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MedPAC Releases June 2025 Report to Congress

On June 11, the Medicare Payment Advisory Commission (MedPAC) released their June 2025 Report to Congress, which included the following chapters:

- Reforming Physician Fee Schedule Updates and Improving the Accuracy of Relative Payment Rates,
- Supplemental Benefits in Medicare Advantage,
- Examining Home Health Care Use Among Medicare Advantage Enrollees,
- Part D Prescription Drug Plans for Beneficiaries in Fee-For-Service Medicare and Medicare Advantage,
- Medicare Beneficiaries in Nursing Homes,
- Medicare's Measurement of Rural Provider Quality, and
- Reducing Beneficiary Cost Sharing for Outpatient Services at Critical Access Hospitals.

The full report is available here.

MEDPAC REITERATES THEIR RECOMMENDATION TO TIE THE PHYSICIAN FEE SCHEDULE TO INFLATION AND PROPOSES SEVERAL CHANGES TO RELATIVE VALUE RATES

This chapter outlines the Commission's recommendations for reforming the Medicare Physician Fee Schedule (PFS) update framework and improving payment accuracy to ensure continued access to quality care for Medicare beneficiaries, while balancing beneficiary and taxpayer burden alongside overall Medicare spending.

The Medicare PFS dictates Medicare payments for approximately 9,000 clinician services across various settings, from independent clinician offices to hospitals. Payments are based on Relative Value Units (RVUs), which reflects three components: 1) clinician work, 2) indirect and direct practice expenses (PE), and 3) malpractice insurance costs (MP). RVUs are multiplied by a conversion factor to determine total payment rates for each service, which may be adjusted based on whether the service was provided in non-facility (i.e., independent clinician office) or facility settings (i.e., hospital).

Physician Fee Schedule

While the 2015 Medicare Access and CHIP Reauthorization Act (MACRA) mandates annual PFS updates, Congress has repeatedly intervened to provide additional one-off increases. If existing provisions remain unchanged, future automatic payment rate updates would be a fraction of recent updates. Compounding this issue is MedPAC's concern that growth in the Medicare Economic Index (MEI) – a measure of practice cost inflation – is forecasted to exceed statutory fee schedule updates by a meaningfully larger margin than in the past.

In the two decades prior to the pandemic, MEI growth only outpaced fee schedule updates by just over 1 percentage point annually. Starting in 2026, payment rates will rise by 0.75 percent annually for qualifying clinicians in advanced alternative payment models (A-APMs) and by 0.25 percent for all others. However, MedPAC projects that input costs based on MEI will increase by 2.2 percent per year between 2025 to 2034, leaving a gap of approximately 1.5 percent and 2 percent annually (for clinicians participating in A-APMs and those not participating, respectively) versus a 1 percent historical gap over the last two decades.

While Medicare beneficiaries continue to experience access to care comparable to those with private insurance, and service volume and intensity per beneficiary have increased, the Commission is concerned that current fee schedule payment rules under MACRA may not sustain access to care as clinician costs continue to rise faster than payment rates.

To address this, MedPAC reaffirmed their recommendation from earlier this year to replace current-law updates with an annual update based on a portion of growth in the MEI, such as "MEI minus one percentage point." MedPAC also encouraged policymakers to consider incorporating minimum update floors or ceilings to account for times of low or rapid inflation. MedPAC argues that a full MEI-based update is not required to maintain access to care and could result in additional unnecessary financial burdens for beneficiaries and the Medicare program. Basing updates on a portion of MEI growth would help protect beneficiary access while controlling Medicare spending and offers several benefits, such as simplicity, automatic adjustments to account for changes in inflation, and greater system-wide predictability. If implemented, MedPAC states it would continue to monitor access to care and recommend future adjustments to the update rate if necessary.

