Executive summary

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By law, the Medicare Payment Advisory Commission reports to the Congress each March on the Medicare fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare prescription drug program (Medicare Part D).

In this year's report, we consider the context of the Medicare program, including the near-term consequences of the end of the coronavirus public health emergency (PHE) and higher-than-usual inflation, and the longer-term effects of program spending on the federal budget and the program's financial sustainability. We evaluate the adequacy of FFS Medicare's payments and make recommendations for how payments should be updated in 2025 for seven FFS payment systems: acute care hospital inpatient and outpatient services, physicians and other health professional services, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and hospice providers. We provide status reports on ambulatory surgical centers (ASCs), the MA program (Medicare Part C), and the Part D prescription drug program. We also include congressionally mandated reports on special needs plans for beneficiaries dually eligible for Medicare and Medicaid and on a new provider designation, rural emergency hospitals.

The PHE related to the coronavirus pandemic officially expired on May 11, 2023. The Commission recognizes that the pandemic has had tragic effects on beneficiaries and damaging impacts on the nation's health care workforce, as clinicians and other health care workers have faced burnout and risks to their health and safety. For the past several years, the direct and indirect effects of COVID-19 on beneficiaries, PHE-related policy changes, and emergency funding for providers have made it difficult to interpret some of our indicators of the adequacy of Medicare's payment rates. Most of our analyses rely on lagged data (the most recent complete data we have for most payment adequacy indicators are from 2022), and they continue to be affected by the pandemic, both directly and through policy changes. Where PHE-related policy changes affect our assessment of payment adequacy in a particular sector, our methods for evaluating those effects are detailed in the relevant chapter of this report. While our most recent measures of payment adequacy indicate that the most pronounced effects of the pandemic have passed, we continue to monitor the health care landscape for further impacts of the pandemic on access to care, quality, and costs.

The Commission's goals for Medicare payment policy are to ensure that Medicare beneficiaries have access to high-quality care and that the program obtains good value for its expenditures. To achieve these goals, the Commission supports payment policies that encourage efficient use of resources. Payment system incentives that promote the efficient delivery of care serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes, premiums, and cost sharing.

The Commission recognizes that updating base payment rates alone will not solve what has been a fundamental problem with FFS Medicare's payment systems—that providers are paid more when they deliver more services, whether or not those additional services provide value. In addition, historically, FFS payment systems have seldom included incentives for providers to coordinate care over time and across care settings. To address these problems, broad payment reforms must be implemented expeditiously, coordinated across settings, closely monitored, and scaled when appropriate. In the interim, it is imperative that the current FFS payment systems be managed carefully and continuously improved.

This report contains the Commission's recommendations for updates to the FFS Medicare payment rates specified in current law. For each recommendation, the Commission presents its rationale, the implications for beneficiaries and providers, and how spending for each recommendation would compare with expected spending under current law. The spending implications are presented as ranges over one-year and five-year periods. Unlike official budget estimates used to assess the impact of legislation, these estimates do not consider the complete package of policy recommendations or the interactions among them. Although we include budgetary implications, our recommendations are not driven by any single budget or financial performance

target, but instead reflect our assessment of the payment rates needed to ensure adequate access to high-value care for FFS beneficiaries while promoting the fiscal sustainability of the Medicare program.

In Appendix A, we list all of this year's recommendations and the Commissioners' votes. The Commission's full inventory of recommendations, with links to relevant reports, is available at medpac.gov/recommendation/.

Context for Medicare payment policy

As described in Chapter 1, external forces can have a substantial impact on Medicare spending and the experience of Medicare beneficiaries. To put the information presented in this report in context, this chapter highlights key trends in national health care spending and Medicare spending, and it reviews the factors that contribute to spending growth.

During the recent coronavirus pandemic, the Congress appropriated several hundred billion dollars in relief funds to offset providers' lost revenues and to ensure that they remained viable sources of care. The Congress and CMS also temporarily changed certain payment and coverage policies. In 2020, those measures doubled the rate of growth in national health care spending. However, by 2021, relief funds tapered off, resulting in slower growth in national health care spending.

By contrast, total Medicare spending grew at a slower-than-usual pace during the pandemic. Although Medicare spending increased on COVID-19 testing and treatment and on services that were made more widely available through waivers of Medicare's usual payment rules, this increase was more than offset by decreased spending on non-COVID-19 care. The most common types of care that Medicare beneficiaries reported forgoing in the early months of the pandemic were dental care, regular check-ups, treatment for an ongoing condition, and diagnostic or medical screening tests; some beneficiaries, however, reported forgoing more serious types of care, such as urgent care for an accident or illness.

Spending growth has recently been particularly slow for FFS Medicare, which Medicare's Trustees attribute to a few factors, including lower average morbidity among Medicare beneficiaries who survived the pandemic. Another factor was joint replacement procedures moving from inpatient to (lower-cost) outpatient settings after their removal from Medicare's "inpatient only" list. In addition, beneficiaries dually enrolled in Medicare and Medicaid (who tend to generate high spending) have increasingly opted to enroll in MA plans rather than traditional FFS coverage, which has helped to reduce FFS Medicare spending per beneficiary.

Between now and the early 2030s, CMS expects total Medicare spending to grow at rates more consistent with historical norms—by 7 percent or 8 percent per year, on average. This growth will double Medicare spending over a 10-year period—rising from $900 billion in 2022 to $1.8 trillion in 2031. Medicare's projected spending growth is driven by economy-wide inflation, an increasing number of beneficiaries (which is projected to grow by about 2 percent per year until 2029, as the baby-boom generation continues to age into Medicare), and continued growth in the volume and intensity of services delivered per beneficiary.

Despite this projected spending growth, the Medicare program finds itself in a better position financially than it was in a few years ago. After an initial economic slowdown at the start of the pandemic, the U.S. economy subsequently experienced strong growth in 2021 and 2022, yielding higher-than-expected Medicare payroll tax revenues. At the same time, Medicare beneficiaries used a lower volume of Part A services than expected during the pandemic, and future Part A spending is now projected to be lower than previously expected. As a result, the balance in Medicare's Hospital Insurance Trust Fund has been increasing. The trust fund is now projected to be able to pay its share of Part A services for several more years than was estimated before the pandemic—until 2031 according to Medicare's Trustees or until 2035 according to the Congressional Budget Office.

Yet pressure to restrain the growth in Medicare's overall spending remains. Medicare spending is projected to constitute a rising share of GDP in the coming years, and growth in Medicare spending will cause beneficiaries to face higher premiums and cost sharing over time. Further, a growing share of general federal revenues must be transferred to Medicare's Supplementary Medical Insurance (SMI) Trust Fund to help pay for Part B clinician and outpatient services

and Part D prescription drug coverage. For example, in 2022, 13 percent of all personal and corporate income taxes collected by the federal government were transferred to the SMI Trust Fund to pay for Part B and Part D, and by 2030, 22 percent of all income tax revenues are expected to be transferred for this purpose.

One way the Medicare program has reduced spending growth relative to the commercial market is by setting prices in certain sectors. Our annual March report recommends updates to FFS Medicare payment rates for various types of providers; these updates can be positive, negative, or neutral, depending on our assessment of Medicare payment adequacy for each sector. Our annual June report typically offers broader recommendations aimed at restructuring the way Medicare's payment systems work.

