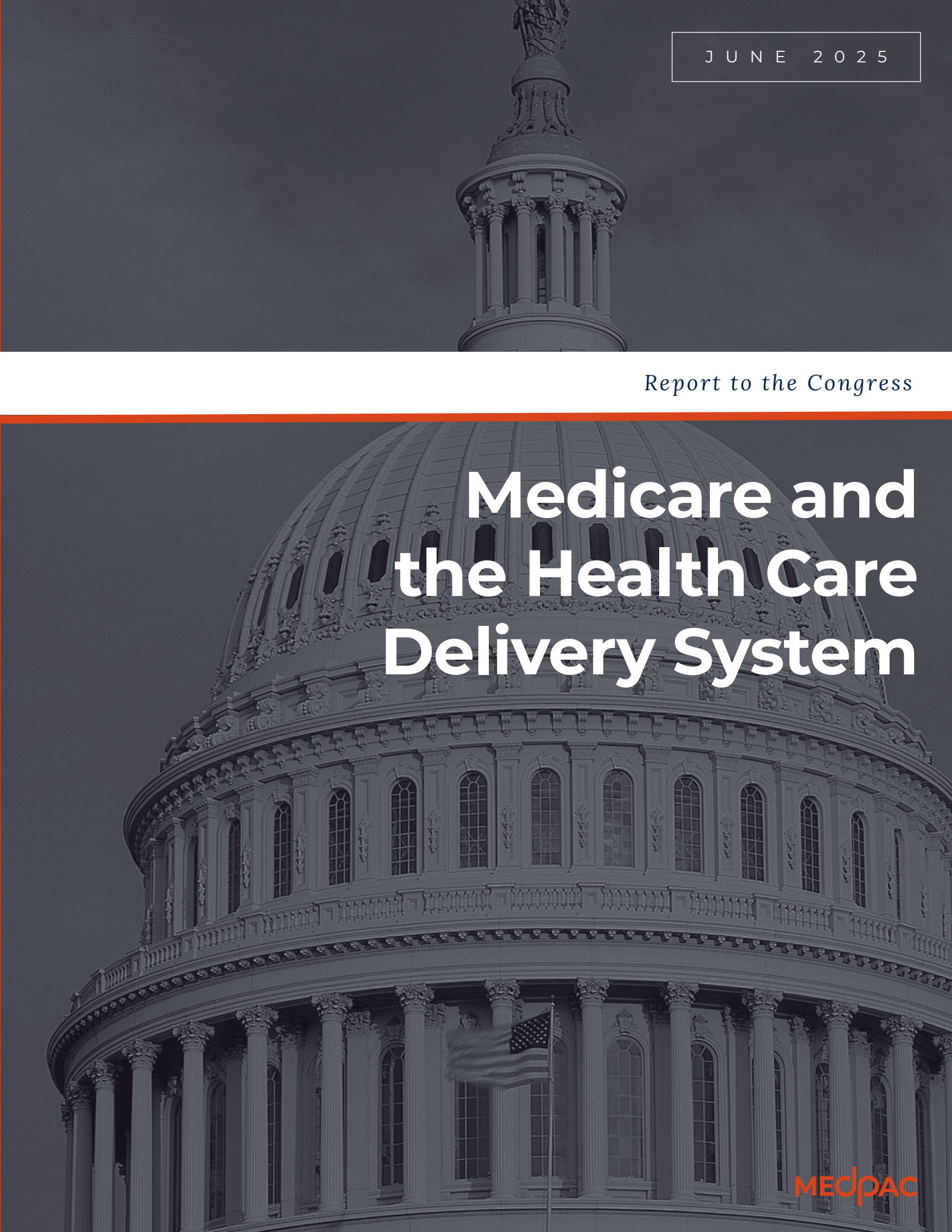




J U N E 2 0 2 5

Report to the Congress

Medicare and the Health Care Delivery System

MEDPAC



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

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

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

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

REPORT TO THE CONGRESS

Medicare and the
Health Care
Delivery System



Medicare Payment
Advisory Commission

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June 12, 2025

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

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

Dear Mister President and Mister Speaker:

I am pleased to submit the Medicare Payment Advisory Commission's June 2025 *Report to the Congress: Medicare and the Health Care Delivery System*. This report fulfills the Commission's legislative mandate to evaluate Medicare payment issues and report to the Congress.

The seven chapters of the June 2025 report cover the following topics:

- 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
- Reducing beneficiary cost sharing for outpatient services at critical access hospitals

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

Sincerely,



Michael E. Chernew, Ph.D.
Chair

Acknowledgments

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

Despite a heavy workload, staff members of the Centers for Medicare & Medicaid Services and the Department of Health and Human Services were particularly helpful during preparation of the report. We thank Lindsey Baldwin, Kathryn Coleman, Inma Hernandez Delso, Julia Driessen, Jermama Keys, Cindy Massuda, Phillip Steiner, and David Wright.

We also appreciate the assistance provided by Leslie Gordon from the Government Accountability Office as we prepared the report.