Relative Value Units

MedPAC also raised concerns about the accuracy of RVUs used to set PFS payment rates, as misvaluations influence payment distribution, service incentives, and beneficiary cost-sharing. The current structure relies on data last updated in 2006, and

MedPAC's research suggests this may not accurately reflect current care delivery models and resource use, especially as more clinicians practice in facility settings. As a result, payments may under- or over-compensate clinicians, which influence incentives for clinicians to provide certain services and in turn impact costs for beneficiaries and the Medicare program. To improve payment accuracy, the Commission recommends the following approaches:

- **Improve Payment Accuracy for Indirect Practice Expenses:** According to MedPAC's analysis, current payment methods may overestimate costs for services by assuming uniform indirect expenses across settings, particularly for services furnished in facility settings. They assert Medicare may be making duplicative and unnecessary payments if facilities cover indirect PE costs for financially associated clinicians. Medicare claims data could help identify if clinicians primarily practice in facility, non-facility, or combined settings, and used to better help align payments with actual resource use.
- **Update RVU Allocations using Current Data:** CMS periodically rebases the MEI using updated base-year data to establish the distribution of costs. Although the MEI was rebased from 2006 to 2017 in 2022, the RVUs were not adjusted accordingly, leaving existing data almost two decades old. The Commission supports using more current data to improve accuracy, but noted challenges in identifying the best data sources.
- **Reform Relative Values of Global Surgical Codes to Address Overpayment:** Global surgical codes are 10- or 90-day bundles that cover all services provided on the day of a procedure and any postoperative visits by the rendering physician during the time-period. Current RVUs are based on assumptions about the number and intensity of follow-up visits, but MedPAC's research has shown many of these valuations are too high, leading to overpayment. To address this, MedPAC recommended two policy options:
    a. Convert all 10- and 90-day global codes to 0-day codes, allowing postoperative visits to be billed separately and ensuring payments reflect actual services provided.
    b. Retain global codes but revalue the codes' RVUs to reflect the actual average number of postoperative visits provided.

MEDPAC HIGHLIGHTS THE GROWING ROLE OF SUPPLEMENTAL BENEFITS IN MEDICARE ADVANTAGE AND ASSOCIATED CHALLENGES REGARDING AVAILABILITY OF DATA

In this chapter, MedPAC reviewed supplemental benefits in Medicare Advantage (MA) that extend beyond traditional Medicare coverage. These benefits, intended to

enhance beneficiary well-being and improve financial protection, have become a defining feature of MA plans. These benefits are wide ranging, including cost sharing reductions for Part A and Part B services, reduced Part B and Part D premiums, expanded Part D benefits, and additional services excluded from traditional fee-for-service (FFS) Medicare – primarily dental, vision, and hearing services. Despite their expansion and growing cost to the Medicare program, MedPAC raises concerns over the lack of transparency, limited data quality, and questionable value of these services.

The cost of supplemental benefits is already significant and only growing. In 2018, Medicare paid $21 billion to MA plans for providing these benefits, totaling $1,160 per enrollee. By 2025, this cost per enrollee more than doubled to $2,530, representing a total Medicare expenditure of $86 billion. Plans reported that roughly $39 billion of these funds will be spent on non-Medicare services, while approximately $27 billion will go toward reducing cost sharing for Medicare-covered services. For the remainder of the funds, MedPAC estimates $15 billion will be spent on enhanced Part D drug benefits, and $5 billion on reduced Part B premiums.

The way rebate dollars are allocated varies widely by plan type. Conventional MA plans generally use rebates to reduce cost sharing for Parts A and B. In contrast, Special Needs Plans (SNPs), especially those serving dual-eligible beneficiaries, tend to allocate more rebate dollars to non-Medicare services, since many SNP enrollees already receive assistance with out-of-pocket (OOP) costs through Medicaid, making cost-sharing less applicable. Recent regulatory changes have also allowed SNPs to meaningfully expand payments for nonmedical services, like air filters, food benefits, and pest control for chronically ill enrollees.

Despite a growing investment in supplemental benefits, the Commission found limited data on how frequently or effectively these benefits are used. MA plans are required to submit encounter data, but these records are often incomplete or missing. Many supplemental services also lack standardized procedure codes, and plans report confusion regarding reporting requirements. One major data challenge identified by MedPAC is that, until 2024, CMS's systems were unable to process encounter records for dental claims. However, MedPAC's analysis using limited available data suggests that many MA enrollees are using dental benefits to reduce OOP costs compared to their FFS counterparts.

The Commission also found that many MA plans outsource supplemental benefits administration to third party vendors or community-based organizations (CBOs). Insurers often contract out dental and vision benefits or use for-profit vendors to manage nonmedical services, sometimes through firms owned by the parent company. CMS does not currently track these vendor arrangements, so MedPAC relied on

marketing materials and websites in their research. These factors contribute to the limited data available on benefit utilization and spending.

