA (home health agency). The study sample includes freestanding HHAs with valid Medicare cost-report fields that treated at least 20 patients during the year (see Appendix 4-B on p. 179 describing how the study sample was defined). Revenues and costs are inflated to 2024 dollars using the HHA market basket. All-payer revenues and margin exclude federal or other coronavirus relief funds. All-payer revenue, all-payer costs, and total visits and patient days were logged in the regression analysis, and results represent the percentage change in the outcome associated with a 10 percentage point increase in MA penetration in the HHA's health service area. Size categories were determined using the <25th (small), 25th to 75th (medium), >75th (large) percentiles of HHAs' average unique patient counts across each of the years the HHA was in the sample. The years 2020 to 2021 were excluded from the analysis because of the coronavirus pandemic. The number of HHA-year records in our sample was 69,110. Statistical significance is shown for *p*-values less than the 10 percent (*), 5 percent (**), and 1 percent (***) significance levels.

Source: MedPAC analysis of Medicare cost reports for freestanding HHAs, enrollment and cost-report data from CMS, as well as supplemental data sources (see Appendix 4-B, p. 179).

largely offset each other, resulting in a small decline in the all-payer margin that was not statistically significant from zero. The decline in total visits and patients associated with MA penetration increases was not statistically significantly different from zero. The estimated decline in revenues could be driven by lower payment rates received for MA enrollees, as noted above by interviewees. The decline in costs could be driven by fewer visits (though we also did not find

statistically significant declines in total visits) or other cost efficiencies that HHAs were able to achieve as MA penetration increased.

Generally, the findings were similar for urban and rural facilities and for different time periods. The point estimates were larger during the most recent, 2022 to 2024, period. It is not clear whether this difference is due to larger impacts of MA penetration or other unrelated factors that affected markets with larger

changes in MA penetration during this period. We observed differences by HHA size. We estimated large decreases in revenues, costs, and volume associated with an increase in MA penetration among the smallest HHAs (those in the bottom quartile based on average patient count) (Table 4-12, p. 171). Among larger HHAs, we found smaller declines in revenues and costs associated with an increase in market MA penetration (and increases in volume among the largest HHAs that were not statistically significant). As with SNFs, these size-stratified patterns warrant further analysis to better understand the underlying mechanisms driving the differential findings.

As with our SNF results, we ran alternative specifications that included defining smaller markets by using counties instead of HSAs, stratifying market MA penetration by quartile of initial penetration (to test for differences between areas that had low vs. high penetration in 2013), and stratifying market MA penetration by quartile of initial hospital discharge rates. Our findings were similar across these specifications: MA penetration was associated with lower all-payer HHA margins, but the estimates were generally not statistically significant.

There have been several large acquisitions of HHA chains by health insurers: Humana began its purchase of Kindred at Home in 2018; UnitedHealth Group purchased LHC Group in 2023 and Amedisys in 2025 (Kindred Healthcare 2018, Marselas 2025, Mertz-Taggart 2025). There are also health systems that include HHAs that have started MA plans. HHAs that are vertically integrated with MA plans may have different experiences of how their finances change as MA enrollment grows. For example, plans may steer patients to their vertically integrated providers and may pay them more per patient. Since some of these acquisitions are recent, we could not fully study their effects. However, using our study sample for 2022 to 2024, we examined whether the estimated association between changes in MA market penetration and all-payer margin differed for HHAs that were vertically integrated. We used information from the Agency for Healthcare Research and Quality (AHRQ) compendium of U.S. health systems and from the National Association of Insurance Commissioners (NAIC) for 2023 to identify vertically integrated HHAs.³⁴ We used Medicare enrollment and home health encounter

data to determine the share of HHAs' MA patients who were enrolled in the affiliated plan. We identified about 10 percent of HHAs in our 2022 to 2024 study sample as vertically integrated; among these HHAs, the median share of MA patients enrolled in the integrated plan was about 35 percent. In our regression, we found a positive-point estimate between market-level MA penetration and all-payer margin among vertically integrated HHAs, but the estimate was not statistically significant at the 10 percent level. Among other HHAs, the point estimate on the association between increases in market-level MA penetration and total margins was negative but also not statistically significant at standard levels of significance.

IRF use by MA enrollees is relatively low, and their mix of conditions differs from FFS beneficiaries'

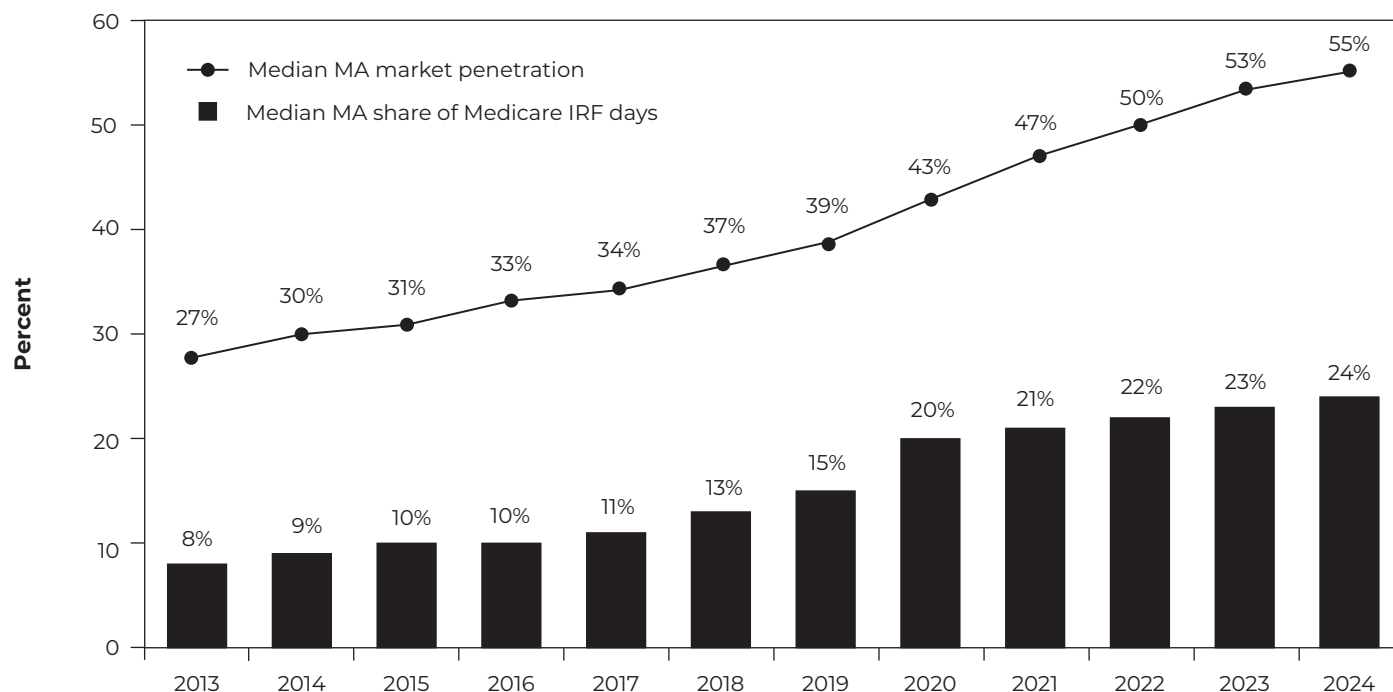
We did not analyze the association between MA penetration and IRF finances because we could not calculate all-payer finances for hospital-based IRFs, which represent the majority of IRFs. We note that across the approximately 300 freestanding IRFs, the median all-payer margin was high—consistently around 10 percent from 2013 to 2024. Below, we present descriptive information on IRF MA volume that is available for both freestanding and hospital-based IRFs and compare the clinical conditions of FFS and MA enrollees receiving IRF services.

MA enrollees' share of IRF days is lower than MA penetration in IRF markets

Between 2013 and 2024, MA penetration in IRF markets increased from 27 percent to 55 percent (similar to increases in SNF and HHA markets), but the MA share of Medicare IRF days has always been substantially lower than the MA penetration rate (Figure 4-2). In 2024, the MA share of Medicare IRF days (24 percent) was less than half of the MA market penetration (55 percent). However, between 2013 and 2024, the MA IRF share increased substantially, from 8 percent to 24 percent. The share rose during the coronavirus pandemic and has steadily grown since then. This finding aligns with financial reports from a large IRF chain: The MA share of Encompass's IRF business jumped from 10.7 percent in 2019 to 15.3 percent in 2020 and continued to rise to 16.8 percent in 2024 (Encompass Health 2024, Encompass Health 2020).³⁵

**FIGURE
4-2**

MA share of Medicare IRF days is substantially lower than overall MA penetration, 2013–2024



Note: MA (Medicare Advantage), IRF (inpatient rehabilitation facility). “Median MA market penetration” refers to the share of Medicare beneficiaries in a health service area with Part A and Part B coverage who were enrolled in MA for the median IRF. “Median MA share of Medicare IRF days” refers to the the number of MA-covered IRF days divided by total Medicare-covered days for the median IRF.

Source: MedPAC analysis of Medicare cost reports and enrollment data from CMS.

Across all IRFs, the MA shares varied, in part depending on the overall MA penetration in the market.

Several factors are likely to contribute to lower use of IRFs by MA enrollees. MA plans are financially incentivized to have their enrollees use lower-cost SNF services instead of the higher-cost IRFs whenever possible.³⁶ IRF representatives we interviewed stated that volume was most affected by MA plans’ use of prior authorizations that can delay or deny care and by network designs. OIG found that IRF services were among the most frequently denied by MA plans, even though requests met Medicare coverage rules and MA billing rules (Office of Inspector General 2022). OIG noted that the denials could delay or prevent

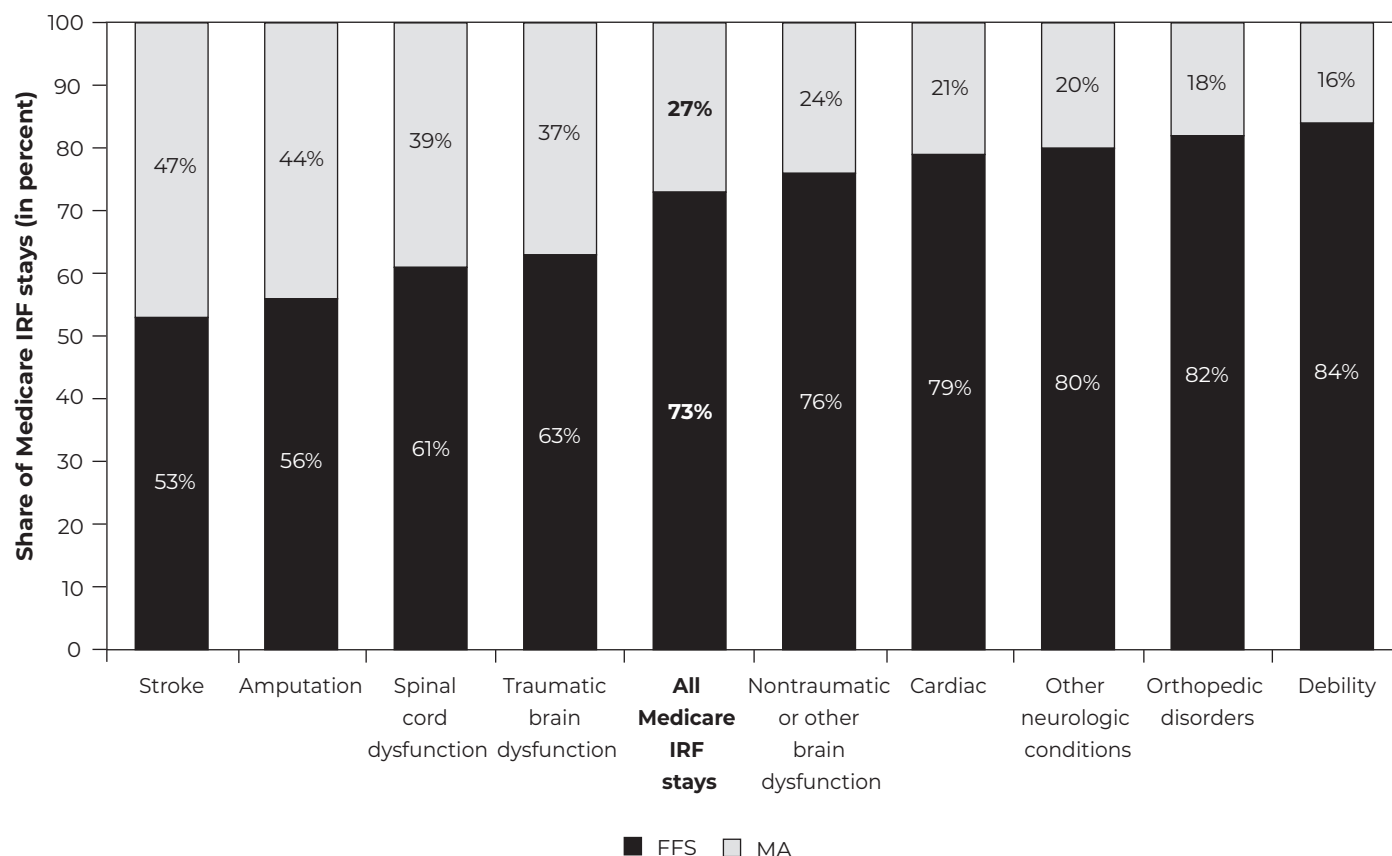
beneficiaries from getting medically necessary care. As previously mentioned, a Senate investigation of three large MA plans found that the use of prior authorization and algorithms to review requests increased between 2019 and 2022, and their denial rates of PAC were higher than for other services (U.S. Senate Permanent Subcommittee on Investigations 2024).

Mix of clinical conditions differs for FFS and MA enrollees

Using data from the IRF Patient Assessment Instrument, we found variation across IRF conditions in the share of beneficiaries enrolled in MA, with higher MA shares among IRF conditions that contribute to meeting the 60 percent threshold (see Endnote 28

**FIGURE
4-3**

MA enrollees tended to be treated by IRFs for strokes, amputations, spinal cord dysfunction, and traumatic brain dysfunction, 2024



Note: MA (Medicare Advantage), IRF (inpatient rehabilitation facility), FFS (fee-for-service). The figure shows the share of MA and FFS IRF stays for conditions for which there were at least 10,000 Medicare stays in the year (these conditions account for 95 percent of all Medicare stays in the year). "All Medicare IRF stays" includes stays for all conditions. Conditions are defined as the Impairment Group Code on admission.

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

for more information on the 60 percent rule for IRFs) (Figure 4-3). For example, the share of beneficiaries recovering from strokes, amputations, spinal cord dysfunction, and traumatic brain injury (TBI) who were enrolled in MA ranged from 37 percent to 47 percent, well above the overall IRF average of 27 percent. Perhaps contributing to these relatively high uses of IRFs for stroke patients are the best-practice guidelines for treating strokes established by the American Heart Association/American Stroke Association. These guidelines state that, whenever possible, stroke patients should be treated in an

IRF rather than a SNF (Winstein et al. 2016). In 2019, Encompass began working with both organizations to develop educational tools for health care professionals, patients, and caregivers. In addition, many SNFs do not have specialized equipment or staff to treat beneficiaries with amputations, spinal cord injuries, and TBI. In contrast, only 16 percent of MA enrollees with debility were treated in IRFs—a condition that does not contribute to the 60 percent compliance threshold because it does not typically require intensive rehabilitation.³⁷

Although MA IRF volume is substantially lower than in FFS Medicare, some FFS use may not reflect clinically appropriate care. The number of IRFs and Medicare FFS volume at IRFs has steadily increased since 2021. In 2021, there were 1,118 IRFs; by 2024, the number had increased 4.5 percent to 1,169 (Medicare Payment Advisory Commission 2026). Most of the growth has been in for-profit facilities and in markets that already had an IRF, while the number of hospital-based IRFs has decreased. From 2019 to 2024, IRF stays per 10,000 beneficiaries increased by 24 percent, with a single-year increase of almost 10 percent between 2023 and 2024 (Medicare Payment Advisory Commission 2026).³⁸ We previously reported that for-profit IRFs disproportionately admit patients with other specific

myopathies and that the Department of Justice alleged that certain IRFs falsely diagnosed patients with these conditions without clinical evidence for the diagnoses (Department of Justice 2019, Medicare Payment Advisory Commission 2024b).³⁹ In 2018, OIG found that of the 220 IRF FFS claims it reviewed, two-thirds did not meet coverage requirements, meaning the patients did not have medical needs and rehabilitation goals that required IRF-level care (Office of Inspector General 2018). Similarly, CMS estimated that in 2025 the IRF improper-payment rate was 22 percent (compared with 6.6 percent for all services), and almost all were attributed to services not meeting medical-necessity rules (Centers for Medicare & Medicaid Services 2025a). ■

4 A P P E N D I X A

Constructing the hospital study sample and regression variables

To develop our sample of inpatient prospective payment systems (IPPS) hospitals and critical access hospitals (CAHs), we started with hospitals that had at least two Medicare cost reports between fiscal year 2013 to 2024 (excluding 2020 and 2021).

To increase the comparability across time periods and hospitals, we performed several additional data-cleaning steps. We annualized revenues and costs to standardize for differences in cost-reporting periods. We linearly imputed metrics when they were missing but did have values for a year immediately before and after. We also inflated hospital financial metrics to 2024 dollars using the hospital market basket.

We then performed multiple exclusions. First, to remove outliers and cost reports with potential data issues, we excluded cost reports in which the all-payer operating margin for the hospital was outside of a Tukey fence (below the 25th percentile less three times the interquartile range or above the 75th percentile plus three times the interquartile range), where the distribution was calculated for IPPS hospitals and CAHs separately. We excluded hospitals in Puerto Rico and Alaska because of their high and low Medicare Advantage (MA)-penetration rates and hospitals in Maryland because of the unique payment system governing hospital payments in the state. We excluded Kaiser Permanente hospitals because they rarely serve nonemergency fee-for-service (FFS) patients (however, our results were similar with Kaiser Permanente hospitals included). We also excluded cost reports from fiscal years 2020 and 2021 because hospitals were most affected by the coronavirus pandemic during those years.

Our three outcome variables were all calculated from hospital cost-report Worksheet G-3:

- all-payer operating margin (excluding coronavirus relief funds)—the percentage of revenues from all payers and sources exclusive of investments and donations (and coronavirus relief funds) that is left as profit after accounting for all costs;
- all-payer operating revenues (excluding coronavirus relief funds); and
- all-payer costs.

For our main outcome variable, MA penetration in a market (i.e., the share of Medicare beneficiaries in a health service area (HSA) with Part A and Part B coverage who were enrolled in MA), we started with county-level Medicare enrollment data. We then assigned the county-level enrollment to its corresponding HSA. We associated each hospital with its county primarily using the 2024 Provider of Services file. We used the National Cancer Institute county-to-HSA crosswalk to group enrollment into HSAs and assign hospitals their HSA (National Cancer Institute 2023).

The various market-level controls were compiled from multiple data sources. For population counts, income, uninsurance, and unemployment rates, we used the Census Bureau's American Community Survey and Small Area Health Insurance Estimates and the Bureau of Labor Statistics' Consumer Price Index and Local Area Unemployment Statistics. We used the Medicaid and Children's Health Insurance Program Payment and Access Commission's state-level Medicaid managed care data. We used the Medicare enrollment file from CMS for Medicare population demographics.

To group hospitals into "sometimes in a system" or "never in a system," we used data from the American Hospital Association (AHA) and the Agency for Health Research and Quality (AHRQ). We used AHA data from 2013 to 2015 and the AHRQ compendium of U.S. health systems from 2016, 2018, and 2020 to 2023 to determine a hospital's health system affiliation. (The AHRQ data classify joint ventures as systems.) For the years without AHRQ data, we assigned health-system groups from the prior year (e.g., we assigned 2017 hospitals to 2016 AHRQ-system groups). While commonly used to identify system membership, our use of the AHA and AHRQ data to assign system membership has limitations. For example, the two data sources assign system membership in somewhat different ways, resulting in differences in system affiliation. We also included hospitals that always were part of a system and those that were only in a system for part of our study period into one category, which makes that group heterogeneous.

We used the 2021 AHRQ compendium of health systems, CMS data, and 2021 MA inpatient encounter data to estimate the level of a hospital's vertical integration with an MA plan. We defined a hospital's

level of vertical integration based on the share of their MA inpatient encounter records that were for beneficiaries who were enrolled in an MA plan that was owned by a health system that the hospital was part of in 2021. To do so, we used AHRQ's Compendium of U.S. Health Systems and CMS data on MA plan parent organizations. This measure has limitations. For example, while relationships between hospitals and MA

plans change over time, we characterized a hospital's level of vertical integration on the basis of data from 2021 due to data-availability issues and the complexity of identifying these relationships. In addition, while this measure was intended to capture the extent of vertical integration, it could also capture other aspects of these hospitals, such as dominant market position or administrative capabilities. ■

4-A P P E N D I XB

Calculating post-acute care providers' finances using Medicare cost reports

We used Medicare cost reports from 2013 to 2024 (excluding 2020 and 2021) for freestanding skilled nursing facilities (SNFs), freestanding home health agencies (HHAs), and inpatient rehabilitation facilities (IRFs) to calculate measures of all-payer revenues, all-payer costs, and volume.

Skilled nursing facilities

We applied the same method using Medicare SNF cost reports as was used in the March 2026 report to the Congress to calculate all-payer margin (Medicare Payment Advisory Commission 2026). We included only SNFs that provide Medicare-covered SNF services (i.e., we excluded nursing facilities that provide only long stays). We obtained all-payer revenues from Worksheet G3, lines 3 and 25, and subtracted coronavirus relief funds (affecting 2020 and later) using Worksheet G3 line 24.5. All-payer expenses were obtained from Worksheet G3 line 30 and Worksheet A line 100 column 3. We calculated the all-payer margin by subtracting all-payer expenses from all-payer revenues and dividing by revenues. Facility days were calculated from Worksheet S-3, Part 1, lines 1 and 2, column 7, and include days for short and long stays. We excluded facilities that provide only long stays, SNFs with reporting periods under 10 months, and SNFs with outlier revenues, expenses, margin, or total resident days. We included only freestanding SNFs, which account for 97 percent of FFS Medicare SNF stays (Medicare Payment Advisory Commission 2026). SNFs' all-payer revenue, costs, and margin include both short- and long-term stays for all payers and other businesses such as hospice and outpatient therapy.

Home health agencies

We applied the same method using Medicare HHAs' cost reports that was used in the March 2026 report to the Congress to calculate all-payer margin (Medicare Payment Advisory Commission 2026). We obtained all-payer revenues from Worksheet F1, column 4, line 3, and column 2, line 32, and subtracted coronavirus relief funds (affecting 2020 and later) using Worksheet

F1, line 31.50. All-payer expenses were obtained from Worksheet F1, column 2, line 17. We calculated the all-payer margin by subtracting all-payer expenses from all-payer revenues and dividing by revenues. The number of all-payer patients was calculated from Worksheet S-3, Part 1, column 8, line 13, and the number of all-payer visits was calculated from Worksheet S-3, Part 1, column 7, line 11. The Medicare HHA cost reports changed versions in 2020, and we mapped the appropriate fields to the prior version for years before 2020. We excluded HHAs with fewer than 20 patients in the year and those with outlier patient-count or margin values. We included only freestanding HHAs, which account for 93 percent of HHAs. The analyses include posthospital and community admissions to home health care.

We assign HHAs to health service areas (HSAs) using the physical location of the HHA that is associated with the HHA's provider number as reported in CMS's Provider of Services (POS) file. For some patients using home health care, this may differ from the HSA where the service is received, though we expect many of the HHAs' patients to be located within the same HSA.

Inpatient rehabilitation facilities

We calculated the number of Medicare FFS, MA, and all-payer days from Worksheet S3. For freestanding IRFs, we calculated all-payer margins in the same way as for the other settings, with total revenue and total costs calculated from Worksheet G on IRFs' Medicare cost reports. ■

Endnotes

- 1 High out-of-network prices have been an issue for those with commercial insurance (including integrated HMO plans such as Kaiser). These concerns have resulted in some limitations on emergency billings in the commercial sector (Adler et al. 2019, Consumer Financial Protection Bureau 2023, Kaiser Permanente 2015).
- 2 Required facility types include acute inpatient hospitals, cardiac surgery programs, cardiac catheterization services, critical care services/intensive care units, surgical services (outpatient or ambulatory surgical center), SNFs, diagnostic radiology, mammography, physical therapy, occupational therapy, speech therapy, inpatient psychiatric facility services, and outpatient infusion/chemotherapy. Beginning in 2025, a new facility-specialty type was added: outpatient behavioral health. This hybrid designation will include a range of providers, such as marriage and family therapists, mental health counselors, opioid-treatment program providers, community mental health centers, or other behavioral health and addiction medicine specialists and facilities, including addiction medicine physicians.
- 3 Counties with extreme access considerations are those with a population density of less than 10 persons per square mile and are generally counties located outside of metropolitan statistical areas.
- 4 Hospitals' all-payer operating margin is defined as the percentage of revenue from all payers and sources exclusive of investments and donations that is left as profit after accounting for all costs; it therefore includes operating revenues and costs across all service lines, including hospitals' post-acute care units.
- 5 These researchers also raised concerns that prolonged hospital stays may delay the initiation of rehabilitative care, slow patient recovery, and expose patients to additional risk of iatrogenic harm in the hospital environment (McGarry et al. 2025).
- 6 Analyzing all the ways in which the growth of MA could affect hospitals is challenging and beyond the scope of this report. The Commission has ongoing work related to denials and MA networks. Other topics are difficult to examine empirically given the relative lack of data (e.g., data on MA bad-debt payments).
- 7 The absolute (not percentage) difference in average length of stay between MA enrollees and FFS beneficiaries was smaller because the average length of stay was shorter at CAHs.
- 8 We believe it is reasonable to conclude that increases in costs per stay are likely to be somewhat lower than the increase in the length of stay for multiple reasons. For example, some hospital costs are fixed and do not increase with longer lengths of stay.
- 9 Some MA plans engage in reconciliation with CAHs while others do not. We are unaware of data that quantify the prevalence of this practice among MA plans. In our site visits with hospitals, most hospitals said that MA plans do not engage in reconciliation.
- 10 The full formula is more complicated; for example, CMS uses the 3 most recent years of audited cost reports and applies some scaling and trims. For more information on how CMS calculates DSH hospitals' UC costs and each hospital's share, see the IPPS final rules.
- 11 Results were significant at the $p < 0.001$ level. Our regression analyzed the correlation between the share of Medicare inpatient stays that were for MA patients in FY 2024 and the log of FY 2026 FFS UC add-ons per stay because CMS uses lagged historical stay data to compute the FFS add-on. For example, CMS used the average number of FFS stays from 2022, 2023, and 2024 to compute the FY 2026 FFS UC add-on per stay. As a sensitivity test, we also ran a regression that used the same year (FY 2024) for both variables of interest (the share of Medicare inpatient stays that were for MA patients and FFS UC add-ons per stay) and found similar results.
- 12 There are other potential issues as well. For example, increasing penetration in particular areas could lead to extremely high UC add-ons per stay because the number of FFS stays becomes very low; higher UC add-ons, in turn, have all the issues discussed in this section of the chapter. Extremely large UC add-ons as a result of very few FFS stays could also create relatively unstable UC add-ons per stay, as a shift in a small number of stays could translate into relatively large swings in the dollar amount of an add-on.
- 13 The Balanced Budget Act (BBA) of 1997 created the Medicare+Choice program and specified that, beginning in 1998, the Medicare program should phase in inpatient operating IME payments for the care of MA enrollees and should carve out these IME payments and direct graduate medical education payments from the calculation of MA rates. While both changes were meant to be complete by 2002, floors and minimum updates to MA rates delayed the removal

- of Medicare's medical education payments from MA rates in many areas. However, because it was not specified in statute, Medicare does not make inpatient capital IME payments to hospitals for care provided to MA enrollees (and these IME payments are not carved out from MA benchmarks).
- 14 For example, CAHs tend to have high prices due to their cost-based reimbursement from FFS Medicare, meaning MA plans have an incentive to steer their enrollees away from those hospitals if the plans are paying those higher prices.
 - 15 In this report, we used HSAs to define markets. We also ran a sensitivity analysis using counties to define markets. There are about 3,200 counties in the U.S. There are many ways to define markets, and other researchers have commonly used two additional definitions—hospital service areas and hospital referral regions. Hospital service areas are a collection of ZIP codes whose residents receive most of their hospitalizations from the hospitals in that area. Most hospital service areas contain only one hospital. There are about 3,400 hospital service areas. Hospital referral regions are much broader. Hospital referral regions represent regional health care markets for tertiary medical care. There are 306 hospital referral regions in the U.S. (Dartmouth Atlas Project 2022).
 - 16 We use a state-specific linear time trend instead of state-by-year fixed effects due to concerns about states with a small number of markets. State-by-year fixed effects rely on within-state-year variation for identification, and there are several states with a small number of markets with providers in them. At the 10th percentile, states have four markets with IPPS hospitals and three markets with CAHs.
 - 17 These time-varying characteristics included the natural logarithm of the population, the share of the population under 65 that is uninsured, the share of the population enrolled in Medicare, a categorical variable for the quartiles of median household income, the share of the population that is unemployed, the share of Medicare beneficiaries who are dually eligible for Medicaid, the share of Medicare beneficiaries who are under 65 years old, the share of Medicare beneficiaries who are 85 years old and older, the share of the state's Medicaid population that has managed care, and the MA organization concentration measured by the Herfindahl-Hirschman Index (HHI), and the health-system HHI.
 - 18 Controlling for linear state-specific time trends allows us to partially control for changes in state-level factors that impact provider finances but are unrelated to MA, such as Medicaid payment-policy changes. However, the trade-off associated with this strategy is that our estimates do not leverage the variation from some states having larger changes in MA penetration over time than other states.
 - 19 The share of hospitals that are in a system (97 percent) is weighted by the number of beds the hospital had in the first year of our study period. The unweighted share of IPPS hospitals that were classified as part of a system is 90 percent. The definition of system used included joint ventures. See Appendix 4-A, p. 176, for more details on system groupings.
 - 20 We also examined the association between MA enrollment changes and hospital finances (1) using a lagged specification (e.g., associating 2017 hospital finances with 2016 MA penetration rather than the same year for both MA penetration and hospital finances); (2) including Kaiser Permanente hospitals (which were excluded from the base model because they generally do not take nonemergency FFS patients); and (3) including 2020 and 2021 (which were excluded from our base model because those years were substantially affected by the coronavirus pandemic). Our results did not materially change for any of these three sensitivity analyses.
 - 21 One potential way to address concerns related to endogeneity is through an instrumental-variables approach. We conducted an instrumental-variables analysis by using whether a new insurer enters a county as an instrumental variable for MA penetration. We found that insurer entry is associated with increased MA penetration, but we did not find statistically significant associations with hospitals' revenues, costs, or margins. This strategy produces highly imprecise estimates, so it is not possible to rule out a wide range of effects of MA on hospital finances using this approach.
 - 22 Some chronically critically ill beneficiaries receive care in long-term care hospitals (LTCHs). Because there are few providers and beneficiaries who use this type of service, we have not included LTCHs in this chapter.
 - 23 For example, although SNFs, IRFs, and HHAs all have nurses and therapists, their skills may differ depending on the patients they treat. For example, an IRF that routinely treats spinal cord injury patients will have therapists who have the training and skills to treat this specialized population.
 - 24 A skilled service is one that requires the skills of technical or professional personnel, such as registered nurses and physical therapists. Most SNFs are part of a nursing home that also provides long-term care (which Medicare does not cover).
 - 25 The price differences across PAC settings reflect the differences in costs due to their regulatory requirements, services, and cost structures.

- 26 In 2024, the FFS Medicare margin for SNFs was 24.4 percent, 21.2 percent for HHAs, and 17.1 percent for IRFs (Medicare Payment Advisory Commission 2026).
- 27 For HHAs, we approximated that 90 percent of HHAs' patients in 2022 were Medicare beneficiaries (MA and FFS) by using Medicare HHA cost reports to calculate the share of FFS patients out of total HHA patients and using home health encounter data and FFS claims to calculate the MA share of Medicare patients. For IRFs, we used Medicare hospital cost reports to calculate the share of total IRF days for Medicare beneficiaries (MA and FFS).
- 28 To be paid as an IRF (instead of as an acute care hospital), 60 percent of a facility's admissions must be for patients with 1 of 13 conditions that typically require intensive rehabilitation (known as the "60 percent rule" or the "compliance threshold"). IRFs consider whether a patient meets IRF-specific coverage rules and not necessarily the diagnosis for the admission criteria.
- 29 In 2025, CMS eliminated the requirement that enrollees forfeit their right to appeal denials when discharged from a SNF (Centers for Medicare & Medicaid Services 2024). In another change, in 2026, CMS restricted a plan's ability to reopen and modify a previously approved hospital admission, which otherwise could eliminate a qualifying hospital stay for SNF coverage (Centers for Medicare & Medicaid Services 2025c).
- 30 Under the FFS home health payment system, home health 30-day periods that consist of fewer visits (typically fewer than six visits) receive a per visit payment called the low-utilization payment adjustment (LUPA) that is lower than the full case-mix payment for non-LUPA periods. Some plans may refer to the LUPA payment as the full FFS payment. However, one plan did specify that they pay 100 percent of the home health bundled rate.
- 31 For each HSA, we calculated the number all-payer discharges from acute care hospitals divided by the total population. It is possible that market MA penetration affects per capita discharges (through changes in MA enrollees' hospitalizations). We also reran our main regressions without per capita discharge and the results were similar.
- 32 Marr and Shen found that from 2012 to 2019, a 10 percentage point increase in county-level MA penetration was associated with a 2.46 percent decrease in revenues, a 1.54 percent decrease in expenses, and a 57.96 percent decrease in profit margin (Marr and Shen 2024).
- 33 Our study sample includes only freestanding HHAs with valid cost reports. Freestanding HHAs accounted for over 90 percent of all HHAs in 2023. The number of HHAs differs from the number reported in the March 2026 report because we include HHAs that have a valid cost report each year and served at least 20 patients (Medicare Payment Advisory Commission 2026). See also Appendix 4-B, p. 179, for other exclusions.
- 34 Appendix 4-A, p. 176, describes how we used the AHRQ compendium to identify MA plans and providers that are vertically integrated. To determine which HHAs and MA plans are vertically integrated, we also used the NAIC Schedule Y, which is part of insurers' statutory reporting statements. Schedule Y provides information on ownership and affiliate relationship within insurance-holding company systems (National Association of Insurance Commissioners 2023). The NAIC does not endorse any analysis or conclusions based upon the use of its data.
- 35 Encompass Healthcare is the largest owner and operator of IRFs.
- 36 Compared with SNFs, IRFs have higher costs because they must meet hospital requirements in terms of staffing and services available and they provide more intensive rehabilitative therapy.
- 37 While debility is not one of the 13 qualifying conditions, the underlying condition could be. Figure 4-3 (p. 174) shows the conditions as defined in the Impairment Group Code on admission.
- 38 From 2019 to 2024, FFS IRF stays per 10,000 FFS beneficiaries increased from 107 to 132 (24 percent growth) (Medicare Payment Advisory Commission 2026). In contrast, from 2014 to 2019, IRF stays per 10,000 FFS beneficiaries rose from 99 to 107 (8 percent growth) (Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2019).
- 39 CMS considered removing these conditions from meeting the compliance threshold but ultimately did not, stating it would continue to monitor the appropriate use of the diagnosis code.

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C H A P T E R

5

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

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

Chapter summary

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 (rather than in the hospital) if they wish to do so. The decision of whether to elect hospice is a deeply personal one for a beneficiary and their family, informed by discussions with their physician and health care providers about disease progression, prognosis, and options for care. While it is important that eligible beneficiaries have the option to enroll in hospice care, it is also important that they can choose not to enroll in hospice care and continue to receive 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 condition and related conditions. According to Medicare policy, services that are unrelated to the terminal illness and related conditions continue to be covered outside of the hospice benefit, though CMS has stated that "virtually all" services at the end of life are related to the terminal condition and thus the responsibility of the hospice provider. Medicare generally pays the hospice provider a prospective daily rate that is not affected by the number of visits or other

In this chapter

- The role of complex services that may be palliative for some hospice patients
- Limited data available on whether hospices furnish certain complex palliative services
- Use of hospice by beneficiaries with ESRD or cancer
- Comparison of hospice payments and estimated costs for certain complex palliative services
- Potential approaches to address access to certain complex palliative services for hospice beneficiaries
- Appendix 5-A: High-cost outlier payments: Medicare precedents and potential approaches for hospice

services a hospice furnishes on a given day. Fee-for-service (FFS) Medicare pays for hospice care for beneficiaries enrolled in either traditional FFS Medicare or Medicare Advantage.