The Commission received valuable insights and assistance from others in government, industry, and the research community who generously offered their time and knowledge. They include Alexa McKinley Abel,

Nathan Baugh, Kirstin Blom, Normandy Brangan, Lane Burgette, Craig Caplan, Joy Cameron, Juliette Cubanski, Toby Edelman, Julia Friedman, David Grabowski, Cornelia Hall, Nisha Hammel, Jennifer Hananoki, Benedic Ippolito, Joanna Kim, Jennifer Kowalski, Steve Landers, Megan Lahr, Sandy Marks, Katie Merrell, David Meyers, Hannah Neprash, George Pink, Apoorva Rama, Asha Saavoss, Sherry Smith, Shannon Wu, and Sarah Young.

Programmers and staff at Acumen LLC provided highly capable assistance to Commission staff. In particular, we appreciate the hard work of Anuradha Gajulapalli, Bruno Garcia, Sridhar Krishna, Cuong Nguyen, Kathrine Sanieel, Susan Siford, Yuting Wang, Xiao Xiao, Dashi Xu, Rio Yan, and Edward Zeng.

Finally, the Commission wishes to thank Sara June Arnold and Melissa Lux for their help in editing and producing this report. ■

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Executive summary

Executive summary

As part of its mandate from the Congress, each June the Commission reports on improvements to Medicare payment systems and issues affecting the Medicare program, including changes to health care delivery and the market for health care services. The seven chapters of the June 2025 report cover the following topics:

- **Reforming physician fee schedule updates and improving the accuracy of relative payment rates.** The Commission recommends replacing the current-law updates to fee-for-service (FFS) Medicare's physician fee schedule (PFS) with an annual update based on a portion of the growth in inflation, as measured by the Medicare Economic Index (MEI). The Commission also recommends that the relative accuracy of PFS payment rates be improved by collecting and using timely data that better reflect the relative costs of delivering care.
- **Supplemental benefits in Medicare Advantage.** The Commission reviews trends in Medicare's spending for Medicare Advantage (MA) supplemental benefits, summarizes the types of supplemental benefits offered by MA plans, and assesses the potential utility of MA encounter data for measuring enrollees' use of these benefits.
- **Examining home health care use among Medicare Advantage enrollees.** Using MA home health encounter and Outcome and Assessment Information Set data, the Commission assesses use of home health care by MA enrollees.
- **Part D prescription drug plans for beneficiaries in fee-for-service Medicare and Medicare Advantage.** The Commission describes how MA and Part D policies and other factors may be affecting trends in plan offerings and relative costs and payments for stand-alone prescription drug plans (PDPs) and MA Prescription Drug plans (MA-PDs).
- **Medicare beneficiaries in nursing homes.** The Commission describes the Medicare long-stay nursing home (NH) population and reviews regulations and programs that CMS has implemented to improve NH quality, including specialized MA plans known as institutional special-needs plans.

- **Medicare's measurement of rural provider quality.** The Commission reviews the inclusion of rural providers in current Medicare's FFS quality-reporting programs.
- **Reducing beneficiary cost sharing for outpatient services at critical access hospitals.** The Commission recommends that FFS beneficiary cost sharing for outpatient services provided at critical access hospitals be based on each hospital's Medicare payment amount instead of on the hospital's charges.

Reforming physician fee schedule updates and improving the accuracy of relative payment rates

In Chapter 1, the Commission makes recommendations to replace the current-law updates to FFS Medicare's PFS with an annual update based on a portion of the growth in inflation, as measured by the MEI, and to improve the relative accuracy of PFS payment rates by collecting and using timely data that better reflect the relative cost of delivering care.

Every year, the Commission assesses the adequacy of FFS payments made under the Medicare PFS and recommends an appropriate update to those payments in our annual March report to the Congress. As part of that process, the Commission considers beneficiaries' access to clinician care. For many years, the Commission has found that this access has been as good as, or better than, that of privately insured individuals; the share of clinicians who accept new Medicare patients has been comparable with the share who accept new privately insured patients; and the volume of and spending on fee schedule services per beneficiary has consistently grown. These trends coincide with the period from 2001 to 2020 during which growth in the MEI (a measure of the growth in clinicians' input costs) exceeded payment updates under the PFS by an average of just over 1 percentage point per year, suggesting that full MEI updates have not been necessary to maintain Medicare beneficiaries' access to care.

Nevertheless, the Commission is concerned about whether payment-rate updates under current law will remain adequate to ensure continued access to

care in the future. Starting in 2026, payment rates will increase by 0.75 percent per year for qualifying clinicians participating in advanced alternative payment models (A-APMs) and by 0.25 percent for all other clinicians. Meanwhile, clinicians' input costs, as measured by the MEI, are expected to increase by an average of 2.2 percent per year from 2025 through 2034—exceeding the growth in PFS payment rates by a greater amount than in the two decades before the coronavirus pandemic. This larger gap between input-cost and payment-rate growth could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program. At the same time, the Commission is concerned about misvaluation of the PFS's relative value units (RVUs), which determine how Medicare spending is distributed among clinician services and places of service. This misvaluation likely leads to overpayment for some services and underpayment for others, which can have undesirable effects on the distribution of program spending, amount of beneficiary cost sharing, and clinicians' decisions about how and where to practice medicine. RVU misvaluation may also create incentives for vertical consolidation between hospitals and clinicians.