Assessing payment adequacy and updating payments in FFS Medicare

As required by law, the Commission annually recommends payment updates for providers paid under Medicare's traditional FFS payment systems. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed relative to the prior year. As explained in Chapter 2, we determine updates by first assessing the adequacy of FFS Medicare payments for providers in the current year (2024), by considering beneficiaries' access to care, the quality of care, providers' access to capital, and how Medicare payments compare with providers' costs. As part of that process, we examine whether FFS payments will support access to high-quality care and the efficient delivery of services, consistent with our statutory mandate. Next, we assess how providers' costs are likely to change in the year the update will take effect (the policy year; here, 2025). Finally, we make a recommendation about what, if any, update is needed for the policy year in question.

The Commission's goal is to identify the base payment rate for each sector that will ensure both beneficiary access and good stewardship of taxpayer resources. We apply consistent criteria across settings, but because data availability, conditions at baseline, and forthcoming changes between baseline and the policy year may vary, the exact criteria used for each sector and our recommended updates vary. We use the best available data to examine indicators of payment adequacy and reevaluate any assumptions from prior years, to make sure our recommendations for 2025 accurately reflect current conditions. Because of standard data lags, the most recent complete data we have are generally from 2022. We use preliminary data from 2023 when available.

In considering updates to FFS payment rates, we may make recommendations that redistribute payments within a payment system to correct biases that may make treating patients with certain conditions or in certain areas financially undesirable, make certain procedures unusually profitable, or otherwise result in inequity among providers or beneficiaries. We may also recommend changes that could improve program integrity.

Our recommendations in this report, if adopted, could significantly change the revenues providers receive from Medicare. Payment rates set to cover the costs of relatively efficient delivery of care help induce all providers to control their costs. Furthermore, FFS Medicare rates have broader implications for health care spending because they are used in setting payments for other government programs and private health insurance. Thus, while setting prices intended to support efficient provision of care directly benefits the Medicare program, it can also affect health care spending across payers.

Hospital inpatient and outpatient services

General acute care hospitals (ACHs) primarily provide inpatient care and various outpatient services. To pay these hospitals for the facility share of providing services, FFS Medicare generally sets prospective payment rates under the inpatient prospective payment systems (IPPS) and the outpatient prospective payment system (OPPS). In 2022, the FFS Medicare program and its beneficiaries spent nearly $180 billion on IPPS and OPPS services at general ACHs, including $7.1 billion in uncompensated care payments made under the IPPS.

As described in Chapter 3, indicators of hospital payment adequacy were mixed. Overall, general ACHs continued to have the capacity to care for FFS Medicare beneficiaries and a financial incentive to serve them, FFS Medicare beneficiaries' inpatient

mortality and readmission rates improved, and investor demand for hospital bonds remained strong. However, in fiscal year (FY) 2022, IPPS hospitals' aggregate all-payer operating margin fell to the lowest level since 2008, and their overall FFS Medicare margin across service lines declined to a record low, both in aggregate and for relatively efficient hospitals. These low all-payer and FFS Medicare margins were largely driven by higher-than-expected input price inflation in 2022.

Beneficiaries' access to care—Indicators of beneficiaries' access to hospital inpatient and outpatient care were generally positive. In FY 2022, the number of inpatient beds remained stable, hospital employment increased, and the aggregate occupancy rate of ACH beds was 67 percent, indicating available capacity in aggregate. The number of general ACHs that closed was similar to the number that opened in that year. In 2023, hospital employment continued to grow; however, more ACHs closed than opened (18 vs. 11, respectively), with many of the hospitals citing declining patient volume as one of the reasons for closing. The number of closures would likely have been higher if not for a new Medicare policy—the rural emergency hospital (REH) designation—that allows hospitals to convert from full-service hospitals to REHs, preserving beneficiaries' access to emergency services and hospital outpatient services. (We discuss REHs in Chapter 15 of this report.)

The volume of both inpatient and outpatient services per FFS Medicare beneficiary declined from 2021 to 2022. This change, however, primarily reflects shifts in the setting where care is provided and declines in COVID-19 care, rather than a decrease in beneficiary access to hospital care. Hospitals' FFS Medicare marginal profit on IPPS and OPPS services declined from 2021 to 2022 but remained positive at 5 percent in aggregate.

Quality of care—Hospital quality indicators were mixed. FFS beneficiaries' risk-adjusted hospital readmission rate improved relative to pandemic highs, falling to the level it was in 2019 (8.1 percent). The risk-adjusted hospital mortality rate improved to 14.7 percent, about a percentage point lower than in 2019. However, most patient experience measures remained below prepandemic levels by several percentage points.

Providers' access to capital—From 2021 to 2022, hospitals' aggregate all-payer operating margin declined by over 6 percentage points, reflecting both a decline in federal coronavirus relief funds and higher-than-expected inflation. IPPS hospitals' all-payer operating margin fell to 2.7 percent when including federal relief funds—the lowest level since 2008—and 1.9 percent exclusive of these funds. In addition, preliminary data from large hospital systems suggest that hospitals' aggregate all-payer operating margin in 2023 remained below prepandemic levels. Hospitals' borrowing costs also increased in 2022 and 2023; however, this growth was slower than that of the general market, indicating continued investor demand for hospital bonds.

FFS Medicare payments and providers' costs—From 2021 to 2022, IPPS hospitals' overall FFS Medicare margin (across inpatient, outpatient, and certain other service lines) declined over 5 percentage points to a record low of −11.6 percent, when including the FFS Medicare share of coronavirus relief funds (and declined to −12.7 percent exclusive of these funds). This decline was largely driven by input price inflation exceeding the market basket update, as well as a decline in federal pandemic support, an increase in high-cost outlier stays, and a decrease in Medicare uncompensated care payments. Nonetheless, some hospitals achieved much lower costs while still performing relatively well on a specified set of quality metrics. We refer to the subset of hospitals that meet this mix of cost and quality criteria as "relatively efficient"; the median FFS Medicare margin among these hospitals was about −2 percent (−3 percent exclusive of relief funds).

In FY 2024, hospitals that participate in the 340B drug payment program are scheduled to receive $9 billion in remedy payments to correct for underpayments in calendar years 2018 through 2021. We project that IPPS hospitals' aggregate FFS Medicare margin will increase to −8 percent inclusive of these remedy payments, and remain at −13 percent exclusive of these payments. Similarly, we project the median FFS Medicare margin among our relatively efficient hospital group to remain at about −3 percent.

Recommendation—The recent volatility in hospital profit margins makes it particularly difficult to assess how FFS Medicare payments should change for 2025. The current-law updates to payment rates for 2025 will not be finalized until summer 2024, but CMS's third-quarter 2023 forecasts and other required updates are currently projected to increase the IPPS and OPPS

base rates by slightly less than 3 percent. We expect hospitals will have a relatively low FFS Medicare margin in 2025 if the update in current law holds.

The Commission contends that increased support is needed to ensure that Medicare beneficiaries continue to have access to ACH services. Therefore, the Commission recommends that, for FY 2025, the Congress update the 2024 Medicare base payment rates for general ACHs by the amount reflected in current law plus 1.5 percent. The Congress should also redistribute existing safety-net payments to hospitals using the Commission's Medicare Safety Net Index (MSNI) and increase the MSNI pool by $4 billion (which would be distributed to hospitals for both their FFS and MA patients). This recommendation would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing particularly significant financial challenges.