The Commission concluded that supplemental benefits have become a core component of the MA program but still lack adequate oversight. CMS has begun improving data collection, including better reporting of utilization and expenditures. However, without major improvements to encounter data quality and transparency into vendor contracts, MedPAC remains concerned that policymakers will face difficulties in assessing whether supplemental benefits provide meaningful value. The Commission plans to continue monitoring developments and may propose further recommendations as improved data become available.

MEDPAC COMBINES OASIS AND ENCOUNTER DATA TO COMPARE UTILIZATION OF HOME HEALTH SERVICES BETWEEN FEE-FOR-SERVICE MEDICARE AND MEDICARE ADVANTAGE

In this chapter, MedPAC analyzed the use of home health care services among MA and FFS Medicare beneficiaries by combining two key datasets: encounter data and the Outcome and Assessment Information Set (OASIS).

Background

Although CMS requires both datasets to be reported for all Medicare beneficiaries that receive home health care, earlier MedPAC work found both datasets to be incomplete. In 2021, among MA enrollees with any home health record, 88 percent had both encounter and OASIS data, 7 percent had only an encounter record, and 5 percent had only an OASIS record. In contrast, 98.3 percent of FFS beneficiaries with a home health record had both claims and OASIS data. As a result, MedPAC asserts that previous nationwide studies investigating home health care use among MA enrollees utilizing only one of these datasets are limited in their ability to draw nationally representative conclusions. To address this gap, MedPAC staff integrated both datasets to provide a more holistic view of home health care use, enabling comparisons between MA and FFS beneficiaries.

Home health care use among MA enrollees is captured through two sources: MA encounter (or claims) data submitted by plans and OASIS data submitted by home health agencies (HHAs). For MA, HHA claims are processed and paid between the HHA and the Medicare Advantage Organization (MAO), without CMS involvement. MAOs must submit encounter data to CMS, and HHAs submit OASIS data directly to CMS for all Medicare patients, including those in MA. For FFS Medicare, HHAs submit both

claims and OASIS data directly to CMS, which adjudicates claims and audits OASIS submissions as part of payment processing. However, HHAs are only required to submit 90 percent or more of mandatory OASIS data elements to avoid FFS payment reductions. Due to these differences, MedPAC notes that data for MA enrollees may be less complete and standardized compared to FFS enrollees.

For its analysis, MedPAC used a sample of Medicare beneficiaries with continuous Part A and Part B coverage in 2021, focusing on those enrolled in Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) MA plans where Medicare was the primary payer throughout the year. To avoid underestimating services and data completeness issues, MedPAC restricted much of the analysis to beneficiaries living in counties with high MA home health data match rates (at least 85 percent of beneficiaries with both encounter and OASIS data), which increased the average match rate to 94 percent. This sample included 16.4 million MA enrollees and 19.5 million FFS beneficiaries. Analyses were adjusted for relevant beneficiary characteristics to enable meaningful comparisons.

Results

Overall, MedPAC found that home health care utilization among MA enrollees is lower than among FFS beneficiaries, with variation based on hospitalization status and plan design, suggesting that MA cost-sharing policies and utilization controls may influence both patient and provider behavior. Specifically, the overall home health use rate was slightly lower for MA enrollees compared to FFS (8.3 percent vs. 8.6 percent). For beneficiaries hospitalized in the previous year, home health use was 3.2 percent higher among MA enrollees (41.7 percent vs. 40.4 percent). Based on this, MedPAC suggests that MA plans may be substituting costlier post-acute care options, such as skilled nursing facilities (SNFs), for home health services.

For beneficiaries without a recent hospital stay, home health use was 13.7 percent lower for MA enrollees than their FFS counterparts (3.7 percent vs. 4.2 percent). MedPAC speculates this difference may be connected to MA plans' use of prior authorization and home health cost sharing, which are measures not applicable to FFS Medicare, or differing preferences regarding admitting FFS beneficiaries.

Enrollment in MA plans with home health cost sharing was associated with a 6.9 percent lower adjusted rate of home health use compared to plans without cost sharing (7.9 percent vs. 8.4 percent), a pattern that persisted even among those recently hospitalized. Differences between PPO and HMO plans or provider-sponsored plans were generally not associated with differences in the probability of any home health care use.