Alternative approach to updating PFS payment rates

In our March 2025 report to the Congress, the Commission recommended that the Congress, for 2026, replace current-law updates for PFS services with a single update equal to MEI minus 1 percentage point. That recommendation applies only to one year—2026—not future years. In contrast, this chapter addresses what default updates should be for future years. Changes to default PFS updates would not obviate the need for continued monitoring of access but instead would set default updates at a level the Commission determines is adequate, in the aggregate, to ensure continued beneficiary access to care, given current knowledge. The Commission will continue to monitor trends in access to clinician care and, to the extent needed, recommend higher or lower updates in the future as part of its annual payment-adequacy analysis.

In Chapter 1, the Commission recommends replacing the current-law updates to the PFS with an annual update based on a portion of the growth in the

MEI, such as MEI minus 1 percentage point, based on the historical evidence suggesting that updates of full MEI have not been necessary to maintain beneficiary access to care. This recommendation would automatically adjust to changes in inflation, improve predictability for clinicians, beneficiaries, and policymakers, be simpler to administer, and balance beneficiary access with beneficiary and taxpayer financial burden. In designing the specific update, policymakers could consider a range of reasonable options, such as whether updates of MEI minus 1 percentage point should be paired with a minimum update floor (e.g., half of MEI growth or 0 percent) or update ceiling (e.g., 75 percent of MEI growth).

This recommendation is expected to maintain FFS Medicare beneficiaries' access to care by maintaining or improving clinicians' willingness and ability to treat them. We also expect that the recommendation would increase federal program spending by between \$15 billion and \$30 billion over five years relative to current law.

Under the approach of updating PFS rates by a portion of MEI growth, the Commission did not address how the A-APM bonus should be treated. Policymakers may choose to include some form of a bonus as an important component of payment for clinician services as they seek policy changes to improve A-APM design and performance.

Improving the accuracy of relative values under the fee schedule

Updating fee schedule rates by an amount similar to MEI minus 1 percentage point would substantially increase Medicare spending relative to current law, which would magnify the effects of problems stemming from misvalued services. Therefore, the Commission recommends that the Congress direct the Secretary to further improve the accuracy of relative values for clinician services by collecting and using timely, objective data that reflect the cost of delivering care. We discuss three illustrative approaches policymakers could explore:

- *Paying more accurately for indirect practice expenses:* When a clinician service is furnished in a facility, Medicare generally includes payments for indirect practice expenses (i.e., overhead costs) in both the PFS rate and the payment to facilities (e.g., under Medicare's hospital outpatient prospective

payment system). However, an increasing portion of clinicians may pay little or no indirect practice expenses because they do not maintain an independent office or their overhead expenses are covered by the hospital that employs them (or owns their practice). Since the PFS does not make these distinctions, Medicare on average likely overpays these clinicians for services furnished in a facility. Payment for indirect practice expenses could be better aligned with clinicians' actual costs by incorporating data that reflect more up-to-date practice patterns.

- *Updating the data used to calculate the aggregate allocation of RVUs:* The share of total RVUs allocated to clinician work, practice expenses, and malpractice insurance is based on cost data from 2006. Using more up-to-date data would produce RVUs that more accurately reflect how costs are distributed among the three RVU categories in a typical clinician practice. However, questions remain about the most appropriate data source for this purpose and how to treat the expenses of clinicians whose practice expenses are covered by other entities, such as hospitals.
- *Addressing overpayments for global surgical codes:* Current payments for 10-day and 90-day global surgical codes include payment for postoperative visits that often do not occur, resulting in substantial overvaluation. Lowering the relative values to reflect only services that are furnished or unbundling these codes into 0-day codes would improve payment accuracy.

This recommendation could improve care for beneficiaries by reducing incentives for clinicians to overprovide or underprovide certain services. Due to statutorily required budget-neutral implementation of changes to RVUs, this recommendation is not expected to affect total program spending.

Supplemental benefits in Medicare Advantage

In Chapter 2, the Commission reviews trends in Medicare's spending for MA supplemental benefits, summarizes the types of supplemental benefits offered by MA plans, and assesses the potential utility of MA encounter data for measuring enrollees' use of supplemental benefits.

In addition to covering basic Part A and Part B services, MA plans may provide "supplemental" benefits to their enrollees, such as reduced cost sharing for Part A and Part B services, reduced Part B and Part D premiums, enhanced Part D benefits, and other benefits not covered under FFS Medicare, such as dental, vision or hearing services (non-Medicare services). These supplemental benefits, which are intended to provide more generous coverage and better financial protection for MA enrollees, are a defining feature of MA, but relatively little is known about their use and associated costs.

The majority of the supplemental benefits provided by MA plans are financed by the rebates that plans receive from Medicare. Medicare spending on plan rebates has increased sharply in recent years. Our analysis of plan rebates shows that, in 2025, Medicare paid MA plans approximately \$86 billion to provide supplemental benefits, up from \$21 billion in 2018.