Physician and other health professional services

Medicare's physician fee schedule pays for about 8,000 different types of medical services—ranging from office visits to surgical procedures, imaging, and tests—that are delivered in physician offices, hospitals, nursing homes, and other settings. The clinicians who are paid to deliver these services include not only physicians, nurse practitioners, and physician assistants but also podiatrists, physical therapists, psychologists, and other types of health professionals. In 2022, the FFS Medicare program and its beneficiaries paid $91.7 billion for services provided by almost 1.3 million clinicians, accounting for just under 17 percent of FFS spending. As described in Chapter 4, most physician payment adequacy indicators have remained positive or improved in recent years, but clinicians' input costs are estimated to have grown faster than the historical trend.

Beneficiaries' access to care—In the Commission's annual survey, Medicare beneficiaries continued to report access to clinician services in 2023 that was comparable with, or better than, that of privately insured people. Other national surveys and our annual focus groups with beneficiaries echo these findings. Surveys indicate that the share of clinicians accepting Medicare is comparable with the share accepting private insurance, despite private health insurers paying higher rates. Almost all clinicians who bill Medicare accept physician fee schedule amounts as payment in full and do not seek higher payments from patients.

The supply of most types of clinicians has been growing in recent years, although the composition of the clinician workforce continues to change, with a rapid increase in the number of advanced practice registered nurses (APRNs) and physician assistants (PAs), a steady increase in the number of specialists, and a slow decline in the number of primary care physicians. Despite the growth in the overall number of clinicians, the number of clinicians per Medicare beneficiary (including those in FFS Medicare and MA) has remained steady due to beneficiary enrollment growth.

The number of clinician encounters per FFS beneficiary has increased over time, with faster growth from 2021 to 2022 (3.1 percent) compared with the average annual growth rate from 2017 to 2021 (0.7 percent). Growth rates varied by clinician specialty and type of service. From 2021 to 2022, the number of encounters per FFS beneficiary with primary care physicians declined by 0.3 percent while encounters per FFS beneficiary with specialist physicians increased by 1.3 percent and encounters with APRNs and PAs increased by 10.4 percent.

Quality of care—We report three population-based measures of the quality of clinician care: risk-adjusted ambulatory care–sensitive (ACS) hospitalization rates, risk-adjusted ACS emergency department (ED) visits, and patient experience measures. In 2022, risk-adjusted rates of ACS hospitalizations and ED visits continued to vary across health care markets. Between 2021 and 2022, patient experience scores in FFS Medicare were relatively stable.

Clinicians' revenues and costs—Clinicians do not submit annual cost reports to CMS, so we are unable to calculate their profit margins from delivering services to Medicare beneficiaries. Instead, we rely on indirect measures of how FFS Medicare payments compare with the costs of providing services. In 2022, spending on clinician services by FFS Medicare and its beneficiaries was $1.1 billion lower than it was in 2021. This decline represents a 1.2 percent decrease in fee schedule spending and is attributable to a 3.9 percent decline in the number of beneficiaries enrolled in FFS Medicare,

as enrollment in MA continued to grow. However, from 2021 to 2022, physician fee schedule spending per FFS beneficiary grew for most types of services.

In 2022, payment rates paid by private preferred provider organization (PPO) health plans for clinician services were 136 percent of FFS Medicare's payment rates, up from 134 percent in 2021. Survey data suggest that providers are increasingly consolidating into larger organizations to improve their ability to negotiate higher payment rates from private insurers (and to gain access to costly resources and help complying with payers' regulatory and administrative requirements). Compensation and productivity data indicate that, while clinicians who work in hospital-owned practices do not necessarily earn more than those working in clinician-owned practices, they do tend to see fewer patients and bill for fewer services.

All-payer clinician compensation appears to be increasing at rates similar to general inflation. From 2021 to 2022, median compensation for physicians grew by 9 percent—a little faster than inflation, which was 8 percent. Over a longer, four-year period that includes the recent coronavirus pandemic (2018 to 2022), physicians' median compensation grew by an average of 3.4 percent per year, slightly less than inflation, which was 3.9 percent over the same period. Median compensation for APRNs and PAs grew more slowly than inflation from 2021 to 2022 (by 5 percent) but kept pace with inflation from 2018 to 2022 (growing by an average of 4 percent per year). Clinicians' input costs—as measured by the Medicare Economic Index (MEI)—grew 4.6 percent in 2022 but are expected to moderate in the coming years. MEI growth projections are 4.1 percent for 2023, 3.1 percent in 2024, and 2.6 percent in 2025.

Recommendation—Under current law, Medicare fee schedule payment rates are expected to decline in 2025, due to the expiration of a 1.25 percent pay increase that will apply in 2024 only and a 0 percent update scheduled for 2025. Given recent high inflation, cost increases could be difficult for clinicians to continue to absorb. Yet current payments to clinicians appear to be adequate, based on many of our indicators.

Given these mixed findings, for calendar year 2025, the Commission recommends that the Congress update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the MEI. Based on CMS's MEI projections at the time of this publication, the recommended update for 2025 would be equivalent to 1.3 percent above current law. Our recommendation would be a permanent update that would be built into subsequent years' payment rates, in contrast to the temporary updates specified in current law for 2021 through 2024, which have each increased payment rates for one year only and then expired.

To promote adequate access to care for all Medicare beneficiaries, the Congress also should establish safety-net add-on payments for clinician services furnished to FFS Medicare beneficiaries with low incomes, with higher add-on payments for primary care clinicians. We estimate that the recommended safety-net add-on policy would increase the average clinician's fee schedule revenue by 1.7 percent.

We estimate the combination of the recommended update and safety-net policies would increase fee schedule revenue for the average clinician by 3 percent above current law, but the effects would differ by provider specialty and share of services furnished to low-income beneficiaries. We estimate the combined effect of the two policies would increase fee schedule revenue by an average of 5.7 percent for primary care clinicians and by an average of 2.5 percent for other clinicians.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2022, about 290,000 beneficiaries with ESRD and on dialysis were covered under FFS Medicare and received dialysis from more than 7,800 dialysis facilities. In 2022, FFS Medicare expenditures for outpatient dialysis services totaled $8.8 billion. As described in Chapter 5, measures of the capacity and supply of outpatient dialysis providers, beneficiaries' ability to obtain care, and changes in the volume of services suggest that FFS Medicare payments are adequate.

Beneficiaries' access to care—Dialysis facilities appear to have the capacity to meet demand. Between 2021 and 2022, the number of in-center treatment stations

was steady, while the number of FFS and MA dialysis beneficiaries declined (due in part to excess mortality among ESRD patients during the PHE, and in part to an increase in treatments furnished at home). A steep (14 percent) decline in FFS treatments in 2022 was largely due to the removal of the statutory provision that prevented most dialysis beneficiaries from enrolling in MA plans. Between January 2021 and December 2022, the share of dialysis beneficiaries enrolled in FFS Medicare declined from 64 percent to 53 percent. An estimated 18 percent FFS marginal profit in 2022 suggests that dialysis providers have a financial incentive to continue to serve FFS Medicare beneficiaries.

***Quality of care*—**FFS dialysis beneficiaries' rates of all-cause hospitalization, ED use, and mortality held relatively steady between 2021 and 2022. The share of beneficiaries dialyzing at home, which is associated with better patient satisfaction, continued to grow.

***Providers' access to capital*—**Information from investment analysts suggests that access to capital for dialysis providers continues to be strong. The number of facilities, particularly for-profit facilities, continues to increase. The two largest dialysis organizations have grown through acquisitions of and mergers with midsize dialysis organizations.