In the hospice proposed rules for fiscal year (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. Medicare does not collect information on the provision of these complex palliative services on the claims that hospice providers submit to CMS. As a result, 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.

We conducted interviews with clinicians (including those specializing in palliative medicine, nephrology, and oncology), hospice providers, dialysis providers, and family caregivers in 2024 and 2025 to learn their perspectives on the current level of access that beneficiaries in hospice have to such services. Clinicians and relevant specialists we interviewed varied in their perspectives on whether and when they consider these services to be palliative and consistent with the hospice benefit criteria and explained the considerations they give to an individual patient’s situation and type of service. We found general consensus among our interviewees 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, depending on the timing of hospice enrollment. Three commonly reported reasons for furnishing these services included providing symptom relief, easing the transition to hospice, or helping patients reach specific goals (e.g., attending a family wedding). 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 like dialysis or blood transfusions. 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 the cost of providing the services varied by a hospice’s ability to negotiate rates and execute contracts with dialysis facilities and hospitals/clinics. The cost

of ambulance transportation, if needed due to a patient's condition, can add significantly to the cost of providing these services.

We also conducted an analysis of available Medicare data (claims, cost reports, and hospice enrollment data) to ascertain what can be known about the use of hospice and certain services under the hospice benefit for beneficiaries with ESRD or cancer. A key limitation is that Medicare lacks patient-level data (via claims or other sources) on hospices' provision of complex services under the hospice benefit. Based on available data, we 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. In 2024, 31 percent of Medicare decedents with ESRD enrolled in hospice compared with 53 percent of all Medicare decedents. Further, although hospice use among decedents with ESRD has grown, the rate of growth is lower compared with that of all Medicare decedents. Hospice cost-report data do not break out dialysis costs, and hospice claims do not include information on hospices' provision of dialysis, so the share of hospices that provide dialysis and the share of patients who receive dialysis under the hospice benefit is unknown. FFS claims data show a small share (12 percent) of Medicare decedents with ESRD who enrolled in hospice in 2019 received dialysis that was paid for outside the hospice benefit, presumably because the hospice and dialysis facility considered it to be unrelated to the terminal condition.
- 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. Among decedents with blood cancer, those who were transfusion dependent were slightly more likely to use hospice but had shorter hospice stays than those who were not transfusion dependent. Few hospice beneficiaries with cancer received antineoplastics (chemotherapy) during their hospice stay in 2017, the last full calendar year that hospices were required to report their provision of drugs on hospice claims. In 2023, only about 3 percent of freestanding hospices reported costs for palliative radiation, and about 1 percent reported costs for palliative chemotherapy on their cost reports. (Hospice cost-report data are not available for blood transfusions.) However, costs for these services may not be accurately or fully reported (e.g., some hospice providers may report costs for these services under other categories).

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. Because we lack data on the provision of these treatments during hospice stays, the comparisons rely on assumptions about service utilization and costs. They are meant to be illustrative only and to give a rough sense of the orders of magnitude. Across the scenarios, we find that over the course of a hospice stay:

- estimated treatment costs for dialysis could range from roughly 40 percent to 50 percent of total hospice payments,
- estimated treatment costs for blood transfusions could range from roughly 30 percent to 50 percent of total hospice payments, and
- estimated treatment costs for radiation could range from less than 10 percent of total hospice payments to over 30 percent.

Complex palliative treatments could represent a substantial portion of Medicare's hospice payment (which is intended to cover all services provided during the stay); such an occurrence 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, to learn more about beneficiary access to such services before considering the need for modifications to the hospice payment system, CMS could, for a limited period, collect data from hospice providers about the use of certain high-cost complex palliative services. Next, if policymakers determine that changes are 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 that would direct additional payments to hospice providers who incur higher costs for providing certain palliative services.

This approach would maintain the bundled nature of the hospice PPS while improving payment accuracy, thus preserving incentives for providing efficient care and flexibility in how providers deliver care. This approach would also ensure that financial risk is shared between hospice providers and the Medicare program. However, some stakeholders might view outlier payments, which pay for only a portion of the additional costs associated with high-cost services, 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 but 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 offer hospice enrollees the option to receive certain services such as dialysis or blood transfusions for some transitional period, or up to a specified number of treatments, paid for outside of the hospice benefit. A voluntary transitional program could help ease the transition to hospice for dialysis- and transfusion-dependent beneficiaries who are near the end of life and wish to enroll in hospice. A transitional program for beneficiaries with ESRD receiving maintenance dialysis or beneficiaries with cancer who are dependent on blood transfusions could give the Secretary the opportunity to, in a limited fashion, directly test transitional concurrent care for hospice enrollees for services where access concerns have been raised by stakeholders. In developing a transitional model, the agency would need to consider a number of design issues, including how to structure a transitional program, how to promote close collaboration between the specialist administering the transitional treatments and the hospice physician, and how to minimize the potential for unintended financial incentives or undermining the hospice benefit criteria.

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. ■

The hospice benefit covers palliative and supportive services for terminally ill beneficiaries with a life expectancy of six months or less if the illness runs its normal course. When a beneficiary chooses to enroll 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 condition and related conditions. Medicare generally pays the hospice provider a prospective daily payment that is not affected by the number of visits or other services a hospice furnishes on a given day. Payments are made according to a fee schedule that has four levels of care.

In the hospice proposed rules for fiscal year (FY) 2024 and FY 2025, CMS raised questions about access to care under the hospice benefit for certain high-cost complex services that may be palliative (i.e., provide symptom relief) for some hospice patients—specifically, dialysis for beneficiaries with end-stage renal disease (ESRD) and radiation, blood transfusions, and chemotherapy for beneficiaries with cancer (Centers for Medicare & Medicaid Services 2024b, Centers for Medicare & Medicaid Services 2023).¹ The agency requested information on a range of issues related to beneficiaries' access to these services and barriers that hospices may face in furnishing such services. CMS sought comment on whether additional payment was warranted when hospices furnish these complex palliative services and how such payment might be structured:

- In the FY 2024 hospice proposed rule, CMS raised the issue of access to dialysis, radiation, blood transfusions, and chemotherapy for palliative purposes in hospice (Centers for Medicare & Medicaid Services 2023). CMS stated that “there is a subset of hospice eligible beneficiaries that would likely benefit from receiving palliative, rather than curative, chemotherapy, radiation, blood transfusions, and dialysis.”² The agency indicated that it had received anecdotal reports from beneficiaries and families that hospice agencies had told them Medicare does not allow for the provision of these types of treatments for patients enrolled in hospice. CMS stated that these types of treatments would be covered under the hospice benefit if the hospice physician, with input from the hospice interdisciplinary group, determined

the treatments would be beneficial for a patient's symptom control (and if the patient wished to receive them).

- In the FY 2025 hospice proposed rule, CMS stated that it had received comments from the public that the daily hospice payment rate does not reflect the cost of providing high-cost palliative services (Centers for Medicare & Medicaid Services 2024b). The agency did not propose a specific hospice payment change but sought additional comment on a number of issues that could inform development of a payment mechanism to account for the increased costs of providing complex palliative treatments in hospice.³

Between 2024 and 2026, the Commission conducted research about access to hospice and the provision of certain complex palliative services under the hospice benefit for beneficiaries with ESRD (dialysis) and beneficiaries with cancer (blood transfusions, radiation, and chemotherapy).⁴ We focused on these beneficiary populations because:

- historically, beneficiaries with ESRD have been less likely to elect hospice compared with all Medicare beneficiaries and because CMS discussed the issue of access to dialysis in hospice (Centers for Medicare & Medicaid Services 2023); and
- although beneficiaries with cancer are more likely to elect hospice than all other hospice-eligible beneficiaries, CMS has received anecdotal reports from beneficiaries and families that hospice agencies have told them Medicare does not allow for the provision of treatments like blood transfusions, radiation, and chemotherapy for palliative purposes under hospice election (Centers for Medicare & Medicaid Services 2023).

We note that Medicare policy permits hospice providers to determine whether they offer services such as dialysis, radiation, blood transfusions, and chemotherapy for palliative purposes. Though we sought to learn more about the palliative services offered to hospice beneficiaries with ESRD or cancer, considerations about the appropriateness of providers' decisions about whether to furnish these services to hospice enrollees and whether such services are consistent with the hospice caregiving philosophy are beyond the scope of this chapter.

In this chapter, we review relevant literature on the role of certain high-cost complex services that may be palliative for some hospice patients and report findings from interviews we conducted with clinicians, hospice providers, dialysis providers, and family caregivers between 2024 and 2025. We also report what can be known, given data limitations, about the use of hospice and certain complex palliative services under the hospice benefit for beneficiaries with ESRD or cancer. In addition, we review how Medicare pays for hospice care and consider whether the hospice payment system creates potential access barriers to certain high-cost complex palliative services for some hospice patients. Finally, we discuss several approaches that policymakers could consider to improve the accuracy of Medicare’s payments for hospice services and address potential concerns about access to complex palliative services.

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Background

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The Medicare hospice benefit is designed to provide pain and symptom relief, comfort, and emotional and spiritual support to eligible beneficiaries with a terminal illness who choose to enroll. The hospice benefit covers services that are reasonable and necessary for palliation of the terminal condition and related conditions. A wide range of palliative services are covered: visits by nurses, aides, social workers, physicians, and therapists; drugs, durable medical equipment, and supplies; short-term inpatient care and respite care; bereavement services for the family; and other services for palliation of the terminal condition and related conditions that are specified in the beneficiary’s plan of care.

Medicare permits—but does not require—hospices to provide certain complex services that may be palliative for some patients. According to the *Medicare Benefit Policy Manual* (Sec. 40.2.4, “Special Modalities”), a hospice “may use chemotherapy, radiation therapy, and other modalities for palliative purposes if it determines that these services are needed. This determination is based on the patient’s condition and the individual hospice’s care giving philosophy” (Centers for Medicare & Medicaid Services 2026b). Similar to how the Commission

approaches treatment choices by other types of providers, issues of what mix of palliative services hospice providers choose to offer patients fall outside the scope of this project. Although the Commission has not taken a position on this policy, the text box on pp. 200–201 discusses varied perspectives on the mix of palliative services that hospice providers offer.

Enrollment in the hospice benefit is voluntary; it is a choice made by individual beneficiaries and their families. Patient autonomy and care according to a patient’s preferences are important principles in end-of-life care. The decision of whether to elect hospice is a deeply personal one for a beneficiary and their family, influenced by their preferences and beliefs and informed by discussions with their physician and health care providers about disease progression, prognosis, and options for care. Hospice offers beneficiaries the option to receive end-of-life care focused on symptom management and quality of life and can enable some beneficiaries to die at home (rather than in the hospital) if they wish to do so. Hospice offers support to both patients and families as they face the end of life and offers bereavement support for survivors afterward. While it is important that eligible beneficiaries have the option to elect hospice, it is also important that beneficiaries can choose not to enroll in hospice care and remain with conventional care throughout the end of life.

For a beneficiary to be eligible for hospice, they must have a life expectancy of six months or less if their disease runs its normal course. When a beneficiary first elects hospice, two physicians—a hospice physician and the beneficiary’s designated attending physician (if any)—certify that the beneficiary meets this life-expectancy criterion. After the first and each subsequent hospice benefit period, a hospice physician can recertify the patient for continued hospice care as long as the patient’s terminal illness continues to engender a life expectancy of six months or less. Beneficiaries can disenroll from hospice at any time and can reelect hospice for a subsequent period as long as they meet the eligibility criteria.

When a beneficiary enrolls in hospice, they elect to receive palliative care for their terminal condition and related conditions under the hospice benefit and forgo care related to the terminal illness outside of

hospice. When a beneficiary enrolls in hospice, the beneficiary or their representative signs a hospice election statement that includes the individual's or representative's acknowledgement that they have been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness and related conditions. Although hospice providers are not required to use this specific language, CMS provides hospices with a model hospice-election statement that states: "The nature of hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers" (Centers for Medicare & Medicaid Services 2020).

Services that are unrelated to the terminal condition and related conditions continue to be covered outside of the hospice benefit by fee-for-service (FFS) Medicare for Part A and Part B services or by a prescription drug plan or Medicare Advantage Prescription Drug plan for Part D drugs. However, CMS guidance on when services are "unrelated" is not specific. CMS has stated in the preamble of regulations that it considers "virtually all" services at the end of life to be related to the terminal condition and thus the responsibility of the hospice provider, while the *Medicare Benefit Policy Manual* indicates that services that are "completely unrelated" or "unrelated" to the terminal condition are eligible for FFS coverage outside of hospice (Centers for Medicare & Medicaid Services 2026a, Centers for Medicare & Medicaid Services 2026b).⁵ In our March 2024 report, the Commission noted that MedPAC interviews conducted with hospice providers on the topic of unrelated services suggest that providers differ in how they define "unrelated" (Medicare Payment Advisory Commission 2024).

Medicare pays hospice providers a prospective daily rate for all services that are reasonable and necessary for palliation of the terminal condition and related conditions. Payments to hospice agencies are made according to a fee schedule that has four levels of care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIP).⁶ RHC has two payment levels, a higher rate for the first 60 days of the stay and a lower rate for days 61 and beyond. RHC accounted for nearly 99 percent of hospice days during 2024.

Medicare's daily payment rate to hospice providers is generally not affected by the number of visits or the cost of nonvisit services that the hospice furnishes on a given day.⁷ This design of the hospice payment system has been in place since the hospice benefit's outset in 1983. In the final rule establishing the hospice payment system, CMS indicated that it received comments suggesting that there be exceptions to the payment rates for special palliative procedures, such as radiation and chemotherapy. The agency declined, stating that "fragmentation of the rates may provide incentives for hospices to increase the use of 'special procedures'" and that they had included a cost component associated with outpatient hospital services (e.g., radiation or chemotherapy) in the bundled rates (Health Care Financing Administration 1983).

When a beneficiary elects hospice, they designate an "attending physician" to oversee their care. A physician, nurse practitioner, or physician assistant can serve as the designated attending physician and can be employed by the hospice or independent of the hospice (e.g., a physician with whom the beneficiary has a long-standing relationship). Medicare makes a separate payment for a professional service such as an evaluation and management visit furnished by the hospice beneficiary's attending physician.⁸

FFS Medicare pays for hospice care for beneficiaries enrolled in either traditional FFS Medicare or Medicare Advantage (MA). Once a beneficiary in an MA plan elects hospice care, the beneficiary receives hospice services through a provider paid by FFS Medicare (while Medicare continues to pay the MA plan for Part D services and Part C rebates but not Part A and Part B services). In March 2014, the Commission urged that this policy be changed, recommending that hospice be included in the MA benefit package (Medicare Payment Advisory Commission 2014).

The role of complex services that may be palliative for some hospice patients

Services such as dialysis, radiation, blood transfusions, and chemotherapy raise complex issues in the context of hospice. First, because these services can be life extending or palliative or both, depending

Medicare policy on complex palliative services in hospice: Varied viewpoints

The Medicare hospice benefit is designed to provide pain and symptom management, comfort, and emotional and spiritual support to beneficiaries with a terminal illness who elect hospice care. The benefit covers a wide range of palliative services such as nurse, aide, social worker, and physician visits; drugs and durable medical equipment; short-term inpatient and respite care; bereavement services for the family; and other services necessary for palliation of the terminal illness and related conditions. Medicare permits—but does not require—hospices to provide certain complex services that may be palliative for some patients. According to the *Medicare Benefit Policy Manual* (Sec. 40.2.4, “Special Modalities”), a hospice “may use chemotherapy, radiation therapy, and other modalities for palliative purposes if it determines that these services are needed. This determination is based on the patient’s condition and the individual hospice’s care giving philosophy. No additional Medicare payment may be made regardless of the cost of the services” (Centers for Medicare & Medicaid Services 2026b).

While the reference to a hospice’s “caregiving philosophy” is unusual in Medicare policy, other types of providers generally have some discretion in the services they choose to offer. For example, skilled nursing facilities may decide whether to admit patients requiring ventilator care, complex wound care, or infusion therapy. Hospitals vary in their service offerings; for instance, nuclear medicine is optional under the hospital conditions of participation.

Although determinations about the mix of palliative services a hospice should provide fall outside the scope of this chapter, the discretion permitted under current Medicare policy concerning specialized services raises complex issues about which there are a range of perspectives.

Our interviews of physicians with expertise in cancer, nephrology, palliative medicine, and hospice care (discussed in more detail later in this chapter) indicated that determinations about the benefits and risks of complex palliative services (e.g., dialysis, blood transfusions, radiation, and chemotherapy) for individual hospice patients involve substantial medical judgment. Among clinicians we interviewed, views varied on when and what types of services were palliative and appropriate for hospice patients. In addition, some interviewees indicated that some hospice clinicians may view certain complex services as inconsistent with the hospice model’s focus on quality of life and less aggressive end-of-life care. Because these services are often used with life-prolonging intent outside of hospice, their use within hospice may also introduce complexities concerning when they are consistent with the hospice benefit–eligibility criteria.

Interviewees told us that decisions about offering complex palliative services may also depend on a hospice’s operational capacity. Some clinicians noted that certain complex services may require frequent labs or specialized monitoring or may have potential side effects that increase the risk of hospitalization. The provision of such complex palliative services

(continued next page)

on the circumstance, it is not always clear whether the purpose of the service is palliative and therefore within the scope of the hospice benefit. These determinations are likely very individualized, specific to the clinical circumstances of an individual patient at a specific time in their disease progression and the

medical judgment of their hospice physician. A second complexity concerns the interaction between the provision of these services and the hospice–eligibility criterion of a life expectancy of six months or less if the disease runs its normal course. If the service (e.g., dialysis or blood transfusion) is both palliative and

Medicare policy on complex palliative services in hospice: Varied viewpoints (cont.)

differs, therefore, from the traditional model of hospice care, and some interviewees stated that some providers may not have the infrastructure to support it.

Commissioners' discussions during MedPAC's 2025 and 2026 public meetings also acknowledged varied perspectives on the discretion hospices have to offer complex palliative services (Medicare Payment Advisory Commission 2026a, Medicare Payment Advisory Commission 2025a, Medicare Payment Advisory Commission 2025b). Some stated that beneficiaries should be able to expect a consistent bundle of services regardless of the hospice they choose and expressed concern that permitting hospices to decide whether to provide certain complex services that may be palliative for some patients may reduce access for patients who might benefit. On the other hand, some noted that expanding the set of services hospices are required to provide may shift the hospice model of care toward more traditional medical care, potentially lessening its emphasis on comfort, quality of life, and less-invasive care and may affect the extent to which some clinicians engage in conversations about prognosis, treatment trade-offs, and goals of care.

Requiring hospices to provide palliative dialysis, radiation, blood transfusions, and chemotherapy might pose enforcement challenges for CMS. It may be difficult to distinguish between a hospice that has failed to offer a complex service with a

palliative benefit for a particular patient from a hospice that did not offer such services because they had no patients for whom the services were clinically appropriate and reasonable and necessary for palliative purposes. A similar challenge surrounds the current requirement that hospices offer all four levels of care: routine home care (RHC), general inpatient care (GIP), continuous home care (CHC), and inpatient respite care (IRC). Some hospices do not provide CHC, IRC, or GIP in a given year, despite the requirement, and it is not always clear why.

Commissioners' discussion in public meetings also touched on the issue of whether beneficiaries had adequate information about individual hospice providers' service offerings. Commissioners discussed the importance of ensuring that beneficiaries have clear information about the complex palliative services offered by individual hospice providers, and some commissioners raised the potential to enhance transparency (for example, by reporting this information on Medicare's Hospice Compare website). Currently, Medicare's Hospice Compare reports some information on whether hospices have furnished at least one other level of care in addition to RHC (i.e., whether, during a three-year reference period, a hospice furnished only the RHC level of care or furnished at least one day of at least one of the three other levels of care to any patient), but it does not report information on whether hospices offer or furnish complex palliative services. ■

life extending, the hospice physician would need to determine the service's expected effect on the patient's life expectancy and whether the patient would meet the hospice-eligibility criteria while receiving the service. A final complexity relates to the hospice model of care and variation across clinicians and hospice providers in their views of certain treatments. Hospice is intended to provide comfort and emotional support to patients near the end of life and generally lessen

reliance on aggressive or invasive care. Some hospices may view treatments such as dialysis, radiation, blood transfusions, and chemotherapy as not palliative or consistent with the hospice model of care.

We reviewed the literature and interviewed clinicians, hospice providers, dialysis providers, and family caregivers to gather perspectives on the palliative role of certain complex services in hospice care. Overall, we found general consensus that dialysis, radiation,

and blood transfusions can provide symptom relief for some hospice patients but less consensus around the role of chemotherapy in symptom relief for hospice patients.

Findings from the literature

The literature suggests that, for some hospice patients, there may be a palliative role for certain complex services that are often used for nonhospice patients with the goal of extending life. To date, however, we have not identified many studies that specifically evaluated the effect of dialysis, radiation, blood transfusions, and chemotherapy on symptoms in patients receiving hospice care or patients in the last months of life. The following are some of our findings from our literature review:

- **Dialysis**—Some researchers indicate that the provision of palliative dialysis may reduce symptoms of fluid overload or uremia (e.g., shortness of breath, nausea, vomiting, poor appetite, altered mental status) and improve comfort in some patients with ESRD (Chen et al. 2019, Grubbs et al. 2014, Kalantar-Zadeh et al. 2020, Romano and Palomba 2014).⁹
- **Radiation**—The American Society for Radiation Oncology's guidelines note that there is strong evidence supporting the use of radiation to palliate pain from bone metastases (Alcorn et al. 2024). While this guideline is not specific to the hospice population, Yerramilli and Johnstone reviewed the literature and concluded that conventional radiation therapy (generally a single fraction) can palliate pain from bone metastases and other symptoms for patients with a life expectancy of two to six months but that it is unlikely to successfully palliate most symptoms for patients with a life expectancy of less than a month (Yerramilli and Johnstone 2023).
- **Blood transfusions**—The American Society of Hematology guidelines panel (2020) reviewed the literature on the effect of blood transfusions on symptoms and concluded that there is evidence that red blood cell transfusions improve fatigue and patient perceptions of well-being for some cancer patients receiving palliative care (Sekeres et al. 2020). They recommended, based on this evidence and a desire to facilitate timely hospice enrollment,

that red blood cell transfusions be made available to adult patients with acute myeloid leukemia who cease antileukemic treatment, including those receiving hospice and end-of-life care (Sekeres et al. 2020).¹⁰

- **Chemotherapy**—Studies suggest that chemotherapy use near the end of life is associated with patterns of care involving more intensive health care services, such as a greater likelihood of later referrals to hospice, emergency room visits, hospitalization, intensive care unit (ICU) stays, and death in the hospital or nonhome setting (Akhlaghi et al. 2020, Wright et al. 2014). Other studies have found that certain intensive services near the end of life—such as hospitalizations, ICU use, and hospital deaths—are associated with poorer patient quality-of-life measures (Chen et al. 2025, Zhang et al. 2012). A few studies have examined the effect of chemotherapy itself on measures of symptoms or quality of life for patients who are in the last months of life. Zhang and colleagues found that chemotherapy in the last week of life was associated with poorer patient quality of life (as reported by caregivers) (Zhang et al. 2012). Chen and colleagues focused on patient-reported end-of-life quality measures over the last six months of life and found no effect of chemotherapy use on quality of life (Chen et al. 2025). Prigerson and colleagues examined quality of life near death for patients with metastatic cancer with a life expectancy of six months or less and found that those who received chemotherapy had similar or worse quality of life than patients who did not receive chemotherapy (Prigerson et al. 2015). The American Society of Clinical Oncology sponsored a quality measure that was adopted by the National Quality Forum in 2012 and remains in use today in the Merit-based Incentive Payment System. The measure is the percentage of cancer decedents who receive chemotherapy in the last 14 days of life, with higher quality indicated by fewer patients receiving chemotherapy in the last two weeks of life (Centers for Medicare & Medicaid Services 2025d). Roeland and LeBlanc noted that some chemotherapy may reduce disease burden and symptoms and possibly extend life for select patients with advanced cancer but that chemotherapy given near death is not effective at relieving symptoms (Roeland and LeBlanc 2016).

Findings from stakeholder interviews

We conducted interviews with clinicians, hospice providers, dialysis providers, and family caregivers in 2024 and 2025. In these interviews, we focused on dialysis, radiation, blood transfusions, and chemotherapy because CMS raised questions in the hospice proposed rules for FY 2024 and FY 2025 about access to these services under the hospice benefit. The text box “Overview of stakeholder interview process,” p. 205, gives additional details on our interview approach. We provide a summary of common themes related to hospice enrollees’ access to all four of the complex palliative services (Table 5-1, p. 204), followed by a summary of interviewees’ perspectives on specific services.

Certain complex services may serve palliative purposes for some hospice patients

The role of specialized services in hospice is complicated because the services can be life extending or palliative or both depending on the patient’s stage of disease. Clinicians and relevant specialists we interviewed varied in their perspectives on whether and when they consider these services to be palliative and consistent with the hospice benefit criteria, and they explained the considerations they give to an individual patient’s situation and type of service. Interviewees generally viewed dialysis, radiation, and blood transfusions as having the potential to be palliative and consistent with the hospice benefit criteria in certain circumstances for some hospice patients. There was less consensus among interviewees about the role of chemotherapy in hospice care.

Hospices that provide these services reported doing so for multiple reasons, depending on the circumstances of the individual patient

Hospice clinicians that we interviewed explained that, depending on the type of service and individual patient situation, services such as dialysis, radiation, and blood transfusions are furnished to provide symptom relief to some hospice patients. Oncologists and palliative care clinicians said that the treatments’ benefits in terms of symptom relief vary across patients and by their end-of-life stage. Some patients may no longer be able to tolerate the treatment by the time they enroll in hospice. Furthermore, patients with a prognosis of

only a few days to weeks may not have enough time to experience the benefits of certain palliative treatments (e.g., radiation). Interviewees said that the process of traveling to a clinic or hospital and spending several hours there receiving dialysis, radiation, or blood transfusions can be physically taxing for patients and that for those in the last few days of life, the burdens of treatment and travel on the patient can often outweigh the benefits.

Physicians and hospice providers also said they offered these services to ease beneficiaries’ decisions to transition to hospice. Multiple hospice physicians stated that patients who enroll in hospice only in the last few days of life do not fully benefit from the symptom management and emotional support that hospice care can offer both the patient and their family. Interviewees indicated that dialysis- or transfusion-dependent patients, in particular, will typically die within one to two weeks after ceasing dialysis or transfusions and may be reluctant to discontinue treatment in order to enroll in hospice. Some hospices said that allowing patients who wished to enroll in hospice to continue these treatments helped to address their fear of “dying right away” and gives them the opportunity to enroll earlier than they otherwise would. A few hospice providers noted that entering hospice and having a hospice system in place at home eases beneficiary decisions to cease treatment.

Another reason hospices said they provide these services in some cases was to help patients have an end-of-life experience that is consistent with their values and goals (e.g., spending more time with family or participating in specific milestones, such as a family wedding).

High-cost services that may serve palliative purposes could be challenging for hospices to provide

Hospice providers are responsible for the cost of all services for palliation of the terminal condition and related conditions, while FFS Medicare continues to pay separately (i.e., outside of the hospice benefit) for services that are unrelated to the terminal illness. Most interviewees indicated that it is rare to consider dialysis, radiation, blood transfusion, and chemotherapy as unrelated to the patients’ terminal condition, while a few said that, for patients with ESRD and certain conditions

**TABLE
5-1****Perspectives on the use of dialysis, radiation, blood transfusions, and chemotherapy in hospice: Summary of findings from interviews**

Themes	Interviewees' perspectives
Palliative role in hospice	• General consensus held that dialysis, radiation, and blood transfusions can provide symptom relief for some hospice patients. • Less consensus existed around the role of chemotherapy in symptom relief for hospice patients.
Potential to affect beneficiary prognosis and eligibility for hospice	• Use of radiation in hospice patients is generally only palliative. • Dialysis and blood transfusions may extend life expectancy by weeks or months for hospice-eligible beneficiaries depending on timing of hospice enrollment. • Chemotherapy may extend life expectancy depending on situation.
Hospice rationale(s) for providing service	• Reasons vary depending on type of service and individual patient situation. • Services may be provided for symptom relief. • Provision of services may ease transition to hospice, particularly for those on life-sustaining treatments. • Provision of services can help beneficiary reach specific goal (e.g., attending a family wedding, graduation).
Cost of services	• Cost of dialysis, radiation, blood transfusions, and some chemotherapy to the hospice generally exceeds Medicare's hospice daily payment rate (for RHC). • These services are likely cost prohibitive for small hospices; larger hospices are more likely to furnish these services, and these agencies are more likely to be nonprofit. • Cost of providing specialized services varies by hospice's ability to negotiate rates and execute contracts with dialysis facilities and hospitals/clinics. • Additional services can be high cost for hospices (e.g., drains for abdominal ascites or pleural effusions, ventilators for ALS patients, total parenteral nutrition, and certain drugs for symptom relief).
Transportation	• Cost of transportation, particularly ambulance if patient's condition requires one, can add significantly to the cost of providing service. • Ambulance use rates vary by type of service. • Some hospices that furnish costly services rely on patients to have access to transportation from family, caregiver, or the community.
Effect on patient decision to elect hospice	• Some patients do not enroll in hospice or enroll very near the end of life due to concern about ceasing treatment, including patients with ESRD or blood cancer who rely on dialysis or blood transfusions, respectively. • Some patients with cancer receiving radiation may delay hospice enrollment by a few days or weeks to receive additional radiation treatments before entering hospice.
Referrals from specialists	• Hospice providers reported that timely referrals to palliative care and hospice are less likely from specialists (e.g., oncologists, hematologists, nephrologists) and are more frequently from hospitals or primary care providers.
Protocol of hospices that provide these services and pay for them under the hospice benefit	• Radiation is often offered as a single treatment (sometimes up to five) to palliate pain. • Dialysis and blood transfusions are often furnished with some type of limit on number or frequency of treatment. • Chemotherapy is less commonly offered.
FFS payment of dialysis for beneficiaries with ESRD enrolled in hospice	• Views differed on whether dialysis is ever unrelated to the beneficiary's terminal condition and related conditions. • Hospices stated that CMS had tightened its guidance on relatedness such that the use of dialysis outside of the hospice benefit had become less common.

Note: RHC (routine home care), ALS (amyotrophic lateral sclerosis), ESRD (end-stage renal disease), FFS (fee-for-service). "Chemotherapy" includes both chemotherapy and immunotherapy.

Source: MedPAC analysis of interviews with clinicians, hospice and dialysis providers, and family caregivers.

Overview of stakeholder interview process

In 2024 and 2025, we conducted interviews with clinicians, hospice providers, dialysis providers, and family caregivers to better understand the current level of access that beneficiaries in hospice have to certain costly complex palliative services. Participation in our interviews was voluntary, and interviewees spoke on the condition of anonymity. Interviews included 12 nonhospice clinicians in several specialties (oncology, hematology, nephrology, and palliative care), clinicians and administrative personnel from nine hospice providers and three dialysis providers (including hospice medical directors, hospice physicians, nephrologists, nurses, social workers, and other administrative staff), and multiple family caregivers of decedents who used hospice.

To identify potential hospices for the study, we sought feedback from industry associations for hospice clinicians or administrative staff with experience or knowledge about the provision of these specialized services. To identify nonhospice clinicians and dialysis providers for the study, we relied on the literature and recommendations by clinical experts and local health care providers in areas where we conducted interviews. The providers and clinicians we interviewed varied by region, urban and rural status, ownership type, and practice setting. In these interviews, we mostly focused on four selected services—dialysis, radiation, blood transfusions, and chemotherapy—because CMS raised questions in hospice proposed rules for fiscal year (FY) 2024 and FY 2025 about access to care under the hospice benefit for these complex palliative services. Interview protocols were tailored to the interviewees' specialty and included the following topics:

- the role of a selected service for hospice patients;
- perspectives on the current level of access that beneficiaries in hospice have to selected services;
- hospices' experience with providing selected services for palliative purposes;
- types of hospice patients who benefit from the selected service and the eligibility criteria, if any, for receiving these services in hospice;
- hospices' experience in contracting with other facilities and providers to furnish selected services;
- frequency and duration of selected services provided to hospice patients;
- whether there are additional high-cost services that hospices report furnishing for palliative purposes; and
- nonhospice clinicians' experience with coordinating patient care with hospices.

Our interviews with family caregivers of decedents who used hospice included the following topics: decedent experience with electing hospice and factors considered during decision-making; change in decedent experience pre- versus post-hospice enrollment; decedent and family caregiver experience with care furnished by hospice clinicians and staff at the end of life; and decedent and family caregiver experience, if applicable, with receiving complex palliative services in hospice. ■

(e.g., certain cancers), dialysis could be considered unrelated and paid separately outside of the hospice benefit. Some interviewees said that CMS has tightened its guidance on "relatedness" over the years and that it has become less common for dialysis to be paid outside of hospice under FFS Medicare.

Interviewees told us the cost of dialysis for beneficiaries with ESRD and radiation, blood transfusions, and chemotherapy for beneficiaries with cancer generally exceeds the Medicare hospice daily payment rate. Several clinicians and hospice providers perceived that cost was a primary reason that many

hospices, especially small and medium-size providers, do not offer dialysis, radiation, blood transfusions, or chemotherapy. They indicated that more hospices might provide some of these services if greater payment was available.

A few hospices reported being able to leverage their large size to absorb the cost of these services. Some also reported that the Veterans Health Administration (VHA) provides coverage for disease-directed therapies after patients enroll in hospice and that their hospice had provided these treatments in some cases for VHA patients. Interviewees indicated that the cost of these services also varies by the hospice's ability to execute contracts and negotiate rates with dialysis facilities, outpatient hospitals, and clinics.¹¹ Several hospices were able to negotiate prices with dialysis facilities and radiation centers such that they never paid more than the Medicare-allowable rate. Another hospice told us, however, that certain dialysis facilities refused to establish "one-time contracts" and that, without a contract in place, the hospice was charged a rate that significantly exceeded the FFS payment per dialysis treatment.

Interviewees described varied approaches that hospice providers may take toward specialized complex palliative services like dialysis and blood transfusions. One clinician noted that some hospice providers may require patients to forgo treatments such as dialysis and blood transfusions when electing hospice because they impact patients' life expectancy. Alternatively, some hospice providers may place a limit on the number or duration of treatments that patients may receive after enrolling in hospice.

Transportation can add financial and logistical challenges for hospices providing these services

Dialysis, radiation, and blood transfusions generally require patients to travel to and from the patient's home or a facility where they reside to a dialysis facility and outpatient hospitals and clinics. Costs and logistical issues related to providing transportation were cited as further barriers to hospices providing these complex palliative services. The cost of transportation services, particularly ambulances in those situations where the patient's condition requires ambulance transport, was described as significantly

higher than the cost of some of these treatments. Under Medicare ambulance coverage policy, nonurgent ambulance services are considered reasonable and necessary in certain circumstances (e.g., when the patient is bedbound and transit meets certain other requirements).¹²

Among hospices that provided dialysis, radiation, and/or blood transfusions, a few hospice representatives indicated that the hospice would cover the cost of the treatment but that patients would be responsible for their own transportation. A few hospices mentioned the availability of county- or local area-supplied transportation services and helping arrange those services for patients. For one hospice, transportation providers were simply unavailable in their service area.

Several hospice physicians cited reasons in addition to cost for why they required patients to have access to private transportation. One physician said that treatments may be delayed for patients who require transportation from third-party providers if there is limited availability of transportation services. Second, several hospice physicians said they use patients' functional status and ability to travel via private transportation without stretchers to gauge patients' ability to tolerate and benefit from the treatment. A few hospices indicated that becoming bedbound and/or requiring an ambulance for transport triggers a discussion with the patient about goals of care. For most interviewees, it was uncommon to incur the cost of the ambulance for these types of services.