According to their 2025 bid projections, plans expect to use about \$39 billion (equivalent to about \$100 per member per month (PMPM)) to provide non-Medicare services to their enrollees and about \$27 billion (\$64 PMPM) to reduce enrollees' cost sharing for Medicare-covered services (such as doctors' visits). Though plans' bids indicate how they intend to use rebate dollars, projections may vary from actual experience, and little is known about how MA rebate dollars are actually spent. Because Part D benefit enhancements and Part D and Part B premium reductions are adjudicated directly between CMS and MA plans, there is less uncertainty about plans' spending for these supplemental benefits. For 2025, we estimate that MA plans will use about \$15 billion of the rebates they receive from Medicare to enhance Part D benefits and reduce Part D premiums (equivalent to about \$37 PMPM), and about \$5 billion (\$10 PMPM) to reduce their enrollees' Part B premiums.

Different types of MA plans tend to offer different types of supplemental benefits. Conventional MA plans (i.e., nonemployer, non-special-needs plans) typically allocate the largest share of their rebate dollars to reducing enrollee cost sharing for Part A and Part B services. In contrast, special-needs plans (SNPs) report allocating a small share of their rebates to reducing cost sharing because most of their enrollees are dually eligible for Medicare and Medicaid and so will have

their out-of-pocket (OOP) costs covered by Medicaid and other programs. Instead, SNPs allocate most of their rebate dollars to the provision of non-Medicare services.

In recent years, CMS and the Congress have gradually increased plans' flexibility in the types of supplemental benefits that can be offered, and plans can now target supplemental benefits to enrollees with a particular health status or disease state. Plans can also provide chronically ill enrollees with supplemental benefits that are not primarily health related; these benefits—which include services such as meals, nonmedical transportation, and pest-control services—are known as special supplemental benefits for the chronically ill.

These new flexibilities, combined with the growth in rebate dollars, have allowed MA plans to significantly expand the number of supplemental benefits they offer. We find that across almost every type of supplemental benefit, the share of MA enrollees in plans offering these benefits has increased since 2018. Growth in the share of SNP enrollees in plans offering the newer forms of benefits has been particularly dramatic. According to plans' bid data, SNPs now intend to devote more rebate dollars to other non-Medicare services than to dental, vision, hearing, and transportation benefits combined.

As Medicare spending for MA supplemental benefits grows, it becomes increasingly valuable for policymakers to fully understand their use. CMS requires MA organizations (MAOs) to submit encounter records for all health care items and services, including supplemental benefits, provided to their enrollees. Accordingly, MA encounter data should be the most detailed source of information for assessing MA enrollees' use of services. However, the Commission has found that encounter data for some MA plans and for some services (including inpatient, home health, and skilled nursing facility services) are incomplete. And to the best of our knowledge, no studies have used encounter data to assess MA enrollees' use of supplemental benefits—likely because the reliability of the data has been unclear.

Indeed, until 2024, the system that CMS used to collect encounter records was not configured to accept encounter records for dental services. For this report, we used data from the Medicare Current Beneficiary

Survey (MCBS) to assess how enrollees use and pay for dental care. Survey data, however, offer limited insight into how MA enrollees use and pay for dental care, underscoring the need for better encounter data pertaining to the services.

We analyzed encounter data for 2021 to assess whether plans are submitting records for other supplemental benefits and whether the submission rates are suggestive of problems with the reliability of the data. Our analysis is a preliminary and exploratory first step toward using encounter data to assess the use of supplemental benefits. As such, we did not attempt—at this stage—to measure utilization rates or draw conclusions about access or value based on our findings. Instead, we focused on assessing whether plans are submitting records and characterizing the potential uses or limitations of the data.

We identified significant limitations to using encounter data to assess supplemental benefits. First, as noted above, few encounter records have been collected for dental services, which are one of the largest categories of supplemental benefits. Second, MA plans have reported that the supplemental-benefit encounter records that they do submit are incomplete because of confusion surrounding reporting requirements and how to populate the records for services that do not have well-established procedure codes. Third, the encounter data system does not contain a way to distinguish which records are for basic or supplemental services or to distinguish which records are for optional or mandatory supplemental benefits.

For some services—particularly vision and hearing services—there are fewer technical limitations to submitting encounter data, and submission rates follow patterns in line with what can reasonably be expected based on survey data about MA enrollees' use of vision and hearing services. Thus, it may be feasible to use encounter data to explore MA enrollees' use of supplemental vision and hearing benefits.

For other types of supplemental benefits, however, we found few encounter records, and the submission rates were well below the utilization rates suggested by survey data. Considering the well-documented data limitations and the discrepancies between encounter data and other sources, we can conclude that—for most supplemental benefits other than vision and hearing

benefits—available encounter data are insufficient for characterizing enrollees' use of the benefits. In 2024, CMS began implementing a series of actions to improve and increase the amount of data that plans report regarding utilization of and spending for supplemental benefits. The Commission will monitor these changes and assess the extent to which they address limitations of the currently available data.