***FFS Medicare payments and providers' costs*—**FFS Medicare payment per treatment in freestanding dialysis facilities (which provide the vast majority of FFS dialysis treatments) grew by 2 percent while cost per treatment rose by 6 percent. The increase in the cost per treatment is attributable to the growth in labor and capital costs between 2021 and 2022, which was substantially higher compared with these categories' historical cost growth. The aggregate FFS Medicare margin fell from 2.3 percent in 2021 to −1.1 percent in 2022. We project a 2024 aggregate FFS Medicare margin of 0 percent.

***Recommendation*—**Under current law, the FFS Medicare base payment rate for dialysis services is projected to increase by 1.8 percent in 2025. Given that our indicators of payment adequacy are generally positive, the Commission recommends that, for calendar year 2025, the Congress update the 2024 ESRD PPS base payment rate by the amount determined under current law.

Skilled nursing facility services

Medicare covers short-term skilled nursing and rehabilitation services for beneficiaries in skilled nursing facilities (SNFs) after an inpatient hospital stay. Most SNFs also furnish long-term care services not covered by Medicare. In 2022, about 14,700 SNFs furnished about 1.8 million Medicare-covered stays to 1.3 million FFS beneficiaries. In that year, FFS Medicare spending on SNF services and swing beds combined was $29 billion. As described in Chapter 6, the indicators of FFS Medicare payment adequacy for SNF care are positive, indicating sufficient beneficiary access to SNF care.

***Beneficiaries' access to care*—**Changes in the indicators of access to SNFs were positive in 2022, with occupancy and utilization increasing after downturns in 2020 and 2021. In 2022, 88 percent of Medicare beneficiaries lived in a county with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds), the same share as in 2021. The supply of SNFs declined by about 1 percent in 2023. Between 2021 and 2022, both Medicare-covered admissions and covered days per 1,000 FFS beneficiaries increased more than 10 percent. In 2022, FFS Medicare marginal profit averaged 27 percent for freestanding facilities. This profit is a strong positive indicator of beneficiary access to SNF care, though factors other than the level of payment (such as bed availability or staffing shortages) could challenge access.

***Quality of care*—**In 2021 and 2022, the median facility risk-adjusted rate of successful discharge to the community from SNFs was 50.7 percent, which was 1 percentage point lower (worse) than the period 2018 to 2019. The median facility risk-adjusted rate of potentially preventable hospitalizations was 10.4 percent. Lack of data on patient experience and concerns about the accuracy of provider-reported function data limit our set of SNF quality measures.

***Providers' access to capital*—**In 2022, the average price per SNF bed reached a record high. The all-payer total margin—reflecting all payers and lines of business—was −1.4 percent. Without pandemic-related funds, the all-payer total margin was −4 percent in 2022.

***FFS Medicare payments and providers' costs*—**From 2021 through 2022, FFS Medicare payments per day to

freestanding SNFs increased over 2.2 percent, while growth in costs per day slowed to 1.7 percent. The FFS Medicare margin for freestanding SNFs was 18.4 percent in 2022. Margins varied greatly across facilities, reflecting differences in costs per day, economies of scale, and cost growth. We project a FFS Medicare margin for freestanding SNFs of 16 percent in 2024.

***Recommendation*—**Efficient purchasing of care for the Medicare program would require FFS Medicare's payments to be reduced to more closely align aggregate payments with aggregate costs. The Commission recommends that, for fiscal year 2025, the Congress reduce the 2024 FFS Medicare base payment rates for skilled nursing facilities by 3 percent.

Home health care services

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2022, about 2.8 million FFS Medicare beneficiaries received care, and the program spent $16.1 billion on home health care services. In that year, 11,353 HHAs participated in Medicare. As described in Chapter 7, the indicators of FFS Medicare payment adequacy for home health care were positive in 2022.

***Beneficiaries' access to care*—**Access to home health care was adequate in 2022. Despite the number of HHAs declining by 1.1 percent that year, over 98 percent of Medicare beneficiaries lived in a ZIP code served by at least two HHAs, and 88 percent lived in a ZIP code served by five or more HHAs. In 2022, the volume of 30-day periods declined by 7.5 percent, but approximately 40 percent of that decline can be attributed to the decreased number of beneficiaries in FFS Medicare as enrollment continues to grow in MA. The rate of inpatient hospital stays per 1,000 FFS beneficiaries declined 2.6 percent in 2022. For FFS beneficiaries who use home health care, the average number of in-person visits per 30-day period fell by 15.6 percent between 2019 (the year before CMS implemented major congressionally mandated changes to the HHA prospective payment system (PPS)) and 2022, but some of the decline might have been offset by greater use of virtual visits through telehealth, which we are unable to observe with available data. In 2022, freestanding HHAs' FFS Medicare marginal profit—that is, the rate at which FFS Medicare payments exceeded providers' marginal costs—was 23 percent, indicating a significant financial incentive for freestanding HHAs with excess capacity to serve additional FFS Medicare patients.

***Quality of care*—**Rates of successful discharge to the community varied by provider type, with lower rates and greater decline observed in for-profit and freestanding agencies. The median rate of potentially preventable readmissions after discharge was 3.88 percent from July 1, 2020, to December 31, 2022, and did not vary significantly across provider types. (Due to a change in the measure calculation, we cannot compare this with a prior period.) Most patient experience measures remained stable in 2022. The Commission continues to have concerns about the accuracy of provider-reported function data.

***Providers' access to capital*—**Access to capital is a less important indicator of FFS Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. Recent years have seen substantial interest in HHAs by private equity and health insurance companies. According to industry reports, investor interest in home health care services slowed in 2023, but the slowdown came after a peak period for HHA mergers and acquisitions in 2021.

***FFS Medicare payments and providers' costs*—**In 2022, FFS Medicare costs per 30-day period in freestanding HHAs increased by 4.0 percent, reflecting a simultaneous increase in costs per visit and reduction in the number of in-person visits per 30-day period. FFS Medicare margins for freestanding agencies averaged 22.2 percent. In aggregate, FFS Medicare's payments have always been substantially more than costs under prospective payment: From 2001 to 2021, the FFS Medicare margin for freestanding HHAs averaged 16.8 percent. We project an aggregate FFS Medicare margin of 18 percent for 2024.

***Recommendation*—**The Commission's review of payment adequacy for Medicare home health services indicates that FFS Medicare payments are substantially in excess of costs. Home health care can be a high-value benefit when it is appropriately and efficiently delivered. However, FFS Medicare's current payment rates diminish that value. On this basis, the Commission recommends that, for calendar year 2025, the Congress reduce the 2024 base payment rate for home health agencies by 7 percent.

Inpatient rehabilitation facility services

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after illness, injury, or surgery. Rehabilitation programs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, speech–language pathology, and prosthetic and orthotic services. In 2022, FFS Medicare spent $8.8 billion on 383,000 FFS IRF stays in about 1,180 IRFs nationwide. The FFS Medicare program accounted for about 51 percent of all IRF discharges. As described in Chapter 8, most IRF payment adequacy indicators remained positive in 2022; however, FFS Medicare margins continued to vary across IRFs.

Beneficiaries' access to care—Between 2021 and 2022, the number of IRFs stayed constant, and the number of IRF beds slightly increased. Consistent with the previous year, the aggregate IRF occupancy rate was 68 percent in 2022, indicating that capacity is more than adequate to meet demand. From 2021 to 2022, Medicare cases per 10,000 FFS beneficiaries increased by about 4 percent, and total FFS IRF users increased by about 1 percent. Marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was 18 percent for hospital-based IRFs and 39 percent for freestanding IRFs—a very strong indicator of access.