Impact on patients' decision to elect hospice

Several clinicians we interviewed explained that dialysis- and transfusion-dependent patients, in particular, may be averse to ceasing these treatments to enroll in hospice. We were told that these patients had typically been receiving these treatments for a long time and had been instructed repeatedly about the importance of not missing treatment for their survival. The prospect of ceasing these treatments to elect hospice, therefore, is dissonant with the messaging they have received over the course of their treatment and may make it psychologically difficult for some patients to accept, no matter how fatigued they may already be from these treatments. In addition, several clinicians said patients receiving dialysis and

transfusions regularly develop trust and relationships with the staff and clinicians who furnish these services. For some patients, these care teams become almost like family, which may make them reluctant to elect hospice and transition to a different model of care. We also heard from clinicians that sometimes families and caregivers of dialysis- and transfusion-dependent patients may be more apprehensive than the patients themselves about the idea of ceasing treatment to enroll in hospice.

Several oncologists and hospice providers explained that the timing of hospice enrollment is an additional consideration for some patients with cancer who are receiving radiation treatment. We were told that some of these patients may choose to wait to enroll in hospice for a few days or weeks until they have received additional radiation. Waiting to finish their radiation treatments before entering hospice was described as preferred by both patients and hospices. Some hospices we interviewed distinguished between radiation that patients might receive before enrolling in hospice versus radiation that might be provided during their stay for a new symptom that arises.

Interviewees reported fewer timely referrals to hospice from specialists

A few hospice providers noted that in their experience, timely referrals to palliative care and hospice (e.g., more than 48 hours before death) are less likely from specialists and that referrals to hospice for patients on dialysis and patients with cancer are more frequently from hospitals or primary care providers. These observations reflect what we heard from interviewees and are not based on quantitative analyses. One palliative care physician described nephrology as having a “very rigid model of care” centered on dialysis adequacy and making sure patients receive thrice-weekly treatments. Another hospice provider indicated that oncologists, like nephrologists, are generally focused on providing disease-directed treatments, with referrals to hospice often occurring very close to the end of life.

Several interviewees suggested that training during medical school and residency can shape specialists’ inclination to consider palliative care options for their patients and their comfort levels with having end-of-life discussions with patients. These interviewees

indicated that those who lack training in palliative care may associate transitioning to hospice with giving up on patients and being contrary to the ethos of medicine. They also noted that the ESRD Quality Incentive Program does not include any quality measures to incentivize nephrologists to recommend palliative care to eligible patients.

Hospices’ experience with providing dialysis to enrollees with ESRD

We asked hospice providers about the role of dialysis for patients with ESRD who are receiving hospice care. Interviewees told us that dialysis is palliative for some of these patients because it can relieve discomfort from symptoms of fluid overload or uremia (e.g., shortness of breath, nausea, vomiting, poor appetite, altered mental status); there are other patients, in contrast, who can no longer tolerate the treatment by the time they enter hospice. Many interviewees noted that dialysis also extends life for these patients; without dialysis, most patients with ESRD would die within one to two weeks.

Given the life-prolonging nature of the treatment, we asked providers whether dialysis affects hospice-eligibility criteria determinations. Several respondents explained that there are certain markers of declining clinical status (e.g., difficulty maintaining blood pressure, frequent hospitalizations, recurrent anemia) and worsening comorbid conditions (e.g., heart failure, cancer) that can be used to identify patients whose lives would be extended by no more than a few weeks through dialysis. A few interviewees noted that better prognostic models are necessary to be able to identify patients who are eligible for hospice because some patients at the outset of dialysis may appear to have a six-month life expectancy but may live for years with dialysis. We were also informed that some of the existing innovative models of concurrent care for beneficiaries on dialysis have tended to focus on patients with life expectancies of less than six months.

We asked hospices whether they provided dialysis to their patients under the hospice benefit (that is, not paid for separately outside of the hospice benefit). We heard about a mix of policies and approaches by hospices that provided dialysis and how, in some cases, policies within a hospice changed over time. Several hospices allowed beneficiaries with ESRD to enroll and continue dialysis up to a specified limit: Some limited

the time that patients could continue on dialysis (30 days or six to eight weeks), and others capped the number of treatments at around 10 to 12. In a few of these hospices, the treatment caps were described as an initial plan of care that could be modified or renewed. Some of the hospices with a treatment cap reported that patients often do not use the maximum allotted number or days. Only one hospice we interviewed had no prespecified limit on dialysis.

According to clinicians we interviewed, beneficiaries who received dialysis while in hospice tended to continue using the modality that they had historically used before hospice entry. In addition, we were told that it is not typical to transition a patient entering hospice from in-center hemodialysis to peritoneal dialysis (PD) due to the complexities of doing so, particularly in the last weeks of life. These complexities include the time (in weeks) that facilities require to train patients and their caregivers to safely administer dialysis in their home. In addition, it is necessary for clinicians to place a PD catheter for patients switching from hemodialysis to PD.

In addition to specifying the number or duration of dialysis treatments offered after entering hospice, some hospices also reduced the intensity or frequency of dialysis in consultation with the medical director and nephrologist (e.g., by dropping from three to two treatments per week or changing prescriptions), while others maintained the standard treatment regimen.¹³ Clinicians' perspectives differed about whether modifications were warranted given the diminished benefits, as well as additional burden to patients at the end of life, of certain lab tests and ESRD medications and even of a third treatment on a given week.

Hospices' experience with providing radiation to enrollees with cancer

We asked hospice and nonhospice clinicians about their views on the role of radiation in hospice care. Physicians described radiation as palliative for hospice patients experiencing pain from bone or other metastases. There was general consensus that indications for radiation treatment are clearer for hospice patients than those for blood transfusions or chemotherapy because radiation for hospice patients does not generally impact prognosis or longevity. Most clinicians indicated that one to two fractions of radiation would be sufficient to relieve pain for most

hospice patients, while other clinicians suggested up to five fractions may be necessary for certain patients in hospice or that some radiation oncologists preferred protocols that involved more than a single fraction. We were also told that it takes time for radiation to provide symptom relief for pain and that palliative radiation is typically used by hospice patients who have a somewhat longer life expectancy (e.g., months) and generally not for those in the last few days or weeks of life.

Several hospice providers told us the cost of radiation was lower than the cost of dialysis, blood transfusions, or chemotherapy, but not all interviewees commented on the relative costliness of each service. A few interviewees described radiation as cost prohibitive for their hospice.¹⁴ Most hospice representatives we interviewed indicated that they furnished one to five fractions of radiation for pain management. Some interviewees said that they start with a week of radiation, regardless of treatment frequency, as an initial plan of care, while others reported that their patients typically elect to stop treatment after getting one to two fractions of radiation while in hospice. Several hospices mentioned working closely with oncologists and relying on their expertise to determine the appropriate treatment regimen for patients.

Hospices' experience with providing blood transfusions to enrollees with cancer

Oncologists, hematologists, and hospice and palliative care clinicians that we interviewed told us that blood transfusions can serve multiple purposes for hospice patients. For some patients with blood cancer who are near the end of life, transfusions can be palliative, helping to relieve symptoms such as fatigue, anemia, and shortness of breath. Physicians told us that the effectiveness of blood transfusions for symptom relief varies across patients depending on the type and stage of the disease process. For some patients, a transfusion may provide effective symptom relief for one or more weeks, whereas for other patients a transfusion may have minimal effects on symptoms or the benefits may dissipate quickly (e.g., last a few days or less). In addition, physicians we interviewed said that blood transfusions prolong life for hospice patients with blood cancer. Physicians described the effect of blood transfusions on life expectancy for hospice-eligible patients as generally modest, with some characterizing

the effect as extending life for a few weeks or a few months. Several hospices shared that they provide blood transfusions in cases where patients had specific goals to reach.

Most hospices we interviewed indicated that they furnished blood transfusions—generally red blood cells—under the hospice benefit in certain circumstances. Several said that they used a criterion for the frequency of furnishing blood transfusions (e.g., ranging from once per week to once per month).¹⁵ Other hospices said that they would admit patients who wished to receive blood transfusions with the understanding that the hospice would provide a specified number of transfusions. Interviewees whose hospices furnished blood transfusions noted that they typically did not furnish platelets due to cost and clinical complexity.

Hospices' experience with providing chemotherapy to enrollees with cancer

We asked hospice and nonhospice physicians about their views on the role of chemotherapy in hospice care. Most hospice clinicians said that in their experience chemotherapy was not provided in hospice care or that it was extremely rare. These hospice clinicians indicated that they did not generally view chemotherapy as palliative for hospice patients, noting that chemotherapy typically made patients feel worse near the end of life. A few hospice clinicians noted that some high-cost immunotherapies or targeted cancer drugs furnished orally have fewer side effects, and they had varied views on whether such products could serve a palliative role for hospice patients. Several hospice interviewees also told us that the purpose of chemotherapy in hospice was more to help patients come to terms with ceasing cancer treatment than to relieve physical symptoms.

Oncologists and hematologists (referred to hereafter as “cancer clinicians”) we interviewed mostly viewed chemotherapy as not beneficial for hospice patients, but opinions varied. Some cancer clinicians believed that chemotherapy would not provide symptom relief for patients near the end of life. In addition, they noted that patients receiving active cancer treatment often need labs and frequent monitoring and are at risk of hospitalization from complications, and they did not perceive hospices as having the infrastructure for that type of care. Others viewed active cancer

treatment as generally inappropriate for patients receiving hospice care but said that there were likely some exceptions in which an individual patient, given their unique clinical circumstances, may get symptom relief from chemotherapy. In addition, some cancer clinicians felt that low-toxicity treatments such as targeted therapies or monoclonal antibodies could help relieve symptoms for some hospice patients, but they noted that currently little literature exists about the effects of these types of products on symptoms and quality of life.

A few hospice interviewees said they do furnish chemotherapy. One hospice stated that it provided oral chemotherapy drugs on a case-by-case basis, noting that products are often too costly, but they do furnish some chemotherapy products if an oncologist determines that it will make a difference for the patient's care. Another hospice shared that when they have provided chemotherapy, it has generally been only a few treatments to help ease the emotional decision to cease active treatment and transition to end-of-life care. One hospice indicated that though they furnished chemotherapy exclusively to VHA hospice patients, these patients also often cease chemotherapy if it is not helpful. A few hospices that did not furnish chemotherapy said that sometimes patients would receive chemotherapy while on hospice because they might finish remaining doses of an existing oral prescription that they had received before hospice enrollment or that they might receive drugs through a pharmaceutical company program.

Other complex services that may be palliative for hospice patients

We asked hospice and nonhospice clinicians if there are any other high-cost treatments and services that can palliate symptoms for hospice patients. They mentioned four types. First, clinicians explained that hospice patients with fluid buildup from abdominal ascites or pleural effusions can benefit from drains. One hospice said that it becomes more financially feasible to provide paracentesis or thoracentesis when patients get permanent drains placed before coming into hospice; another provider reported that they do not admit patients who do not already have permanent drains for ascites. Second, amyotrophic lateral sclerosis, or ALS, patients rely on ventilators for breathing support. However, because they are a higher-

**TABLE
5-2**

Few hospices reported costs for palliative radiation or chemotherapy on the hospice cost report, 2023

	Share of freestanding hospice providers that reported costs for:	
	Palliative radiation	Palliative chemotherapy
All freestanding hospices	3%	1%
Hospice provider size		
Smallest quartile	<1	<1
Second quartile	1	<1
Third quartile	3	<1
Largest quartile	7	2
Ownership		
Nonprofit	9	4
For profit	2	<1

Note: Percentages are calculated by taking the number of freestanding hospice providers that report positive costs in the listed category divided by the total number of freestanding hospices that submitted a cost report in 2023. Hospice provider size is calculated based on the number of days of hospice care furnished to Medicare beneficiaries in 2023. It is unknown whether all providers accurately report costs in these fields because cost-report data are not used for payment and are not audited. It is also unknown whether some hospice providers report costs for these services in other categories (such as the outpatient services category).

Source: MedPAC analysis of Medicare cost reports and hospice claims data.

cost type of durable medical equipment, ventilators were described as too expensive for many hospices. Third, some patients require feeding through total parenteral nutrition, or TPN. Similar to hospice-eligible patients with ESRD on dialysis, those on TPN may live for a few weeks to months with TPN versus a few days to weeks without it. However, at least three hospices noted it was not financially feasible to provide TPN due to high cost. Furthermore, one hospice provider explained that to provide TPN safely requires a high level of monitoring, “beyond the scope of hospice.” A few clinicians noted that hospices may disallow TPN, provide “TPN-Lite” (e.g., modified TPN without lipids), or provide TPN for a short period, with weekly reassessments of the need for treatment. Finally, some physicians mentioned that there are certain drugs that may palliate symptoms for some hospice patients but are generally too costly for hospices, such as certain drugs for heart failure and other cardiovascular conditions (e.g., certain inotropes).

Limited data available on whether hospices furnish certain complex palliative services

Medicare generally lacks data on how frequently hospice providers furnish services like dialysis, radiation, blood transfusions, and chemotherapy. Medicare hospice claims data do not include information about when hospice providers furnish these services.¹⁶ Without such data, policymakers are very limited in their ability to understand the extent to which hospice providers currently furnish these services.

The only claims data available on hospice enrollees’ use of high-cost services are for those services paid for outside of the hospice benefit. FFS Medicare pays for these services outside of hospice when they are

reported to be unrelated to the terminal condition. In subsequent sections of this chapter, we discuss the frequency of such services provided outside the hospice benefit, but it is important to keep in mind that these data do not give us any information about whether or how often hospice providers furnish these services under the hospice benefit.

The Medicare hospice cost report includes limited data on costs incurred by hospices for some services: Palliative radiation and palliative chemotherapy are included but not dialysis or blood transfusions. However, we note several caveats with the cost-report data. It is unknown whether providers accurately report data in the radiation and chemotherapy spending categories. For example, because payment is not dependent on reporting costs for these services, it is possible there could be underreporting. It is also unknown whether some hospice providers report costs for these services in other categories (such as the outpatient services category) rather than in the more specific categories.

In 2023, about 3 percent of freestanding hospices reported incurring costs for palliative radiation, and about 1 percent reported incurring costs for palliative chemotherapy (Table 5-2). These amounts represent a small decrease from 2019, when 5 percent of freestanding hospices reported palliative radiation costs and 2 percent reported palliative chemotherapy costs (data not shown). Larger hospices and hospices with nonprofit ownership were more likely to report costs for palliative radiation and chemotherapy than other hospices (Table 5-2). Overall, total costs (across all patients) reported by freestanding providers for these services were very small in 2023: \$1.2 million for palliative radiation and \$0.5 million for palliative chemotherapy (data not shown).

Other researchers' analyses of cost-report data for earlier time periods also indicate that the share of hospices reporting radiation and chemotherapy costs on their cost reports has declined over time. Jarosek and colleagues found that 22 percent of freestanding hospices reported radiation costs in 2002 (Jarosek et al. 2009). According to Hsu and Wang, the share of freestanding hospices reporting costs for radiation declined from about 13 percent in 2011 to 5 percent in 2018; for chemotherapy, the figure declined from

5 percent in 2011 to 3 percent in 2018 (Hsu and Wang 2020). Both studies noted that nonprofit providers were more likely to report radiation costs than for-profit providers. The rapid growth in the number of for-profit hospice providers over the last two decades may account for some of the decline observed in the overall share of providers reporting radiation costs. However, according to Hsu and Wang, the share of nonprofit hospices reporting radiation costs also declined between 2011 and 2018 (Hsu and Wang 2020).

Finally, a survey by Knight and colleagues of a 10 percent random sample of hospice providers found that a majority (55 percent) of hospice survey respondents reported never offering blood transfusions in 2022, while 41 percent reported "sometimes," and 3 percent reported "always" offering blood transfusions. Larger and nonprofit hospices were more likely to report offering blood transfusions than other hospices. The most common "somewhat" or "extremely" contributing factors cited by hospices for never or only sometimes offering blood transfusions were the hospice organization's belief that transfusions are not consistent with the philosophy of hospice (75 percent), cost (65 percent), and transportation barriers (59 percent) (Knight et al. 2024).

Use of hospice by beneficiaries with ESRD or cancer

We analyzed FFS claims data pertaining to use of hospice services and certain complex services (dialysis, radiation, and blood transfusions) by beneficiaries with ESRD receiving maintenance dialysis and beneficiaries with cancer. This analysis examines the rate of enrollment in hospice by decedents with ESRD who received maintenance dialysis from a dialysis facility in their last year of life (or for selected analyses based on a longer look-back period) and beneficiaries with cancer, as well as the use of dialysis by hospice enrollees with ESRD and the use of radiation and blood transfusions by hospice enrollees with cancer, when those services are covered outside of the hospice benefit. We mostly focused on 2019, the last year before the coronavirus pandemic.¹⁷ We found that Medicare decedents with ESRD are substantially less likely to use hospice and those who do have much shorter stays than other Medicare decedents. Decedents with cancer are

**TABLE
5-3**

Lower hospice use among Medicare decedents with ESRD than among Medicare decedents overall

	All Medicare decedents	Decedents with ESRD
Share of decedents who used hospice, by year		
2010	44%	27%
2019	52	30
2024	53	31
LOS among hospice decedents, 2024		
Average	100 days	24 days
10th percentile	2	2
50th percentile	19	6
90th percentile	291	41
Share of decedents with hospice, by LOS, 2024		
≤3 days	17%	33%
4–7 days	15	27
8–14 days	13	18
≥15 days	55	22

Note: ESRD (end-stage renal disease), LOS (length of stay). For beneficiaries with ESRD, data are limited to those beneficiaries who received dialysis at some time during the last calendar year of life.

Source: MedPAC analysis of Medicare hospice claims and enrollment files from CMS.

more likely to use hospice but have shorter hospice stays compared with other Medicare decedents. Beneficiaries with blood cancer, particularly those who are transfusion dependent, have shorter stays than beneficiaries with other cancers.

Though we are unable to know how frequently hospices furnish dialysis, blood transfusions, and radiation under the hospice benefit due to data limitations, we can assess hospice agencies' provision of drugs, including chemotherapy, using claims data from 2017, the last full year hospices were required to report drug data on Medicare claims. Here we found that hospices furnished drugs such as analgesics, central nervous system agents, and gastrointestinal agents to a majority of their enrollees with cancer in 2017, but few of these enrollees received antineoplastics (chemotherapy) from their hospice providers.

Last, we reviewed the literature on various models of concurrent care for patients on dialysis and patients

with cancer—both within and outside of the Medicare program—to understand more about the scope of the various models and researchers' evaluations of their effects (where available).¹⁸

Hospice use remains lower for Medicare decedents with ESRD than for all Medicare decedents

According to the Commission's analysis, hospice use among Medicare decedents with ESRD lags behind hospice enrollment for all Medicare decedents. In 2024, 31 percent of decedents with ESRD received hospice services compared with 53 percent of all Medicare decedents (Table 5-3). Hospice use among decedents with ESRD has grown since 2010, but the pace of that growth has been slower than the pace for all Medicare decedents. Between 2010 and 2024, hospice use grew by 4 percentage points among decedents with ESRD but 9 percentage points among all Medicare decedents (Table 5-3).

Similar to all Medicare decedents, hospice use among decedents with ESRD:

- varies geographically (with rates ranging from 12 percent to 53 percent across the 50 states and the District of Columbia in 2024);
- is generally higher in states where rates of hospice use for the overall decedent population are higher; and
- is higher for beneficiaries who are older, White, and not dually eligible for Medicare and Medicaid than for other beneficiaries.

Hospice lifetime length of stay among decedents with ESRD is lower compared with decedents overall (Table 5-3). In 2024, the average lifetime length of stay was 24 days for decedents with ESRD compared with 100 days for Medicare decedents overall, and the median hospice length of stay was 6 days for decedents with ESRD compared with 19 days for Medicare decedents overall.

In 2024, unlike the overall Medicare decedent population, rates of hospice use among decedents with ESRD varied little by rural and urban status; among all Medicare decedents, hospice use is lower for those in rural areas than in urban areas (Medicare Payment Advisory Commission 2026b). Decedent hospice users with ESRD were more likely to have their hospice stay preceded by a hospitalization than decedent hospice users with other terminal conditions (64 percent vs. 49 percent of hospice users, respectively, based on prepandemic data). Our finding that hospice use is lower for Medicare decedents with ESRD compared with all decedents is consistent with other researchers' findings.¹⁹

Hospice use rates vary by ESRD decedent characteristics

In 2019, there were a total of 2.37 million FFS Medicare decedents. Approximately 1.25 million of these decedents were continuously enrolled in Medicare Part A and Part B during the last 24 months of life, of whom 4 percent (53,391) were FFS Medicare decedents with ESRD who were on dialysis. Roughly a third (or 16,665) of decedents with ESRD elected hospice. Compared with FFS Medicare decedents with ESRD who did not elect hospice, a greater share of those who used

hospice were older (36 percent were over age 80 vs. 21 percent), White (65 percent vs. 49 percent), newer to dialysis (41 percent vs. 31 percent initiated dialysis between 2017 and 2019), and had Alzheimer's disease (54 percent vs. 39 percent) (Figure 5-1, p. 214). Relative to decedents with ESRD who did not elect hospice, a smaller share of decedents with ESRD who elected hospice had full (31 percent vs. 36 percent) or partial (6 percent vs. 9 percent) dual eligibility. Decedents with ESRD who elected hospice were on dialysis for approximately 4.3 years before death, compared with 5.1 years for those who did not elect hospice. About three-fifths of decedents with ESRD who did not use hospice died in the hospital (data not shown). In contrast, the last location of care as reported by the hospice for decedents with ESRD who used hospice was the hospital for 15 percent of decedents and an inpatient hospice facility for 20 percent of decedents. Other researchers have reported similar findings with respect to site of death (Wachterman et al. 2018).

Factors that may influence enrollment in hospice for beneficiaries with ESRD

For beneficiaries with ESRD, hospice offers a different model of care from maintenance dialysis. As with other patients with chronic diseases, hospice care offers beneficiaries with ESRD who wish to enroll:

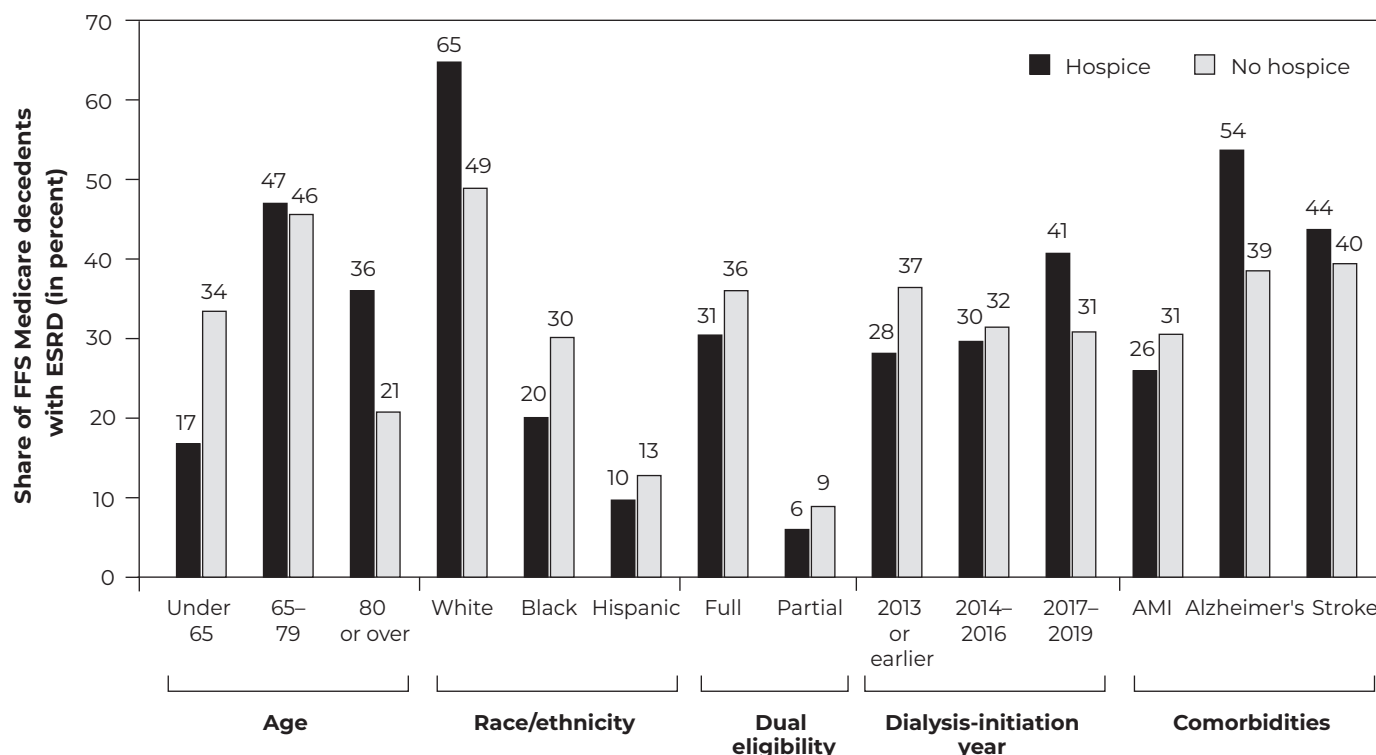
- physical, emotional, and psychological pain and symptom management;
- less aggressive care at the end of life;
- greater choice over site of care at the end of life; and
- caregiver support.

As with hospice patients in general, patients with ESRD may wish to access the palliative services that hospice offers to help minimize physical and emotional symptoms during their end-of-life stage, depending on their personal and family preferences.²⁰

The literature suggests that several factors may influence decisions about hospice enrollment for beneficiaries with ESRD. Although most patients on maintenance dialysis are treated in a dialysis facility and thus have access to providers trained in nephrology thrice weekly, some researchers have

FIGURE 5-1

A greater share of FFS Medicare decedents with ESRD who used hospice were older, White, not dually eligible, newer to dialysis, or had Alzheimer's disease, 2019



Note: FFS (fee-for-service), ESRD (end-stage renal disease), AMI (acute myocardial infarction). Comorbidity indicators are based on the Medicare Beneficiary Summary File.

Source: Acumen analysis of Part A and Part B claims, Medicare enrollment data, and data from the ESRD Quality Reporting System for MedPAC.

noted limitations in some nephrology providers' end-of-life training, including for palliative care (Culp et al. 2016). Specifically, some research shows that low hospice enrollment may be due in part to a lack of training or experience among nephrologists with advance care planning and the hospice model of care (Adenwalla et al. 2024, O'Hare et al. 2018, Wachterman et al. 2024). A survey of patients on dialysis conducted by the U.S. Renal Data System (USRDS) indicates that some patients may not be having discussions with their health care providers and family members about their preferences for care, including end-of-life care (United States Renal Data System 2020).²¹ In addition, a number of researchers have pointed to a lack of access to dialysis in hospice and patients' reluctance to withdraw from dialysis upon hospice election as factors

contributing to lower hospice use among decedents with ESRD (Ernecoff and Anhang Price 2023, Forlini and Goldberg 2014, O'Hare et al. 2018, Schell and Johnson 2021, Wachterman et al. 2018).

Another factor that may influence referrals to and use of hospice among beneficiaries with ESRD is clinician determinations about a beneficiary's prognosis, eligibility for hospice, and whether the beneficiary could potentially benefit from hospice care. Below, we discuss how providers—clinicians and ESRD facilities—become aware that patients with ESRD on dialysis are unstable and may be approaching their end of life.

The patients' terminal illness, comorbidities, and disease progression, including functional decline and

frequency of hospitalization, play a role in clinicians' consideration of prognosis and potential discussions of palliative care and hospice with their patients. Clinician organizations such as the Renal Physicians Association and the American Association of Nephrology have developed clinical practice guidelines about the appropriate initiation and withdrawal of dialysis and the use of shared decision-making with their patients. Guidelines include providing information to patients with advanced kidney injury, Stage 5 chronic kidney disease (CKD), or ESRD about their diagnosis, prognosis, and all treatment options (including conservative treatment), and instituting advance care planning (Moss 2001, Renal Physicians Association 2010). The Renal Physicians Association also has developed an advance care–planning tool that they recommend clinicians use within the first 90 days of providing care and review annually or more frequently, particularly if a change in patient status occurs (Renal Physicians Association 2010).

In addition to clinical guidelines, researchers and clinicians have developed a number of prognostic tools over the past two decades to estimate 6-, 12-, and 18-month survival for patients with ESRD on dialysis.²² These tools aim to assist clinicians in better meeting patients' needs and preferences and to help clinicians interact more productively with patients and their families about a patient's prognosis. For example:

- Moss et al. (2008) reported that clinicians' response to "Would I be surprised if this patient died in the next year?" (known as the "surprise question") was effective in identifying a subgroup of patients on dialysis who were significantly sicker than the majority of patients on dialysis (Moss et al. 2008).²³
- Couchoud et al. (2009) developed a prognostic score for predicting early death (six months) in elderly patients with ESRD based on the following nine factors: body mass index, diabetes, congestive heart failure Stage 3 to Stage 4, peripheral vascular disease Stage 3 to Stage 4, dysrhythmia, active malignancy, severe behavioral disorder, total dependency for transfers, and unplanned dialysis (Couchoud et al. 2009).
- Cohen et al. (2010) developed a prognostic model that used clinical information from patients' medical records and nephrologists' responses to

the surprise question (Cohen et al. 2010). In a Cox multivariate analysis of the derivation cohort, the researchers reported that the following variables were independently associated with patient mortality: older age, dementia, peripheral vascular disease, decreased albumin, and a "no" response to the surprise question.²⁴

- An online model by Fadem and Fadem that is based on Cohen et al. (2010) requires users to enter information concerning the patient's age, serum albumin level, and presence or absence of dementia and peripheral vascular disease and to respond to the surprise question (Fadem and Fadem 2024).

However, according to some researchers and clinicians, even with the ability of these tools to predict mortality in the dialysis population, estimating life expectancy in individual patients continues to be challenging (O'Hare et al. 2019).

In addition to these prognostic tools, Medicare's conditions of coverage for ESRD facilities require that facilities have an interdisciplinary team conduct a patient plan of care at least annually and more frequently—at least monthly—for unstable patients exhibiting clinical changes such as (1) extended or frequent hospitalizations, (2) marked deterioration in health status, (3) significant change in psychosocial needs, or (4) concurrent poor nutritional status, unmanaged anemia, and inadequate dialysis.

Use of hospital care during the last week of life was lower for decedents with ESRD who used hospice versus those who did not

We examined whether and how Medicare decedents with ESRD who ultimately did versus did not elect hospice in 2019 differed in their use of certain types of health care before death in the last year of life.²⁵ According to our analysis, similar shares of Medicare decedents with ESRD who did versus did not elect hospice in 2019 had short-stay hospitalizations in the last 360 days, 90 days, and 30 days of life (Table 5-4, p. 216). However, in the last seven days of life, a substantially smaller share of decedents with ESRD who elected hospice had a short-stay hospitalization (45 percent) compared with those who did not elect hospice (63 percent). Skilled nursing facility and home health use rates were higher among decedents with ESRD who elected hospice than those who did not in

**TABLE
5-4**

**Use of certain types of health care during the last year of life
among decedents with ESRD, based on hospice enrollment, 2019**

FFS Medicare decedents with ESRD who:		
	Elected hospice (n = 16,665)	Did not elect hospice (n = 36,726)
Percentage admitted to short-stay hospital		
Last 360 days of life	95%	92%
Last 90 days of life	85	83
Last 30 days of life	71	74
Last 7 days of life	45	63
Percentage admitted to SNF		
Last 360 days of life	52	41
Last 90 days of life	38	29
Last 30 days of life	27	22
Last 7 days of life	9	14
Percentage using home health		
Last 360 days of life	60	50
Last 90 days of life	40	33
Last 30 days of life	27	23
Last 7 days of life	11	15
Percentage using ICU		
Last 360 days of life	69	74
Last 90 days of life	54	62
Last 30 days of life	37	49
Last 7 days of life	8	24

Note: ESRD (end-stage renal disease), FFS (fee-for-service), SNF (skilled nursing facility), ICU (intensive care unit). For those who elected hospice, the use measures reflect the beneficiary's last year of life in which use may have occurred either before hospice enrollment or during hospice enrollment.

Source: Acumen analysis of Part A and Part B claims, Medicare enrollment data, and data from the ESRD Quality Reporting System for MedPAC.

the last 360, 90, and 30 days of life, but the opposite was true in the last 7 days of life. Finally, intensive care unit use was lower throughout the last 360 days of life, on average, among decedents with ESRD who elected hospice versus those who did not. In addition to hospice enrollment, several factors may affect differences in the use of certain types of health care before death, such as demographic characteristics (hospice users are on average older than those who do not elect hospice) and beneficiaries' preferences for care.

Dialysis paid for outside of the hospice benefit while beneficiaries were enrolled in hospice

Among the 16,665 decedents with ESRD who elected hospice in 2019, approximately 12 percent (or 2,076 total) received dialysis that was paid for outside of the hospice benefit during their hospice stay.²⁶ These 2,076 decedents had, on average, 1.3 hospice stays across a median of 33 hospice days and received a median of nine dialysis treatments paid for outside of the hospice benefit, compared with an average of 1.0 hospice stay

**TABLE
5-5****A greater share of decedents with ESRD received dialysis paid for outside of the hospice benefit in freestanding, for-profit hospice agencies, 2019**

	Share of hospice providers' Medicare patients with ESRD	Share of decedents with ESRD who received dialysis paid for outside of the hospice benefit while enrolled in hospice
All hospices	1.8%	12%
Hospice provider size, by quartile		
Smallest quartile	1.7	13
Second quartile	1.8	15
Third quartile	1.8	13
Largest quartile	1.8	12
Provider ownership		
Nonprofit	1.8	9
For profit	1.7	17
Government	1.7	3
Type of hospice		
Freestanding	1.8	14
HHA	1.7	8
Hospital	1.9	7

Note: ESRD (end-stage renal disease), HHA (home health agency). "Share of hospice providers' Medicare patients with ESRD" includes beneficiaries with fee-for-service (FFS) Medicare or Medicare Advantage. "Share of decedents with ESRD who received dialysis paid for outside of the hospice benefit while enrolled in hospice includes only FFS beneficiaries.

Source: MedPAC analysis of Acumen data files on use of hospice by Medicare beneficiaries with ESRD.

across a median of 5 hospice days among the 14,589 decedents who did not receive dialysis paid for outside of the hospice benefit. When analyzing the number of dialysis treatments and days in hospice, we observe a right-skewed distribution, with the 75th percentile equal to 85 hospice days and 29 dialysis treatments.

There are differences in the terminal conditions of those who did versus did not receive dialysis paid for outside of the hospice benefit during their hospice stay in 2019. The top three terminal conditions of the 2,076 decedents with ESRD under hospice care who received dialysis paid for outside of the hospice benefit were cancer (29 percent), heart conditions (24 percent), and renal disease (11 percent), while the top three terminal conditions of 14,589 decedents under hospice care who did not receive dialysis paid for outside of the hospice benefit were renal disease (72 percent), cancer (8 percent), and heart conditions (6 percent).²⁷

Characteristics of hospice agencies who care for decedents with ESRD

Beneficiaries with ESRD accounted for about 1.8 percent of all hospice patients in 2019, and the share of patients with ESRD varied little by hospice characteristic (e.g., hospice size, type of ownership, and freestanding vs. provider-based hospice) (Table 5-5).