Medicare does not collect information about the businesses or community-based organizations with which MAOs contract to provide or administer some supplemental benefits. To better understand how supplemental benefits are administered, we reviewed the websites of MAOs and entities that administer MA supplemental benefits. We found that many MAOs contract with dental and/or vision insurers that manage the supplemental dental and vision benefits on behalf of the MA plan, and with for-profit vendors to provide nonmedical supplemental benefits. Plans may also contract with community-based organizations, though information about these arrangements was harder to find. We also found that MAOs frequently administer supplemental benefits through entities with which the insurer is vertically integrated, and in several instances, MAOs structure their supplemental benefits to be provided exclusively by providers owned by the plan's parent organization.

Altogether, our review of numerous data sources pertaining to MA supplemental benefits reveals a fundamental lack of transparency about how often enrollees use the benefits and plans' spending for the benefits. The data that Medicare collects are currently insufficient for examining the use of most of these benefits. The lack of reliable data makes it difficult to answer many important questions about how the rebates Medicare pays to MA plans are used. The Medicare program currently relies on competition between insurers to incentivize plans to offer benefits that enrollees will value and use. But, because of different challenges in the program, including the complexity of the choice environment and the absence of reliable data, it is unclear to what extent supplemental benefits address enrollees' needs or affect outcomes. Without reliable information about how the benefits are used or administered, it is difficult for policymakers to assess the adequacy of the access provided or to know whether the spending provides

good value to enrollees and the taxpayers who fund the program. Better information could be used to help beneficiaries navigate the options available to them and could help policymakers identify ways of making the program work more efficiently.

Examining home health care use among Medicare Advantage enrollees

In Chapter 3, the Commission assesses home health care use rates and visits per user among MA enrollees using MA home health encounter and the Outcome Assessment Information Set (OASIS) data.

Home health care is the most frequently used post-acute care (PAC) setting among FFS beneficiaries, and the Commission regularly assesses their use of FFS home health care paid for by Medicare's home health prospective payment system (PPS). Many published studies have examined home health care use among MA enrollees, frequently with the goal of contrasting use with FFS beneficiaries. However, these studies have relied on data that have limitations for drawing nationally representative conclusions. Home health care use by MA enrollees is reported in the home health MA encounter data submitted by plans and in the OASIS records submitted by home health agencies (HHAs). Although CMS requires that both data sources be reported for all Medicare beneficiaries receiving home health care, prior Commission work has found that both data sets are incomplete. Combining these data sources allows for a more complete view of nationwide home health care use among MA enrollees than either data source alone: Among MA enrollees with a home health encounter record or an OASIS record in 2021, 88 percent had both types of data, 7 percent had only a home health encounter record, and 5 percent had only an OASIS record.

Using these data sources and incorporating beneficiary, plan, and provider characteristics, we conducted multivariable regressions to estimate the probability of home health care use among FFS and MA beneficiaries in 2021 and, among those who used home health care, visits per beneficiary. We found that, after adjusting for beneficiary characteristics, the overall home health use rate among MA enrollees was slightly lower than among FFS beneficiaries (8.3 percent vs. 8.6 percent, respectively). However, there were differences

depending on whether beneficiaries had an acute care hospitalization during the year. For those with a hospitalization, the adjusted probability of home health care use was 3.2 percent higher among MA enrollees than FFS beneficiaries (41.7 percent vs. 40.4 percent), which could suggest that home health care is sometimes used in MA as a substitute for other types of PAC, such as costlier skilled nursing facility (SNF) stays. Among beneficiaries without a hospital stay, the probability of home health care use was 13.7 percent lower among MA enrollees than FFS beneficiaries (3.7 percent vs. 4.2 percent), which could be related to plans' implementation of prior authorization and home health cost sharing (which do not exist in FFS) or to HHAs' preferences for admitting FFS beneficiaries.

As for total visits received by home health care users, we found that enrollment in MA was associated with fewer average visits per beneficiary per year compared with FFS (18.2 vs. 20.4 visits per user, respectively) after controlling for beneficiary characteristics. This difference in visits per beneficiary was similar regardless of whether beneficiaries had a prior acute care hospital stay.

We examined how home health care use differed among MA enrollees by plan attributes. We found that enrollment in plans with home health cost sharing was associated with both lower rates of home health care use and a lower average number of visits per user compared with enrollment in plans without home health cost sharing. Enrollment in preferred provider organization (PPO) plans (vs. HMO plans) was associated with more visits per user but no change in the probability of any home health care use. We did not find any differences in the probability of home health care use for those enrolled in provider-sponsored plans relative to other types of plans, but we did find that beneficiaries enrolled in provider-sponsored plans tended to have fewer visits in the year compared with those not enrolled in these plans.

Overall, fewer HHAs treated MA enrollees (4,600 HHAs treated at least 20 MA enrollees) than FFS beneficiaries (7,000 HHAs treated at least 20 FFS beneficiaries). After controlling for the HHA treating the beneficiary, we found that home health users in MA received 1.8 fewer visits than those in FFS.