Quality of care—In 2021 and 2022, the median facility risk-adjusted rate of successful discharge to the community from IRFs was 67.3 percent, about 2 percentage points higher (better) than the rate for the period of 2018 and 2019. The median facility risk-adjusted rate of potentially preventable readmissions was 8.6 percent and was higher (worse) for freestanding and for-profit providers than hospital-based and nonprofit providers. (Because of a change in the measure calculation, we cannot compare this rate with a prior period.) Lack of data on patient experience and concerns about the accuracy of provider-reported function data limit our set of IRF quality measures.

Providers' access to capital—Between 2021 and 2022, freestanding IRFs' all-payer total margin decreased from 13 percent to about 9 percent. The decrease reflects inflation in the greater macroeconomic environment. Despite the decline in the all-payer margin, the largest IRF chain (which accounted for almost a third of all FFS Medicare IRF discharges) continued to open new IRFs and enter joint ventures with other organizations, suggesting strong access to capital. The extent to which other freestanding IRFs can access capital is less clear. Hospital-based IRFs access capital through their parent hospitals.

FFS Medicare payments and providers' costs—IRFs' FFS Medicare margin in 2022 decreased to 13.7 percent due to cost growth that exceeded payment growth. We expect cost growth in 2024 to be lower, more in line with the historical trend, and thus project that the 2024 margin will increase to 14 percent.

Recommendation—FFS Medicare's payments to IRFs must be reduced to more closely align aggregate payments with aggregate costs. The Commission recommends that, for fiscal year 2025, the Congress reduce the 2024 base payment rate for IRFs by 5 percent.

Hospice services

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill with a life expectancy of six months or less if the illness runs its normal course. When beneficiaries elect to enroll in the Medicare hospice benefit, they agree to forgo Medicare coverage for conventional treatment of their terminal illness and related conditions. FFS Medicare pays for hospice care for beneficiaries enrolled in both traditional FFS Medicare and MA. In 2022, more than 1.7 million Medicare beneficiaries (including almost half of decedents) received hospice services from about 5,900 providers, and Medicare hospice expenditures totaled $23.7 billion. As described in Chapter 9, the indicators of FFS Medicare payment adequacy for hospice services are positive.

Beneficiaries' access to care—In 2022, indicators of beneficiaries' access to care were positive. In 2022, the number of hospice providers increased by about 10 percent as more for-profit hospices entered the market, a trend that has continued for more than a decade. The overall share of Medicare decedents using hospice services increased from 47.3 percent in 2021 to 49.1 percent in 2022. The number of hospice users and total days of hospice care also increased. For decedents, average lifetime length of stay increased by about 3 days in 2022 to 95.3 days. Between 2021 and 2022, median length of stay was stable, increasing

slightly from 17 days to 18 days. In 2021, FFS Medicare payments to hospice providers exceeded marginal costs by 17 percent. This rate of marginal profit suggests that providers have a strong incentive to treat Medicare patients and is a positive indicator of patient access.

***Quality of care*—**Scores on the Hospice Consumer Assessment of Healthcare Providers and Systems® were stable in the most recent period. Scores on a composite of seven processes of care at admission were generally topped out (meaning scores are so high and unvarying that meaningful distinctions and improvement in performance can no longer be made). The provision of in-person visits at the end of life was stable in 2022 but remained lower than 2019 levels.

***Providers' access to capital*—**Hospices are not as capital intensive as other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (an increase of at least 10 percent in 2022) and reports of strong investor interest in the sector suggest that capital is available to these providers. Less is known about access to capital for nonprofit freestanding providers, for which capital may be more limited. Hospital-based and home health–based hospices have access to capital through their parent providers.

***FFS Medicare payments and providers' costs*—**Hospice FFS Medicare margins are presented through 2021 because of the data lag required to calculate cap overpayment amounts. Between 2020 and 2021, average cost per day increased 4.3 percent. The aggregate FFS Medicare margin for 2021 was 13.3 percent, down slightly from 14.2 percent in 2020. If Medicare's share of pandemic-related relief funds is included, the aggregate FFS Medicare margin rises to about 14.5 percent. Hospice average cost per day increased 3.7 percent in 2022. We project an aggregate FFS Medicare margin for hospices of about 9 percent in 2024.

***Recommendation*—**Based on the positive indicators of payment adequacy and strong margins, the Commission concludes that current payment rates are sufficient to support the provision of high-quality care without an increase to the payment rates in 2025. The Commission recommends that the Congress eliminate the update to hospice base payment rates for fiscal year 2025.

Ambulatory surgical center services: Status report

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay. As described in Chapter 10's ASC status report, in 2022, about 6,100 ASCs treated 3.3 million FFS Medicare beneficiaries. FFS Medicare program spending and beneficiary cost sharing on ASC services was about $6.1 billion.

The supply of ASCs and volume of services continued to grow in 2022. There was a net increase of 13 ASCs in the first quarter of 2022, and the volume of ASC surgical procedures per FFS beneficiary grew by about 2.8 percent. Numerous factors have contributed to this sector's growth, including changes in clinical practice and health care technology that have expanded the provision of surgical procedures in ambulatory settings. The most common ASC procedure, which accounted for almost 19 percent of volume and 20 percent of spending in 2022, was extracapsular cataract removal with intraocular lens insertion.

Most ASCs are for profit, and geographic distribution is uneven. The vast majority are located in urban areas, and the concentration of ASCs varies widely across states. About 68 percent of the ASCs that billed Medicare in 2022 specialized in a single clinical area, of which gastroenterology and ophthalmology were the most common. The remainder were multispecialty facilities, providing services in more than one clinical specialty. From 2017 to 2022, the ASC specialties that grew most rapidly were pain management and cardiology.

Medicare spending per FFS beneficiary on ASC services rose at an average annual rate of 8.2 percent from 2017 through 2021 and by 10.0 percent in 2022. However, policymakers know little about the costs ASCs incur in treating beneficiaries because Medicare does not require ASCs to submit cost data, unlike its cost data requirements for other types of facilities. The Commission contends that ASCs could feasibly provide such information, and we reiterate our recommendation that the Congress require ASCs to submit cost data.

The Medicare prescription drug program (Part D): Status report

As described in Chapter 11, in 2023, Part D paid for outpatient prescription drug coverage on behalf of

more than 51 million Medicare beneficiaries. For Part D plan enrollees, Medicare subsidizes about three-quarters of the cost of basic benefits. Part D also includes a low-income subsidy (LIS) that provides assistance with premiums and cost sharing for nearly 14 million beneficiaries with low income and assets.

In 2022, Part D expenditures totaled $117.3 billion. Of that amount, Medicare paid $101.3 billion in subsidies for basic benefit costs and extra help for LIS enrollees and $0.6 billion in retiree drug subsidies, and enrollees paid $15.4 billion in premiums for basic benefits. Medicare spending for the LIS totaled $39.7 billion: $35.2 billion for cost sharing and $4.5 billion for premiums. In addition, Part D plan enrollees paid $18.5 billion in cost sharing and $9.9 billion in premiums for enhanced benefits.