However, the prevalence of dialysis paid for outside of the hospice benefit for beneficiaries with ESRD did vary by hospice characteristic. The share of hospice decedents with ESRD who received dialysis paid for outside of the hospice benefit while enrolled in hospice in 2019 was higher in for-profit hospices (17 percent) than nonprofit hospices (9 percent) and government hospices (3 percent) (Table 5-5). The prevalence of dialysis paid for outside of the hospice benefit was also more common among freestanding hospices

**TABLE
5-6**

Hospice decedents with blood cancer had shorter stays in hospice than those with other cancers, 2019

	FFS decedents with:		
	Blood cancer	Other cancers	Without cancer
Share of decedents who used hospice	57%	66%	45%
Among hospice decedents, lifetime length of stay (in days)			
Average	41	53	114
10th percentile	2	2	2
50th percentile	9	16	20
90th percentile	101	132	346

Note: FFS (fee-for-service). We define “decedents with cancer” as those with a primary diagnosis of cancer on a claim for inpatient or outpatient hospital services, physician services, or hospice services in the last year of life. We define “decedents with blood cancer” as those with leukemia, multiple myeloma, or myelodysplastic syndrome. Analysis includes only FFS beneficiaries who died in 2019 and were not in Medicare Advantage in 2018 and 2019.

Source: MedPAC analysis of Medicare hospital inpatient, outpatient, physician, and hospice claims and Common Medicare Environment data.

(14 percent) than provider-based hospices. The share of hospice decedents with ESRD receiving dialysis paid for outside of the hospice benefit varied little by provider size. As noted previously, these data about the provision of dialysis paid for outside of the hospice benefit cannot tell us whether hospice enrollees are receiving dialysis under the hospice benefit.

Hospice use is higher, but also shorter, for Medicare decedents with cancer than for all other Medicare decedents

We analyzed data on the use of hospice by beneficiaries with cancer, focusing on beneficiaries with blood cancer (who may rely on blood transfusions) compared with beneficiaries with other cancers and those without cancer.²⁸ We found that decedents with cancer are more likely to use hospice but have shorter stays than decedents with other terminal illnesses. Among decedents with cancer, those with blood cancer tend to have lower rates of hospice use and shorter hospice stays than decedents with other cancers. In 2019, a greater share of decedents with cancer—both blood cancer (57 percent) and other cancers (66 percent)—used hospice than decedents without cancer (45 percent) (Table 5-6).

Hospice lifetime length of stay for decedents with cancer was shorter than for decedents with other terminal diagnoses (median 20 days). Among decedents with cancer, those with blood cancer had shorter stays (median of 9 days) than those with other types of cancer (median of 16 days). The average length of stay was 41 days for blood-cancer decedents, 53 days for other cancer decedents, and 114 days for noncancer decedents, reflecting differences in length of stay for the longest stays (e.g., at the 90th percentile) (Table 5-6).

Some researchers’ surveys of hospices and oncologists indicate that several factors may contribute to lower hospice use among beneficiaries with blood cancer, including access to transfusions. Knight and colleagues (2024) interviewed hospice providers about their perceptions of factors that contribute to lower hospice enrollment of patients with blood cancer. The most frequently cited factors were oncologists’ late referrals to hospice (89 percent) or low rates of referral to hospice (79 percent), misconceptions by patients and oncologists about hospice (87 percent and 74 percent, respectively), lack of access

**TABLE
5-7**

Hospice decedents with cancer who were transfusion dependent had shorter stays in hospice than those with cancer who were not transfusion dependent, 2019

	FFS decedents with:			
	Blood cancer		Other cancers	
	Transfusion dependent	Not transfusion dependent	Transfusion dependent	Not transfusion dependent
Share of decedents who used hospice	60%	57%	60%	66%
Among hospice decedents, lifetime length of stay (in days)				
Average	17	44	22	53
10th percentile	2	2	2	2
50th percentile	7	10	9	16
90th percentile	37	112	55	133
Number of decedents	5,309	40,252	4,185	349,069
Share of decedents with cancer type, by transfusion status	12%	88%	1%	99%

Note: FFS (fee-for-service). We define “decedents with cancer” as those with a primary diagnosis of cancer on a claim for inpatient or outpatient hospital services, physician services, or hospice services in the last year of life. We define “decedents with blood cancer” as those with leukemia, multiple myeloma, or myelodysplastic syndrome. We define “transfusion dependent” as those receiving at least two red blood cell transfusions in an outpatient or inpatient setting at least 5 days apart in the last 30 days of life or in the 30 days before hospice admission (similar to definition in LeBlanc et al. (2018)). Analysis includes only FFS beneficiaries who died in 2019 and were not in Medicare Advantage in 2018 and 2019.

Source: MedPAC analysis of Medicare hospital inpatient, outpatient, physician, and hospice claims and Common Medicare Environment data.

to transfusions (74 percent), and concern about bleeding risk or managing bleeding in hospice (over 50 percent) (Knight et al. 2024). Odejide and colleagues (2016) conducted a survey of 349 oncologists in 2015 about their perceptions of hospice for blood-cancer patients. Overall, 62 percent of oncologists “agreed” or “strongly agreed” that they would refer more patients to hospice if patients could have red blood cell and/or platelet transfusions in hospice. Specifically, 61 percent reported that they would refer more patients to hospice if red blood cell transfusions were offered, and 46 percent would refer more patients if platelet transfusions were offered. Other factors also affected hospice referrals: 46 percent “agreed” or “strongly agreed” that home hospice is not an adequate level of

care for some of their patients’ needs, and 27 percent “agreed” or “strongly agreed” that they would refer more patients if they could continue to have regular clinic visits after hospice begins (Odejide et al. 2016).

To explore whether transfusion dependence affects hospice utilization patterns among decedents with cancer, we constructed a measure of dependence on red blood cell transfusion.²⁹ Following an approach similar to LeBlanc and colleagues, we identified an individual as transfusion dependent if they received at least two transfusions of red blood cells in an outpatient or inpatient setting at least 5 days apart in the last 30 days of life or in the 30 days before hospice enrollment (LeBlanc et al. 2018). Among FFS decedents

**TABLE
5-8****Hospice use varied more by age and race among decedents with blood cancer and those without cancer than among decedents with other cancers, 2019****Share of FFS decedents who used hospice, 2019**

	Decedents with blood cancer	Decedents with other cancers	Decedents without cancer
All	57%	66%	45%
Age			
<65	40	60	19
65-79	52	64	32
80+	64	71	57
Sex			
Male	55	63	38
Female	61	70	51
Race/ethnicity			
White	59	68	47
Black	47	58	32
Hispanic	48	62	30
Asian	43	59	30
Dual eligibility			
Full or partial	51	63	44
None	58	67	45

Note: FFS (fee-for-service). We define “decedents with blood cancer” as those with a primary diagnosis of leukemia, multiple myeloma, or myelodysplastic syndrome in the last year of life. We define “decedents with cancer” as those with a primary diagnosis of cancer on a claim for inpatient or outpatient hospital services, physician services, or hospice services in the last year of life. Analysis includes only FFS beneficiaries who died in 2019 and were not in Medicare Advantage in 2018 and 2019.

Source: MedPAC analysis of Medicare hospice claims and Common Medicare Environment data.

with blood cancer in 2019, about 12 percent met the criteria for transfusion dependence. Decedents with blood cancer who were transfusion dependent were slightly more likely to enroll in hospice than those who were not (60 percent vs. 57 percent), but they had shorter hospice stays (median of 7 days vs. 10 days; average of 17 days vs. 44 days) (Table 5-7, p. 219).

These results are directionally similar to LeBlanc and colleagues’ (2018) analysis of data for individuals with leukemia from 2006 to 2011, which found a greater likelihood of hospice use but shorter hospice stays among those who were transfusion dependent than among those who were not. We also examined transfusion dependence among decedents with types

of cancer other than blood cancer. Only about 1 percent of decedents with other cancers were transfusion dependent, and those who were transfusion dependent were less likely to use hospice or used it for shorter periods than those with other cancers who were not transfusion dependent.

Rates of hospice use vary by decedent characteristics (Table 5-8). Regardless of diagnosis (blood cancer, other cancers, or no cancer), older, female, and White decedents were more likely to elect hospice in 2019 than younger, male, and non-White decedents. Differences by age and race/ethnicity in hospice enrollment were more pronounced for decedents without cancer and decedents with blood cancer than

for decedents with other cancers. Hospice use was lower among dually eligible decedents with cancer than decedents with cancer who were not dually eligible, but use did not vary by dual eligibility for decedents without cancer.

Hospice enrollees with cancer received many therapeutic classes of drugs, but receipt of antineoplastic drugs was rare

Using hospice claims data from 2017, the last year in which hospices were required to report information on the drugs they furnished during hospice stays, we found that hospice providers rarely furnished antineoplastic (chemotherapy) drugs. Hospice beneficiaries with cancer did, however, commonly receive many other types of drugs.

First, to assess the completeness of data reporting, we examined what share of hospices reported at least one drug for one hospice patient in 2017. We found that approximately 90 percent of hospices (4,013 of 4,488) reported that drugs were used during hospice stays and paid for by hospice. Among the 4,013 hospices that reported at least one drug claim line in 2017, drugs were furnished, on average, for 86.6 percent of beneficiary stays (standard deviation of 18.2 percent). The rest of this analysis is restricted to beneficiary stays in these hospices.

Five therapeutic classes of drugs (central nervous system agents; analgesic, anti-inflammatory, or antipyretic agents; cardiovascular therapy agents; gastrointestinal therapy agents; and respiratory therapy agents) accounted for about 80 percent of those drug claim lines reported by hospices. Drugs in the antineoplastic therapeutic class accounted for less than 1 percent of drug claim lines in these hospices. Furthermore, antineoplastic drugs were reported by only about a third (1,411 of 4,013) of hospices that reported drug claim lines.

Next, we examined drugs reported specifically for hospice enrollees with cancer. Approximately a quarter (383,886 of 1,455,789) of hospice enrollees in 2017 had cancer as their hospice terminal diagnosis. Nearly one-fifth of hospice stays by these enrollees (71,951) had no drugs reported on their hospice claims during their stay. We are unable to discern whether these hospices actually provided no drugs to these enrollees or their hospices did not report certain types of drugs that

were provided or drugs provided in certain settings of care (e.g., drugs for enrollees in GIP or drugs included in comfort packs of drugs). Approximately 30 percent of enrollees without any drugs reported were enrolled in hospice under the GIP level of care, relative to 11 percent of those with some drugs reported.

Less than 1 percent (1,628) of beneficiaries with cancer received any antineoplastic drugs in hospice. Four drugs accounted for about three-quarters of all drug claim lines for antineoplastic drugs: megestrol acetate (primarily indicated for extreme weight loss and muscle wasting due to end-stage cancer); anastrozole and letrozole (indicated for treatment of breast cancer); and bicalutamide (indicated for treatment of prostate cancer). We do not have information on whether these drugs were used for on- versus off-label indications (e.g., loss of appetite). Use of drugs in therapeutic classes other than antineoplastics was far more common among beneficiaries with cancer. The top three drugs associated with these other therapeutic classes include:

- analgesics, anti-inflammatories, or antipyretic therapeutic class—morphine sulfate, fentanyl, hydrocodone-acetaminophen (drugs primarily indicated for moderate to severe pain relief and management);
- central nervous system agents—lorazepam, haloperidol lactate, gabapentin (drugs primarily indicated for treatment of anxiety, agitation, and neuropathic pain);
- gastrointestinal therapy agents—hyoscyamine sulfate, prochlorperazine maleate, omeprazole (drugs primarily indicated for peptic ulcers, gastroesophageal reflux, drooling, nausea, and vomiting);
- respiratory therapy agents—ipratropium-albuterol, albuterol sulfate, promethazine hydrochloride (drugs primarily indicated for chronic obstructive pulmonary disease, asthma, or allergy symptom management);
- endocrine agents—dexamethasone, prednisone, levothyroxine sodium (drugs primarily indicated for treating hypothyroidism, relieving inflammations, and decreasing adverse effects of radiation therapy); and

**TABLE
5-9****Antineoplastic drugs were rarely prescribed for Medicare hospice enrollees in 2017**

Share of Medicare hospice stays with ≥1 drug reported during stay among enrollees with:

	Cancer (<i>n</i> = 317,251)	Diagnosis other than cancer (<i>n</i> = 861,797)
Type of hospice		
Freestanding	74.2%	80.1%
HHA	12.7	10.2
Hospital	12.7	9.3
Ownership type		
Nonprofit	51.8	41.0
For profit	35.9	47.4
Government	1.1	0.9
Hospice-stay level of care		
Routine home care	88.3	86.8
General inpatient care	11.0	10.2
Hospice LOS		
Mean (SD)	13.2 (9.6)	15.3 (10.7)
Median (IQR)	11 (5–20)	13 (5–26)
Share of stays, by LOS in hospice		
≤3 days	16.6	15.9
4–7 days	21.0	17.7
8–14 days	24.1	19.7
≥15 days	38.3	46.6
Share of stays with drugs provided, by therapeutic class		
Analgesic, anti-inflammatory, or antipyretic	89.4	80.5
Central nervous system agents	86.8	84.8
Gastrointestinal agents	69.1	59.2
Respiratory agents	25.6	26.2
Endocrine agents	24.5	12.2
Cardiovascular agents	20.5	32.0
Dermatological agents	8.2	11.8
Hematological agents indicated for blood thinning	3.9	5.5
Antineoplastic agents	0.5	0.2
Other	52.8	54.8

Note: HHA (home health agency), LOS (length of stay), SD (standard deviation), IQR (interquartile range). The unit of analysis is a unique beneficiary stay in a hospice. The study population includes any fee-for-service (FFS) Medicare or Medicare Advantage beneficiary with a hospice stay in 2017, regardless of whether they had a hospice stay extending past December 31, 2017. Any drug claims billed under Part D were not included in the analysis. "Other" therapeutic class includes products from therapeutic classes such as, but not limited to, chemical-pharmaceutical adjuvants, anti-infective agents, electrolyte balance-nutritional products, ophthalmic agents, genitourinary therapy, locomotor system agents, and cognitive disorder therapies. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System. Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of hospice claims, 2017.

- cardiovascular therapy agents—furosemide, spironolactone, metoprolol tartrate (drugs primarily indicated for treatment of fluid retention, high blood pressure, and heart failure).

Last, we compared the drugs that hospices furnished to enrollees with cancer versus other diagnoses. While antineoplastic drug use was rare for all enrollees, these drugs were provided both for enrollees with cancer and noncancer diagnoses, which may indicate that some of these antineoplastic drugs were used for off-label indications (e.g., management of nausea and vomiting) (Table 5-9).

Hospice enrollees with cancer rarely received blood transfusions or radiation treatments paid for outside of the hospice benefit

We analyzed data on the use of certain cancer-related services paid for outside of the hospice benefit while beneficiaries are in hospice. We focused on beneficiaries with blood cancer who may have received blood transfusions or beneficiaries with any type of cancer who may have received radiation paid for outside of the hospice benefit.

It is rare for hospice beneficiaries with cancer to receive blood transfusions or radiation paid for outside of the hospice benefit as “unrelated” to the terminal condition. In 2019:

- less than 1 percent of hospice decedents with blood cancer received a blood transfusion during hospice that was paid separately outside of the hospice benefit, and
- less than 1 percent of hospice decedents with any cancer type received radiation during hospice paid separately outside of the hospice benefit.³⁰

It is unsurprising that we observe few blood transfusions and radiation services paid for outside of the hospice benefit for hospice decedents. These services are typically directed at symptoms of cancer and would likely be considered “related” to the terminal condition and thus the responsibility of the hospice if furnished to a hospice patient. Because of the data limitations discussed above, we do not know how often hospice patients received these services covered under the hospice benefit.

Among the small share of hospice patients with cancer who received blood transfusions or radiation treatments that were paid for outside of the hospice benefit, ambulance use was uncommon. A very small share of these hospice patients (less than 1 percent of those receiving radiation paid for outside of the hospice benefit and 3 percent of those receiving blood transfusions paid for outside of the hospice benefit) had an ambulance ride paid for outside of the hospice benefit on the same day.

Experiences with models of concurrent care

In general, “concurrent care” refers to models of care under which patients continue to receive conventional treatments while enrolled in hospice (or while receiving nonhospice palliative care). The structure of concurrent care models varies, ranging from models focused on specific concurrent services (e.g., dialysis for a limited period or specified number of treatments) to models that cover a broad range of conventional services while individuals are enrolled in hospice, like the VHA’s. Researchers have studied a few models of concurrent care, including for patients with ESRD and cancer, both within and outside of the Medicare program. Below we summarize the literature describing the scope of the various models or approaches and researchers’ evaluations of their effects (where available).

Models of concurrent dialysis care

Since 2009, the VHA, unlike Medicare, has allowed patients to continue disease-directed therapies even after enrolling in hospice as part of its Comprehensive End-of-Life Care Initiative (Ernecoff and Anhang Price 2023, Wachterman et al. 2022).³¹ Wachterman and colleagues found that among veterans with ESRD, the share of patients receiving concurrent dialysis and hospice services was higher among those with VHA-financed, compared with Medicare-financed, hospice stays (42 percent vs. 25 percent).³² Furthermore, the majority of concurrent dialysis treatments were financed by the VHA, regardless of the payer for hospice (VHA vs. Medicare) and of the primary hospice diagnosis (ESRD vs. others). The median length of stay in hospice was longer for patients who received concurrent dialysis than those who did not (43 days vs. 4 days) (Wachterman et al. 2022).

Two dialysis organizations, in Pittsburgh and Seattle, have partnered with hospices to implement models of concurrent hospice and dialysis use. These models furnish dialysis to their patients with ESRD on dialysis after they enroll in hospice. Under the models, dialysis is covered under the hospice benefit.

In Pittsburgh, Dialysis Clinic Inc. (DCI), a nonprofit dialysis organization, and the University of Pittsburgh Medical Center (UPMC) Family Hospice partnered to create the Concurrent Hospice and Dialysis Program. The program began in January 2018 to improve access to hospice and quality end-of-life care for patients with ESRD whose goals of care align with the palliative services that hospice offers but are not yet ready to stop dialysis. Patients may be referred to the program from an inpatient palliative care clinician, an outpatient dialysis clinician, or other outpatient clinician (such as primary care or subspecialty physician). The program enrolls patients with an estimated prognosis of less than two months.³³ Participating patients must also agree to continue dialysis for only a limited time. UPMC Family Hospice pays a contracted fixed rate to DCI to furnish palliative dialysis treatments to patients, up to 10 hemodialysis treatments or 30 days of PD treatments. The program stops routine blood draws and certain ESRD medications that do not address comfort. As part of this program, the hospice also covers the cost of transportation to and from the dialysis facility. Patients can receive hospice services at home, in a nursing home, or, for those with symptoms requiring more intensive management, in an inpatient hospice unit (Ernecoff et al. 2022).

According to Ernecoff and colleagues (2022), based on electronic health records data from 2018 through 2021, just under half of program participants (20 out of 43 participants) received at least one dialysis treatment, with 75 percent of these patients furnished with hemodialysis and 25 percent furnished with PD. The average number of treatments furnished was 3.5 for hemodialysis and 19.2 for PD. The authors noted that the finding that roughly half of program participants ultimately chose not to receive any dialysis treatments while in hospice may be reflective of variation in patient preferences for end-of-life care, including dialysis. The median hospice length of stay was longer for participants who received dialysis than participants who did not (13 vs. 6 days).³⁴ The share of program enrollees who died at home was roughly double (65

percent) the combined share of those who died in inpatient hospice (23 percent) or a nursing facility (12 percent); none died in the hospital (Ernecoff et al. 2022).

In Seattle, Northwest Kidney Centers, a nonprofit dialysis organization, began its kidney palliative care program in 2017, providing services focused on “minimizing pain, symptoms and stress” to roughly 450 patients over time (Northwest Kidney Centers 2026). In 2019, Northwest Kidney Centers partnered with Providence Hospice to create a care model that furnishes dialysis to patients with ESRD enrolled in hospice who have a prognosis of six months or less such that these patients would not have to forgo the treatment upon hospice enrollment. Cambia Health Foundation provided a two-year \$180,000 grant to the dialysis and hospice partners to launch the program (Aleccia 2021). Dialysis is furnished up to three times a week for as long as the patients are enrolled and wish to continue treatment. Of the 278 patients in the kidney palliative care program between 2017 and 2023, roughly half (47 percent) utilized hospice. Approximately two-fifths of these patients who elected hospice utilized concurrent care. The median number of palliative hemodialysis treatments furnished was four. The median length of stay was longer for patients who received concurrent care than those who did not (22.5 days vs. 8 days) (University of Washington Division of Nephrology 2025).

Within Medicare, CMMI has included in its Kidney Care Choices (KCC) Model, whose goal is to improve care for patients with advanced (late-stage) kidney disease and ESRD, a waiver for the restrictions against concurrent care (e.g., dialysis) paid for outside of hospice while a beneficiary is enrolled in hospice (Negrusa et al. 2024). About 21 percent of model participants have relationships with hospice agencies, but the uptake of this waiver has not been reported in KCC Model evaluations to date.

Models of concurrent cancer care

Like veterans with ESRD, veterans with cancer can receive hospice care concurrently with cancer services, including radiation and chemotherapy (Haverhals et al. 2019). According to researchers who examined use of concurrent cancer care (radiation and chemotherapy) among decedents with cancer in the VHA who elected hospice between 2006 through 2012:

- the receipt of hospice care in the last six months of life (provided by either the VHA or Medicare) increased from 55 percent to 68 percent;
- the share of decedents receiving concurrent care chemotherapy or radiation therapy increased from 16 percent to 25 percent; and
- the median number of days between decedents' first occurrence of concurrent care and death ranged from 21 to 28 days (Mor et al. 2016).

Haverhals and colleagues (2019) interviewed clinicians and staff at VHA medical centers and community hospices about the VHA's concurrent cancer care model, and they identified several themes. First, clinician and staff interviewees described concurrent cancer care as a means of honoring care that patients valued, preserving relationships with current clinicians, and easing transitions to hospice services. Second, the presence of dedicated liaisons at the VHA provided coordination and education about concurrent cancer care. The findings from the interviews of community hospice providers were mixed. Some community hospice clinicians furnished concurrent cancer care if its intent was palliative, regardless of Medicare or the VHA paying. However, they described needing to consider overall costs when patients chose to continue chemotherapy or radiation (these hospices tended to have larger patient censuses, while other hospices relied on the VHA to offset costs). Some hospice clinicians said that concurrent care was inconsistent with hospice philosophy. Another theme from community hospice providers was the issue of ensuring that they were compliant with Medicare hospice regulations (Haverhals et al. 2019).

Egan and colleagues (2023) reported on results from a very small pilot study (10 patients) that involved providing transfusions of red blood cells and/or platelets to beneficiaries with blood cancer who were enrolled in hospice. The authors reported a hospice median length of stay of 13 days (with a range of 4 to 103 days), with all enrolled patients dying outside of the hospital (at home or in inpatient hospice). No patient received chemotherapy within 14 days of death (Egan et al. 2023).

Other approaches to concurrent care

Within Medicare, CMMI has carried out models with elements of concurrent care. The center launched a

value-based insurance design (VBID) demonstration in January 2021 that tested the inclusion of hospice services in the MA benefit. Plans that participated offered hospice as part of the MA benefit package and could offer enrollees transitional concurrent hospice and conventional care (TCC), palliative care outside the hospice benefit, and hospice supplemental benefits (e.g., waiver of hospice cost sharing for drugs and respite care or additional in-home caregiver support). An evaluation of the first three years of the model reported that, of beneficiaries who elected hospice in VBID plans in 2023, less than 1 percent received TCC and 7 percent received hospice supplemental benefits (Eibner et al. 2025). Participating parent organizations (POs) varied in their approach to offering TCC: Some capped the benefit at a set number of days (e.g., 30 to 60 days), while others did not impose any limits. Most POs offered TCC to beneficiaries with specific diagnoses (e.g., ESRD, cancer, chronic obstructive pulmonary disease, recent ischemic stroke). Services furnished under TCC by POs included dialysis, transfusions, radiation therapy, paracentesis, catheter placement, chemotherapy, and immunotherapy. Based on interviews with VBID-participating POs and hospices, the evaluation cites a few reasons for the low uptake of TCC, including delayed referral to and enrollment in hospice, low awareness of TCC among providers who refer beneficiaries to hospice, beneficiary preference to not stop concurrent treatments after a set number of days, and financial disincentives for hospices to promote TCC to patients because of low payment from POs to hospices (Eibner et al. 2025).

Another example of a CMMI initiative is the ACO (Accountable Care Organization) REACH (Realizing Equity, Access, and Community Health) Program that began in 2023, in which one benefit enhancement that ACOs can offer is concurrent care for beneficiaries who elect hospice. Out of 132 ACOs in 2023, 46 chose to offer this benefit enhancement.

Finally, in 2016, CMMI launched a demonstration program called the Medicare Care Choices Model (MCCM) that permitted certain FFS Medicare beneficiaries who were eligible for hospice (but not enrolled in the Medicare hospice benefit) to enroll in the demonstration and receive palliative and supportive care from a hospice provider while continuing to receive "curative" care from other

providers. Different from the FFS Medicare hospice benefit, under the MCCM demonstration, beneficiaries' regular nonhospice physicians directed their care and the hospice furnished supportive services, with FFS Medicare paying the hospice provider \$400 per month (far less than the hospice payment rate of \$196 per day for the first 60 days of routine home care). The MCCM focused on beneficiaries with certain terminal illnesses including cancer, congestive heart failure, chronic obstructive pulmonary disease, and HIV/AIDS. Eligibility for the MCCM was limited to beneficiaries with a life expectancy of 6 months or less who had a certain utilization and location of care (at least one hospital encounter and at least three office visits in the last 12 months; no election of hospice in the last 30 days; lived in a traditional home continuously for the last 30 days).

An evaluation of the MCCM reported that participants were more likely to enroll in hospice and to do so more days before their death than the comparison group of decedents. The evaluation also reported that MCCM enrollees were more likely to receive better quality end-of-life care (i.e., they were less likely to receive aggressive procedures, surgeries, or diagnostic tests in the last 30 days of life, and they spent more days at home on average than the matched comparison group). The final evaluation also reported, based on the experience of 5,153 MCCM enrollees who enrolled between January 2016 and June 2021 and died before December 2021, that the MCCM was associated with a 13 percent net reduction in Medicare expenditures for these beneficiaries relative to a matched comparison group due to greater hospice use and lower acute care costs at the end of life (Kranker et al. 2023). The report cautioned against broadly extrapolating from these findings because the model involved a very small number of beneficiaries and hospice providers.³⁵

Comparison of hospice payments and estimated costs for certain complex palliative services

Hospice providers we interviewed and interested parties submitting responses to CMS's FY 2024 and FY 2025 hospice proposed rules indicated that the costs of services such as dialysis, radiation, and blood transfusions exceed Medicare's daily payment rate,

making it challenging for hospices to furnish these services. To get a sense of how the cost of these services might compare with Medicare's payment rate to hospice providers, we compared Medicare's daily payment rate for hospice services with our estimate of the average payment FFS Medicare makes to nonhospice providers when they furnish these services to beneficiaries who are not enrolled in hospice, based on 2019 payment rates (Table 5-10). For this comparison, we estimated the average payment per treatment for dialysis, radiation, or blood transfusion in the 30 days before beneficiaries enrolled in hospice. We also calculated how commonly ambulance rides occurred in conjunction with these treatments and estimated the average payment, per day, for ambulance services.

Several caveats should be noted about our estimates of average FFS payment rates for dialysis, radiation, blood transfusions, and ambulance services. These estimates reflect FFS payment rates and do not necessarily reflect the price a hospice provider would incur when it contracts with a dialysis facility, hospital, or clinic for these services. These estimates also reflect the average payment for a radiation or blood transfusion treatment in the 30 days before a beneficiary receives hospice and may not necessarily reflect the type of radiation or blood transfusion service a beneficiary receives for palliative purposes when enrolled in hospice.

FFS payment rates for dialysis, radiation, and blood transfusions generally exceed Medicare's daily payment rate for hospice services (Table 5-10). We estimate that Medicare FFS payment rates per treatment day in 2019 averaged about \$284 for dialysis, \$618 for radiation, and \$710 for blood transfusion.³⁶ In comparison, FFS Medicare's daily payment rate for hospice in 2019 was \$196 (Table 5-10).^{37,38} For beneficiaries who require an ambulance for transit to these treatments, FFS Medicare payments for ambulance transit averaged just over \$400 per day for beneficiaries receiving dialysis and roughly \$500 per day for beneficiaries receiving radiation or blood transfusions. However, it was relatively uncommon for beneficiaries to use Medicare-paid ambulance transit to these services in the 30 days before hospice enrollment: We estimate that about 12 percent of beneficiaries receiving dialysis used ambulance transit, while 5 percent of beneficiaries receiving radiation and 4 percent receiving blood transfusions had an ambulance trip on the same day when receiving these treatments.

**TABLE
5-10****How FFS Medicare hospice payment rates compare with average Medicare payment for certain treatments for nonhospice patients**

Service type	Medicare payment rate, 2019
Hospice	
Routine home care, days 1–60	\$196 per day
Routine home care, days 61+	\$154 per day
Dialysis for beneficiaries with ESRD	
Payment for dialysis	\$284 per treatment
Payment for nonurgent ambulance	\$412 ambulance per user per day
Blood transfusions for beneficiaries with blood cancer	
Payment for transfusion	\$710 per user per day
Payment for nonurgent ambulance	\$487 ambulance per user per day
Radiation treatment for beneficiaries with any cancer type	
Payment for radiation	\$618 per user per day
Payment for nonurgent ambulance	\$526 per user per day

Note: FFS (fee-for-service), ESRD (end-stage renal disease). We estimated the average FFS payment rate per dialysis, blood transfusion, and radiation treatment based on claims for beneficiaries with ESRD or cancer in the 30 days before hospice enrollment. The share of beneficiaries receiving an ambulance service includes those beneficiaries who received one of these services in the 30-day period before hospice enrollment. The average FFS payment for a blood transfusion reflects payments for the transfusion (Current Procedural Terminology code 36430) and red blood cells; it does not include payments for other related services such as laboratory services. For radiation treatments, we included (1) radiation therapy Healthcare Common Procedure Coding System (HCPCS) codes from the American Society of Radiation Oncology, Restructured BETOS Classification System, and the Agency for Healthcare Research and Quality's Clinical Classification Software codes; and (2) HCPCS codes associated with ablation therapy.

Source: MedPAC analysis of Medicare claims and Common Medicare Environment data.

However, because services like dialysis, radiation, and blood transfusions are furnished periodically rather than daily, we also analyzed how Medicare payments to hospices and the costs of these services compare over a hospice stay (rather than comparing payments and costs only for days when treatments are provided) to get a sense of the extent to which Medicare payment policy may pose an access barrier. Table 5-11 (p. 229) presents illustrative examples comparing Medicare's payment to hospices with proxy estimates of the cost of these treatments over the course of a hospice stay for hypothetical scenarios.

Because we lack data on the provision of these treatments during hospice stays, we modeled two illustrative scenarios for each type of treatment.

Each scenario includes assumptions about hospice length of stay and treatment frequency based on what is available from the literature, stakeholder interviews, and/or our analysis of Medicare data. These assumptions were developed with input from MedPAC's staff physician. As a proxy for the cost of treatments, we used the estimated average FFS payment amount per treatment day from Table 5-10. These comparisons are meant to be illustrative only and to give a rough sense of the orders of magnitude. The illustrative scenarios are based on assumptions about treatment frequency and hospice length of stay that may not be representative of actual utilization patterns, and we use average FFS payments as a proxy for treatment costs, which may not reflect the actual costs that hospices would incur when procuring these services.

Dialysis

We modeled two scenarios based on two published studies of dialysis use during hospice stays (Table 5-11) (Ernecoff et al. 2022, Wachterman et al. 2022). Scenario 1 assumes a hospice length of stay of 13 days with an average of 3.5 dialysis treatments per stay (i.e., just under two treatments per week). Scenario 2 assumes a hospice length of stay of 47 days with an average of 15.4 treatments per stay (i.e., just over two treatments per week).³⁹ In the two scenarios, estimated treatment costs for dialysis amounted to roughly 40 percent to 50 percent of hospice payments. For individuals requiring ambulance transportation to dialysis, the estimated cost of dialysis plus ambulance was nearly equal to or slightly greater than Medicare hospice payments for the hospice stay.

Blood transfusions

Based on data from a small pilot program that offered blood transfusions for hospice patients, we modeled two scenarios with transfusions occurring once every two weeks (Scenario 1) and once every week (Scenario 2) (Table 5-11) (Egan et al. 2023). We assumed a hospice length of stay of 35 days, based on our analysis of the 75th percentile of hospice length of stay in Medicare data for beneficiaries with blood cancer. In the two scenarios, estimated treatment costs for blood transfusions ranged from roughly 30 percent to 50 percent of total hospice payments during the stay. For individuals requiring an ambulance for transit to a blood transfusion, the estimated cost of blood transfusions plus ambulance ranged from roughly 50 percent to 90 percent of Medicare hospice payments for the stay.

Radiation

We modeled two scenarios with different numbers of radiation treatments (Table 5-11). Scenario 1 assumes a single radiation treatment, a choice we based on feedback from clinician interviews and literature supporting the efficacy of a single fraction for palliation of pain from bone metastases in patients with poor prognoses. Scenario 2 assumes five radiation treatments, which we chose based on feedback from some clinicians we interviewed indicating that up to five treatments may be needed in some cases. We assumed a 48-day hospice stay, based on the 75th percentile length of stay for Medicare hospice patients

with cancer. We did not model a shorter length of stay because our interviews with clinicians and the literature suggested that radiation is not generally indicated for pain management for individuals whose survival clinicians estimate at less than one month (Yerramilli and Johnstone 2023). Estimated treatment costs for radiation ranged from less than 10 percent (Scenario 1) to over 30 percent of total hospice payments (Scenario 2). For individuals requiring an ambulance for transit to radiation, the estimated cost of radiation plus ambulance amounted to less than 15 percent of total hospice payments in Scenario 1 and over 60 percent in Scenario 2.

While the estimates across the scenarios suggest that the costs of these treatments could constitute a substantial portion of Medicare's hospice payment (which is intended to cover all services the hospice furnishes during the stay), we note that this circumstance is not necessarily problematic in a PPS. A PPS operates under the assumption that some patients will have higher costs and some will have lower costs but that over a provider's patient population, average costs will generally align with payments. However, a mismatch between payments and costs for patients with certain conditions or characteristics can create potential access concerns if it is easy for providers to identify in advance which patients are likely to be costly and to avoid those costs by not admitting these patients or by not furnishing costly services.⁴⁰ Such a scenario may arise for some patients with ESRD or certain cancers, with the hospice payment system potentially creating a disincentive for hospice providers to furnish services such as palliative dialysis, blood transfusions, or radiation.

Potential approaches to address access to certain complex palliative services for hospice beneficiaries

Based on our interviews, literature review, and data analyses, we have identified several approaches that the Congress and the Secretary could consider if they choose to examine and address potential concerns about access to certain high-cost complex palliative services. First, we discuss enhanced data reporting for a limited period, an approach that would permit

**TABLE
5-11****Illustrative scenarios comparing Medicare hospice payments and proxy estimates of costs for dialysis, blood transfusions, and radiation treatments during hypothetical hospice stays**

Type of treatment and scenario	Assumptions	Assumed hospice LOS	Assumed number of treatments	Estimated Medicare payment to hospice	Proxy for cost of treatment (percent of hospice payment)	Proxy for cost of treatment and ambulance (percent of hospice payment)
Dialysis Scenario 1	Median hospice LOS and average of 3.5 dialysis treatments per stay (Ernecoff et al. 2022)	13 days	3.5	\$2,548	\$994 (39%)	\$2,436 (96%)
Dialysis Scenario 2	Median hospice LOS and average of 15.4 dialysis treatments per stay (Wachterman et al. 2022)	47 days	15.4	\$9,212	\$4,374 (47%)	\$10,718 (116%)
Blood-Transfusion Scenario 1	75th percentile hospice LOS for decedents with blood cancer; blood transfusion every 2 weeks (Egan et al. 2023)	35 days	3	\$6,860	\$2,130 (31%)	\$3,591 (52%)
Blood-Transfusion Scenario 2	75th percentile hospice LOS for decedents with blood cancer; blood transfusion every week (Egan et al. 2023)	35 days	5	\$6,860	\$3,550 (52%)	\$5,985 (87%)
Radiation Scenario 1	75th percentile hospice LOS for decedents with cancer; one radiation treatment (Yerramilli and Johnstone 2023)	48 days	1	\$9,408	\$618 (7%)	\$1,144 (12%)
Radiation Scenario 2	75th percentile hospice LOS for decedents with cancer; 5 radiation treatments (Alcorn et al. 2024)	48 days	5	\$9,408	\$3,090 (33%)	\$5,720 (61%)

Note: LOS (length of stay). These comparisons of Medicare hospice payments and proxy estimates of costs for dialysis, blood transfusions, and radiation treatments during hypothetical hospice stays are meant to be illustrative only and give a rough sense of magnitude. We estimated a proxy for the cost of treatment based on the average fee-for-service payment rate per dialysis, blood transfusion, and radiation treatment and per daily ambulance transport using claims for beneficiaries with end-stage renal disease or cancer in the 30 days before hospice enrollment. The average FFS payment for a blood transfusion reflects payments for the transfusion (Current Procedural Terminology code 36430) and red blood cells; it does not include payments for other related services such as laboratory services. For radiation treatments, we included (1) radiation therapy Healthcare Common Procedure Coding System (HCPCS) codes from the American Society of Radiation Oncology, Restructured BETOS Classification System, and the Agency for Healthcare Research and Quality's Clinical Classification Software codes; and (2) HCPCS codes associated with ablation therapy.