We emphasize that it is not possible to draw conclusions on the appropriateness of care based solely on observing differences in use (and most of the differences we observed are relatively modest). Home health care is one component of the broader PAC landscape, and its use is likely to be affected by the availability of other PAC providers, the prior hospitalization (if there is one), and other factors such as types of MA plans, their provider networks, and the supplemental benefits they offer. In future work, we plan to incorporate analyses of MA enrollees' use of other PAC settings (including SNFs and inpatient rehabilitation facilities).

Part D prescription drug plans for beneficiaries in fee-for-service Medicare and Medicare Advantage

In Chapter 4, the Commission describes how MA and Part D policies and other factors may be affecting trends in plan offerings and relative costs and payments for prescription drug plans (PDPs) and MA-PDs.

Beneficiaries can choose among Medicare coverage options that include traditional FFS Medicare and an array of MA plans. Beneficiaries who opt for FFS Medicare can obtain Part D prescription drug coverage by enrolling in a PDP. (Many FFS beneficiaries also purchase a Medigap plan to reduce their cost-sharing liability for medical services.) With MA, beneficiaries generally do not separately enroll in a prescription drug plan because their plan is an MA-PD plan that includes prescription drug coverage.

The Part D program has evolved since its inception, and the numerous changes have altered the dynamics in the PDP and MA-PD markets. Consistent with the shift in enrollment from FFS to MA in the broader Medicare program, Part D's enrollment has also shifted from PDPs to MA-PDs. While the average number of PDPs available in 2025 was the lowest since the program began, FFS beneficiaries will continue to have at least 12 PDPs from which to choose.

Four trends raise concerns about the long-term stability of the PDP market. Those trends reveal differences that may affect competition both within and between the two sectors and the benefits that PDPs and MA-PDs offer to Medicare beneficiaries.

First, the Commission found that Part D premiums for the basic benefits charged by PDPs have tended to exceed those of MA-PDs. Second, in some areas of the country, the number of PDPs qualifying as “benchmark” plans (premium-free for FFS beneficiaries with low income and limited assets) has continued to decline. Third, drug costs, on average, have been higher among PDPs compared with MA-PDs, but average risk scores for PDPs have been lower. Because risk scores are intended to reflect average drug costs across a group of individuals, this finding suggests that Part D’s payment system may not have adequately adjusted for PDPs’ higher costs before 2025. Finally, PDPs have been more likely to incur losses in Part D’s risk corridors compared with MA-PDs.

With more than half of Part D beneficiaries receiving their drug coverage through MA-PDs, certain MA and Part D policies that were primarily intended to guide plan operations in the MA market may be having unintended effects on PDP and MA-PD offerings and benefits:

- MA-PDs have an additional funding source (“MA rebates”) that can be used to enhance their Part D plan offerings or to reduce their premiums.
- MA-PDs may adjust their premiums after CMS publishes Part D subsidy amounts, allowing them to better target particular premium amounts.
- MA-PDs can offer dual-eligible special-needs plans (D-SNPs) that are open only to individuals who are dually eligible for Medicaid and Medicare, which allows them to restrict enrollment to enrollees who receive Part D’s low-income subsidy (LIS) and to tailor their benefits more effectively to balance enrollees’ needs and plans’ financial goals.

The effects of these policies may result, over time, in the PDP market becoming less attractive to insurers. Other differences may also be at work between PDPs and MA-PDs. For example, compared with PDPs, MA-PDs may be able to manage drug costs more effectively through their contractual relationships with clinicians who prescribe medicines to their enrollees; face different incentives for managing drug spending, particularly for medications that affect medical spending; or employ diagnostic coding practices that, on average, increase Medicare’s relative payments to

MA-PDs. Such differences create a divergence between the relative costs and payments for MA-PDs and PDPs and could compound the effects of MA and Part D policies discussed above.

We conducted further analyses of PDP and MA-PD drug costs and risk scores between 2019 and 2023 to understand why risk-standardized costs—that is, costs divided by risk scores—were lower for MA-PDs than for PDPs in those years. Our analysis of plans’ formularies did not find evidence that MA-PDs achieved lower costs compared with PDPs by having more narrow formularies, higher cost sharing, or greater use of utilization management. Our estimates for 2019 through 2023 show that, relative to the overall Part D population, differences in coding intensity produced higher risk scores for MA-PD enrollees and lower risk scores for PDP enrollees on average. Those differences imply that systematic differences in coding practices by MA-PDs and PDPs affected the ability of Part D’s risk-adjustment model to accurately predict costs for either sector in those years. While differences in coding intensity explain some of the difference in average risk-standardized costs between MA-PDs and PDPs, a substantial difference persisted in all years between 2019 and 2023, which suggests that there are other factors that differentially affect spending in the two markets.