Since its inception in 2006, Part D has changed in important ways. Part D enrollees have greatly expanded their use of generics, while a relatively small share of prescriptions for high-cost biological products (referred to as "biologics" hereafter) and specialty medications account for a mounting share of spending. A growing share of Medicare's payments has taken the form of cost-based reimbursements to plans through Medicare's reinsurance and LIS. As a result, the financial risk that plans bear, as well as their incentives to control costs, has declined markedly. In 2020, the Commission recommended major changes to the Part D benefit design and Medicare's subsidies in order to restore the role of risk-based, capitated payments that was present at the start of the program. In 2022, the Congress passed the Budget Reconciliation Act of 2022, which included numerous policies related to prescription drugs; one such provision is a redesign of the Part D benefit with many similarities to the Commission's recommended changes. The reforms to Part D's benefit structure have begun to be implemented, with more changes coming over the next several years.

About 300 organizations operate Part D plans, but most beneficiaries are enrolled in plans sponsored by a handful of large health insurers. Most of the largest sponsors have their own pharmacy benefit managers (PBMs) that operate mail-order and specialty pharmacies. Formularies (a plan's list of covered drugs) remain plan sponsors' most important tool for managing drug benefits. In Part D, plans and their PBMs reduce benefit costs with postsale rebates and discounts. Generally, pharmaceutical manufacturers pay larger rebates when the sponsor positions a drug on its formulary in a way that increases the likelihood of gaining market share over competing drugs. Historically, most plan sponsors also used provisions in network contracts with pharmacies that required postsale recoupments or payments for meeting performance metrics. Beginning this year, however, sponsors may no longer recoup payments from pharmacies after the point of sale. Rebates and pharmacy fees have grown as a share of Part D spending, but these legislative and regulatory changes may affect their magnitude.

Enrollment in 2023 and benefit offerings for 2024— In 2023, 78 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 1 percent obtained drug coverage through employer-sponsored plans that received Medicare's retiree drug subsidy. We estimate that among the remaining beneficiaries, just under 10 percent had comparable drug coverage from other sources and about 11 percent had no coverage or coverage less generous than Part D.

Enrollment in stand-alone prescription drug plans (PDPs) peaked in absolute terms in 2019 at 25.5 million (56 percent of total plan enrollment) but declined to 22.5 million by 2023 (44 percent). Enrollment in MA Prescription Drug plans (MA–PDs) surpassed enrollment in PDPs for the first time in 2021 and reached 29.1 million in 2023. Since 2020, LIS enrollees have comprised 27 percent of total enrollment and in 2022 they accounted for 46 percent of gross program spending.

For 2024, beneficiaries continue to have a broad choice of plans. Plan sponsors offered 3,507 general MA–PDs (a slight decline from 2023) and 1,306 MA–PDs tailored to specific populations (special needs plans, or SNPs; a 4 percent increase). In 2024, plan sponsors are offering 709 PDPs, the fewest since the program began.

For 2024, the base beneficiary premium increased to $34.70. A recent legislative change capped annual premium increases at 6 percent, so the increase this year was less than the 20 percent increase that would have otherwise been incurred. While this cap is intended to protect beneficiaries from bearing the full cost of plan sponsors' increased liability under the new

benefit design, cost increases beyond 6 percent will be borne by the Medicare program. Further, although the increase in the base beneficiary premium was capped, individual plans' premiums still vary substantially, with PDPs typically having higher premiums than MA–PDs. In 2024, 126 PDPs, roughly one-sixth of all PDPs, are available premium free to enrollees who receive the LIS, compared with one-fourth of all PDPs last year. This drop in benchmark plans has left 8 regions out of 34 with just 2 premium-free PDPs for LIS enrollees. Most Part D plans use a five-tier formulary with differential cost sharing between preferred and nonpreferred drugs, as well as a specialty tier for high-cost drugs.

***Part D program spending*—**In 2022, Medicare program spending on Part D (excluding the $15.4 billion in premiums paid by enrollees) totaled $101.9 billion, up from about $95 billion in 2021. That amount includes the monthly capitated payments to Part D plans for each enrollee (the "direct subsidy"); the reinsurance amount that Medicare pays plans to cover 80 percent of costs for enrollees while in the benefit's catastrophic phase; the LIS; and the retiree drug subsidy. Reinsurance continued to be the largest and fastest-growing component of program spending, totaling $56.8 billion, or about 56 percent of the total. In 2023, direct subsidy payments averaged $2 per member per month, while cost-based reinsurance payments averaged about $94 per member per month. However, in 2024, as a result of legislative and regulatory changes, we see a reversal in the trend toward higher reinsurance payments: Direct subsidy payments increased to an average of nearly $30 per member per month, while average reinsurance payments are expected to decline to about $90 per member per month.

In 2022, drug list prices continued to rise, approaching rates observed before the pandemic. Decreasing prices of generic drugs continued to moderate overall price growth. However, generics' share of prescriptions has plateaued at about 90 percent since 2017, and further opportunities for generic substitution may be limited given the shift in the drug development pipeline toward biologics with longer periods of market exclusivity. Inflation in prices for brand-name drugs and biologics will likely continue to drive spending upward. Going forward, meaningful savings for biologics will depend largely on the successful launch and adoption of biosimilars by prescribers and beneficiaries. In 2022, about 482,000 beneficiaries filled a prescription that, by itself, was sufficiently expensive to reach the catastrophic phase of the benefit, up from just 33,000 enrollees in 2010.

***Beneficiary access and quality in Part D*—**Surveys suggest high overall satisfaction with Medicare Part D. At the same time, focus groups show that both prescribers and beneficiaries are acutely aware of high drug costs. Among beneficiaries without the LIS, high cost sharing for expensive therapies can be a barrier to access. However, the redesigned benefit now places an annual limit on beneficiaries' cost sharing. As a result, going forward, beneficiaries are less likely to face cost-related access issues.

Medicare beneficiaries take an average of nearly five prescription drugs per month and are at higher risk for adverse drug events associated with polypharmacy. By law, Part D plans are required to carry out medication therapy management (MTM) programs and programs to manage opioid use. For years, the Commission has had concerns about the effectiveness of MTM programs, particularly among stand-alone PDPs, which do not bear financial risk for medical spending. A recent evaluation of a CMS demonstration testing an enhanced MTM model found that new payment incentives and regulatory flexibilities surrounding MTM failed to promote better health outcomes for beneficiaries. In addition, the demonstration yielded no significant reductions in Medicare spending for Part A and Part B services, with a net increase in Medicare spending after accounting for model payments.

The Medicare Advantage program: Status report

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the FFS Medicare program. As described in Chapter 12, in 2023, the MA program included 5,635 plan options offered by 184 organizations, enrolled about 31.6 million beneficiaries (52 percent of Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated $455 billion (not including Part D drug plan payments). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for beneficiaries enrolled in traditional FFS Medicare. We also provide

updates on risk adjustment, risk coding practices, the structure of the MA market, and the current state of quality reporting in MA.

The Commission strongly supports the inclusion of private plans in the Medicare program. Beneficiaries should be able to choose among Medicare coverage options since some may prefer to avoid the constraints of provider networks and utilization management by enrolling in the traditional FFS Medicare program, while others may prefer the additional benefits and alternative delivery systems that private plans provide. As evidenced by rapid growth in enrollment, additional benefits (including lower cost sharing for basic Medicare benefits, a cap on out-of-pocket expenses, and reduced premiums for Part D coverage) are attractive to beneficiaries. Because Medicare pays private plans a partially predetermined rate—risk adjusted per enrollee—rather than a per service rate, plans should have greater incentives than FFS providers to deliver more efficient care.