Additionally, MedPAC reports that MA enrollees received fewer home health visits than FFS beneficiaries across all levels of need, with differences linked to MA plan features such as prior authorization, cost sharing, and plan type. On average, MA enrollment was associated with 2.1 (11 percent) fewer visits per beneficiary per year compared with FFS (18.2 vs. 20.4 visits per user). This difference remained consistent for all patients, regardless of whether they had an acute care hospital stay in the last year. Interviews with a large HHA chain suggested that their MA patients likely receive fewer visits than FFS patients with similar conditions partly due to prior authorization requirements for additional visits.

Skilled nursing and therapy (physical, occupational, speech-language pathology) visits comprised over 90 percent of home health visits for both MA and FFS users. Beneficiaries with greater functional impairment or clinical severity, as categorized by OASIS data, generally received more visits. However, FFS beneficiaries received more visits across all impairment categories compared to MA beneficiaries. PPO plans were associated with 4.5 percent more visits per user than HMO plans (18.4 vs. 17.6 visits), while provider-sponsored plans at large also had 9.4 percent fewer visits per beneficiary (16.5 vs. 18.2 visits). Plans with home health cost sharing also saw reduced utilization, with 2.7 percent fewer visits compared to those without cost sharing (17.6 vs. 18.0 visits). One HHA chain interviewed by MedPAC reported that per-visit copays in MA plans led some patients to limit their number of visits.

Looking ahead, MedPAC expressed interest in expanding this research to include MA enrollees' utilization of other post-acute care settings, such as SNFs and Inpatient Rehabilitation Facilities, and further examining the relationship between MA plan types, payer, and specific home health visit categories. The Commission also plans to explore utilization and provision of telehealth services in MA home health encounters, noting that insufficient data currently exist as MA plans were not required to report telehealth services on claims forms until July 2023.

MEDPAC EXPRESSES CONCERN ABOUT THE LONG-TERM STABILITY OF THE PDP MARKET AND DISCUSSES TRENDS IN THE PART D COVERAGE MARKET

Medicare beneficiaries can receive Part D prescription drug coverage through multiple pathways. Beneficiaries enrolled in traditional fee-for-service (FFS) Medicare can opt for Prescription Drug Plans (PDPs), with some also purchasing supplemental insurance (or Medigap) to reduce their out-of-pocket costs. For Medicare Advantage (MA) beneficiaries, enrollment in a separate plan is generally not required, with a MA–Prescription Drug Plans (MA–PDs) already included in the MA plan benefits. In recent

years, enrollment has increasingly shifted toward MA–PDs, reflecting broader trends in MA growth.

Stability of the PDP Market

MedPAC is concerned about the long-term stability of the PDP market due to trends placing increasing pressure on beneficiary access and costs. While MA–PD offerings have continued to expand (with an average of 34 plans per region in 2025), the number of PDPs has fluctuated, with two years of sustained decline beginning in 2023. This year marks the lowest average number of PDPs per region since the start of Part D.

MA–PDs generally offer lower premiums and more generous benefits than PDPs, making them more attractive to beneficiaries. MA–PDs receive Medicare Advantage rebates, which can be used to reduce premiums or enhance Part D benefits, an option that is not available to PDPs. MedPAC also cites several other flexibilities, including incentives and opportunities to manage utilization within MA plans, contractual relationships with physicians, and an additional opportunity to adjust rates compared with PDPs, as providing MA-PDs greater latitude to create desirable terms for beneficiaries.

The availability of benchmark PDPs, which are used to set low-income subsidy (LIS) payments, are declining. Benchmark plans (a PDP without a premium), play an important role in ensuring beneficiaries with limited assets and income can access prescription drugs. In 2025, most regions have only one or two benchmark PDPs available, limiting LIS beneficiary options.

PDPs compared with their MA-PD counterparts have higher drug costs and lower average risk scores. This combination reduces competitiveness of PDPs in the marketplace, with MedPAC also raising concerns that Part D's current payment system is not appropriately reflecting lower costs despite average lower PDP risk scores. MedPAC partially ascribes these differences to MA-PDs documentation of diagnoses more aggressively, which leads to higher risk scores and payments. To partially address these differences, CMS introduced separate normalization factors for MA–PDs and PDPs beginning in 2025. Additionally, the Part D Premium Stabilization Demonstration provides temporary subsidies to PDPs to help limit premium increases caused by recent program changes.