Finally, the redesign of the Part D benefit significantly increased plan liability for benefit spending. As more of Medicare’s subsidies to Part D plans take the form of risk-adjusted capitated payments rather than cost-based payments, the difference in coding intensity between PDPs and MA-PDs and other factors that affect risk-score trends in the two markets could be amplified. In 2025, CMS began applying separate normalization factors for MA-PDs and PDPs to adjust for the diverging risk-score trends in these two markets. The use of separate normalization factors is expected to increase risk scores for PDPs (and decrease risk scores for MA-PDs) on average and, consequently, may decrease the difference in risk-standardized costs between the two plan types. However, the use of separate normalization factors alone may still result in inaccuracies in Part D’s risk adjustment at the individual plan level. In turn, those inaccuracies could affect enrollee premiums and payments to plans. At the same time, CMS’s Part D

Premium Stabilization Demonstration, which provides additional subsidies to PDPs beginning in 2025 to stabilize their enrollee premiums, may help moderate some of the effects of the redesign. The Congressional Budget Office expects that the additional subsidies paid to PDPs under the demonstration would increase federal spending for Part D by roughly \$5 billion in 2025.

For FFS beneficiaries, PDPs are the only options available for obtaining Part D's drug coverage; for FFS beneficiaries who receive the LIS, benchmark PDPs are the only premium-free options for Part D coverage. Because of these critical roles, the Commission plans to continue to assess the drivers of differences in average risk-standardized costs between MA-PDs and PDPs and monitor the availability of PDPs—particularly benchmark PDPs—as plans adjust to the new Part D benefit structure.

Medicare beneficiaries in nursing homes

In Chapter 5, the Commission describes the Medicare long-stay NH population and reviews regulations and programs CMS has implemented to improve NH quality, including specialized MA plans known as institutional special-needs plans (I-SNPs).

About 1.2 million beneficiaries live in NHs due to functional and/or cognitive impairments that prevent them from living in the community. Medicare's coverage of NH care is largely limited to coverage of short-term skilled care after a hospitalization, although Medicare covers other services received by beneficiaries living in nursing homes, such as physician and other clinician services and ancillary services (for example, lab tests and physical therapy). More than 80 percent of Medicare beneficiaries in NHs are also covered by Medicaid, the predominant payer for NH care.

In 2023, there were about 15,000 nursing homes nationwide. Nearly all NHs operate as both nursing facilities that provide long-term custodial care and as SNFs that provide short-term skilled care. The industry is characterized by independent providers and regional chains. The industry reports low profit margins across all payers (0.4 percent in 2023), but that average margin may be understated due to the ways some NHs report their payments. The reported average profit margin on Medicare-covered SNF care is much higher, at 22 percent in 2023.

The quality of care provided to NH residents is a long-standing and well-documented problem. The National Academies have described the financing, delivery, and regulation of NH care as “ineffective, inefficient, fragmented, and unsustainable.” Among other problems, NHs have a financial incentive to hospitalize residents so they qualify for Medicare-covered SNF care, and Medicaid's payment rates are often low and typically do not cover the cost of care.

CMS has made a variety of efforts to improve care for beneficiaries in NHs. NHs are subject to regular quality and safety inspections, but evaluations have concluded that these inspections sometimes fail to identify serious quality problems and may not lead to effective corrections. To encourage NHs to improve their care, CMS publicly reports a star rating (ranging from 1 to 5) for each NH, which evaluators have found modestly helps consumers select NHs with higher ratings and encourages NHs to improve. Additionally, the payment system for SNF care includes a value-based purchasing (VBP) program that raises or lowers payment rates to SNFs based on their quality performance. CMS has made several improvements that address some of the issues raised by the Commission in 2021 regarding the design of the SNF-VBP, but the VBP program still has important design flaws that would require congressional action to correct.

I-SNPs are specialized plans that serve MA beneficiaries who need NH care. I-SNPs now cover about 12 percent of Medicare NH residents. These plans aim to reduce the use of expensive services such as inpatient care by using teams of physicians and nurse practitioners to deliver more preventive and coordinated care within the NH and reimbursing NHs in ways that encourage facilities to deliver more care on-site. The available evidence is somewhat limited but suggests that I-SNPs reduce the use of inpatient care and emergency department visits and perform better on some quality measures. Enrollment in I-SNPs has been growing, but their ultimate reach may be limited.

The Commission may consider future work in two areas. First, building on the modest success of the star-rating system and the clear relationships between NH staffing and quality, alternative designs could elevate the role of staffing in calculating the overall rating of NHs. Second, given the limited but favorable evidence for I-SNPs, new work could examine factors that

currently limit the use of I-SNPs and consider potential policy changes that encourage broader use of I-SNPs and reduce barriers to expansion, while enabling more rigorous measurement and oversight of I-SNPs.

Medicare's measurement of rural provider quality

In Chapter 6, the Commission reviews the inclusion of rural providers in current Medicare FFS quality-reporting programs.

The Commission supports Medicare's measurement of the quality of care furnished by providers to monitor performance, inform patients and payers, and incentivize high-quality care. However, there are practical challenges in measuring some individual rural providers' quality of care and in holding these providers accountable in quality-reporting programs because of low patient volumes in many rural health care settings. For example, low patient volume means that it is difficult to produce reliable and valid estimates on quality measures for some rural providers. In addition, low-volume providers may have limited staff and funds available for quality-improvement activities.

The Commission acknowledged these difficulties when it established specific principles to guide expectations about quality in rural areas: First, expectations for quality of care in rural and urban areas should be equal for the nonemergency services that rural providers choose to deliver. Second, all providers should be evaluated on the full range of services they provide (emergency and nonemergency alike), and the quality measures for the services should be collected and reported publicly.