Source: MedPAC estimates for hypothetical scenarios are based on assumptions displayed in the table. Assumptions were informed by utilization patterns in published studies where available (including Ernecoff et al. (2022), Wachterman et al. (2022), Egan et al. (2023), Yerramilli and Johnstone (2023), and Alcorn et al. (2024)), clinician interviews, MedPAC analysis of Medicare claims data on 75th percentile length of stay for decedents with any cancer and blood cancer, and input from MedPAC's staff physician.

the Secretary, before considering any changes to the hospice payment system, to assess the types of high-cost complex services that hospices furnish and gauge beneficiary access to care.

Then we discuss the following two budget-neutral approaches that could be considered to improve the accuracy of the current hospice PPS:

- establishing an outlier payment mechanism for certain high-cost complex palliative services, or
- establishing an add-on payment for certain high-cost complex palliative services.

Last, we discuss a “voluntary transitional program” that would offer hospice enrollees the option to receive services such as dialysis or blood transfusions paid for outside of the hospice benefit for some transitional period or up to a specified number of treatments.

Addressing potential concerns about beneficiary access to certain high-cost complex palliative services would be a goal of modifying the hospice PPS (through an outlier or add-on payment) or launching a transitional program outside the PPS. If policymakers elect to address hospice beneficiaries’ access to certain high-cost palliative services, we envision that just one of the approaches—changes to the hospice payment system or a voluntary transitional program—would be sufficient for Medicare.

Overall, in considering approaches to improve the accuracy of Medicare’s payments for hospice services and address potential concerns about access to care, policymakers may wish to consider the following principles as a guide:

- maintain incentives for efficiency present in the hospice bundled-payment approach,
- target any additional payments toward providers that are furnishing high-cost complex palliative services in an efficient manner, and
- structure any changes to minimize vulnerability to fraud and abuse.

Depending on how policymakers implement changes and how the changes affect beneficiary decisions to elect hospice and utilization of hospice and nonhospice services, there could be implications for overall

Medicare spending, although it is not clear whether spending would increase or decrease.⁴¹

Enhanced data reporting

Medicare lacks data on the provision of high-cost services by hospice providers under the hospice benefit, including what share of patients receive such services, how many of these services patients receive, and the characteristics of patients receiving these services in terms of their length of stay, level of care, and diagnoses. CMS could collect data from hospice providers about the use of certain high-cost services for a limited period (e.g., two to three years).

Such data would enable policymakers to know more about the current provision of high-cost services—such as frequency and types of patients who are furnished such services—that may be palliative among some hospice beneficiaries before considering whether the hospice payment system should be modified. In addition, if changes were made to CMS’s payment for certain complex palliative services or for certain types of patients who may rely on such services, CMS would have baseline data on utilization that would help the agency structure and model new payment-policy changes and against which the effects of the policy changes could be assessed over time.

There are several straightforward options to collect additional utilization data using data-collection mechanisms that CMS already has in place for hospice and other Medicare providers. First, hospice providers could report such data on the claims they submit to CMS, similar to how dialysis facilities currently report units of ESRD drugs furnished under the ESRD PPS, as well as certain clinical measures, on the monthly claims they submit to CMS.^{42,43} Hospice providers have experience submitting utilization data on Medicare claims. Between April 2014 and September 2018, CMS required line-item reporting for hospice drugs on the claims that providers submitted to the agency. Sec. 3132(a) of the Affordable Care Act of 2010 (ACA) authorized the Secretary to collect data (as needed) to revise payments for hospice care, consistent with the Commission’s 2009 recommendation (Medicare Payment Advisory Commission 2009).

CMS could also collect information about the use of high-cost complex services through a web-based

data-management system. Since October 2025, CMS has used a web-based platform—the Internet Quality Improvement and Evaluation System—to collect patient-level clinical data from hospice providers through the new Hospice Outcomes and Patient Evaluation (HOPE) data-collection tool. For patients under their care (at the time of their admission and other points in time), hospice providers submit information about hospice patients’ physical symptoms and the impact of pain and nonpain symptoms. Although the HOPE instrument has defined data fields, CMS could consider modifying future versions of the instrument to include information related to specialized services.

Approaches to modify hospice payment policy

Medicare’s current hospice payment system may create a disincentive for hospices to offer certain complex services that are palliative for certain beneficiaries. For example, FFS payment rates for dialysis, radiation, and blood transfusions generally exceed Medicare’s daily payment rate for hospice services (Table 5-10, p. 227), and our illustrative examples found that the estimated treatment costs for dialysis, blood transfusions, and radiation ranged from about 10 percent to 50 percent of the total Medicare payment for a hospice stay (Table 5-11, p. 229).

We discuss below (and summarize in Table 5-12, p. 233) two alternative payment-policy approaches—high-cost outlier payments and add-on payments for certain complex palliative services—that could be considered to improve hospice payment accuracy for hospice patients receiving complex palliative services. We discuss some of the advantages, disadvantages, and design considerations associated with each approach.

Both of these approaches could be implemented in a budget-neutral manner by adjusting hospice base rates to offset the changes. Other Commission analyses have concluded that Medicare’s aggregate level of hospice payments across all patients is sufficient to support high-quality care. In our March 2026 report to the Congress, the Commission found that the aggregate FFS Medicare margin was 8.0 percent across all hospice types in 2023 and projected to be about 9 percent in 2026. Based on these data and indicators of access to care, the Commission recommended no increase

to the hospice base payment rates in 2027. Thus, the Commission maintains that if policymakers pursue either payment approach, it would be appropriate to do so in a budget-neutral manner without an increase to aggregate hospice payments (e.g., by making a budget-neutral reduction to the hospice base rates to offset the additional payments).

High-cost outlier payments

One approach would be to establish an outlier payment mechanism in the hospice payment system. Several of Medicare’s other payment systems include high-cost outlier payments (see Appendix 5-A, p. 236). An outlier policy could direct additional payments to hospice providers that incur higher costs for providing certain complex palliative services to hospice patients (funded by a percentage reduction to the hospice base rate for all providers). This approach has several advantages. First, it would target additional payments toward only those providers that furnish complex palliative services. That is, Medicare would pay hospice providers an outlier payment when the estimated cost for outlier-eligible services (e.g., dialysis, blood transfusions, radiation) exceeds a threshold, similar to how outlier payments are computed for certain other Medicare PPSs. Second, this approach would maintain the bundled nature of the hospice payment system while improving payment accuracy, thus preserving incentives for providing efficient care and flexibility for how providers deliver care. Third, outlier payments represent shared financial risk between hospice providers and the Medicare program because these payments are typically calculated as a specified percentage of excess costs above a fixed loss amount, maintaining incentives for efficiency. On the other hand, some stakeholders (e.g., small providers) may view outlier payments, which pay for a portion of the additional costs associated with outlier-eligible services rather than the full costs, as insufficient incentive to furnish these services.

A complexity of outlier payments is that CMS must calculate the parameters of the outlier policy (e.g., a budget-neutral fixed loss amount) each year such that the estimated revenues from the reduction to the hospice base rate equals the projected amount of outlier payments. In other Medicare payment systems, the projection of outlier payments estimated by CMS has sometimes been imprecise, with actual outlier

payments being less than or more than the agency projected. (See Appendix 5-A, p. 236, for discussion of outlier payment approaches in other Medicare payment systems and potential approaches for hospice.)

Add-on payment for complex palliative services

Policymakers could consider modifying the hospice payment system to include an add-on payment for the provision of certain complex palliative services based, for example, on how much FFS Medicare pays for these services outside of hospice. Under this approach, Medicare would pay hospice providers each time they furnish a complex palliative service to a patient. The advantages of this approach are that it targets additional funds only to those providers that furnish complex palliative services and it increases incentives for hospices to furnish these services. However, an add-on payment would effectively unbundle some hospice services (that is, provide the hospice with separate payment for the service on top of the hospice per diem payment amount). Over time, this action could lead to pressure to unbundle more services, weakening the structure of the hospice payment system. When the hospice payment system was developed in 1983, CMS contemplated separate payment for palliative radiation and chemotherapy but instead opted to maintain a bundled-payment approach, citing incentives for efficiency. Another potential unintended consequence of this approach is that some providers seeking higher payments might offer complex services under the hospice benefit that are not consistent with the palliative intent of the hospice benefit. That is, separately paying for certain services with an add-on payment could incentivize some providers to furnish these services even if they are not palliative or not aligned with the patient-centered plan of care. Further, it may be difficult for CMS to determine when such services are being appropriately provided to hospice patients because of the complex medical judgments associated with palliation at the end of life. Limiting the amount of add-on payments a hospice provider could receive (e.g., limiting the aggregate amount of add-on payments a provider receives or setting an add-on payment rate at a level that is lower than 100 percent of the cost of the service) may provide some program-integrity safeguards.

Other approaches

Adding a case-mix adjustment to the hospice payment system is another potential approach to address concerns about beneficiary access to certain complex palliative services. This approach might involve increasing the hospice daily payment rates for patients with certain diagnoses (ESRD, leukemia, or other cancers) who tend to use certain complex palliative services (dialysis, blood transfusions, or radiation) while decreasing the daily payment rate for those with other diagnoses. This approach would maintain the bundled nature of the hospice payment system. However, it would not significantly improve the accuracy of Medicare's hospice payments and could have unintended effects, such as creating incentives to preferentially admit patients with certain diagnoses. Further, it would benefit hospice providers that treat patients with the selected diagnoses eligible for a case-mix adjustment even if the providers do not offer complex palliative services (because Medicare policy permits hospice providers to determine whether they offer services such as dialysis, radiation, blood transfusions, and chemotherapy for palliative purposes).⁴⁴ In addition, it is unclear whether this approach would meaningfully alter incentives to furnish high-cost services because the magnitude of the increase in the payment rates for certain diagnosis groups could be modest, especially if only a small proportion of beneficiaries in the diagnosis group (e.g., patients with ESRD) receive high-cost services or only a small proportion of hospices offer the service (e.g., dialysis).

Voluntary transitional program

Certain services identified by CMS—such as dialysis and blood transfusions—may fall in a gray area of being both palliative and life extending for some hospice beneficiaries, who may be concerned that ceasing these treatments could quickly result in death. Clinicians, hospice providers, and family members we interviewed stated that concern about ceasing these treatments before entering hospice led some patients who wished to enroll in hospice to forgo or delay hospice enrollment. Hospices that did offer these treatments to patients indicated that the possibility of receiving the treatments made it easier for the beneficiary to elect hospice and that, once enrolled in hospice, beneficiaries often chose to receive few treatments.

**TABLE
5-12**

Alternative policy approaches to modify the Medicare hospice payment system to address complex palliative services

Policy option description	Advantages	Disadvantages/complexities
1. High-cost outlier payment		
Create a high-cost outlier payment within the hospice payment system, in which Medicare pays providers who furnish certain complex palliative services an outlier payment for a portion of costs above a fixed loss amount	• Targets funds to providers furnishing these services • Maintains bundled nature of hospice payment system • Involves sharing of cost by provider and government, which helps retain incentives for efficiency	• Some stakeholders may view compensating providers for only a portion of their higher cost as insufficiently increasing incentives to furnish these services • May be subject to imprecision in estimation of budget-neutral fixed loss amount
2. Add-on payment for high-cost services		
Provide an add-on payment to hospices within the hospice payment system, in which Medicare pays providers who furnish certain complex palliative services a payment in addition to the daily hospice payment rate	• Targets funds to providers furnishing these services • Would increase incentives to furnish these services	• Unbundles some hospice services, which could increase pressure to unbundle more services over time, potentially undermining the structure of the payment system • Potential for inappropriate provision of services by some hospice providers, spurred by additional payments • Program-integrity safeguards could be challenging to successfully implement

Source: MedPAC analysis of Medicare's fee-for-service payment policies and payment systems.

To address potential concerns about access to hospice care for beneficiaries who are dependent on dialysis and blood transfusions, the Congress or the Secretary through CMMI could develop a transitional program that offers hospice enrollees the option to receive dialysis or blood transfusions paid for outside of the hospice benefit for some transitional period or up to a specified number of treatments. Such a structure would give dialysis- or blood transfusion-dependent beneficiaries who are near the end of life and wish to wean off these treatments while enrolled in hospice an opportunity to do so. If a hospice enrollee used the specified number or full duration of dialysis or blood transfusion treatments available in the transitional program, the patient would remain in hospice unless the patient chose to voluntarily disenroll.

A transitional program would be a type of concurrent care. In general, “concurrent care” refers to models of care under which patients continue to receive conventional treatments while enrolled in hospice (or while receiving nonhospice palliative care).⁴⁵ The structure of concurrent care models varies, ranging from models focused on specific concurrent services (e.g., dialysis for a limited period or specified number of treatments) to models that cover a broad range of conventional services while individuals are enrolled in hospice, like the VHA does. The transitional program we describe has similarity with efforts by providers or CMMI to focus on concurrent care for specific services motivated by potential concern about access to hospice for certain types of patients (see Table 5-13 (p. 234) for an overview of these approaches and the section “Experiences with models of concurrent care” (p. 223)).

**TABLE
5-13****Continuum of concurrent care approaches**

Organization	Patient population	Approach: Narrow or broad	Are patients enrolled in hospice?
Provider based			
UPMC/DCI	ESRD	Narrow: Hospice services and concurrent dialysis (specified number of treatments) ^a	Yes
Providence Hospice/ Northwest Kidney Centers	ESRD	Narrow: Hospice services and concurrent dialysis (no limit on number of treatments)	Yes
CMS/CMMI			
KCC Model	FFS late-stage kidney disease or ESRD beneficiaries	Narrow: Organizations with waiver may offer hospice services and concurrent care ^b	Yes
VBID	MA beneficiaries	Broad: Hospice services, transitional concurrent care, and supplemental benefits ^c	Yes ^c
MCCM	FFS beneficiaries with cancer, congestive heart failure, chronic obstructive pulmonary disease, or HIV/AIDS	Broad: Hospice services and concurrent care	Hospice eligible but not enrolled in hospice
ACO REACH	FFS beneficiaries	Broad: Hospice services and concurrent care	Yes

Note: UPMC (University of Pittsburgh Medical Center), DCI (Dialysis Clinic Inc.), ESRD (end-stage renal disease), CMMI (CMS Innovation Center), KCC (Kidney Care Choices), FFS (fee-for-service), VBID (value-based insurance design), MA (Medicare Advantage), MCCM (Medicare Care Choices Model), ACO (accountable care organization), REACH (Realizing Equity, Access, and Community Health). For more details on these models, see the section “Experiences with models of concurrent care” (p. 223).

^a The program enrolls patients with an estimated prognosis of less than two months. UPMC Family Hospice pays a contracted fixed rate to DCI to furnish palliative dialysis treatments to patients, up to 10 hemodialysis treatments or 30 days of peritoneal dialysis treatments. The program stops routine blood draws and certain ESRD medications that do not address comfort.

^b CMS makes available to kidney contracting entities (KCEs) a conditional waiver of the requirement that beneficiaries who elect hospice agree to forgo conventional treatments for their terminal condition outside of hospice. The KCE identifies to CMS the specific services to include in the benefit enhancement.

^c In addition to hospice services and transitional concurrent care for hospice enrollees, the model also involved palliative care for nonhospice enrollees.

Source: MedPAC analysis of concurrent care models implemented by provider-based organizations and CMS.

One collaborative program developed by a dialysis provider and a hospice provider located in Pennsylvania furnishes up to 10 palliative dialysis sessions concurrent with hospice services (Ernecoff et al. 2022). In another program, a Seattle dialysis facility partnered with a hospice to create a care model that furnishes dialysis up to three times weekly to patients with ESRD who are enrolled in hospice without a specified limit on how long patients can continue dialysis treatments.

CMMI has previously tested some models that have offered participants (FFS providers or MA plans) the flexibility to offer concurrent care to hospice enrollees for certain services, but this flexibility has been an element of the models and not the focus (Table 5-13). Both the KCC and ACO REACH models (that began in 2022 and 2023, respectively) offered participating organizations the option to furnish concurrent care to hospice enrollees with ESRD (KCC model) or

concurrent services more generally (ACO REACH), but little is known about the extent to which concurrent care was utilized in these models. In the hospice component of the MA VBID model, participating plans furnished hospice services and were required to offer some form of transitional concurrent care. Participating plans had discretion over which type of concurrent services to include and any limits; some chose to cover dialysis or transfusions. According to the evaluation, uptake of transitional concurrent care among hospice enrollees was lower than expected. Plans and hospices cited factors such as delayed hospice referrals, limited awareness of the option among referring providers, beneficiary preferences, and concerns about MA payment rates for concurrent care (Eibner et al. 2025). CMMI also tested the Medicare Care Choices Model in which hospice-eligible beneficiaries who were not enrolled in hospice could receive limited palliative care services while remaining in conventional care.

Building on its efforts in this area, CMMI could consider developing and testing a model that directly focuses on hospice and transitional concurrent care for patients who are dialysis or transfusion dependent. This approach would give CMS the opportunity to design a model that directly tests transitional concurrent care for hospice enrollees in a limited fashion for services about which access concerns

have been raised by stakeholders. While dialysis and blood transfusions are a logical starting point for a focused test of transitional concurrent care, CMS could consider whether there are other services such as palliative radiation that would benefit from inclusion in such a model.⁴⁶ The effect of a voluntary transitional program on beneficiaries' use of hospice and on overall Medicare spending is not known but could be studied under a CMMI model. In developing a model, the agency would need to consider a number of issues, including how to structure the transitional program (what length of time or number of treatments would be appropriate, whether a beneficiary could receive the transitional benefit only once or could receive it more than once if disenrolled from and reenrolled in hospice); how to design the model to promote close collaboration between the specialist administering the transitional treatments and the hospice physician; and how to design the model to minimize the potential for unintended financial incentives or undermining the hospice benefit criteria. With respect to dialysis, an additional issue that could be explored is whether a transitional benefit could be structured to offer nephrologists the flexibility to provide palliative dialysis (fewer treatments per week and fewer medicines and lab studies, if that is better suited to the patient's comfort) without it adversely affecting their quality metrics.⁴⁷ ■

5—A

APPENDIX

High-cost outlier payments: Medicare precedents and potential approaches for hospice

Outlier payments in other Medicare payment systems

A high-cost outlier mechanism exists in several Medicare prospective payment systems (PPSs), including the inpatient hospital prospective payment systems (IPPS), long-term care hospital (LTCH) PPS, inpatient rehabilitation facility (IRF) PPS, end-stage renal disease (ESRD) PPS, hospital outpatient PPS (OPPS), and home health agency (HHA) PPS. Medicare's fee-for-service (FFS) PPSs with an outlier policy generally share the following features:

- The estimated cost for a case or service(s) is compared with the Medicare payment amount.
- Medicare pays the provider an additional amount equal to a percentage of the excess costs above the fixed loss amount for those cases or services in which the estimated cost exceeds the payment by more than a specified fixed loss amount.
- Medicare structures outlier payments to be budget neutral in aggregate, funded through a prospective percentage reduction to the base payment rate(s) of the PPS.

Some of the dimensions on which outlier approaches vary across Medicare's FFS payment systems pertain to:

- what services are eligible for an outlier payment,
- what type of data sources are used to estimate providers' costs for outlier services, and
- how budget neutrality is implemented and the target amount of spending that outlier payments would account for.

The ESRD PPS and IPPS provide examples of the different ways that outlier-payment approaches are structured. The ESRD PPS takes a targeted approach to outlier payments: Only certain services are eligible for outlier payments, and CMS estimates the provider's cost of outlier-eligible services reported on a claim using external sources of cost data (e.g., FFS payment rates for similar services in other Medicare payment systems). In contrast, the IPPS takes a broad approach to what services are eligible for outlier payments by estimating the total cost of all services reported on the claim for an individual patient. The IPPS uses an

estimate of the hospital's cost for a case by taking the hospital's reported charges on the claim multiplied by the hospital's overall cost-to-charge ratios (CCRs) from its cost report.⁴⁸ The two payment systems also differ on what share of payments is directed to outliers, with the ESRD PPS targeting 1 percent and IPPS targeting about 5 percent of total payment for outliers.⁴⁹

Hospice outlier payments: Policy-design and implementation considerations

Below we discuss the key design choices and operational issues that policymakers would need to consider if they established an outlier approach in hospice.

Services eligible for an outlier payment

One key element of an outlier approach is the choice of services that are eligible for outlier payments. Across Medicare payment systems, the scope of services eligible for outlier payments varies. In the IPPS, OPPS, LTCH, and IRF PPSs, the services eligible for outlier payments are broad. For example, the IPPS has an outlier for all services associated with high-cost stays. In contrast, home health outliers pertain to whether the number of visits provided is an outlier compared with other providers. In the ESRD PPS, CMS makes outlier payments for only certain services—drugs, laboratory services, and other items that facilities had billed for separately under the prior payment system.⁵⁰

If the goal of adding outlier payments to the hospice payment system is to address concern about access to certain high-cost services like dialysis, blood transfusions, and radiation that are palliative for some patients, an outlier approach that applied only to selected services would be a focused and efficient way to address that goal. While any outlier approach would increase data reporting for providers, an approach that focuses on selected services would minimize the additional data-reporting burden. An approach to outliers that focuses on a select group of services might give rise to requests for additional services to be considered for outliers. CMS could establish criteria and processes for considering such requests (e.g., by establishing a technical expert panel and notice and comment rulemaking).

Alternatively, CMS could consider a broad approach to outlier payments for hospices that would make all services provided by hospices eligible for outlier payments, similar to the IPPS. With a broad approach, CMS would not need to designate what services are eligible for outlier payments. However, a broad approach may not direct outlier payments toward the service types that may be of most concern from an access and quality perspective. Program integrity might also be more difficult for CMS to monitor under a broad approach. In addition, implementation of a broad approach would require changes to the hospice cost-report form and could involve substantially more data reporting by providers on claims and cost reports than they currently do.⁵¹

Below, we discuss policy-design choices for an outlier policy focused on select services because such an approach would likely better address the concern about access to certain complex palliative services than a broad approach that is focused on an entire stay.

Data used to estimate the costs of outlier-eligible services

How CMS estimates the provider's cost of a service or case for purposes of determining outlier eligibility varies across Medicare's FFS payment systems:

- In the IPPS, LTCH PPS, IRF PPS, and OPPTS, CMS estimates costs using charges reported on claims, multiplied by a CCR from the provider's cost report.
- In the HHA PPS, the cost of the case is estimated based on the number and mix of visits provided; standard labor cost amounts per minute and type of visit are applied.⁵²
- In the ESRD PPS, CMS estimates a provider's costs for drugs based on external price measures used in other Medicare payment systems (i.e., the average sales price plus 6 percent for Part B drugs, national average pricing data from the Medicare Prescription Drug Plan Finder for other drugs, payment rates from the Clinical Laboratory Fee Schedule for laboratory tests, and prices established by the local Medicare administrative contractors for medical/surgical supplies).

Relying on external data sources to estimate a provider's cost of furnishing specific services for outlier-calculation purposes may be the simplest

and most efficient approach for hospice. Using a standardized, objective measure of the cost of a service would lessen the potential for an outlier system to be vulnerable to fraud and abuse and help maintain incentives for hospices to efficiently contract for these services. For example, CMS could use FFS Medicare payment rates to nonhospice providers as an estimate of the cost of services—such as the average FFS payment rate for a dialysis treatment, blood transfusion, or radiation service. This approach would be similar to the approach used in the ESRD PPS.

Alternatively, CMS could use a provider-specific CCR approach, but doing so would require CMS to make changes to the hospice cost-report form. CMS would need to add charges to the hospice cost-report form and break out or restructure certain cost categories to align with services eligible for outlier payments, which may increase providers' administrative burden. Using a CCR approach would also likely necessitate more oversight and auditing of the hospice cost reports from CMS and the agency's administrative contractors than currently exists. In addition, a CCR approach may involve retroactive reconciliations of outlier payments for some providers. For example, under the IPPS, CMS initially uses a provider's CCR from a prior cost-report period when calculating outlier payments. If the hospital's CCR (for operating costs) for the period in which the service was actually furnished differs substantially from the historical ratio used and the total outlier amount exceeds a threshold, CMS will retroactively reconcile the outlier payments (Centers for Medicare & Medicaid Services 2025a).

Parameters of outlier payments and budget neutrality

Outlier mechanisms rely on several parameters designed to achieve budget neutrality. They include:

- a prospective percentage reduction to the base rate intended to fund outlier payments in a budget-neutral fashion (across Medicare's FFS payment systems, this reduction ranges from 1 percent under the ESRD and OPPTS to 8 percent under the LTCH standard payment system);
- a fixed dollar loss amount (and percentage loss amount in the case of the OPPTS) that must be exceeded before a case or service(s) qualifies for outlier payments; and

- a percentage of estimated costs above the fixed loss amount that Medicare pays (this share varies by payment system—from 50 percent in the OPPS to 80 percent in several payment systems (e.g., IPPS, ESRD PPS, IRF PPS, LTCH PPS, and home health PPS)).⁵³

Establishing these parameters for a newly established hospice outlier policy would involve a combination of policy judgment and data analysis. For example, determining the share of costs above the fixed loss amount that would be paid by Medicare is purely a policy judgment: It reflects a decision about how to balance the goals of providing additional payments for unusually high-cost services and maintaining incentives for efficiency.

CMS would need utilization data on outlier-eligible services to establish reasonable parameters for an outlier policy and set them at levels that would result in budget neutrality. CMS currently does not have patient-level data on the provision of hospice services (other than visits) on hospice claims. As discussed previously, several options exist for obtaining additional data on the provision of specific services. One approach is to require hospices to report utilization of selected services that would be eligible for outlier payments (via Healthcare Common Procedure Coding System codes) on Medicare claims for a few years before implementing a new outlier approach (see section “Enhanced data reporting,” p. 230). This approach is similar to CMS, in 2025, obtaining additional data to support expanding services that are eligible for ESRD outlier payments.

If only a small number of hospice beneficiaries currently receive certain complex palliative services, utilization data that CMS collects may indicate that only a very modest prospective adjustment to the hospice base rate would be needed to fund outlier payments in a budget-neutral manner. Over time, however, utilization of outlier-eligible services may increase in response to the availability of outlier payments. Growing utilization and payments for outlier services would typically be addressed by raising the fixed loss amount in subsequent years so that projected outlier payments equal the same target percentage of aggregate payments established in prior years. After several years of experience with outlier payments, CMS could also reassess the initial parameter it established for the targeted percentage reduction to the base payment rate in light of observed utilization and consider whether that percentage remains appropriate or warrants adjustment.

Alternatively, if there is concern that current use of certain complex palliative services is low and limits CMS’s ability to set reasonable initial parameters for an outlier policy, CMS could consider adopting a different approach before implementing an outlier system. CMS could consider temporarily paying hospices for these services separately to generate more complete utilization data. After this limited period of separate payment, CMS could transition to a budget-neutral outlier policy using the utilization data gathered during that period. ■

Endnotes

- 1 “Chemotherapy” in this chapter refers to both chemotherapy and immunotherapy unless otherwise specifically referenced.
- 2 Beneficiaries who elect hospice agree to forgo Medicare payment for treatments for their terminal condition and related condition outside of hospice. These disease-directed services are commonly referred to as “curative” or “conventional” care. The term “curative” in this context is not meant to imply that the disease-directed services are expected to cure the hospice beneficiary’s terminal illness. For example, we note that dialysis does not cure end-stage renal disease; rather, it is a life-sustaining treatment that filters waste and excess fluids for individuals with this illness.
- 3 CMS sought comment on what specific financial risks or costs are of particular concern to hospices that would prevent the provision of high-cost palliative treatments and what would address those risks; whether there should be parameters around when palliative treatments should qualify for a different type of payment; whether CMS should consider defining “palliative services” more specifically with regard to high-cost treatments; whether there should be documentation that all other palliative measures have been exhausted before billing for a higher-cost treatment; and whether there should be separate payments for different types of higher-cost palliative treatments or one standard payment for any higher-cost treatment.
- 4 Throughout this chapter, we use the phrase “complex palliative services” to refer to the services that CMS raised in its rulemaking for beneficiaries with complex palliative needs: dialysis for patients with ESRD and radiation, blood transfusions, and chemotherapy for cancer patients (Centers for Medicare & Medicaid Services 2023). Our analyses focus on these four treatments; consideration of other treatments for beneficiaries with complex palliative needs is outside our scope. However, in our interviews, we note that some clinicians mentioned other complex palliative services that may raise similar issues (e.g., ventilators for patients with amyotrophic lateral sclerosis, certain drugs for heart failure and certain other cardiovascular conditions (e.g., certain inotropes), and procedures to insert drains for fluid buildup).
- 5 The *Medicare Benefit Policy Manual* states that services that are “completely unrelated” to the terminal condition are eligible for FFS coverage outside of hospice. In addition, the policy manual states specifically for beneficiaries with ESRD that “if the patient’s terminal condition is unrelated to ESRD, the patient may receive covered services under both the ESRD benefit and the hospice benefit” (Centers for Medicare & Medicaid Services 2026a, Centers for Medicare & Medicaid Services 2026b).
- 6 CHC is intended to manage a short-term symptom crisis in the home and involves eight or more hours of care per day, at least half of which is nursing care. IRC is care in a facility for up to five days to provide an informal caregiver a break. GIP is provided in a facility on a short-term basis to manage symptoms that cannot be managed in another setting. Unless a hospice provides CHC, IRC, or GIP on any given day, it is paid at the RHC rate.
- 7 There are two exceptions in which the number of visits furnished affects Medicare’s hospice payment rate. For CHC, Medicare pays the hospice provider an hourly rate rather than a per diem rate. To qualify for CHC payment on a given day, the hospice provider must furnish at least eight hours of visits to a particular patient, with at least 50 percent being nurse visits. For RHC in the last seven days of life, Medicare pays the hospice provider the standard RHC daily rate and an additional amount for registered nurse or social worker visits based on an hourly rate. In both of these cases, payment is not affected by the amount of nonvisit services furnished.
- 8 The hospice per diem includes payment for the administrative services of the hospice medical director or a hospice physician member of the interdisciplinary group (e.g., for review and updating of plans of care, supervising care and services, and establishing governing policies). However, if the beneficiary’s designated attending physician furnishes a professional service related to the terminal condition to the beneficiary (e.g., an evaluation and management visit), Medicare will make a separate payment for the physician service. If the attending physician is employed by the hospice, Medicare Part A will make a separate payment to the hospice for each attending physician professional service. If the attending physician is independent, Medicare Part B will make a separate payment to the attending physician for the professional service.
- 9 A palliative approach to dialysis care prioritizes comfort and minimizing symptom burden (over life prolongation) by aligning treatment with the patient’s goals of care (Grubbs et al. 2014). Patients on maintenance dialysis may experience, on average, 7.5 symptoms (Davison et al. 2006). A common difference between conventional (i.e., maintenance) versus palliative approaches to dialysis care, according to our interviews with hospice providers, includes the treatment frequency (three vs. fewer treatments per week) and modifications to ESRD prescriptions and lab tests.
- 10 Sekeres and colleagues indicated, however, that this recommendation was based on “very low certainty of the evidence of effects.” They wrote that they did not find any

- studies specific to blood transfusions in older adults with acute myeloid leukemia who were no longer receiving antileukemic therapy. They stated that they relied on two published systematic reviews of the literature for broader populations and that most studies in the systematic reviews were case studies involving noncomparative data (Sekeres et al. 2020).
- 11 When a hospice provider furnishes a complex palliative service like dialysis, radiation, or blood transfusions that is related to the patient's terminal condition, the hospice provider typically arranges for another provider (e.g., a hospital, clinic, or dialysis facility) to furnish the service to the hospice enrollee. In that situation, the hospice provider is responsible for paying the other provider furnishing the treatment based on a rate negotiated between the hospice and the other provider.
 - 12 According to Sec. 410.40 of the Code of Federal Regulations, "The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Nonemergency transportation by ambulance is appropriate if either: the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required." In addition, under Medicare ambulance coverage policy, nonemergency ambulance transport is covered only between certain types of health care facilities or locations.
 - 13 One interviewee discussed what considerations are given to structuring payment for palliative dialysis in which the intensity or frequency of dialysis is reduced.
 - 14 The cost of providing radiation may vary by the number of fractions and the negotiated payment rate between a hospice and radiation center.
 - 15 A number of physicians and hospices noted that before hospice enrollment, some blood-cancer patients may receive transfusions several times per week. Some of the hospice clinicians we interviewed stated that they did not view that frequency of transfusion services as being consistent with the philosophy of hospice care.
 - 16 Hospices were required between April 2014 and September 2018 to report drugs used during hospice stays on FFS hospice claims, but they are no longer required to do so.
 - 17 A number of analyses focus on 2019, the last year before the pandemic, but some analyses use other years (2017, 2023, and 2024) depending on data availability and the objective of the analysis.
 - 18 "Concurrent care" refers to models of care under which patients continue to receive conventional treatments while enrolled in hospice (or while receiving nonhospice palliative care).
 - 19 According to an analysis of enrollment in hospice between 2000 and 2014 among nearly 771,000 Medicare decedents who were on hemodialysis, 20 percent of beneficiaries received hospice services at the time of their death during this period, with hospice use increasing from 11 percent of decedents with ESRD in 2000 to nearly 27 percent in 2014; the median length of stay in hospice was five days; about 42 percent of decedents with ESRD who elected hospice did not do so until the last three days of life; and hospice use was higher among older and White decedents with ESRD relative to younger and non-White decedents with ESRD (Wachterman et al. 2018). An earlier study of hospice use among beneficiaries on dialysis found that, between January 2001 and December 2002, 14 percent of the 115,239 decedents had enrolled in hospice (Murray et al. 2006). Murray and colleagues reported higher hospice use for older and White decedents with ESRD than younger and non-White decedents with ESRD, similar to findings by the Commission and Wachterman and colleagues (2018).
 - 20 Under Medicare policy, the ESRD PPS pays for the delivery of maintenance outpatient dialysis. During our interviews, we learned that some dialysis providers may be reluctant to furnish palliative dialysis (e.g., fewer treatments per week) under the ESRD benefit because of its potential to affect the facility's clinical performance under the ESRD PPS's Quality Incentive Program.
 - 21 USRDS Study of Treatment Preferences is a survey conducted among patients dialyzing at 31 nonprofit facilities in the greater Seattle and Nashville areas between 2015 and 2018 and was funded by the National Institute of Diabetes and Digestive and Kidney Diseases as part of the USRDS Special Study Center on Palliative and End-of-Life Care.
 - 22 In addition to these prognostic tools for patients with ESRD on dialysis, some researchers have also developed prognostic tools for individuals with CKD Stages 4 and 5 (Schmidt et al. 2019).
 - 23 A systematic review by White et al. (2017) reported that the accuracy of the surprise question was variable. Across 22 studies examined, the authors found a wide range of sensitivity (11.6 percent to 95.6 percent), specificity (13.8 percent to 98.2 percent), positive predictive value (13.9 percent to 78.6 percent), negative predictive value (61.3