The Inflation Reduction Act (IRA) also reshaped the Part D benefit design, eliminating the coverage gap and substantially increasing plan liability. These changes are expected to raise bids and premiums across the board, but MedPAC projects the impact will be more pronounced for PDPs, which lack the financial safeguards that MA–PDs have through rebates and cross-subsidization within broader MA plan offerings.

MedPAC plans to continue monitoring these differences closely. In particular, the Commission will focus on the growing differences in risk-adjusted costs between MA–PDs and PDPs, the shrinking availability of benchmark PDPs for LIS beneficiaries, and the overall stability of the PDP market.

Trends in Utilization Management and Formularies

The Commission also examined trends in utilization management and formularies, finding that:

- MA-PDs cover more products than PDPs on average, on lower tiers.
- MA-PD beneficiaries were slightly less likely to have utilization management requirements associated with their drugs, with an average of 51 percent of products in 2025 having any form of utilization management applied. For PDP enrollees, an average of 53 percent of products have utilization management requirements.
- Among both MA-PDs and PDPs, quantity limits are the most applied utilization management tool. Quantity limit use increased by about 5 percentage points in 2025 for both plan types.
- Prior authorization is required for approximately 25 percent of products, with PDP beneficiaries having slightly more products subject to these restrictions (1 to 2 percentage points).
- Step therapy is rarely used across all products in both MA-PDs and PDPs but has increased in use by 1 percentage point in both markets in 2025.
- Although utilization management use increased in 2025 for MA-PDs and PDPs, overall utilization management use decreased by 1 percentage point from 2024. MedPAC suggests that this decrease could mean that while less products have utilization management, more products have more than one type of utilization management being applied (e.g., a product requires prior authorization and has quantity limits).
- Highly utilized and high-cost products were frequently placed on specialty tiers and had utilization management rates above average.

MEDPAC PROVIDES OVERVIEW OF NURSING HOME CARE

Around 1.2 million Medicare beneficiaries rely on nursing homes (NHs) for support due to physical and cognitive limitations that limit independent living. These individuals are generally older and have higher healthcare expenses than the broader Medicare

population. Although Medicare helps cover short-term skilled nursing care following hospital stays, it does not pay for extended stays in NHs. Instead, Medicaid shoulders most long-term nursing home costs, accounting for 63 percent of total patient days in 2023. However, to become eligible to receive nursing home coverage under Medicaid, beneficiaries must have both limited income and assets – with some exceptions.

The NH sector includes roughly 15,000 facilities across the U.S., most of which serve dual roles, providing both long-term care and skilled nursing care (as a skilled nursing facility (SNF)). Overall industry profit margins average 0.4 percent across all payers, though facilities earn substantially more (approximately 22 percent) on SNF care. MedPAC has raised concerns that this payment imbalance may motivate some NHs to unnecessarily hospitalize residents to trigger higher Medicare payments upon their return for SNF-level care. MedPAC also expresses concern that opaque financial practices, including transactions with affiliated companies or artificially inflated expenses, may mask actual profitability. The majority of NHs (72 percent) operate on a for-profit basis and tend to rely more heavily on Medicaid funding than nonprofit facilities.

MedPAC's findings suggest that the widely recognized poor quality of care in many NHs is partly driven by inadequate Medicaid reimbursement rates, which frequently fall short of covering actual care costs and contribute to chronic staffing challenges. One major issue is the high turnover among nursing staff, reaching 53 percent nationwide as of October 2022, which disrupts continuity of care and worsens working conditions. Moreover, minority residents are disproportionately placed in facilities that have fewer staff and lower overall care quality.