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 private plans in the aggregate have never been paid less than FFS Medicare because of policies that have increased payments to MA above FFS. As examples, MA benchmarks are set above FFS spending in many markets in part to encourage more uniform plan participation across the country, and payments under the quality bonus program further increase MA payments above FFS (without, the Commission has found, producing meaningful information on plan quality for Medicare beneficiaries or the Medicare program). Favorable selection of enrollees into MA leads to plan enrollees having actual spending that is lower than predicted (independent of the effects of any plan utilization management). MA plans' diagnostic coding practices also increase payments. Currently, the Commission does not quantify the extent to which favorable selection stems from plan behavior, beneficiary preferences, or other reasons, nor the extent to which higher MA coding intensity reflects documenting diagnoses more comprehensively than providers in FFS Medicare do, the fraudulent submission of diagnostic data, or other reasons. Regardless of the causes, favorable selection of enrollees in MA and higher MA coding intensity increase payments to plans.

When accounting for favorable selection of enrollees in MA and higher MA coding intensity, we estimate that Medicare spends approximately 22 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected $83 billion in 2024. The Commission acknowledges that a portion of these increased payments to MA plans are used to provide more generous supplemental benefits and better financial protection for MA enrollees. Nevertheless, the Commission is concerned that the relatively higher payments to MA plans are subsidized by the taxpayers and beneficiaries who fund the program. Higher MA spending increases Part B premiums for all beneficiaries (including those in FFS who do not have access to the supplemental benefits offered by MA plans); the Commission estimates premiums will be about $13 billion higher in 2024 because of higher MA spending. Further, the Commission is concerned that policies leading to higher MA payments also distort the nature of plan competition on the basis of improving quality and reducing health care costs.

A major overhaul of MA policies is urgently needed for several reasons. First, beneficiaries lack meaningful quality information when choosing among MA plans. Second, Medicare is paying more for MA than for comparable beneficiaries in FFS Medicare. Third, the disparity between MA and FFS payment disadvantages beneficiaries who—for medical reasons or personal preferences—do not want to enroll in MA plans that use tools like provider networks or utilization management policies and instead want to remain in FFS (which includes care provided through alternative payment models). Fourth, the lack of information about the use and value of many MA supplemental benefits prevents meaningful oversight of the program such that we cannot ensure that enrollees are getting value from those benefits. Finally, the continued growth in MA will increasingly create challenges for benchmark setting because beneficiaries remaining in FFS may be higher risk (and thus have higher spending) in ways that risk adjustment cannot adequately capture.

Over the past few years, the Commission has made several recommendations to improve the program. These recommendations call for the Congress and CMS

to address coding intensity, replace the quality bonus program, establish more equitable benchmarks, and improve the completeness of MA encounter data. In addition, the growing subsidization of supplemental benefits remains a concern. Because of Medicare's fiscal situation, the subsidization of supplemental benefits, if desired by policymakers, should be considered with attention to their value. In the Commission's view, current policy does not meet that standard. If payments to MA plans were lowered, plans might reduce the supplemental benefits they offer. However, because plans use these benefits to attract enrollees, they might respond instead by modifying other aspects of their bids.

Enrollment, plan offerings, and extra benefits— Substantial growth in MA plan enrollment, availability, and rebates indicates a robust MA program. From 2018 to 2023, the share of eligible Medicare beneficiaries enrolled in MA rose by 3 percentage points per year, from 37 percent to 52 percent. In 2024, the average Medicare beneficiary has a choice of 43 plans (offered by an average of 8 organizations), and the average enrollee in a conventional MA plan has $2,142 in extra benefits available from the plan (such benefits are not available to beneficiaries in FFS Medicare unless they purchase additional health insurance coverage or pay for the services out of pocket). The average rebate amount, which finances extra benefits, has more than doubled since 2018 among conventional plans and, in 2024, accounts for 17 percent of payments to MA plans. Although plans are required to submit encounter data for supplemental benefits, CMS does not have reliable information about enrollees' actual use of these benefits.

Medicare payments to plans— As noted above, total Medicare payments to MA plans in 2024 (including rebates that finance extra benefits) are projected to be $83 billion higher than if MA enrollees were enrolled in FFS Medicare. Payments to MA plans average an estimated 122 percent of what Medicare would have expected to spend on MA enrollees if they were in FFS Medicare. This estimate reflects the impact of higher MA coding intensity (even after the CMS coding adjustment); favorable selection of beneficiaries in MA; setting benchmarks above FFS spending in low-FFS-spending counties; and payments associated with benchmark increases under the quality bonus program (which the Commission contends does not effectively promote high-quality care).

Risk adjustment and coding intensity— Medicare payments to MA plans are specific to each enrollee, based on a plan's payment rate and the enrollee's risk score. Risk scores account for differences in expected medical expenditures and are based in part on diagnoses that providers code. In both MA and FFS Medicare, claims include both procedure and diagnosis codes. However, most FFS Medicare claims are paid using only procedure codes, which offers little incentive for providers to record more diagnosis codes than necessary to justify providing a service. In contrast, MA plans have a financial incentive to ensure that their providers record all possible diagnoses because adding new risk-adjustment-eligible diagnoses raises an enrollee's risk score and results in higher payments to the plan. And plans have several mechanisms that do not exist in FFS Medicare to document diagnoses for their enrollees, including chart reviews (which document diagnoses not captured through the usual means of reporting diagnoses) and health risk assessments (which sometimes rely on unverified enrollee-reported data). Coding differences may reflect MA plans documenting diagnoses more comprehensively than providers in FFS Medicare do, the fraudulent submission of diagnostic data, or other reasons. There are no data available to parse the share of higher MA coding intensity due to these or other reasons; however, because the risk-adjustment model is calibrated on FFS claims, relatively higher MA coding intensity—regardless of the reason—increases payments to MA plans above FFS spending.

We estimate that in 2022, MA risk scores were about 18 percent higher than scores for similar FFS beneficiaries due to higher coding intensity (the Commission has adopted a new method of estimating the effects of coding intensity; see Chapter 13). We project that in 2024, MA risk scores will be about 20 percent higher than scores for similar FFS beneficiaries (accounting for the phase-in of the V28 risk-adjustment model). By law, CMS reduces all MA risk scores by the same amount to make them more consistent with FFS coding; CMS has the authority to impose a larger reduction than the minimum required by law but has never done so. In 2024, the adjustment will reduce MA risk scores by the minimum amount, 5.9 percent, resulting in MA risk scores that will remain about 13 percent higher

than they would have been if MA enrollees had been enrolled in FFS Medicare. In 2024, higher scores will result in a projected $50 billion in higher payments to MA plans. We continue to find that coding intensity varies significantly across MA plans, with some plans having coding intensity that falls below the 5.9 percent reduction (and even below FFS levels), and other plans coding far above that amount, including 10 MA organizations having average coding intensity that is more than 20 percent higher than FFS levels. Among the eight largest MA organizations, we estimate a 15 percentage point variation in average coding intensity. Higher coding intensity allows some plans to offer more extra benefits—and attract more enrollees—than other plans. That result distorts both the nature of competition in MA and plan incentives to improve quality and reduce costs.