- percent to 99 percent), and c-statistic (0.512 (poor) to 0.822 (good)) (White et al. 2017).
- 24 The area under the curve (AUC) for six-month survival from this prognostic model was 0.87 (95 percent confidence interval (CI) 0.82 to 0.92). The AUCs for 12- and 18-month survival were 0.82 (95 percent CI 0.76 to 0.88) and 0.79 (95 percent CI 0.73 to 0.86, respectively).
 - 25 For those who elected hospice, the use measures reflect the beneficiary's last year of life in which use may have occurred either before or during hospice enrollment.
 - 26 The only claims data available on hospice enrollees' use of high-cost services are for those services paid for outside of the hospice benefit. FFS Medicare pays for these services outside of hospice when they are reported to be unrelated to the terminal condition. We lack any data to analyze the characteristics of decedents with ESRD in hospice who received dialysis that the hospice paid for.
 - 27 We identified renal disease with the following principal International Classification of Diseases–10 diagnosis codes for their hospice episode: E1121, E1122, E1129, I120, I129, I130, I1310, I1311, I132, N181, N183, N184, N185, N186, N189, and N19. Among hospice decedents with ESRD who received dialysis paid for outside of the hospice benefit and had renal disease as their terminal condition, 44 percent had an I-code or E-code as their hospice primary diagnosis, and the remaining 56 percent had an N-code. Among hospice decedents with ESRD who did not receive dialysis paid for outside of the hospice benefit and had renal disease as their terminal condition, 31 percent had an I-code or E-code as their hospice primary diagnosis, and the remaining 69 percent had an N-code.
 - 28 For the purposes of this analysis, we classified the following International Classification of Diseases–10 diagnosis codes as blood cancer: C90–C96 and D46, excluding codes that indicated the condition was in remission.
 - 29 We focused on red blood cell transfusions because some hospice and cancer clinicians we interviewed indicated that red blood cell transfusions may be palliative for some hospice patients with blood cancers; platelets, on the other hand, were not generally viewed by those we interviewed as having a palliative role in hospice.
 - 30 We excluded any treatment received on the day of hospice election.
 - 31 According to Mor and colleagues (2016), “The VHA Comprehensive End-of-Life Care Initiative was designed to ensure reliable access to hospice and palliative-care services at all VHA facilities and to build an infrastructure for long-term sustainability of high-quality end-of-life care. In less than three years, the VHA tripled the number of veterans provided with home hospice care, enhanced access to inpatient VHA palliative care, and built a nationwide network of partnerships with community hospice programs.”
 - 32 Wachterman et al. (2022) adjusted for age, race, sex, residence (rural/urban), and proximity to a VHA facility, and they included Veterans Integrated Service Networks fixed effects in their logistic regression models comparing the share of VHA-financed versus Medicare-financed patients receiving concurrent dialysis and hospice services.
 - 33 According to Ernecoff and colleagues, “This [two-month] criterion was chosen for this pilot project due to financial feasibility and to create an argument more likely to be accepted for policy changes. Ideally, a program like this would be offered to patients with a longer prognosis (e.g., 6 months)” (Ernecoff et al. 2022).
 - 34 The maximum number of days enrolled in hospice was 76 for participants who received dialysis compared with 17 days for participants who stopped dialysis when entering hospice.
 - 35 According to the report, “A small percentage of all hospices nationwide volunteered to participate in MCCM, with only five hospices enrolling about half the beneficiaries. Further, the beneficiaries enrolled in MCCM represent a small percentage of the beneficiaries who, according to Medicare claims and enrollment data, lived near a participating hospice during model implementation and satisfied the model eligibility criteria but were neither referred to the model nor enrolled. The enrollees were also notably different from nonparticipating beneficiaries before matching, more often having cancer and high rates of Medicare expenditures” (Kranker et al. 2023).
 - 36 The average FFS payment for a blood transfusion reflects payments for the transfusion (Current Procedural Terminology code 36430) and red blood cells; it does not include payments for other related services such as laboratory services. For radiation treatments, we included (1) radiation therapy Healthcare Common Procedure Coding System (HCPCS) codes from the American Society of Radiation Oncology, Restructured BETOS Classification System, and the Agency for Healthcare Research and Quality's Clinical Classification Software codes; and (2) HCPCS codes associated with ablation therapy.
 - 37 For purposes of this analysis, we assume a hospice payment rate of \$196 per day, the payment rate for RHC for the first 60 days of a hospice stay. RHC accounts for more than 99 percent of hospice days. In 2019, Medicare paid \$196 per day

- for hospice RHC for the first 60 days of a hospice stay and \$154 per day for days 61 and beyond. For this analysis, we chose the rate for days 1 to 60 because hospice patients with ESRD and cancer tend to have shorter stays.
- 38 The Commission found positive indicators of payment adequacy for outpatient dialysis payments in the year of our analysis, 2019, and in the years since then (Medicare Payment Advisory Commission 2026b, Medicare Payment Advisory Commission 2021).
 - 39 The dialysis treatment frequency of roughly two treatments per week reported in these studies reflects dialysis provided for palliative purposes while beneficiaries were enrolled in hospice. This amount is different from the frequency of maintenance hemodialysis treatments furnished to beneficiaries who are not enrolled in hospice (which is typically three times per week). In interviews with nephrologists and palliative care physicians, we heard that palliative dialysis frequency is guided by what will help ease a particular patient's symptoms and may involve fewer treatments per week than maintenance dialysis.
 - 40 In general, Medicare has a variety of approaches it can employ to help ensure that appropriate care is received under a PPS, such as (1) quality reporting programs and patient experience-of-care surveys (e.g., Hospice Quality Reporting Program and Hospice Consumer Assessment of Healthcare Providers and Systems); (2) program monitoring or oversight (e.g., the ESRD claims-based monitoring program); and (3) pay-for-performance approaches utilized in some payment sectors.
 - 41 Currently, we lack data on the provision of complex palliative services by hospice providers. Even if we had data on current provision of these services, it is unknown whether and by how much potential Medicare payment-policy changes would affect election of hospice, hospice length of stay and utilization of complex palliative services, and use of nonhospice Medicare services.
 - 42 The ESRD PPS does not pay separately for ESRD-related drugs (with the exception of new drugs that are paid for under an add-on payment for a limited period). Rather, the base payment rate for each dialysis treatment covers all operational and capital costs that providers incur for furnishing a dialysis treatment, including ESRD-related drugs with nursing services, dialysis equipment and supplies, social services, and certain laboratory tests.
 - 43 Dialysis facilities report the following clinical measures on monthly claims submitted to CMS: dialysis adequacy reading (the dialysis patient's Kt/V (the ratio of total volume of blood cleared of urea to the total volume of fluid in the body)); anemia levels (the dialysis patient's hematocrit level); type of vascular access used (vascular catheter, arteriovenous graft, arteriovenous fistula only); patient height and weight; and "time on machine," defined as the number of minutes that hemodialysis is provided (i.e., the minutes spent dialyzing) (Centers for Medicare & Medicaid Services 2024a).
 - 44 For example, under this approach, a provider that elected not to furnish dialysis to a given patient with ESRD (because the provider viewed dialysis as not consistent with the patient-centered plan of care or because the provider did not offer the specialized service) would still be paid a higher case-mix-adjusted payment.
 - 45 Ernecoff and Anhang Price describe concurrent care as allowing "select disease-directed therapies to facilitate transitions to hospice, with the aim of promoting goal-concordant care" (Ernecoff and Anhang Price 2023).
 - 46 Although according to interviewees, palliative radiation generally does not affect life expectancy, interviewees reported that access to palliative radiation can influence the timing of hospice enrollment, with some patients delaying hospice entry to receive treatment. Interviewees also noted that the need for radiation may arise during a hospice stay, such as pain associated with a newly symptomatic bone metastasis. Because radiation may be needed mid-hospice stay, a transitional program may be less well suited to palliative radiation than to blood transfusions or dialysis. However, it may be possible to structure a transitional program to include palliative radiation—for example, by defining the transition in terms of a number of radiation treatments rather than a fixed time period.
 - 47 Under the ESRD Quality Incentive Program, the PPS bundled-payment rate is reduced by up to 2 percent for dialysis facilities that do not achieve or make progress toward specified quality measures.
 - 48 Under the IPPS, Medicare pays hospitals for both operating and capital costs. The IPPS outlier policy incorporates both operating and capital costs into the outlier calculation and uses two hospital-specific CCRs—an operating CCR and capital CCR—to calculate a hospital's operating and capital costs for a case. The hospital's operating and capital CCRs come from the most recent tentative or final settled cost report. Under certain circumstances, CMS may substitute a statewide average CCR for a hospital-specific CCR if the Medicare administrative contractor is unable to determine an accurate operating or capital CCR for a hospital (Centers for Medicare & Medicaid Services 2025a).

- 49 Under the IPPS, CMS sets the national fixed loss amount at the level it estimates will result in outlier payments equaling the target operating offset of 5.1 percent (plus a projection for outlier reconciliation, which is 0.04 percentage points in 2026).
- 50 Effective 2025, ESRD drugs and biological products that were or would have been included in the composite rate before the establishment of the ESRD PPS became eligible for outlier payments (Centers for Medicare & Medicaid Services 2025c).
- 51 At a minimum, a broad approach to estimating costs for a case that involves multiplying total charges on the claim by a hospital-specific CCR would require changes to the hospice cost report to include total charges. However, from a policy and program-integrity perspective, more disaggregated information on charges and costs by type of service could be beneficial, permitting an understanding of which types of services are driving outlier payments. As a result, this approach may involve more data reporting by hospices on claims and cost reports than providers currently do.
- 52 Medicare's HHA PPS limits the amount of outlier payments an individual HHA can receive to no more than 10 percent of the agency's total Medicare home health payments (Centers for Medicare & Medicaid Services 2025b).
- 53 Under the IPPS, the percentage of costs paid above the fixed loss amount is generally 80 percent, but for burn diagnosis-related groups it is 90 percent.

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C H A P T E R

6

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

R E C O M M E N D A T I O N

- 6** The Congress should direct the Secretary to continue collecting cost and revenue data from suppliers and providers of ground ambulance services.
- Data collection should focus on information essential to assessing both the accuracy of Medicare payments and Medicare beneficiaries' access to care; and
 - The Secretary should pursue opportunities to streamline data collection to minimize burden on suppliers and providers.

COMMISSIONER VOTES: YES 14 • NO 0 • NOT VOTING 1 • ABSENT 2

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

Chapter summary

Since 2002, Medicare has paid for ground ambulance services provided to fee-for-service (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, adjusted for geographic differences in costs. It is calculated using a relative-value unit (RVU), a conversion factor, a geographic adjustment, and an add-on payment depending on whether the transport begins in an urban, rural, or super-rural area. (“Super-rural” areas are ZIP codes located in rural counties that are in the lowest quartile of all rural counties by population density.) The payment for the mileage component reflects the distance traveled with the patient and is adjusted with add-on payments that differ depending on whether the transport begins in an urban or 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 as well as other information and found evidence that suggested

In this chapter

- The ambulance payment system was largely developed without cost data
- Accurate cost data needed to assess payment accuracy and access to care
- GADCS dataset allows for effective analysis of ambulance costs and payments, but it needs refinement
- Stakeholders support continued collection of a more streamlined dataset
- Substantial variation among ground ambulance organizations in services provided and costs
- CMS should continue to collect GADCS data, streamlined to reduce burden

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. Without cost data, policymakers must rely on indirect measures of payment adequacy to determine whether Medicare's payments to ambulance organizations are adequate to ensure beneficiary access to care. Further, the extent to which payments under the AFS align with the costs to efficiently provide ground ambulance services to beneficiaries with different needs in different locations cannot be determined.

To support analysis of whether the AFS payments are appropriate, the Congress directed CMS—via the Bipartisan Budget Act (BBA) of 2018—to implement the Medicare Ground Ambulance Data Collection System (GADCS). CMS collected data for 2022 and 2023 from a sample of ambulance organizations, including information on organization characteristics, service area, service volume, response times, staffing and service mix, and certain categories of costs and revenues over a 12-month period. The BBA of 2018 also directed MedPAC to assess and analyze the GADCS data and report on geographic variation in the cost of furnishing ambulance services and the adequacy of Medicare's payments under the AFS. In addition, the Commission is required to assess the burden on ambulance organizations of reporting the data and recommend whether CMS should continue the data-collection effort or revise it.

The GADCS contains a rich set of variables. The data are sufficient to allow policymakers to assess the appropriateness of the AFS payment adjustments (RVUs; urban, rural, or super rural; and geographic areas). Although the GADCS cost data reflect the costs of providing ambulance services for all patients and do not separately estimate the costs specifically associated with providing services to FFS Medicare patients, our analysis suggests that the cost of serving FFS Medicare beneficiaries generally is similar to the cost of serving all other patients. Therefore, the GADCS cost data are useful in assessing FFS Medicare's payments.

However, measures of ambulance organizations' revenues relative to costs (such as financial margins) should be viewed cautiously. The GADCS collection effort marked the first time that most ambulance organizations submitted cost and revenue data, so there are likely reporting errors across the data elements. CMS has expressed particular concern that organizations may have made errors reporting revenue from sources, such as local government funding,

that are unrelated to billing for ground ambulance services. These reporting errors are especially relevant for government-owned organizations because 52 percent of the overall revenue reported by these organizations stemmed from such sources. Reporting errors may underlie the extremely large differences between revenues and costs that we found for some organizations. These data issues suggest that GADCS-based measures of revenues relative to costs might not be reliable indicators of payment adequacy at this time.

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, with RCRs for some organizations indicating that revenues were well below costs, while revenue was well above costs for other organizations.

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 the number of fully staffed ambulance units varies by day, time, or season) compared with those that used a static staffing model (meaning the same number of fully staffed ambulance units is available at all times). 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. In other words, if a rural organization and urban organization were otherwise the same—including providing the same number of transports—the organization with a rural service area tended to have lower costs. 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 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 (such as variables indicating the number of hours worked by staff for nonambulance responsibilities). Also, many of the cost variables are quite granular, such as specific costs (depreciation, loan interest, purchase price) for each ambulance vehicle that the organization operates. To assess the burden on ambulance organizations of reporting the data and help inform our consideration of whether the data collection should continue, we consulted stakeholders including ambulance organizations, ambulance trade associations, CMS, and RAND (which contracted with CMS to perform the data collection). All stakeholders we spoke with supported continued data collection but emphasized the need to reduce its burden.

The GADCS is a good first step toward a dataset that policymakers can use to effectively evaluate the adequacy of AFS payments. 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 large enough to ensure beneficiary access and the accuracy of AFS payments 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 ground ambulance organizations, 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 providers and suppliers. ■

Since 2002, Medicare has paid for ground ambulance services using the ambulance fee schedule (AFS). In 2024, approximately 10,600 ground ambulance suppliers and providers delivered 11.3 million ambulance transports to fee-for-service (FFS) Medicare beneficiaries, with total Medicare payments for AFS-covered transports of \$5.3 billion.

The AFS factors that CMS uses to adjust payments to ambulance organizations generally are not based on cost data, and many of them have remained unchanged since they were implemented. Without cost data, policymakers must rely on indirect measures of payment adequacy such as number of ambulance organizations to determine whether Medicare's aggregate payments to ambulance organizations are adequate to ensure access to care for beneficiaries. Further, the extent to which payments under the AFS align with the costs required to efficiently provide ground ambulance services to beneficiaries with different needs in different locations cannot be determined.

To support analysis of the appropriateness of AFS payments, the Congress directed CMS—via the Bipartisan Budget Act (BBA) of 2018—to undertake a ground ambulance data-collection effort. CMS responded by creating the Medicare Ground Ambulance Data Collection System (GADCS), which gathers detailed information from ambulance organizations on their service areas, total time for ambulance responses, number of responses and transports (volume), service mix (emergency, nonemergency, basic life support, advanced life support, specialty care transport), labor costs, facility costs, vehicle costs, equipment and supply costs, and revenues. The BBA of 2018 also directed the Commission to evaluate the GADCS data, including the burden on ambulance organizations of collecting it, and report to the Congress on the adequacy of Medicare payments for ground ambulance services and geographic variation in the costs of providing those services (see text box on the BBA of 2018, p. 256).

In this chapter, we review Medicare's AFS and the Commission's prior work assessing the adequacy of Medicare's payments for ambulance services. We then describe CMS's GADCS data-collection effort and provide an overall assessment of the dataset. Next, we present findings from interviews with stakeholders regarding the potential value of the GADCS dataset and

the burden of data collection and report results from our analyses of the GADCS data. Finally, we make a recommendation to continue to collect a streamlined set of GADCS data.

Background

Medicare pays for ground ambulance transports for FFS Medicare beneficiaries under the AFS. Ground ambulance services include both emergency and nonemergency transport from the point of patient pickup to an appropriate medical facility or the patient's home. These services include:

- transports to the nearest hospital, critical access hospital (CAH), rural emergency hospital (REH), or skilled nursing facility (SNF) that is capable of furnishing the required level and type of care for the beneficiary's illness or injury;
- transports from a hospital, CAH, REH, or SNF to the beneficiary's home;
- transports from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip; and,
- for a beneficiary who is receiving renal dialysis for treatment of end-stage renal disease, from the beneficiary's home to the nearest facility that furnishes renal dialysis, including the return trip.

CMS has defined organizations providing ambulance services as either suppliers (such as local fire departments or private for-profit entities unaffiliated with institutions), which compose 96 percent of all ambulance organizations, or providers (institutions, primarily affiliated with hospitals), representing 4 percent of organizations.

Medicare Part B covers ground ambulance services when other transportation sources would endanger the patient's life and the service is not part of a Part A benefit.¹ Under the AFS, Medicare provides a single payment for the transport to the nearest appropriate facility, including necessary items and services such as oxygen, medications, extra attendants, and electrocardiogram testing. Under the AFS, Medicare

Section 50203(b)(F) of the Bipartisan Budget Act of 2018

“(F) GROUND AMBULANCE DATA COLLECTION SYSTEM STUDY.—

“(i) IN GENERAL.—Not later than March 15, 2023, and as determined necessary by the Medicare Payment Advisory Commission thereafter, such Commission shall assess, and submit to Congress a report on information submitted by providers and suppliers of ground ambulance services through the data collection system under subparagraph (A), the adequacy of payments for ground ambulance services under this subsection, and geographic variations in the cost of furnishing such services.

“(ii) CONTENTS.—A report under clause (i) shall contain the following:

“(I) An analysis of information submitted through the data collection system.

“(II) An analysis of any burden on providers and suppliers of ground ambulance services associated with the data collection system.

“(III) A recommendation as to whether information should continue to be submitted through such data collection system or if such system should be revised under subparagraph (E)(i).

“(IV) Other information determined appropriate by the Commission.”

Section 311 of the Consolidated Appropriations Act of 2022 amended the due date for this report from March 15, 2023, to the second June 15th following the date on which the Secretary transmits data for the first representative sample of providers and suppliers of ground ambulance services to MedPAC. We received the first representative sample in August 2024, so this report is due June 15, 2026. ■

pays for a transport but not for a response that does not result in a transport. A response occurs when an ambulance or other emergency medical vehicle is dispatched; a transport is a response that results in a patient being transported.²

Payment under the ambulance fee schedule

AFS payments consist of two components: a level-of-service payment and a mileage payment. The service payment is the product of three factors: the relative-value unit (RVU), which reflects the relative intensity of the transport; a conversion factor that translates RVUs into dollar amounts; and an adjustment for geographic differences in costs. The mileage payment reflects the costs attributable to the use of the ambulance vehicle (for example, maintenance, fuel, and depreciation) and is the product of miles traveled with the patient and a mileage rate determined by CMS.

The AFS has seven levels of ground ambulance service, each with its own Healthcare Common Procedure Coding System (billing) code and an RVU based on relative service intensity—determined by whether the transport is emergency or nonemergency and the level of clinical staff (basic life support (BLS), advanced life support (ALS), or specialty care transport (SCT)).³ RVUs for each billing code are set relative to the lowest-intensity service (BLS nonemergency, RVU = 1.00) (Table 6-1).

The conversion factor (CF) translates RVUs into dollar amounts to determine the base payment for ambulance services. In 2026, CMS set the CF at \$284.56 for all ground ambulance transports. CMS updates the conversion factor each year by the Consumer Price Index for All Urban Consumers (CPI-U), reduced by the 10-year moving average of multifactor productivity.⁴ The CPI-U measures the cost of a market basket of consumer goods and

**TABLE
6-1****Medicare ground ambulance service levels and associated RVUs, 2026**

Ground ambulance service level	HCPCS code	RVU
BLS nonemergency	A0428	1.00
BLS emergency	A0429	1.60
ALS nonemergency, Level 1	A0426	1.20
ALS emergency, Level 1	A0427	1.90
ALS, Level 2	A0433	2.75
Specialty care transport	A0434	3.25
Paramedic ALS intercept	A0432	1.75

Note: RVU (relative-value unit), HCPCS (Healthcare Common Procedure Coding System), BLS (basic life support), ALS (advanced life support). For each ground ambulance service, the RVU is multiplied by a conversion factor of \$284.56 to obtain a payment base rate.

Source: MedPAC analysis of table of ambulance fee schedule services from CMS's ambulance fee schedule public use files.

services and may not accurately measure changes in the costs of providing ambulance services.

To adjust for geographic differences in costs, CMS uses the practice expense (PE) component of the geographic practice cost index (GPCI), based on the ZIP code where the patient is picked up. To determine the service payment for a transport, CMS applies the GPCI to 70 percent of the base payment for ground ambulance transports and adds that product to 30 percent of the unadjusted base payment. The PE GPCIs may not effectively track geographic differences in costs because 34 states have a single PE GPCI value for the entire state. Therefore, in these states, there is no difference in payment between low-cost areas and high-cost areas for the same service.

The mileage payment under the AFS covers vehicle-related costs such as fuel, maintenance, and depreciation. It is calculated by multiplying the miles traveled with the patient—from pickup to the nearest appropriate facility—by a CMS-set base rate. For 2026, the base rate is \$9.15 per mile. Each year, CMS updates the base rate by the CPI-U reduced by the 10-year moving average of multifactor productivity.

The AFS includes several add-on payments based on pickup location. For pickups occurring in rural and super-rural areas, the mileage rate is increased by 50

percent for the first 17 miles of transport.⁵ Temporary add-ons—effective through December 31, 2027—raise service and mileage payments by 3 percent for rural transports and 2 percent for urban transports. Additionally, super-rural transports receive the temporary 3 percent rural increase and a temporary 22.6 percent increase to the service component of the payment (Table 6-2, p. 258).

The ambulance payment system was largely developed without cost data

The AFS includes payment adjustments for three factors:

- transport intensity (via the RVUs),
- geographic location of the patient pickup (urban, rural, or super rural), and
- geographic differences in costs (via the PE GPCIs).

None of these adjustments are based on cost data from ambulance organizations, except for the adjustment for super-rural location. Use of the RVUs and the GPCIs was determined from deliberations in negotiated rulemaking in 2002 (Centers for Medicare & Medicaid

**TABLE
6-2****Medicare's ambulance fee schedule payment formulas for services and mileage, 2026**

Payment category	Payment formula
Service payment	
Urban pickup	$RVU \times \$284.56 \times (0.7 \times PE\ GPCI + 0.3) \times 1.02$
Rural pickup	$RVU \times \$284.56 \times (0.7 \times PE\ GPCI + 0.3) \times 1.03$
Super-rural pickup	$RVU \times \$284.56 \times (0.7\ PE\ GPCI + 0.3) 1.03 \times 1.226$
Mileage	
Urban pickup	$Miles \times \$9.15 \times 1.02$
Rural and super-rural pickup, first 17 miles	$Miles \times \$9.15 \times 1.03 \times 1.5$
Rural and super-rural pickup, 17+ miles	$(Miles - 17) \times \$9.15 \times 1.03$

Note: RVU (relative-value unit), PE GPCI (practice expense geographic practice cost index). CMS defines rural areas as ZIP codes outside of metropolitan statistical areas (MSAs) or in a rural census tract within an MSA; super-rural areas as ZIP codes located in rural counties that are among the lowest quartile of all rural counties by population density; and urban areas as ZIP codes in MSAs modified to exclude rural census tracts in MSAs. The payments listed in this table occur only if an ambulance response results in a patient transport. Responses that do not result in a transport are not covered under the ambulance fee schedule.

Source: MedPAC analysis of table of ambulance fee schedule services from CMS's ambulance fee schedule public use files.

Services 2002). The RVUs are of particular concern because they have not been updated since then. The temporary 2 percent add-on for urban transports and 3 percent add-on for rural transports were established by the Congress and did not have an underlying empirical basis (Centers for Medicare & Medicaid Services 2002). The temporary 22.6 percent add-on for super-rural transports was based on 1999 data from the Project Hope Center for Health Affairs (Centers for Medicare & Medicaid Services 2004, Government Accountability Office 2003). Congress has extended these add-ons at different intervals since their implementation. The add-ons are currently effective through December 31, 2027.

The Government Accountability Office (GAO) previously collected cost and revenue data on ambulance organizations in 2004 and 2010 in response to a mandate from the Congress to evaluate the adequacy of payments under the AFS (Government Accountability Office 2012). However, those datasets were limited, covering only a few hundred organizations and excluding those that shared costs with other entities (fire departments, police departments, hospitals). These excluded organizations tended to be government owned, low volume, and

urban, so the GAO data might not have been nationally representative.

Prior MedPAC work on ambulance payment

In June 2013, the Commission published a report on Medicare payments for ambulance services under the AFS (Medicare Payment Advisory Commission 2013). The report concluded that the continued entry of private equity and for-profit organizations into the ambulance market indicated the availability of profit opportunities. However, the Commission's report also indicated that AFS payments might not accurately track variation in costs. Though no cost data were available to comprehensively assess the adequacy or accuracy of ambulance payments, the available evidence suggested that Medicare's add-on payments were poorly targeted. While the super-rural designation boosted payments for isolated, low-volume providers, it also benefited providers in midsize micropolitan areas that may not face the same challenges in furnishing ambulance services. However, without cost data, the Commission was not able to determine to what extent the urban, rural, and super-rural add-on payments should have been adjusted.

In that report, the Commission recommended that the Congress:

- allow the three temporary add-on payments (2 percent for urban transports, 3 percent for rural and super-rural transports, and an additional 22.6 percent for super-rural transports) to expire;
- replace the permanent rural and super-rural 50 percent add-on payment for the first 17 miles of a transport with an add-on payment for transports provided by low-volume organizations and that originate in geographically isolated areas to better target payments to organizations with high costs due to factors beyond their control;
- enact a series of measures to reduce clinically inappropriate use of BLS ground ambulance services; and
- lower payments for nonemergency BLS transports and transfer those savings to payments for emergency transports in a budget-neutral manner.

Accurate cost data needed to assess payment accuracy and access to care

Accurate cost data provide important information about how well a payment system functions. It is important that cost data allow CMS to set payment rates that accurately reflect the relative costs of providing services to help ensure that health care providers make delivery-of-care decisions based on clinical rather than financial considerations. For example, each year, the Commission uses cost data, where available, to assess the adequacy of Medicare's FFS payment systems for hospitals, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, dialysis facilities, and hospices.

To help policymakers understand how well the AFS is functioning, ambulance cost data can help policymakers determine whether:

- the aggregate of all payments under the AFS is high enough to ensure that ambulance organizations are willing to provide services to FFS Medicare beneficiaries;

- the values of the RVUs in the AFS accurately represent differences in resource needs across service levels;
- current payment adjustments for urban, rural, and super-rural transports accurately reflect the differences in the cost of providing ambulance services across these geographic definitions; and
- other factors that affect the costs of providing ground ambulance services are accounted for in AFS payments.

Part of our evaluation of the GADCS data involves assessing whether the dataset can be used to make these determinations.

GADCS dataset allows for effective analysis of ambulance costs and payments, but it needs refinement

In response to a congressional mandate, CMS created the GADCS, which includes data for 2022 and 2023 from about 71 percent of all ground ambulance organizations, including information from organizations that share costs with other entities. The GADCS contains a rich set of variables, including information on organizational characteristics, service area, service volume, response times, staffing and service mix, and certain categories of costs and revenues. The data are a valuable resource for assessing the appropriateness of AFS payments and could be used to identify adjustments to the payment rates that would improve payment accuracy. However, the GADCS includes over 600 variables (though due to the structure of the GADCS instrument, organizations often were not required to answer all the questions), with very specific cost variables and other variables that are not pertinent to assessing the adequacy or accuracy of AFS payment rates or Medicare beneficiaries' access to ambulance services.

CMS's ground ambulance data-collection effort

In the BBA of 2018, the Congress directed CMS to establish a ground ambulance data-collection effort. CMS responded by creating the GADCS. To collect the GADCS data, CMS divided ground ambulance

organizations into four cohorts—Year 1 through Year 4—based on the order in which the organizations were sampled to participate in the GADCS. Year 1 included organizations active in 2017, Year 2 in 2018, and Years 3 and 4 in 2020. The BBA of 2018 required ambulance organizations to participate in the GADCS. Organizations that did not furnish the requested data were subject to a one-year, 10 percent payment reduction on AFS ground ambulance services in a subsequent calendar year.

The four cohorts combined included 10,581 organizations. CMS collected data from the Year 1 and Year 2 organizations during 2023 and from the Year 3 and Year 4 organizations during 2024, and 84 percent of these organizations were still billing Medicare when CMS collected the data. Of these remaining organizations, 86 percent (7,572) submitted and certified a complete response to CMS (meaning they had completed all data fields). A small number of organizations (313) were not actively billing Medicare (so they could not complete all data fields) during the data-collection years but submitted data, for a total of 7,885 submitted and certified (but not always complete) GADCS responses.

While CMS collected data for the Year 1 and Year 2 cohorts during 2023, the data that the organizations submitted were from one-year periods that began in 2022. Likewise, CMS collected the data from the Year 3 and Year 4 cohorts during 2024, but the data were from a one-year period that began in 2023. CMS allowed the Year 1 and Year 2 organizations to select a “data year” that started either January 1, 2022, or the start of the organization’s annual accounting period in 2022. CMS made the same allowance for the Year 3 and Year 4 organizations for submission of their 2023 data.

The GADCS allows for detailed analysis of ambulance organizations’ costs

The GADCS dataset provides a rich set of variables that allow for detailed analysis of ambulance organizations’ operations and costs (see Table 6-3 for key data elements used to produce the empirical results in this report).

The GADCS includes data from about 71 percent of all ground ambulance organizations and captures information from those that share costs with other entities (fire departments, police departments, or

hospitals). Previous ground ambulance datasets had excluded organizations that shared costs because difficulties separating the ambulance costs from the entity with which costs were shared made the data unreliable. For the GADCS, CMS worked with the organizations that share costs to ensure the reliability of their data. As a result, the GADCS data are useful to policymakers to analyze the adequacy of AFS payments and estimate whether the AFS payments appropriately vary with the cost of caring for beneficiaries with different needs in different locations. CMS found that organizations that were for profit or had relatively low transport volume were less likely to complete the GADCS reporting requirement, so the agency was concerned that the participating organizations were not a nationally representative sample. As a result, the GADCS includes survey weights that can be used to create nationally representative empirical results.⁶

Concerns about the GADCS data

The GADCS is a major step forward in understanding ambulance organizations’ costs. If collection of the GADCS data is continued, the data would be a valuable resource for assessing the appropriateness of AFS payments and identifying adjustments to the payment rates that would improve payment accuracy.

However, the GADCS includes over 600 variables, and not all are necessary for evaluating ambulance costs or beneficiaries’ access to ambulance services. For example, in our analysis of ambulance costs, we used 181 variables to generate the empirical results presented later in this chapter, and many of those variables were more granular than needed. Examples of variables that may not be needed to evaluate the AFS include whether the organization is the primary provider in its service area, whether the organization has a secondary service area (with several related questions), the work hours that ambulance personnel spend on nonambulance responsibilities, and the number of facilities and vehicles owned by the reporting organization (with several questions related to each facility). Given the size and complexity of the dataset, collecting and submitting the data could be burdensome, especially for small ambulance organizations. Streamlining the GADCS could reduce this burden while preserving its analytical value.

At the same time, the GADCS does not separately estimate the costs specifically associated with

**TABLE
6-3**

GADCS variables used in MedPAC's analysis

Variable category	Variables used
Organizational characteristics	Type of ownership (for profit, nonprofit, government), use of volunteer labor, affiliation (fire/police department, hospital, or independent), and service area classification (urban, rural, super rural)
Response times	The time from when a call comes in to dispatch to when a ground ambulance or other EMS vehicle arrives at the patient's location
Service volume	Number of responses and transports
Staffing mix	Hours worked by volunteers; hours worked and compensation for EMRs, EMTs, paramedics, nurses, physicians, drivers, and administrative staff
Service mix	Emergency versus nonemergency responses; share of transports that are BLS, ALS, and SCT
Cost categories	Cost of labor, facilities, vehicles, equipment, supplies, and medications for ground ambulance services provided to all patients; cost for contracted services such as billing and accounting
Sources of payment for ground ambulance services	Payments from FFS Medicare, Medicare Advantage, Medicaid, TRICARE, Veterans Health Administration, commercial insurance, workers' compensation, and patient self-pay
Revenue from sources other than payment for ground ambulance services	Revenue from 21 sources that are not related to billing for services, such as from local government funding, contracted services, grants, and charitable donations
Total organization revenue	Revenue from all sources, some of which are not specified in the GADCS

Note: GADCS (Medicare Ground Ambulance Data Collection System), EMS (emergency medical service), EMR (emergency medical responder), EMT (emergency medical technician), BLS (basic life support), ALS (advanced life support), SCT (specialty care transport), FFS (fee-for-service). CMS assigned "service area classification" based on which category had the largest share of an organization's FFS Medicare transports. We constructed many of the variables listed using more granular variables in the GADCS. For a list of all the GADCS variables we used, see the Excel data file accompanying this chapter, available at <https://www.medpac.gov/document/june-2026-report-to-the-congress-medicare-and-the-health-care-delivery-system/>.

Source: MedPAC analysis of data from the Medicare Ground Ambulance Data Collection System.

providing ground ambulance services to FFS Medicare beneficiaries. Lack of Medicare-specific data could make it difficult to use the GADCS to evaluate the adequacy of AFS payments. However, our analysis of the GADCS cost data indicates that the cost of providing ground ambulance services to FFS Medicare beneficiaries is similar to the cost of providing ground ambulance services to all patients (see text box on patients' costs, pp. 268–269). Therefore, using the current GADCS, analysts could calculate cost per transport for all patients (including those who are not FFS Medicare beneficiaries), which could be compared with the AFS payment rates. This comparison could

be useful in analyzing of the adequacy of AFS payment rates.

Stakeholders support continued collection of a more streamlined dataset

The BBA of 2018 requires that the Commission analyze the burden on organizations associated with the data-collection system and recommend whether data collection should continue or should be revised. To

obtain information about the burden of the data collection and how the GADCS could be improved, we spoke with representatives from trade associations, CMS, RAND (which CMS contracted with to help determine the data to collect), and ground ambulance organizations during the summer and fall of 2025.

All of the entities we interviewed conveyed that it would be beneficial to continue the data collection and that discontinuation would be a mistake. Interviewees—which represented a broad range of ambulance companies (for profit, nonprofit, urban, rural, large, small)—said that some organizations, especially smaller ones, had difficulties collecting and submitting the data, and some organizations required a lot of assistance to complete their reporting requirements. Despite these difficulties, they agreed that the high participation rate among the organizations indicates strong organizational engagement. Also, interviewees observed that because ambulance organizations had incurred start-up costs associated with the new data-collection effort, it would be unfortunate to discontinue collecting the data after just one iteration. These interviewees reported that the quality of the data should improve as organizations gain more experience with the data-collection instrument.

Although all of the stakeholders that we interviewed supported continued data collection, some noted that the current data-collection instrument could be streamlined without a loss in effectiveness. For example, the reporting requirement instrument is very granular concerning questions about costs for labor, vehicles, and facilities. Organizations commented that the burden of the data collection would be reduced if these questions were at a more aggregated level. Therefore, streamlining could be accomplished by reducing the number of questions in the GADCS reporting requirement and by having only a subset of the organizations complete the reporting requirement each year. Finally, a representative from one of the trade associations emphasized that because the AFS payment adjustments were largely created without cost data, discontinuing the GADCS would hinder efforts to improve payment accuracy in the AFS.