Quality Initiatives

CMS has introduced several initiatives to improve NH quality, including required state inspections every 15 months. However, MedPAC argues these inspections often fail to catch serious issues or drive lasting change due to underfunding and inconsistent enforcement. Federal staffing rules mandate a Registered Nurse (RN) be on duty 7 days a week for at least 8 hours per day, and a licensed nurse (RN or Licensed Practical Nurse (LPN)) on site 24/7, with many states setting stricter standards. Higher RN staffing and lower turnover are consistently linked to better outcomes. MedPAC has also not taken a position on a 2024 rule that would have raised staffing requirements, which was dismissed by federal court in April 2025. CMS has announced plans to appeal, and Congress is considering removing the requirement in ongoing reconciliation negotiations. CMS also publishes Star Ratings for NHs based on inspections, staffing, and quality metrics to inform consumers and promote accountability. However, the system may be undermined by limited public awareness, with MedPAC's previous research showing potential issues with the quality of self-reported data for payment

and the absence of patient experience measures. For-profit and larger SNFs are more likely to have lower ratings. Finally, CMS adjusts SNF Medicare payments based on a set of quality measures including hospital readmission rates as part of the SNF Value-Based Purchasing (VBP) Program, but the financial incentives are modest (ranging from -2 percent to +1.8 percent). Since 2019, average SNF performance has declined, and MedPAC has questioned the overall effectiveness of CMS's quality programs.

Alternative Payment Models

In addition to traditional quality improvement efforts, alternative payment models are a growing focus, including Institutional Special Needs Plans (I-SNPs). I-SNPs are a type of MA plan designed specifically for beneficiaries who are expected to require NH-level care either in a facility or their home. These plans aim to curb costly hospital and emergency care by deploying nurse practitioner teams to provide proactive, coordinated services within the facility and by promoting on-site treatment for beneficiaries. I-SNPs have shown promise in lowering hospital admissions and emergency visits while improving certain hospital-related quality metrics, though studies remain limited and often omit patient experience data. I-SNP enrollment has grown steadily, doubling over the past ten years to reach 122,000 enrollees in 2025. However, expansion challenges include limited NH participation, market competition, and enrollment challenges in smaller facilities. NHs that adopt I-SNPs are typically large, urban, and for-profit, and they tend to have lower quality ratings compared to homes not involved in these plans.

Accountable Care Organizations (ACOs) are another growing alternative payment model. While most ACOs do not focus on long-term care settings, some - specifically High Needs ACOs - target patients with complex conditions, including NH residents. ACOs may reduce hospitalizations, emergency department use, and time spent in SNFs, while possibly increasing hospice utilization, aligning with better end-of-life care. However, these quality improvements are measured across the broader ACO population and may not directly reflect outcomes for NH residents alone.

Looking ahead, MedPAC is evaluating further research regarding how NH star ratings are calculated to give greater weight to staffing levels, citing research linking staffing and care quality. Future analyses may also focus on identifying barriers that limit broader use of I-SNPs and potential policy solutions to encourage their expansion.

MEDPAC PROVIDES OVERVIEW OF RURAL HEALTH

In this chapter, MedPAC reviewed the current quality of care provided to Medicare beneficiaries in rural areas. Rural communities represent approximately 17 percent of

the Medicare population, but the wide geographic distribution of these beneficiaries creates several unique challenges to delivering quality care. In addition to challenges related to access to care, where beneficiaries may have to travel significant distances to access services, low volumes and limited facility resources make measuring and improving quality especially challenging. Despite this, for many provider types, existing quality measures show mixed results compared with their urban counterparts.

MedPAC also examined rural provider inclusion in value-based programs such as Medicare Advantage (MA) and Accountable Care Organizations (ACOs). While participation is growing, the Commission highlighted that current quality measurement approaches may underrepresent rural beneficiaries. MA and Part D plans also calculate ratings based on sample populations that may exclude rural enrollees, leading to less accurate quality assessments.

To address these concerns, Congress has implemented a mix of pay-for-reporting and pay-for-performance programs for fee-for-service (FFS) Medicare providers. The aim of these programs is to improve care quality by financially incentivizing healthcare providers to report quality metrics and link payment with performance. Though some rural providers are exempt from these requirements, the majority of rural providers the Commission analyzed reported some quality data, with the share of providers reporting varying by setting. MedPAC broadly criticizes these programs as being overly complex and inconsistent with best practices in quality measurement, especially when considering additional challenges rural providers face. The Commission states that these programs are "overbuilt" with providers being held to hundreds of distinct quality metrics.