The Commission previously recommended changes to MA risk adjustment that would exclude diagnoses collected from health risk assessments, use two years of diagnostic data, and apply an adjustment to eliminate any residual impact of coding intensity. We find that about half of higher MA coding intensity could result from use of diagnoses from chart reviews and health risk assessments and that these two mechanisms are primary factors driving coding differences among MA plans. Thus, the Commission expects that the recommendation, along with the exclusion of chart reviews from risk adjustment, would improve the heterogeneity in observed coding intensity across MA organizations.

Quality in MA—To make informed choices about enrolling in an MA plan, beneficiaries need good information about the quality and access to care provided by MA plans in their local market. However, the Commission has long been concerned about the ability of the current MA quality bonus program to help beneficiaries meaningfully differentiate across plans and between MA and FFS. Furthermore, the Commission contends that the program does not effectively promote high-quality care and has several other flaws. For instance, it relies on too many measures that do not reflect salient enrollee outcomes or experiences; it distorts improvement incentives with performance thresholds that introduce "cliff effects"; and it evaluates quality for large and sometimes geographically disparate contracts, rather than for plans at the local market level.

In 2024, nearly three-quarters of MA enrollees (23.3 million beneficiaries) were in a plan that received a quality bonus increase to its benchmark, generating about $15 billion in additional program spending. In its June 2020 report, the Commission recommended replacing the current quality bonus program, which is not achieving its intended purposes and is costly to Medicare, with a new value incentive program for MA. In this report, we focus on the spending implications and other concerns regarding the current quality bonus program. In a future report, we plan to include a more detailed chapter on MA quality and access to care, which will provide more information about the Commission's approach to these topics, including some empirical analysis of MA plan performance.

Estimating Medicare Advantage coding intensity and favorable selection

Chapter 13 describes the Commission's methods for estimating the effects of higher MA coding intensity and of a favorable selection of enrollees into MA, including recent revisions to those methods. Estimating the effects of these two factors presents several challenging analytic issues, and we will continue to refine our methods based on the results of our continuing analytic work.

Estimating MA coding intensity—In prior years, the Commission has estimated the impact of higher coding intensity on MA risk scores by comparing changes in MA and FFS risk scores over time for cohorts of beneficiaries with similar age, sex, and MA or FFS enrollment length—the "MedPAC cohort method." For this report, we revised our cohort method to account for differences in Medicaid eligibility between MA and FFS beneficiaries (which has changed significantly since we first developed our method) and to remove a restriction requiring continuous enrollment in either MA or FFS. These model improvements produced higher estimates of coding intensity compared with our original cohort method.

In the advance notice of payment rates for 2019, CMS requested comment on adopting an alternative method for calculating the MA coding adjustment factor, including the Commission's cohort method and the demographic estimate of coding intensity (DECI) method (Centers for Medicare & Medicaid Services 2018). The DECI method has produced estimates of coding intensity that are double the estimates

produced by the Commission's cohort method. Therefore, we estimated coding intensity using the DECI method to understand the reasons for the differing coding intensity estimates. We found that by (1) applying this method to complete enrollment, demographic, and risk-score data; (2) accounting for differences in Medicaid eligibility between MA and FFS beneficiaries; and (3) constraining new Medicare enrollees to have no coding intensity, the DECI method yielded very similar estimates of coding intensity (within 1.5 percentage points for all years 2008 through 2021) to our revised cohort method. Because the DECI method includes a greater share of both MA and FFS beneficiaries than the Commission's revised cohort method, we will use the revised DECI method to estimate the impact of coding intensity going forward.

Estimating MA favorable selection—In addition to coding intensity, favorable selection in MA causes payments to plans to be systemically greater than plans' spending for their enrollees. Seeking to both estimate the extent of higher payments that result from favorable selection and incorporate favorable selection into our annual March report to the Congress, the analysis described in Chapter 13 maintains the same analytic framework that we used in our June 2023 report but makes four key technical improvements. In our updated estimates, we continue to estimate that the effect of favorable selection resulted in Medicare payments that were substantially higher for MA enrollees than if those same beneficiaries were in FFS.

The Commission will continue to refine these estimates in future work. We continue to conduct sensitivity analyses of certain aspects of our method, particularly related to how our analysis deals with regression to the mean and attrition of beneficiaries from MA cohorts.

Mandated report: Dual-eligible special needs plans

Individuals who qualify for both Medicare and Medicaid, known as dual-eligible beneficiaries or "dual eligibles," may receive care that is fragmented or poorly coordinated because of the challenges of navigating two distinct and complex programs. The Bipartisan Budget Act (BBA) of 2018 directs the Commission to periodically compare the performance of several types of Medicare managed care plans that serve dual eligibles but vary in their level of integration with Medicaid. Many of the plan types are variations of the dual-eligible special needs plan (D–SNP), which is a specialized MA plan. Chapter 14 contains our second report under the BBA of 2018 mandate.

As required by the mandate, we compare plans' performance using quality measures that plans report as part of the Healthcare Effectiveness Data and Information Set® (HEDIS®) and patient experience data that plans collect using the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) beneficiary survey. (We used HEDIS data in our first mandated report, while our analysis of CAHPS data is new.) We find that these data sources provide limited insight into the relative performance of D–SNPs because most HEDIS measures are not tied to clinical outcomes and because HEDIS and CAHPS scores on many measures are fairly similar across plan types. MA plans perform better on some measures than Medicare-Medicaid Plans (MMPs), which are demonstration plans that operate outside the MA program, but those differences could reflect structural differences between the two types of plans. These findings are consistent with our first mandated report and with other Commission analyses that have examined the difficulties of assessing the quality and performance of MA plans.

The landscape of health plans that serve dual eligibles will change in 2025, when the MMP demonstration is scheduled to end. Most evaluations have found that MMPs increase Medicare spending and have had mixed effects on service use. After the demonstration ends, we expect most MMPs to convert into D–SNPs.

Mandated report: Rural emergency hospitals

Historically, Medicare's support for rural hospitals has focused on making inpatient services more profitable. However, inpatient volume has declined dramatically over the past 40 years, especially at rural hospitals. Such declines diminish the impact of Medicare's inpatient-centric support of hospitals and, in the 2010s, contributed to an increase in rural hospital closures. This situation led the Congress to create the new REH designation in the Consolidated Appropriations Act, 2021 (CAA). These entities do not furnish inpatient care, but must meet several other criteria, including having an emergency department that is staffed 24/7 and a transfer agreement with a Level I or Level II trauma center. They are paid fixed monthly payments from

Medicare (approximately $270,000 per month, totaling $3.2 million per year in 2023), in addition to rates of 105 percent of standard OPPS rates for emergency and outpatient services.

The CAA also requires the Commission to report annually on payments to REHs, beginning in March 2024. Chapter 15 contains our first mandated report on REHs. Because this program began in 2023, complete REH claims data are not yet available. Therefore, this chapter provides context on the evolution of Medicare's support for rural hospitals, gives background on the REH designation and the hospitals that have converted to REHs, and describes our 2023 site visits to (prospective) REHs to understand their experiences and decision-making processes. In 2023, 21 hospitals converted to REHs. Before converting, these hospitals often furnished a low (and declining) volume of inpatient care, received enhanced payments from Medicare, were located relatively close to other hospitals, and had financial difficulties. The REH designation has been seen as a way to overcome financial difficulties and retain local access to emergency and outpatient services in communities that cannot support a full-service hospital. The Commission will continue to monitor the new REH designation, including analysis of REH claims when they become available, and consider possible modifications in the future. ■