Substantial variation among ground ambulance organizations in services provided and costs

The BBA of 2018 requires the Commission to provide information about the adequacy of Medicare payments for ambulance services and geographic variations in the costs of providing services. It is important to know whether the current AFS payment adjustments reflect the key drivers of the ambulance organizations' costs. Therefore, for this report we identified the factors that affect ambulance costs, assessed whether current AFS payment adjustments reflect those factors, and compared the organizations' costs with their revenues.

We analyzed the GADCS data and found that the strongest driver of differences in ground ambulance cost per transport between organizations is the volume of transports that an organization provides. As the number of transports increases, costs grow at a much lower rate, which is suggestive of economies of scale. This result is consistent with analyses by GAO and a previous analysis by the Commission (Government Accountability Office 2012, Government Accountability Office 2007, Medicare Payment Advisory Commission 2013). In addition, we found that cost per transport is lower for for-profit organizations relative to nonprofit and government-owned organizations. Cost per transport is also lower for organizations that use a dynamic staffing model (meaning the number of fully staffed ambulance units varies by day, time, or season) compared with those that use a static staffing model (meaning the number of fully staffed ambulance units does not change over time). Finally, we found that organizations that have rural service areas have lower cost per transport than organizations that have urban service areas if we control for other factors that affect costs, such as number of transports, which is consistent with results from GAO studies (Government Accountability Office 2012, Government Accountability Office 2007).

Finally, we compared organizations' revenues with their costs by calculating revenues divided by costs. We found extremely wide variation among the organizations, with large differences between low-volume organizations and high-volume organizations and between government-owned organizations and for-profit organizations.

Methods

Earlier studies of ambulance costs relied on data from only a few hundred of the more than 10,000 organizations that provide ambulance services to Medicare beneficiaries (Centers for Medicare & Medicaid Services 2015, Government Accountability Office 2012, Government Accountability Office 2007, Government Accountability Office 2003). These studies excluded many very small organizations and those that shared costs with other entities—such as fire departments, police departments, or hospitals—due to concerns about data reliability. To address these concerns, CMS provided extensive support to organizations participating in the GADCS to improve data quality and completeness.

To assess the reliability of GADCS data from organizations that share costs with fire departments, police departments, or hospitals, we compared their reported costs and revenues with those of organizations that do not share costs. While organizations that shared costs were more likely to report implausibly high values, these cases were rare. After excluding these outliers, we found no substantial differences between the two groups. As a result, we applied only minimal exclusions to the GADCS data used in our analysis.

To prepare the GADCS data for analysis, we first calculated cost and revenue per response for each organization that did not share costs with another entity (52 percent of the organizations). We excluded organizations with values more than three standard deviations above the mean—specifically, cost per response over \$20,067 or revenue from ground ambulance operations per response over \$31,025—removing 66 organizations. We applied the same exclusion criteria to organizations that shared costs (48 percent of the organizations), which excluded an additional 50 organizations.

We also excluded 313 organizations that were not actively billing Medicare, as well as 6 organizations with critical data issues (zero reported staff hours, no revenue, invalid ZIP codes, or missing transport counts). After these edits, our final analytic sample included 7,450 organizations (70 percent of the 10,581 organizations in the four cohorts that CMS sampled for the GADCS).

To ensure that the results from our analysis presented in this report were nationally representative, we used the survey weights that the GADCS provides.

Majority of ambulance organizations are government owned, urban, and use a static deployment model

We evaluated descriptive characteristics of the ground ambulance organizations including type of ownership, location of service area (urban, rural, or super rural), and type of staff deployment used (static, dynamic, or hybrid). Under static deployment, the organization never changes the number of fully staffed ambulance units, meaning that the ambulance provider is fully staffed 24/7. Under dynamic deployment, the organizations change the number of fully staffed ambulance units over time. Hybrid deployment is a mix of static and dynamic deployment.

We found that more than 50 percent of the organizations had an urban service area, were government owned, or used a static deployment model. However, distribution of transports among these categories is different from the number of organizations. For example, there were fewer for-profit organizations than government-owned or nonprofit organizations, but for-profit organizations provided more ground ambulance transports than the other two ownership categories. Also, while slightly more than half of the organizations had urban service areas, the urban organizations had 82 percent of the ground ambulance transports (Table 6-4, p. 264).

An important finding from these descriptive statistics is that over half of the organizations are government owned, which is different from other health care sectors. For example, only about 20 percent of acute care hospitals are government owned. In addition, most of the government-owned ambulance organizations also provide fire or other first response services. Finally, a majority of urban, rural, and super-rural organizations are government owned—51 percent, 56 percent, and 65 percent, respectively (data not shown).

Average service intensity was higher for government-owned organizations than for-profit organizations and nonprofit organizations

Transport intensity can influence ambulance service costs, as reflected in the AFS's seven service levels, each

**TABLE
6-4****The majority of ground ambulance organizations were urban, government owned, or used a static deployment model, 2022 and 2023**

Organization category	Number of organizations	Share of organizations	Number of transports	Share of transports
Primary service-area location				
Urban	5,539	53.5%	40,997,213	82.2%
Rural	2,876	27.8	7,041,153	14.1
Super rural	1,943	18.8	1,863,064	3.7
Ownership				
For profit	1,937	18.7	20,995,123	42.1
Nonprofit	2,769	26.7	9,692,384	19.4
Government	5,652	54.6	19,213,923	38.5
Type of staffing model				
Static	5,764	55.6	16,725,633	33.5
Dynamic	2,516	24.3	17,228,415	34.5
Hybrid	2,078	20.0	15,947,382	32.0
Total	10,358		49,901,430	

Note: CMS assigned "service-area location" (urban, rural, or super rural) based on which category had the largest share of an organization's fee-for-service Medicare transports. "Rural" areas are ZIP codes outside of metropolitan statistical areas (MSAs) or in a rural census tract within an MSA; "super-rural" areas are ZIP codes located in rural counties that are among the lowest quartile of all rural counties by population density; and "urban" areas are ZIP codes in MSAs modified to recognize rural census tracts in MSAs. "Number of transports" is transports for all patients. For some groups, the percentages do not sum to 100 due to rounding.

Source: MedPAC analysis of data from the Medicare Ground Ambulance Data Collection System.

assigned a different RVU based on service intensity. Using GADCS data, we analyzed transport intensity by ownership type—for profit, government owned, and nonprofit—based on the share of transports that were nonemergency, BLS, ALS, or SCT. We found that government-owned organizations had a notably lower share of nonemergency transports—8.9 percent, compared with 48.7 percent for for-profit organizations and 25.4 percent for nonprofit organizations (Table 6-5). By contrast, government-owned organizations had a higher share of ALS transports (56.5 percent) compared with for-profit and nonprofit organizations (32.2 percent and 43.7 percent, respectively). These findings indicate higher service intensity among the government-owned organizations. The effect that the share of transports that are nonemergency has on organization costs is reflected in Table 6-8 (p. 271), which indicates that a 10 percentage point increase

in the share of transports that are nonemergency decreases costs by 4.2 percent.

Ground ambulance cost per transport varies substantially among ambulance organizations

For each organization in our analytic file, we calculated total costs for ground ambulance services as the sum of ground ambulance costs for labor (response staff, administration, and nurses/physicians), facility (lease, rent, mortgage, insurance, maintenance, utilities, and taxes), vehicles (purchase, lease, remount, license, taxes, fuel, and maintenance), equipment, supplies, and medications. We also calculated for each organization the average RVU of their ambulance transports, which is a measure of service intensity. Due to data limitations, our analysis used costs for all patients, not costs specific to the services provided to FFS Medicare beneficiaries. However, an analysis of the data found

**TABLE
6-5****Government-owned organizations had fewer nonemergency and more advanced life support services than for-profit and nonprofit organizations, 2022 and 2023**

Organization ownership category	Share of transports that are nonemergency	Share of transports that are:		
		BLS	ALS	Specialty care
For profit	48.7%	65.9%	32.2%	1.8%
Nonprofit	25.4	54.4	43.7	1.9
Government owned	8.9	43.0	56.5	0.4

Note: BLS (basic life support), ALS (advanced life support). A "transport" is an ambulance response that results in a patient being transported to another location, such as a hospital or dialysis facility. The components in the first row and the third row do not sum to 100 percent due to rounding.

Source: MedPAC analysis of data from the Medicare Ground Ambulance Data Collection System from CMS.

that the cost of providing services to all patients is sufficiently close to the cost of providing services to FFS Medicare beneficiaries to provide a reasonable representation (see text box, pp. 268–269).

We found that ground ambulance cost per transport varied widely across organizations. At the 90th percentile, costs were \$4,136—11 times higher than the 10th percentile value of \$367. We also examined how cost per transport and RVUs per transport differed by organization service area (urban, rural, super rural), ownership type (for profit, nonprofit, government), transport volume, and staffing model (static, dynamic, or hybrid).

Cost per transport was similar for urban and rural service areas—\$1,018 and \$997, respectively—but was more than 20 percent higher in super-rural service areas, \$1,263. However, the average RVU per transport was consistent across geographic areas, suggesting that service intensity and associated revenue levels were comparable (Table 6-6, p. 266).

In contrast, cost per transport varied widely by ownership type. For-profit organizations had the lowest average cost (\$563), followed by nonprofit organizations (\$830) and government-owned organizations (\$1,626). For-profit organizations also reported lower average RVUs, indicating less intense transports.

The higher costs among government-owned organizations were partially offset by local government

funding. Thirty percent of these organizations received such funding, with an average of \$322 per transport—substantially more than nonprofit (\$32) and for-profit (\$12) organizations.

We also found large cost differences by type of staffing model. Organizations using a dynamic or hybrid staffing model had substantially lower cost per transport (\$636 and \$918, respectively) compared with those using a static staffing model (\$1,524) (Table 6-6, p. 266). The organizations using a dynamic or hybrid staffing model also reported lower average RVUs (1.53 and 1.52, respectively) than organizations using a static staffing model (1.72), indicating lower average service intensity.

Transport volume had the greatest impact on cost per transport. We grouped organizations into quartiles by transport volume and found that cost per transport ranged from \$2,878 in the lowest quartile to \$918 in the highest. Despite these differences, average RVUs per transport were similar across the three lowest-volume quartiles and only 5 percent lower in the highest-volume quartile relative to the lowest-volume quartile, indicating that smaller organizations face higher costs not due to service intensity but likely due to scale inefficiencies. These findings align with prior GAO studies that highlighted the effect of volume on ambulance costs (Government Accountability Office 2012, Government Accountability Office 2007, Government Accountability Office 2003).

**TABLE
6-6****Substantial differences in size and cost among
ambulance organizations, 2022 and 2023**

Organization category	Number of organizations	Mean transports	Mean cost per transport	Average RVU of services
Primary service-area location				
Urban	5,539	7,402	\$1,018	1.58
Rural	2,876	2,448	997	1.61
Super rural	1,943	959	1,263	1.64
Ownership				
For profit	1,937	10,838	563	1.44
Nonprofit	2,769	3,500	830	1.62
Government	5,652	3,400	1,626	1.74
Type of staffing model				
Static	5,764	2,902	1,524	1.72
Dynamic	2,516	6,847	636	1.53
Hybrid	2,078	7,674	918	1.52
Number of transports by quartile				
Lowest quartile	2,590	148	2,878	1.65
Second quartile	2,589	714	1,934	1.70
Third quartile	2,590	2,121	1,406	1.67
Highest quartile	2,589	15,291	918	1.57

Note: RVU (relative-value unit). A “transport” is when a ground ambulance is called to a site and the patient is picked up and transported to another site. CMS assigned “service-area location” (urban, rural, or super rural) based on which category had the largest share of an organization’s fee-for-service Medicare transports. “Rural” areas are ZIP codes outside of metropolitan statistical areas (MSAs) or in a rural census tract within an MSA; “super-rural” areas are ZIP codes located in rural counties that are among the lowest quartile of all rural counties by population density; and “urban” areas are ZIP codes in MSAs modified to recognize rural census tracts in MSAs. All dollar figures have been deflated to 2022 levels using the Consumer Price Index for All Urban Consumers.

Source: MedPAC analysis of data from the Medicare Ground Ambulance Data Collection System.

In 2013, the Commission recommended that the Congress direct the Secretary to replace the permanent rural short-mileage add-on for ground ambulance transports with a new budget-neutral adjustment directing increased payments to ground transports provided by low-volume organizations that originate in isolated areas (Medicare Payment Advisory Commission 2013). Our rationale was that transport volume was a strong driver of organizations’ costs and that AFS payments should therefore be adjusted to better support low-volume organizations. However, the Commission also recommended that these adjustments should be targeted at organizations that are low volume because of geographic isolation, not because they are located near another organization. In contrast, the current rural and super-rural adjustments increase payments for all

transports, regardless of whether the rural/super-rural organization is low volume or high volume.

Although Table 6-6 highlights several factors that affect cost per transport, interactions among these variables complicate interpretation. For instance, for-profit organizations tend to have lower costs and are more likely to use a dynamic staffing model. Because they also perform more transports than nonprofit and government organizations, it is difficult to isolate whether their lower costs stem from volume, efficiency, or both. Therefore, we have performed cross tabulations of type of ownership with type of staffing model and with quartile of transport volume to help clarify the extent of interaction between these variables.

**TABLE
6-7**

For-profit organizations have relatively high shares of organizations with dynamic staffing models and high transport volumes, which partially explains the relatively low costs reported by these organizations, 2022 and 2023

Organization category	Share of organizations in category	Mean cost per transport	Mean number of transports
For profit			
Static staffing	29.5%	\$840	4,751
Dynamic staffing	38.7	538	13,835
Hybrid staffing	31.8	500	12,840
Nonprofit			
Static staffing	49.2	1,204	1,892
Dynamic staffing	28.1	647	4,901
Hybrid staffing	22.8	750	5,245
Government			
Static staffing	67.8	1,759	2,985
Dynamic staffing	17.5	958	3,080
Hybrid staffing	14.7	1,736	5,690
For profit			
Lowest quartile of transports	11.8	4,294	111
Second quartile of transports	11.7	1,168	742
Third quartile of transports	24.1	666	2,196
Highest quartile of transports	52.4	547	19,468
Nonprofit			
Lowest quartile of transports	30.2	2,149	151
Second quartile of transports	28.7	1,467	705
Third quartile of transports	22.9	1,212	2,105
Highest quartile of transports	18.2	695	15,230
Government			
Lowest quartile of transports	27.0	3,122	151
Second quartile of transports	27.8	2,282	714
Third quartile of transports	26.3	1,733	2,106
Highest quartile of transports	18.9	1,530	13,783

Note: A "transport" is when a ground ambulance is called to a site and the patient is picked up and transported to another site. All dollar values have been deflated to 2022 levels using the Consumer Price Index for All Urban Consumers.

Source: MedPAC analysis of data from the Medicare Ground Ambulance Data Collection System.

These cross tabulations provide some insight into why for-profit organizations have lower cost per transport than government organizations. The for-profit organizations have a disproportionately high share of organizations with a dynamic staffing model and a disproportionately high share in the highest quartile of transports (Table 6-7). In contrast, government-owned organizations have a disproportionately high

share of organizations that have a static staffing model and a disproportionately high share of organizations in the lowest quartile of transports. However, these cross tabulations do not explain all of the reasons that for-profit organizations have lower costs than government-owned organizations. In nearly all of the cross-tabulation cells for the for-profit organizations, cost per transport is lower than in the analogous cells

Cost of all patients is similar to cost of FFS Medicare patients

Due to data limitations, some may be concerned that the cost data in the Medicare Ground Ambulance Data Collection System (GADCS) reflect the costs of all patients and do not specify the costs of providing ambulance services to fee-for-service (FFS) Medicare beneficiaries. The basis of this concern is that if the cost of serving Medicare beneficiaries is different from the cost of serving all other patients, it will be difficult to determine the overall adequacy of payments from the Medicare ambulance fee schedule (AFS) using the GADCS data.

We analyzed whether the cost of serving FFS Medicare beneficiaries is different from that of all other beneficiaries. We used Medicare claims for FFS Medicare beneficiaries with data from the GADCS to calculate for each ambulance organization the share of all of their transports that were for FFS Medicare beneficiaries. We found that, in general, there is little difference between cost per transport for organizations that have low shares

of transports for Medicare beneficiaries and those that have high shares. However, we also found that organizations with extremely low shares of FFS Medicare beneficiaries have relatively low cost per transport, and those that have extremely high shares have relatively high cost per transport (Figure 6-1). Nevertheless, because cost per transport is similar for a broad range of share of transports that are for Medicare beneficiaries, we conclude that the GADCS cost data provide a reasonable estimate of the cost of providing ground ambulance services to FFS Medicare beneficiaries.

A regression analysis confirmed the relationship between ground ambulance costs and share of transports that are for FFS Medicare beneficiaries, suggested in Figure 6-1. We added to the regression used to produce the results in Table 6-8 (p. 271) an explanatory variable for the share of transports that were for FFS Medicare beneficiaries. When we used the full sample of organizations used to produce the results in Table 6-8, we found that the coefficient

(continued next page)

for the government organizations. For example, the for-profit organizations have lower costs than government organizations in each of the staff-deployment cells. The lower cost per transport for for-profit organizations could also be due in part to the for-profit organizations having a lower service intensity, on average, than the government organizations (Table 6-5, p. 265, and Table 6-6, p. 266).

Regression analysis indicates that larger ambulance organizations benefit from economies of scale and that AFS payment adjustments may not be well targeted

To isolate the effects of various factors on ambulance organization costs, we conducted a regression analysis.

The model included organizations' total costs as the dependent variable and the following explanatory variables:

- **Operational characteristics:** Number of transports, average trip time, share of transports that were nonemergency, and type of staffing model (static, dynamic, or hybrid)⁷
- **Profile of labor inputs:** Share of all labor hours that were volunteer hours⁸
- **Financial factor:** Share of revenue from ground ambulance operations that was from local tax revenue

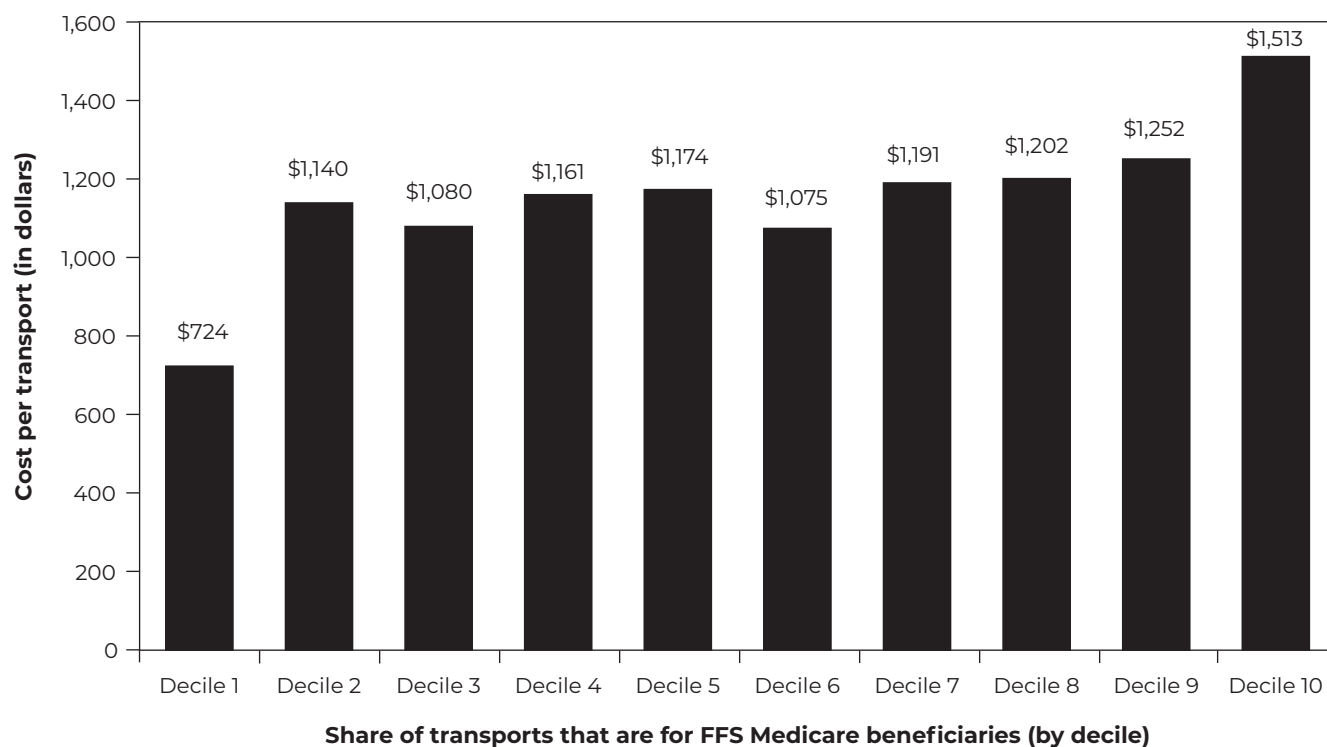
Cost of all patients is similar to cost of FFS Medicare patients (cont.)

on share of transports that were for FFS Medicare beneficiaries was significant. But when we excluded the organizations that had the 10 percent lowest shares and those that had the 10 percent highest

shares, the coefficient on the share of transports that were for FFS Medicare beneficiaries was very small and not statistically significant. ■

FIGURE 6-1

Cost per transport does not vary much by Medicare share, except for organizations with the highest and lowest shares, 2022 and 2023



Note: FFS (fee-for-service). This chart sorts ambulance organizations by the share of their ground ambulance transports that are for FFS Medicare beneficiaries. The bars indicate the median cost per transport in each decile. All dollar values have been deflated to 2022 levels using the Consumer Price Index for All Urban Consumers.

Source: MedPAC analysis of data from the Ground Ambulance Data Collection system and Medicare ambulance claims data.

- **Organizational characteristics:** Ownership type (for profit, nonprofit, or government owned), service-area location (urban, rural, or super rural)
- **Adjustment for geographic differences in costs:** PE GPCI

We selected these variables because they represent the factors that we expect to influence the costs that ambulance organizations incur when providing ground ambulance services. However, we would not use all of these variables in an analysis to determine how AFS payment rates should be adjusted for relevant factors

because many of these variables are impractical (such as type of staffing model) or could create problematic incentives (such as average trip time) (see text box on the regression analysis, pp. 272–273).

Because the ground ambulance cost data are right skewed, we used the natural logarithm of the organizations' costs as the dependent variable rather than the organizations' nontransformed costs.⁹ We also log-transformed two continuous explanatory variables, number of transports and the PE GPCI values. Finally, we used the GADCS organization-level survey weights in the regression to produce nationally representative results.

The regression had an $R^2 = 0.75$ and identified several statistically significant predictors of cost: transport volume, average trip time, share of labor hours that were attributed to volunteer workers, share of transports that were nonemergency, share of revenue from local taxes, rural service area (vs. urban), ownership type (government or nonprofit vs. for profit), whether the organization does standby events, PE GPCI, and staffing model (dynamic or hybrid vs. static) (Table 6-8).

While the regression identified several significant cost drivers, two are particularly relevant when considering how AFS payments should be adjusted to ensure payment adequacy: transport volume and service-area location (urban, rural, super rural).

Transport volume strongly affects ambulance costs

The coefficient for the natural log of transport volume is especially important because it is less than 1.0 (0.73), which indicates economies of scale, meaning that costs rise at a slower rate than volume (Table 6-8). For example, increasing the number of transports by 10 percent results in total costs rising by only 7 percent, resulting in a 2.5 percent reduction in cost per transport.¹⁰ This finding suggests that larger organizations have a financial advantage over smaller ones, a finding consistent with studies by GAO and CMS (Buttorff et al. 2025, Government Accountability Office 2012, Government Accountability Office 2007, Government Accountability Office 2003).

The AFS does not have a payment adjustment based on transport volume, but the Commission and the

GAO have both suggested volume-based payment adjustments. The Commission also emphasized in our 2013 report that a volume-based payment adjustment should be directed toward organizations that are low volume because they serve isolated areas and not toward organizations that are low volume because they are located near other organizations.

Relationship between ground ambulance costs and location of organization's service area

The AFS provides payment adjustments for whether a ground ambulance pickup occurs in an urban, rural, or super-rural area. The payment adjustments are larger for rural pickups than for urban pickups and are larger for super-rural pickups than for rural pickups. However, our regression results suggest that organizations serving rural areas have 15 percent lower costs than organizations serving urban locations when controlling for other factors that affect costs such as number of transports. We also found that the difference in costs between urban and super-rural organizations is not statistically significant (Table 6-8).¹¹

Our results describing the relationship between organization costs and whether the organization primarily serves a rural, super-rural, or urban area are not inconsistent with the results of a study by GAO (Government Accountability Office 2012). However, the results from our analysis may be more accurate than GAO's results because the GADCS data represent far more ambulance organizations (about 7,500 organizations) than the GAO dataset (154 organizations). Further, our empirical findings suggest that factors such as service volume, type of ownership, and deployment model are more important drivers of ambulance costs than whether an organization serves a rural, super-rural, or urban area. These findings are consistent with the Commission's 2013 recommendation to retarget the rural and super-rural 50 percent add-on for the first 17 miles of a transport toward providers that are low volume and geographically isolated (Medicare Payment Advisory Commission 2013). Because rural and super-rural organizations tend to provide far fewer transports than urban organizations (Table 6-6, p. 266) and are more likely to be geographically isolated, such an approach would disproportionately benefit rural and super-rural organizations while better targeting those most in need.

**TABLE
6-8**

Regression results suggest that transport volume significantly affects ground ambulance costs, with larger organizations benefiting from economies of scale, 2022 and 2023

Variable	Coefficient estimate	Standard error	p-value
Intercept	8.845	0.070	<0.0001
Log of number of transports	0.730	0.007	<0.0001
Average trip time 31–60 minutes	0.092	0.030	0.002
Average trip time 61–90 minutes	0.090	0.031	0.004
Average trip time 91–120 minutes	0.085	0.036	0.018
Average trip time 121–150 minutes	0.188	0.051	0.0002
Average trip time > 150 minutes	0.202	0.059	0.0007
Share of ambulance hours worked that are volunteer	–0.005	0.0003	<0.0001
Share of revenue that is from local taxes	0.005	0.0004	<0.0001
Share of transports that are nonemergency	–0.004	0.0003	<0.0001
Organization is nonprofit	0.098	0.031	0.002
Organization is government owned	0.381	0.029	<0.0001
Rural service area	–0.157	0.023	<0.0001
Super-rural service area	–0.016	0.028	0.556
Organization participates in standby events	0.097	0.025	<0.0001
Log of organization's PE GPCI	0.772	0.121	<0.0001
Uses dynamic staffing model	–0.190	0.024	<0.0001
Uses hybrid (dynamic and static) staffing model	–0.143	0.025	<0.0001

Note: PE GPCI (practice expense geographic practice cost index). The coefficients for the response-time categories indicate the effect on costs relative to the lowest response-time category. The coefficients for the nonprofit and government-owned organizations indicate the effect on costs relative to for-profit organizations. The coefficients for rural and super-rural service areas indicate the effect on costs relative to an urban service area. The coefficients for dynamic and hybrid staffing models indicate the effect on costs relative to organizations that use a static staffing model. The $R^2 = .75$. Statistical testing indicated that multicollinearity is not an issue in this model. We used organization-level survey weights provided in the Ground Ambulance Data Collection System dataset to produce nationally representative results. The cost data used in this regression were deflated to 2022 levels using the Consumer Price Index for All Urban Consumers.

Source: MedPAC analysis of data from the Medicare Ground Ambulance Data Collection System.

Comparing organization revenues with their costs

MedPAC typically uses a comparison of health care providers' revenues and costs, when the data are available, to evaluate the adequacy of Medicare payments in various health care sectors. Although we use the GADCS data to conduct such an analysis in this report, this comparison of revenue with cost should be viewed cautiously for two reasons:

- Over half the ground ambulance organizations (55 percent) are government owned, and over half
- the total revenue (52 percent) for the government organizations comes from sources that are unrelated to the billing for ground ambulance services, such as funding from local governments, grants, and charitable donations. In addition, government organizations have higher average service intensity than for-profit and nonprofit organizations. Consequently, government organizations generally operate in a different financial context from other organizations.
- The GADCS data collection is the first time many ground ambulance organizations have submitted

Regression analysis of relationship between ground ambulance costs and factors that could be used to adjust ambulance fee schedule payments

In the future, the data in the Ground Ambulance Data Collection System (GADCS) could be used in a regression analysis to inform how Medicare payments for ground ambulance services should be adjusted for the relevant factors that affect the cost to ambulance organizations for providing these services. Variables like the number of transports provided by the organization in a typical year; whether the organization primarily serves an urban, rural, or super-rural area; a measure that accounts for geographic differences in costs; and the intensity of the ambulance services provided by the organization are important factors in such an analysis.

We provide an example of a regression that could serve as the basis for adjusting payments for ground ambulance services. For this regression, we used the same dataset that we used for the regression in Table 6-8 (p. 271), which included data on 7,450 ground ambulance organizations. We used organization-level survey weights from the GADCS to produce nationally representative results. The dependent variable was the natural log of total costs of providing ground ambulance services for each organization. The explanatory variables included:

- the natural log of number of transports for all patients;
- whether the organization had an urban, rural, or super-rural service area;
- the natural log of the organization's practice expense geographic practice cost index (PE

GPCI), which CMS uses to adjust payments to ground ambulance organizations for geographic differences in costs; and

- the share of the organization's transports that are in each of six billing codes for ground ambulance services that are included in the GADCS. These billing codes represent different levels of intensity for ambulance transports, and CMS adjusts payments depending on the code recorded on a claim.

Results from this regression indicate an $R^2 = 0.74$ and the following relationships between costs and these variables (Table 6-9):

- As an organization increases the number of transports, their costs increase at a slower rate, indicating economies of scale. For example, a 10 percent increase in the number of transports correlates with a 7.2 percent increase in costs.¹²
- Organizations that have rural service areas have lower costs than organizations that have urban service areas, holding constant the other factors used in this regression.
- A 10 percent increase in an organization's PE GPCI correlates with an 8.9 percent increase in costs.
- A 1 percentage point increase in the share of transports that are for basic life support (BLS) emergency transports increases costs by 0.5 percent.

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cost and revenue data, so there are likely some errors in reporting that should improve as these organizations gain experience reporting these data. CMS specifically mentioned that organizations may have made errors in reporting revenue from local

government and other sources unrelated to billing for ground ambulance services (Buttorff et al. 2025). Reporting errors for these revenue sources have a larger effect on government organizations than other organizations.

Regression analysis of relationship between ground ambulance costs and factors that could be used to adjust ambulance fee schedule payments (cont.)

- A 1 percentage point increase in the share of transports that are for advanced life support (ALS) nonemergency transports, ALS Level 1 emergency transports, ALS Level 2 transports, or specialty care transports increased costs from 1.2 percent to 1.3 percent.

The coefficient of 0.733 on the natural log of the number of transports is an important result. It suggests that as an organization increases the number of transports, its costs rise at a slower rate, which indicates economies of scale. Therefore, high-volume organizations have a financial advantage over low-volume organizations. ■

**TABLE
6-9**

Regression results show that transport volume significantly affects ground ambulance costs, with larger organizations benefiting from economies of scale, 2022 and 2023

Variable	Coefficient estimate	Standard error	p-value
Intercept	8.252	0.060	<0.0001
Log of number of transports	0.733	0.006	<0.0001
Rural service area	-0.186	0.023	<0.0001
Super-rural service area	0.002	0.028	0.9406
Log of organization's PE GPCI	0.895	0.126	<0.0001
Share of ambulance transports that are BLS, emergency	0.005	0.0004	<0.0001
Share of ambulance transports that are ALS, nonemergency, Level 1	0.012	0.0009	<0.0001
Share of ambulance transports that are ALS, emergency, Level 1	0.013	0.0004	<0.0001
Share of ambulance transports that are ALS, Level 2	0.012	0.002	<0.0001
Share of ambulance transports that are specialty care transports	0.013	0.002	<0.0001

Note: PE GPCI (practice expense geographic practice cost index), BLS (basic life support), ALS (advanced life support). The coefficients for rural and super-rural service areas indicate the effect on costs relative to an urban service area. The coefficients on the share of transports in each of the service categories indicate the effect on costs of increasing the share in that category by 1 percentage point and decreasing the share for BLS nonemergency transports by 1 percentage point. The $R^2 = .74$. We used organization-level survey weights provided in the Ground Ambulance Data Collection System dataset to produce nationally representative results. The cost data used in this regression were deflated to 2022 levels using the Consumer Price Index for All Urban Consumers.

Source: MedPAC analysis of data from the Medicare Ground Ambulance Data Collection System.

Taken together, these considerations lead us to view government ambulance organizations as operating in a different financial context from other ambulance organizations. In addition, we have found that some organizations reported extremely large differences between their revenues and costs, which may reflect this year being the first in which many organizations submitted these data. These data issues suggest that

GADCS-based measures of ambulance organizations' revenues relative to costs might not be reliable indicators of payment adequacy. To improve our confidence in these measures, after applying exclusions described in the methods above—including the exclusion of organizations with costs more than three standard deviations from the mean—we further limited the influence of outliers by dropping the 5 percent of

**TABLE
6-10****Revenues relative to costs, by type of ownership, 2022 and 2023****Median total revenue-to-cost ratio for ambulance services**

Ownership category	Weighted by number of transports	Unweighted
For profit	1.11	1.03
Nonprofit	1.02	0.88
Government	0.98	0.72

Note: In all cells, the measures are calculated as revenues divided by costs. The revenues are from all sources, and costs are from ambulance transports for all patients. We used organization-level survey weights provided in the Ground Ambulance Data Collection System dataset to produce nationally representative results. The reported values are medians for each ownership category. All dollar values have been deflated to 2022 levels using the Consumer Price Index for All Urban Consumers.

Source: MedPAC analysis of data from the Medicare Ground Ambulance Data Collection System.

organizations with the largest negative differences and the 5 percent with the largest positive differences. This process yielded a trimmed analytic sample of 6,688 organizations.

Due to our concerns about the differences between government organizations and other organizations, we present two analyses of revenue relative to cost. The first analysis includes all 6,688 organizations in the trimmed analytic sample, and we report results separately for government, nonprofit, and for-profit organizations. The second analysis excludes from the trimmed 6,688 organizations the 3,721 government organizations, leaving 2,967 organizations. We used the data for the remaining 2,967 organizations to examine revenue relative to cost across several organizational characteristics, including whether the service area is urban, rural, or super rural; the number of transports; and the share of transports that are nonemergency.

In both analyses, we measure the ratio of revenue to cost for each ambulance organization. “Revenue” reflects the total revenues that the organization received from all sources, and “cost” reflects the total costs of providing ground ambulance services. We caution that these results should not be interpreted as Medicare margins because the revenue includes sources beyond FFS Medicare and the costs reflect ambulance services provided to all patients, not just FFS Medicare beneficiaries. Also, in both analyses,

we calculated two median revenue-to-cost ratios (RCRs) for each category of ambulance organization. For the first RCR, we weighted each organization by the number of transports. The result is the RCR for the median transport. Half of the transports were in organizations that had higher RCRs and half were in organizations that had lower RCRs. For the second RCR, we did not weight the organizations by number of transports. The result is the RCR for the median organization. Half of the organizations had higher RCRs and half had lower RCRs.¹³

In the first analysis, we found a median weighted RCR of 0.98 for government organizations, which was lower than corresponding ratios for nonprofit and for-profit organizations (1.02 and 1.11, respectively) (Table 6-10). The government organizations also had a lower unweighted median ratio (0.72) than nonprofit and for-profit organizations (0.88 and 1.03, respectively). The RCRs vary widely within these categories. For example, among the government organizations, the RCR was 0.34 at the 25th percentile and 1.31 at the 75th percentile.