To address these inefficiencies, MedPAC has previously recommended merging existing programs. In 2018, it called for the elimination of Merit-based Incentive Payment System (MIPS) for clinicians, stating that it hinders the transition to more high-valued care. In 2019, the Commission recommended replacing four of Medicare current hospital quality programs with a single, outcome-based Hospital Value Incentive Program (HVIP). Similarly, in 2020, MedPAC recommended that Congress replace the Medicare Advantage (MA) based quality programs with a value-based MA Value Incentive Program that places greater focus on outcomes-based measures. Aside from these larger structural changes, the Commission expressed support for existing efforts to align existing measures across programs to reduce provider burden. The Commission also discussed positive feedback from interviewees regarding the role of Quality Improvement Organizations (QIOs) in providing technical assistance, and that resources available through the Medicare Beneficiary Quality Improvement Project (MBQIP) can help Critical Access Hospitals with reporting and improvement activities. MedPAC plans to continue its research on rural health quality, including why quality reporting rates and overall performance vary by provider type.

MEDPAC RECOMMENDS REDUCING BENEFICIARY COST SHARING AT CRITICAL ACCESS HOSPITALS

Critical Access Hospitals (CAHs) are small rural hospitals with 25 or less acute care beds that provide essential care to underserved, rural communities. Established by Congress, they help address the unique challenges of rural areas, including geographic isolation, low patient volume, limited healthcare services, and long travel distances.

Congress has looked to implement several policies to preserve beneficiary access to CAHs, including current cost payments, fixed payments, and add-on payments. Currently, CAHs are reimbursed for FFS Medicare patients based on their actual costs. This includes 101 percent of costs for inpatient, outpatient, laboratory, and therapy services, as well as post-acute care provided in hospital swing beds. In 2022, Medicare's cost-based payments to CAHs (including beneficiary cost sharing) totaled $12 billion, while the average payment to an individual CAH was $9 million. These cost-based payments to CAHs are significantly higher than what they would receive under Medicare's Prospective Payment Systems (PPS). Higher payments to CAHs are paid partly by taxpayers through Medicare and partly by patients and their insurance through higher cost-sharing.

CAHs depend on these payments to remain financially viable. FFS Medicare payments make up about $10 million, or 25 percent of a CAH's total revenue, compared to around 16 percent for other acute care hospitals. MedPAC estimated that if CAHs were paid under PPS rates, their FFS Medicare revenue would be about $4 million (or 40 percent) lower per hospital. MA plans also pay CAHs based on reported costs, with payment rates generally aligning with FFS Medicare. Without these cost-based payments, CAHs' total revenue would drop and threaten their sustainability.

In addition to these higher charges, beneficiaries also face higher cost-sharing at CAHs. Beneficiary coinsurance is calculated as 20 percent of the hospital's charges, not 20 percent of the costs or Medicare's payment amount—which are often higher than actual cost of service. There is also no cap on coinsurance at CAHs. The Commission noted that beneficiary cost-sharing and charge markups can vary greatly, based on size and location. Due to the wide variation in markups, beneficiary coinsurance for CAH outpatient services averaged approximately 52 percent of total Medicare payments in 2022. Notably, about 16 percent of rural FFS Medicare beneficiaries lack supplemental insurance to offset high coinsurance costs, while the 84 percent with supplemental coverage may pay even higher premiums to offset these costs. As a result, beneficiaries can encounter substantial and unpredictable costs. This payment structure for CAHs has raised equity concerns amongst the Commission because of the cost-sharing disparities, lack of co-insurance caps, and significant financial risks for those without supplemental coverage.

To offset these concerns, the Committee discussed a cap nearly identical to that of most other hospitals, formally recommending that the CAH coinsurance cap be set at 20 percent of the payment amount and capped per service at the inpatient deductible, which is currently $1,676. This would limit cost-sharing for high-cost services and promote greater equity for beneficiaries.

If coinsurance was set at 20 percent, the Commission estimated that:

- FFS beneficiary coinsurance for CAH outpatient services would drop by about 60 percent;
- FFS program spending would increase by $2.1 billion;
- CAHs would see a reduction in bad debts by $102 million;
- Federal spending on Part B services would increase;
- FFS Medigap premiums would decrease, although premiums would vary by state;
- Payments to CAHs would slightly decrease overall, but the net effect would be nearly zero; and
- Medicare spending would rise by an estimated $2–$5 billion in the first year and $25–$50 billion over five years.

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This Applied Policy® Summary was prepared by Hugh O'Connor with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact him at hoconnor@appliedpolicy.com or at 202-558-5272.