In the second analysis, which excluded government organizations, we found large differences in median weighted RCRs between low-volume and high-volume organizations. Organizations in the lowest quartile of transports had a median weighted RCR of 0.77, while those in the highest quartile had a median weighted

**TABLE
6-11****Ratio of revenue to cost was much lower for low-volume organizations than for high-volume organizations, 2022 and 2023**

Group	Median total revenue-to-cost ratio for ambulance services	
	Weighted by number of transports	Unweighted
Service area location		
Urban	1.10	1.01
Rural	1.02	0.90
Super rural	1.03	0.90
Quartile of transports		
Lowest quartile	0.77	0.77
Second quartile	0.86	0.84
Third quartile	0.98	0.97
Highest quartile	1.10	1.04
Share of transports that were nonemergency		
<0.25	1.08	0.94
0.25–0.50	1.10	0.96
0.50–0.75	1.10	0.98
>0.75	1.10	1.02

Note: The reported value in each cell is the median. In all cells, the measures are calculated as revenues divided by costs. The revenues are from all sources, and costs are from ambulance transports for all patients. We used organization-level survey weights provided in the Ground Ambulance Data Collection System dataset to produce nationally representative results. All dollar values have been deflated to 2022 levels using the Consumer Price Index for All Urban Consumers.

Source: MedPAC analysis of data from the Ground Ambulance Data Collection System.

ratio of 1.10 (Table 6-11). This relationship between quartile of transports and revenue-to-cost ratio is another indication of economies of scale.

We found smaller differences when we grouped the organizations by service area location and by share of transports that were nonemergency. Organizations with urban service areas had a higher median weighted RCR of 1.10 compared with rural and super-rural organizations (1.02 and 1.03, respectively). However, all of these categories had median RCRs greater than 1.0, indicating that revenues were higher than costs for the median transports. We also found that there was not much difference in ratios between organizations that had a low share of transports that were nonemergency and those that had a high share of transports that were nonemergency.

In addition to comparisons of cost and revenue, the Commission also uses measures of beneficiary access to care, provider quality, and provider access to capital to assess payment adequacy in Medicare's FFS payment systems. Though we are not aware of data on the quality of ambulance services or on ambulance organizations' access to capital, analysis of measures of access to ambulance services could be part of future work, such as differences in average response times between geographic areas and whether residents in some geographic areas are farther from an ambulance organization than others.¹⁴ A study of "ambulance deserts" (defined as census blocks in which the center is more than a 25-minute trip from an ambulance station) in 41 states suggested that access to ambulance services is limited in some areas. This study found that in 2021, 7.2 percent of the population in these states

(4.5 million people) lived in ambulance deserts (Jonk et al. 2023). Residents of rural counties were more likely to live in ambulance deserts than residents of urban counties (9.3 percent vs. 3.5 percent).

CMS should continue to collect GADCS data, streamlined to reduce burden

The current AFS largely is not based on cost or revenue data. Instead, it was established in 2002, predominantly based on negotiated rulemaking and not on data that allowed for the identification of factors that affect the variation in ambulance costs. Moreover, the RVUs used to adjust AFS payments for differences in service intensity have not changed since 2002, and the adjustments for whether an ambulance transport occurred in an urban, rural, or super-rural location have not changed since 2008. Finally, before the GADCS, there was no comprehensive dataset that could be used to assess the adequacy of the AFS payment rates.

The GADCS is a good first step toward a dataset that policymakers can use to effectively evaluate the adequacy of AFS payments. As ambulance organizations become experienced with collecting and submitting data to CMS, the GADCS should be sufficient to allow analysts to evaluate whether aggregate AFS payments are large enough to ensure patient access and the accuracy of AFS payments across patient severity levels or geographic locations. In interviews and correspondence, stakeholders including ambulance organizations, CMS, RAND, and trade associations expressed support for continued collection of GADCS data. In addition, they indicated that collection of the data should continue in order to ensure that reliable data are available to maintain AFS payments that accurately reflect the cost of providing ambulance services to FFS Medicare beneficiaries. Also, for many organizations, the GADCS data collection was the first time they collected and submitted cost and revenue data, so there are likely errors in the data. With continued data collection, the quality of the data the organizations submit would improve. However, there is strong support among the stakeholders to reduce the burden of data collection by streamlining the GADCS.

RECOMMENDATION 6

The Congress should direct the Secretary to continue collecting cost and revenue data from suppliers and providers of ground ambulance services.

- **Data collection should focus on information essential to assessing both the accuracy of Medicare payments and Medicare beneficiaries' access to care; and**
- **The Secretary should pursue opportunities to streamline data collection to minimize burden on suppliers and providers.**

RATIONALE 6

The GADCS dataset represents an improvement over prior datasets used to evaluate AFS payments. However, the GADCS data-collection effort marked the first time that most ambulance organizations submitted cost and revenue data to CMS, so there are likely some reporting errors in the dataset. For example, CMS has expressed concerns that organizations may have made errors in reporting revenue from sources such as local government funding that are unrelated to billing for ground ambulance services as well as payments from FFS Medicare. Over time, as ambulance organization reporting improves, the dataset will become more useful in analyzing whether AFS payments are adequate to ensure beneficiaries' access to ground ambulance services and to determine how payments should vary with the costs of caring for beneficiaries with different needs across different locations.

Keeping the possibility of data-reporting errors in mind, we used the GADCS to examine the factors that affect the costs of providing ground ambulance services and found evidence that some payment adjusters in the current payment system may not be well targeted. For example, adjustments based solely on whether a service originates in an urban, rural, or super-rural area may not adequately direct payments to providers with the highest cost per transport. An adjustment for low-volume organizations operating in isolated areas could do a better job of targeting payments to organizations with high costs due to a lack of economies of scale. This finding is consistent with our June 2013 recommendation and with prior analyses by GAO (Government Accountability Office 2012, Government Accountability Office 2007).

The GADCS could be improved by streamlining the data elements and data-collection process. We found that the GADCS includes more variables than are necessary to assess average costs or beneficiaries' access to care, a concern that was emphasized by several stakeholders we interviewed. Many interviewees also reported that the volume of data collected was overly burdensome for some ambulance organizations.

CMS could ease this burden by simplifying how cost data are collected. Rather than requiring detailed reporting on the costs of each vehicle and facility, CMS could collect data on total costs for all vehicles and total costs for all facilities used by an organization. In addition, the GADCS currently includes data on 21 sources of revenue that are not related to billing for ambulance services. Many of these are very small sources of revenue, and these smaller sources could be combined into a single variable. CMS could also eliminate variables that are less critical to evaluating costs and access, such as whether the organization is the primary provider in its service area, whether the organization has a secondary service area (with several related questions), and the hours that ambulance personnel spend on nonambulance responsibilities.

Variables that should be retained include the number of transports and responses; response time; miles traveled by ambulances; measures of transport intensity; labor costs by type of personnel; total vehicle, equipment, supply, and facility costs; other costs such as billing services; ownership type (for profit, nonprofit, government owned); service area location (urban, rural, super rural); ambulance service revenue by type of payer (FFS Medicare, Medicare

Advantage, Medicaid, commercial insurance, Veterans Administration, workers' compensation, and patient self-pay); revenue from sources not related to billing for ambulance services; and the ambulance organizations' uncompensated care and bad debt. CMS should determine whether to retain other variables that could be important measures of access to ambulance services. We note that reported average response time could be a useful measure of access to ambulance services, but many organizations did not provide an answer. We encourage CMS to work with ambulance organizations to improve their response rate to this question.

CMS could further ease the burden on organizations by requiring them to submit the GADCS data less frequently than every year. CMS could field the GADCS less frequently or use rotating panels (organizations would be grouped into panels, with panels alternating so that only one panel would collect and submit data each year).

IMPLICATIONS 6

Spending

- This recommendation would not affect program spending relative to current law.

Beneficiaries and providers

- We do not expect this recommendation to have any adverse effect on beneficiaries' access to ground ambulance services. We do not expect that the recommendation will affect organizations' willingness or ability to provide these services. ■

Endnotes

- 1 Ambulance services are part of a Part A benefit when the patient experiences an event during an inpatient stay that requires ambulance services to another facility.
- 2 There are some exceptions to this definition of a transport, such as when the patient dies during the transport.
- 3 In federal regulations under 42 CFR 414.605, BLS is defined as transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by at least two people who meet the requirements of state and local laws where the services are being furnished. Also, at least one of the staff members must be certified, at a minimum, as an emergency medical technician-basic by the state or local authority where the services are furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. These laws may vary from state to state. Advanced life support Level 1 (ALS1) is transportation by ground ambulance vehicle, medically necessary supplies and services, and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention. An ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. An ALS intervention is a procedure that is, in accordance with state and local laws, required to be furnished by ALS personnel. Advanced life support Level 2 (ALS2) is either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (dextrose, normal saline, Ringer's lactate); or transportation, medically necessary supplies and services, and the provision of at least one of several ALS procedures such as chest decompression. SCT is interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of an EMT-paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.
- 4 CMS uses the CPI-U for the 12-month period ending with June of the previous year, and the multifactor productivity adjustment is a 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity.
- 5 Under the AFS, CMS defines rural areas as ZIP codes outside of metropolitan statistical areas (MSAs) or in a rural census tract within an MSA; super-rural areas as ZIP codes located in rural counties that are among the lowest quartile of all rural counties by population density; and urban areas as ZIP codes in MSAs modified to exclude rural census tracts in MSAs. MSAs are defined at the county level, whereas census tracts are subdivisions of a county. Rural census tracts in MSAs generally have lower population density and limited commuting flow to the urban center of the MSA.
- 6 CMS created the survey weights so that empirical results reflect the full set of organizations from the four survey cohorts used to develop the GADCS. Using information for all 10,581 Year 1 through Year 4 organizations, CMS estimated a regression model expressing the likelihood of an organization's participation in the GADCS. The explanatory variables used by CMS included urbanicity, state, provider versus supplier status, and ownership type at the time of sampling; whether the organization had any paid FFS Medicare claims in each year from 2017 through 2022; the organization's FFS Medicare transport volume in 2023; the percentage of the organization's FFS Medicare claims that were to or from a dialysis center in 2023; and the percentage of the organization's FFS Medicare claims that were for emergent transports in 2023. CMS used the estimated coefficients from this model to predict the probability of GADCS participation for each organization and defined organization-level weights equal to the inverse of this probability.
- 7 "Trip time" is the time from when an ambulance begins a response to a call for service to when the same ambulance is ready to respond to another call.
- 8 We considered including share of labor hours that reflect different types of emergency personnel, such as emergency medical responders, emergency medical technicians, or paramedics, but inclusion of those variables caused collinearity issues.
- 9 Log-transforming the skewed cost data created a distribution that approximates a normal, bell-shaped distribution.
- 10 To calculate the effect of a 10 percent increase in transports on an organization's costs, we used the formula $(1.10)^{0.73} = 1.07$.

- 11 To calculate the effect of having a rural location on an organization's costs, we used the formula $\exp(-0.157) - 1 = -0.15$.
- 12 To calculate the effect of a 10 percent increase in transports on an organization's costs, we used the formula $(1.10)^{0.733} = 1.0724$.
- 13 For both the unweighted and weighted results, we first weighted by the sampling weights in the GADCS.
- 14 Section 50203(b) of the BBA of 2018, which mandated that CMS collect data from ground ambulance organizations, did not specify that the data collection include quality data. The statute authorized the collection of cost, revenue, utilization, and other information as determined appropriate by the Secretary.

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A P P E N D I X

A

**Commissioners' voting
on recommendations**



Commissioners' voting on recommendations

In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Congress required MedPAC to call for individual commissioner votes on each recommendation and to document the voting record in its report. The information below satisfies that mandate.

Chapter 1: Improving payment incentives in Medicare

No recommendations

Chapter 2: The complexity of Medicare enrollment decisions for beneficiaries

No recommendations

Chapter 3: Medicare payment operations and their role in identifying improper payments

No recommendations

Chapter 4: Estimated association between Medicare Advantage enrollment and hospitals' and post-acute care providers' finances

No recommendations

Chapter 5: Access to hospice and certain complex palliative services for beneficiaries with end-stage renal disease or cancer

No recommendations

Chapter 6: Mandated report: Assessment of the Medicare Ground Ambulance Data Collection System

- 6** The Congress should direct the Secretary to continue collecting cost and revenue data from suppliers and providers of ground ambulance services.
- Data collection should focus on information essential to assessing both the accuracy of Medicare payments and Medicare beneficiaries' access to care; and
 - The Secretary should pursue opportunities to streamline data collection to minimize burden on suppliers and providers.

Yes: Casale, Chernew, Cherry, Damberg, Diller, Dusetzina, Konetzka, Liao, Metan, Poulsen, Rambur, Riley, Sarran, Upchurch

Abstain: Miller

Absent: Barr, Kan

Acronyms

Acronyms

ABIM	American Board of Internal Medicine	CPI-U	Consumer Price Index for All Urban Consumers
ACA	Affordable Care Act of 2010	CPT	Current Procedural Terminology
ACL	Administration for Community Living	C-SNP	chronic-condition special-needs plan
ACO	accountable care organization	DCI	Dialysis Clinic Inc.
AEP	annual enrollment period	DME	durable medical equipment
AFS	ambulance fee schedule	DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
AHA	American Hospital Association	DOJ	Department of Justice
AHEAD	Achieving Healthcare Efficiency through Accountable Design	DPP	disproportionate patient percentage
AHIP	America's Health Insurance Plans	DRG	diagnosis-related group
AHRQ	Agency for Healthcare Research and Quality	DSH	disproportionate share
AI	artificial intelligence	D-SNP	dual-eligible special-needs plan
AIDS	acquired immunodeficiency syndrome	E&M	evaluation and management
ALS	advanced life support	ECG	electrocardiogram
ALS	amyotrophic lateral sclerosis	ED	emergency department
APM	alternative payment model	EDI	electronic data interchange
ASM	Ambulatory Specialty Model	EMR	emergency medical responder
ASP	average sales price	EMS	emergency medical service
AUC	area under the curve	EMT	emergency medical technician
BBA	Balanced Budget Act	ESRD	end-stage renal disease
BLS	basic life support	FAP	fraud and abuse perpetrator
BLS	Bureau of Labor Statistics	FBI	Federal Bureau of Investigation
CAA	Consolidated Appropriations Act	FFS	fee-for-service
CAH	critical access hospital	FI	fiscal intermediary
CAHPS	Consumer Assessment of Healthcare Providers and Systems	FMO	field marketing organization
CBO	Congressional Budget Office	FMV	fair market value
CCR	cost-to-charge ratio	FPS	Fraud Prevention System
CDC	Centers for Disease Control and Prevention	FY	fiscal year
CERT	Comprehensive Error Rate Testing	GADCS	Ground Ambulance Data Collection System
CF	conversion factor	GAO	Government Accountability Office
CHC	continuous home care	GDP	gross domestic product
CI	confidence interval	GEP	general enrollment period
CKD	chronic kidney disease	GIP	general inpatient care
CMMI	Center for Medicare and Medicaid Innovation (now the CMS Innovation Center)	GPCI	geographic practice cost index
CMS	Centers for Medicare & Medicaid Services	HCC	hierarchical condition category
CMS-HCC	CMS hierarchical condition category	HCFAC	Health Care Fraud and Abuse Control
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985	HCPCS	Healthcare Common Procedure Coding System
CPI	Center for Program Integrity	HEDIS	Healthcare Effectiveness Data and Information Set
		HHA	home health agency

HHI	Herfindahl–Hirschman index	MCBS	Medicare Current Beneficiary Survey
HI	Hospital Insurance (Medicare Part A)	MCCM	Medicare Care Choices Model
HIPAA	Health Insurance Portability and Accountability Act of 1996	MCO	managed care organization
HIV	human immunodeficiency virus	MDS	Minimum Data Set
HMO	health maintenance organization	MEDIC	Medicare Drug Integrity Contractor
HOPD	hospital outpatient department	MedPAC	Medicare Payment Advisory Commission
HOPE	Hospice Outcomes & Patient Evaluation	MedPAR	Medicare Provider Analysis and Review
HOS	Health Outcomes Survey	MIPPA	Medicare Improvements for Patients and Providers Act of 2008
HPSA	health professional shortage area	MLR	medical loss ratio
HRA	health risk assessment	MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
HSA	health savings account	MMP	Medicare–Medicaid Plan
HSA	health service area	MOOP	maximum out of pocket
ICD	International Classification of Diseases	MPF	Medicare Plan Finder
ICU	intensive care unit	MSA	metropolitan statistical area
IEP	initial enrollment period	MS–DRG	Medicare severity diagnosis-related group
I-MEDIC	Investigations Medicare Drug Integrity Contractor	MSP	Medicare Savings Program
IME	indirect medical education	MSSP	Medicare Shared Savings Program
IPM	improper payment measurement	N/A	not applicable
IPPS	inpatient prospective payment systems	NAIC	National Association of Insurance Commissioners
IQR	interquartile range	NCCI	National Correct Coding Initiative
IRA	Inflation Reduction Act of 2022	NCD	national coverage determination
IRC	inpatient respite care	NCPDP	National Council for Prescription Drug Programs
IRE	independent review entity	NP	nurse practitioner
IRF	inpatient rehabilitation facility	NPI	national provider identifier
IRF–PAI	Inpatient Rehabilitation Facility–Patient Assessment Instrument	NPPES	National Plan and Provider Enumeration System
IRMAA	Income-Related Monthly Adjustment Amount	NUBC	National Uniform Billing Committee
I–SNP	institutional special-needs plan	NUCC	National Uniform Claim Committee
KCC	Kidney Care Choices	OASDI	Old-Age, Survivors, and Disability Insurance
LCD	local coverage determination	OEP	open enrollment period
LEAD	Long-term Enhanced ACO Design	OIG	Office of Inspector General
LIPSA	low-income premium subsidy amount	OPPS	outpatient prospective payment system
LIS	low-income subsidy	PA	physician assistant
log	natural logarithm	PAC	post-acute care
LOS	length of stay	Part B–ID	Part B Immunosuppressive Drug Benefit
LTCH	long-term care hospital	PBM	pharmacy benefit manager
LUPA	low-utilization payment adjustment	PCP	primary care physician
MA	Medicare Advantage	PCS	Procedure Coding System
MAC	Medicare administrative contractor	PD	peritoneal dialysis
MAO	Medicare Advantage organization	PDE	prescription drug event
MA–PD	Medicare Advantage Prescription Drug [plan]		

PDP	prescription drug plan	SHIP	State Health Insurance Assistance Program
PE	practice expense	SMP	Senior Medicare Patrol
PECOS	Provider Enrollment, Chain, and Ownership System	SMRC	supplemental medical review contractor
PFFS	private fee-for-service	SNF	skilled nursing facility
PO	parent organization	SNP	special-needs plan
PPI	Plan Program Integrity	SPAP	State Pharmaceutical Assistance Program
PPI-MEDIC	Plan Program Integrity Medicare Drug Integrity Contractor	SSA	Social Security Administration
PPO	preferred provider organization	SSI	Supplemental Security Income
PPS	prospective payment system	STARS	SHIP Tracking and Reporting System
PS&R	Provider Statistical & Reimbursement	TBI	traumatic brain injury
RAC	recovery audit contractor	TCC	transitional concurrent hospice and conventional care
RADV	risk-adjustment data validation	TDD/TTY	telecommunications device for the deaf/teletypewriter
RAPS	Risk Adjustment Processing System	TEAM	Transforming Episode Accountability Model
RCR	revenue-to-cost ratio	TPMO	third-party marketing organization
REACH	Realizing Equity, Access, and Community Health	TPN	total parenteral nutrition
REH	rural emergency hospital	UC	uncompensated care
RFI	request for information	UPIC	unified program-integrity contractor
RHC	routine home care	UPMC	University of Pittsburgh Medical Center
ROI	return on investment	USRDS	U.S. Renal Data System
RSNAT	repetitive, scheduled nonemergent ambulance transport	VA	Department of Veterans Affairs
RVU	relative-value unit	VBID	value-based insurance design
SCT	specialty care transport	VHA	Veterans Health Administration
SD	standard deviation	WISer	Wasteful and Inappropriate Service Reduction
SEP	special enrollment period	ZPIC	zone program-integrity contractor

More about MedPAC

Commission members

Michael E. Chernew, PhD, chair

Harvard Medical School
Boston, MA

Betty Rambur, PhD, RN, FAAN, vice chair

University of Rhode Island
Kingston, RI

Term expires April 2026

Michael E. Chernew, PhD

R. Tamara Konetzka, PhD

University of Chicago
Chicago, IL

Brian Miller, MD, MBA, MPH

Johns Hopkins University
Baltimore, MD

Betty Rambur, PhD, RN, FAAN

Wayne J. Riley, MD, MPH, MBA

State University of New York Downstate
Brooklyn, NY

Term expires April 2027

Lynn Barr, MPH

Barr-Campbell Family Foundation
Lahaina, HI

Paul N. Casale, MD, MPH

Weill Cornell Medical College
New York, NY

Cheryl L. Damberg, PhD

RAND
Santa Monica, CA

Stacie B. Dusetzina, PhD

Vanderbilt University School of Medicine
Nashville, TN

Joshua Liao, MD, MSc

University of Texas Southwestern Medical
Center
Dallas, TX

Gina Upchurch, RPh, MPH

Senior PharmAssist
Durham, NC

Term expires April 2028

Robert A. Cherry, MD, MS

UCLA Health
Los Angeles, CA

Thomas Diller, MD, MMM

AdventHealth Provider Network
Maitland, FL

Kenny Kan, FSA, CPA, CFA, MAAA

Horizon Blue Cross Blue Shield
Newark, NJ

Gokhan Metan, MSc, PhD, NACD.DC

WiseCare AI; Catalight
St. Louis, MO

Gregory P. Poulsen, MBA

Intermountain Healthcare
Salt Lake City, UT

Scott Sarran, MD, MBA

Harmonic Health; Triple Aim Geriatrics
Cook County, IL

Commissioners' biographies

Lynn Barr, MPH, is the director of the Barr-Campbell Family Foundation, which focuses on rural health, the underserved, education, and the environment. Previously, she recruited and organized small rural hospitals across three states to form the first National Rural Accountable Care Organization (ACO). To manage the ACO's services, she founded and led Caravan Health and was awarded a \$30 million Transformation of Clinical Practice Initiative grant from CMS to provide similar services to rural providers and small practices that were not yet ready to participate in value-based payments. In March 2022, Ms. Barr sold Caravan Health to Signify, a division of CVS Health. Prior to forming Caravan Health, Ms. Barr shepherded four start-up companies and 12 medical inventions through the Food and Drug Administration and worldwide markets. Prior to that, she led the group purchasing of electronic medical records for California's rural hospitals, including individual needs assessments, vendor selection, negotiations, contracting assistance, and financing. Ms. Barr earned her master of public health degree from the University of California, Berkeley.

Paul N. Casale, MD, MPH, is a professor of population health sciences in the Division of Health Policy and Economics, a professor of clinical medicine in the Division of Cardiology at Weill Cornell Medical College, and an adjunct professor of medicine at Columbia University Vagelos College of Physicians and Surgeons. He previously served as the executive director of NewYork Quality Care, an accountable care organization that is a joint initiative of NewYork-Presbyterian, Columbia University, and Weill Cornell Medical College. Dr. Casale has served on many national committees, including as chair of the Physician-Focused Payment Model Technical Advisory Committee and a member of the advisory council of the Agency for Healthcare Research and Quality. Dr. Casale's research focuses on clinical cardiology, value-based care, and payment reform. He has held multiple leadership positions in various health care settings including a rural private practice, a regional health system, and a large urban academic medical center. Dr. Casale earned his medical degree from Weill Cornell Medical College, completed training in cardiology at Massachusetts General Hospital/Harvard Medical

School, and earned his master of public health from the Harvard School of Public Health.

Michael E. Chernew, PhD, is the Leonard D. Schaeffer Professor of Health Care Policy and the director of the Healthcare Markets and Regulation Lab in the Department of Health Care Policy at Harvard Medical School. Dr. Chernew's research examines several areas related to improving the health care system, including studies of novel benefit designs, Medicare Advantage, alternative payment models, low-value care, and the causes and consequences of rising health care spending. He is also a member of the Congressional Budget Office's Panel of Health Advisors and a member of the Massachusetts Health Connector Board. Dr. Chernew is a member of the National Academy of Sciences, a research associate at the National Bureau of Economic Research, and a MITRE fellow. He is currently a coeditor of the *American Journal of Managed Care*. He has served on a number of CMS technical advisory panels reviewing the assumptions used by Medicare actuaries to assess the financial status of the Medicare trust funds. Dr. Chernew previously served on the Commission from 2008 to 2014 and was vice chair from 2012 to 2014. He earned his undergraduate degree from the University of Pennsylvania and his PhD in economics from Stanford University.

Robert A. Cherry, MD, MS, is the associate vice president for clinical affairs and chief health officer at University of California Health and is the chief medical and quality officer at UCLA Health in Los Angeles, CA. Dr. Cherry has extensive experience in quality and safety improvements and value-based care in health systems located in different parts of the U.S. He has coordinated innovative analytical methods to increase clinical quality of care, improve patient experience, and provide value to patients. He also has served on the board of many organizations, including the California Community Foundation, and he was appointed to the California Health Facilities Financing Authority, which helps nonprofit organizations with financing, construction, and remodeling of health facilities. A trauma and critical care surgeon, Dr. Cherry earned his medical degree from Columbia University and a

master's degree in health care management from the Harvard T. H. Chan School of Public Health.

Cheryl L. Damberg, PhD, is director of the RAND Center of Excellence on Health System Performance, distinguished chair in health care payment policy, and a principal senior economist at RAND. Her research explores the impact of strategies to drive cost and quality improvements in health care and the effects of health care consolidation on health care spending and quality performance. She also studies how providers are redesigning health care delivery in response to alternative payment models and has developed strategies to improve the design of value-based payment systems to address disparities in care and improve health equity. Dr. Damberg is an international expert in value-based payment reforms and Medicare payment policy, and she regularly advises the Congress and federal agencies on these and other issues. Dr. Damberg has served on many federal and state committees and currently is a member of the California Healthcare Payments Database Committee that oversees the state's all-payer claims database and the California Department of Managed Care's Quality and Equity Committee. She is an editorial board member of *Health Services Research*. She received her PhD in public policy from the RAND Graduate School of Public Policy and her master of public health degree from the University of Michigan School of Public Health.

Thomas Diller, MD, MMM, is vice president and chief medical officer for the AdventHealth Population Health Services Organization (PHSO) and serves as the president for the AdventHealth Provider Network, a clinical integration network. In this role, he oversees clinical operations for the PHSO, including quality and bundles, as well as health and care management. He also has oversight of clinically integrated network governance and leads physician engagement across the network. Dr. Diller has more than two decades of medical management experience with demonstrated expertise in population health, quality and safety, hospital operations, clinical informatics, academics, and research. Before joining AdventHealth, he served as vice president of population health and quality transformation for Blue Cross and Blue Shield of Louisiana. Before that, he held various senior clinical leadership roles at entities that include the University of North Texas Health Science Center, CHRISTUS Health, and Greenville Health System. A board-certified internist, Dr. Diller has practiced internal, emergency,

and occupational and preventive medicine. He earned a medical degree from the Southern Illinois University School of Medicine, a master's degree in medical management from Carnegie Mellon University, and a bachelor's degree from Illinois Wesleyan University.

Stacie B. Dusetzina, PhD, is a professor of health policy and an Ingram Professor of Cancer Research at Vanderbilt University Medical Center in Nashville, TN. She has conducted extensive research on topics related to Medicare coverage for and patient access to prescription drugs. This research includes studies focused on drug pricing, Medicare Part D benefit design, and Medicare formulary coverage policies. She received her PhD in pharmaceutical sciences from the Eshelman School of Pharmacy at the University of North Carolina at Chapel Hill and postdoctoral training in the Department of Health Care Policy at Harvard Medical School.

Kenny Kan, FSA, CPA, CFA, MAAA, is vice president and chief actuary of Horizon Blue Cross Blue Shield (BCBS) of New Jersey in Newark, NJ, where he recently helped launch a Medicare Advantage plan. Before joining Horizon BCBS, Mr. Kan was chief actuary for two other large health plans, where he oversaw efforts to assess payment and delivery innovations designed to improve quality and reduce cost. He also served for six years on the Maryland Health Care Commission. He is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. Mr. Kan earned his master's degree in professional accounting from the University of Texas.

R. Tamara Konetzka, PhD, is the Louis Block Professor of Public Health Sciences at the University of Chicago, with a secondary appointment in the Department of Medicine, Section of Geriatrics and Palliative Medicine. She is the codirector of the Health Policy Data Lab and an associate director of the Center for Chronic Disease Research and Policy at the University of Chicago, and she serves as the editor-in-chief of *Medical Care Research and Review*. Her research addresses the incentives created by health care payment policy affecting the quality of post-acute and long-term care, including the effects of public reporting of quality and the costs and benefits of home-based care. She received her PhD in health economics from the University of North Carolina at Chapel Hill and

completed a postdoctoral fellowship at the University of Pennsylvania and the VA Philadelphia.

Joshua Liao, MD, MSc, is an internist, physician executive, and scholar whose work focuses on combining public and private policy with clinical transformation to improve health outcomes. Dr. Liao is the national associate vice president for clinical transformation at Ascension, one of the nation's largest nonprofit health systems, where he oversees enterprise programs using technology and capabilities, including remote patient monitoring, patient-reported outcomes, clinician decision support, and large-scale engagement campaigns, to engage patients and clinicians and ultimately improve outcomes across diverse communities. He is also a professor of medicine and professor of health economics, systems, and policy at the University of Texas Southwestern Medical Center, where he founded the Program on Policy Evaluation and Learning. Dr. Liao earned his medical degree Alpha Omega Alpha from Baylor College of Medicine, completed his clinical training at Brigham & Women's Hospital/Harvard Medical School, and obtained his master of science in health policy research from the University of Pennsylvania, where he served as senior fellow at the Leonard Davis Institute of Health Economics in the Wharton School.

Gokhan Metan, MSc, PhD, NACD.DC, currently serves as the chief risk and technology officer at Catalight, a nonprofit organization providing care for individuals with developmental disabilities, and as cofounder and chairman of the board at WiseCare AI, an artificial intelligence (AI) startup focused on matching Medicare and Affordable Care Act (ACA) beneficiaries with the most suitable health care coverage through a proprietary intelligence platform. In addition, Dr. Metan is the founder and chief technology and analytics officer of Full Spectrum Insights, a consulting firm specializing in data infrastructure, cloud computing, machine learning, AI, and software delivery. Dr. Metan has served as an executive in organizations ranging in size from Fortune 100 companies to start-ups with the aim of creating reliable, high-impact technologies that improve health care access and outcomes. Before his current roles, Dr. Metan held executive positions at Centene Corporation, a publicly traded managed care company; SSM Health, a not-for-profit U.S. health care system; and Humana, the second-largest Medicare Advantage insurer in the country. He is directorship

certified by the National Association of Corporate Directors (NACD.DC). Dr. Metan holds dual master of science degrees in management and industrial engineering and earned his PhD in operations research with a minor in finance from Lehigh University.

Brian Miller, MD, MBA, MPH, is an associate professor of medicine at Johns Hopkins University and a visiting fellow at the Hoover Institution. His research focuses on the Medicare Advantage program, the Food and Drug Administration's (FDA's) regulation of pharmaceutical products and medical devices, and competition in health care markets. His research leverages his previous experience at CMS, the FDA, the Federal Communications Commission, and the Federal Trade Commission. Dr. Miller also serves as a trustee and vice chairman of the board for the North Carolina State Health Plan, a \$4.5 billion health plan covering over 750,000 employees, dependents, and retirees. A practicing hospital medicine physician, Dr. Miller earned his medical degree from Northwestern University, a master of public health degree from Johns Hopkins University, and a master's degree in business administration from the University of North Carolina at Chapel Hill.

Gregory P. Poulsen, MBA, is senior vice president at Intermountain Healthcare, an integrated health system based in Salt Lake City, UT. He has vast experience in strategy and policy for providing higher-quality health care while reducing health care costs. In addition, Mr. Poulsen was a key architect of many innovations at Intermountain Healthcare, including offering a Medicare Advantage plan and assisting with the transition to a value-based integrated health care-delivery system. Mr. Poulsen was a founding member of the Commonwealth Fund Commission on a High Performance Health System, has been a board and executive committee member for the American Hospital Association, and trustee for the American Board of Internal Medicine Foundation, and is a national guest scholar at Stanford University. He has also been a member of several other value-focused boards and task forces. He earned his master of business administration degree from Brigham Young University.

Betty Rambur, PhD, RN, FAAN, is the Routhier Endowed Chair for Practice and professor of nursing in the College of Nursing at the University of Rhode

Island, where she has conducted research on such topics as alternative payment models, telehealth nursing, and value-based workforce redesigns. Before joining the University of Rhode Island, Dr. Rambur served on the Green Mountain Care Board—a five-member regulatory, innovation, and evaluation board that has broad responsibility for cost containment and oversight of Vermont's transition to post-fee-for-service provider reimbursement. Previously, Dr. Rambur served as dean of the College of Nursing and Health Sciences at the University of Vermont and was chairperson for the North Dakota Health Task Force, a statewide health care–financing reform initiative. Dr. Rambur received her PhD in nursing from Rush University.

Wayne J. Riley, MD, MPH, MBA, is president of the State University of New York Downstate Health Sciences University, tenured professor of internal medicine and of health policy and management, and the chair of the board of the New York Academy of Medicine. Immediately before joining Downstate, Dr. Riley served as clinical professor of medicine and adjunct professor of health care management at Vanderbilt University and as the 10th president and chief executive officer of Meharry Medical College. He began his career at Baylor College of Medicine, where he completed residency training in internal medicine and held several key administrative posts, including vice president and vice dean for health affairs and governmental relations, assistant dean for education, and assistant chief of medicine at Ben Taub Hospital—a leading public safety-net teaching hospital. Dr. Riley is a member of the National Academy of Medicine (NAM) of the National Academy of Sciences, where he served as vice chair and chair of the NAM section on the administration of health services, education, and research. He is also president emeritus of the American College of Physicians, the nation's largest medical specialty society representing internal medicine, and the president of the Society of Medical Administrators, an organization of 50 of the nation's leading physician-executives. He is an independent director of HCA Healthcare, Compass Pathways PLC, and HeartFlow Group. Dr. Riley earned a BA in anthropology from Yale University, an MPH in health systems management

from the Tulane University School of Public Health and Tropical Medicine, an MD from Morehouse School of Medicine, and an MBA from Rice University's Jesse H. Jones Graduate School of Business.

Scott Sarran, MD, MBA, is the founding chief medical officer of Harmonic Health, a start-up company solely focused on revolutionizing the dementia care journey for patients, caregivers, and providers. Dr. Sarran is also the principal at Triple Aim Geriatrics, where he provides consultative services to managed care entities (payers and providers) to improve systems of care and outcomes for Medicare and dually eligible beneficiaries. His leadership experience includes chief medical officer roles across the payer—both large (Blue Cross Blue Shield IL, Health Care Service Corporation) and small (MoreCare IL, Fidelis Senior Care)—and provider (Advocate Health Care, University of Chicago, Cook County Health) sectors. In all these roles, his focus has been the intersection of improving care for high-risk patients while enabling win-win payer-provider partnerships. Dr. Sarran received his MD from the Northwestern University Feinberg School of Medicine and his MBA from Northwestern's Kellogg School of Management.

Gina Upchurch, RPh, MPH, is the founder and executive director of Senior PharmAssist, a nonprofit organization that helps older adults obtain and manage medication and provides Medicare benefits counseling and tailored community referrals in Durham, NC. Ms. Upchurch is a registered pharmacist and has participated in various committees at the state and national levels, such as the American Geriatrics Society Public Policy Committee and several working groups for the North Carolina Institute of Medicine. She received her bachelor of science degree in pharmacy and her master of public health degree from the University of North Carolina at Chapel Hill, where she also completed her geriatric pharmacy practice residency and still holds adjunct positions. In 2001, she was named a Robert Wood Johnson Community Health Leader for her patient advocacy and health-literacy efforts. Ms. Upchurch began her career as a science teacher with the U.S. Peace Corps in Botswana.

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Graduate fellow

Renuka Diwan

Errata

The Medicare Payment Advisory Commission has corrected this report since its original publication.

The following changes were made on July 15, 2026

Page 13: In Figure 1-3, The “Inpatient hospital” and “Skilled nursing facility” lines were corrected.

Advising the Congress on Medicare issues



Medicare Payment Advisory Commission

425 I Street, NW | Suite 701 | Washington, DC 20001
(202) 220-3700 | www.medpac.gov