Because of the Commission's continued interest in rural provider quality, we expanded our reporting of provider quality to include comparisons of rural and urban areas, where relevant and available, in our March 2025 report on the adequacy of payments in the FFS payment systems. In general, the comparisons of provider quality in rural and urban areas were mixed across and within settings. For some quality measures, rural quality was better than urban; for others, urban quality was better; and for others, the quality results were similar.

The Congress has enacted pay-for-reporting quality programs for FFS provider types that account for

a large majority of services furnished to Medicare beneficiaries. In these programs, providers that successfully report designated quality-measure data are financially rewarded (or not penalized). CMS uses the quality data to publicly report provider performance on the Care Compare website to hold providers accountable to consumers and encourage improvement. Some rural providers may not be required to participate in the Medicare quality payment programs; however, the majority of rural providers do have at least some Medicare quality results publicly reported.

We reviewed the requirements of quality-reporting programs and used Care Compare data files to determine participation by rural and urban providers. Hospitals, clinicians, and inpatient rehabilitation facilities had comparable shares of rural and urban providers with publicly reported quality results. Rural SNFs and dialysis facilities had lower shares of providers with publicly reported quality results compared with their urban counterparts; in contrast, rural HHAs and hospices had higher shares of providers with publicly reported quality results compared with their urban counterparts.

MA plans, Part D plans, and accountable care organizations (ACOs) are also required to report quality-measure data, typically calculated based on the experience of a sample of patients across participating providers, to CMS. Beneficiaries residing in rural areas who are assigned to ACOs or are enrolled in MA plans may or may not be included in the quality-measure results that CMS currently collects for those entities because of sampling methodologies.

There are several federal and stakeholder initiatives to drive improved quality measurement of rural providers, including identifying and developing the most relevant metrics for rural providers and making technical assistance available to rural providers for quality measurement and improvement. The Commission will continue to monitor the implementation and effectiveness of these initiatives.

Reducing beneficiary cost sharing for outpatient services at critical access hospitals

In Chapter 7, the Commission recommends setting FFS beneficiary cost sharing for outpatient services

provided at critical access hospitals (CAHs) based on each hospital's Medicare payment amount instead of the hospital's charges.

The CAH program provides cost-based reimbursement to certain rural hospitals with 25 or fewer acute care beds who provide care to Medicare beneficiaries rather than the PPS rates received by other hospitals. For many CAHs, the higher rates associated with cost-based payments are necessary to remain financially viable. The Commission estimates that Medicare's cost-based FFS payments to CAHs averaged about \$4 million more per CAH than would have been paid under the inpatient and outpatient PPSs in 2022. If CAHs had been paid standard PPS rates, many would have incurred significant losses.

However, FFS beneficiaries pay substantially more coinsurance at CAHs than they do for the same services at PPS hospitals. For most outpatient services, CAH coinsurance for FFS beneficiaries is set at 20 percent of charges. Charges are the list prices that hospitals set for their services, and they typically far exceed CAHs' reported costs of providing those services. Charges can be seen as arbitrary and can vary widely across hospitals and services. According to our analysis of outpatient cost-sharing liabilities at CAHs, cost sharing averaged 52 percent of total FFS Medicare payments for CAH outpatient services in 2022; however, cost sharing varied widely across services and CAHs. This variation among CAHs creates inequities in beneficiaries' cost sharing depending on whether they receive services at a CAH with high or low markups (the ratio of charges to costs) and may subject CAH patients to cost sharing that is much higher than what they would be liable for if they had received care at a hospital where coinsurance equals 20 percent of Medicare's payment rate for the service at that specific hospital.

FFS beneficiaries who receive outpatient services in hospitals paid under Medicare's outpatient PPS (OPPS) also receive financial protection in the form of a cap on coinsurance. Under the OPPS, coinsurance for an outpatient procedure provided at most hospitals cannot be greater than Medicare's inpatient hospital

deductible (\$1,676 in 2025). However, there is no cap on cost sharing for FFS beneficiaries who receive outpatient services at CAHs. We found that, in 2022, about 200,000 (out of 26 million) CAH outpatient line items had coinsurance over the OPPS cap. If Medicare had imposed a cap on CAH coinsurance for each line item in 2022, the coinsurance on the 200,000 claims would have been reduced by an average of about \$2,000 per line item.

In a majority of cases, CAH coinsurance for beneficiaries in FFS Medicare is paid for by the beneficiary's supplemental insurer. However, we estimate that about 16 percent of rural FFS beneficiaries do not have supplemental insurance and are directly billed 20 percent of charges when they receive outpatient services at a CAH. And, even when a beneficiary has supplemental insurance that directly shields them from high coinsurance amounts, the cost of that coverage may be passed on in the form of higher supplemental insurance premiums in states with CAHs. The higher supplemental insurance premiums are borne by all policyholders, whether they receive outpatient services at CAHs or not.

The Commission recommends that CAH coinsurance for outpatient services received by FFS beneficiaries be set at 20 percent of the payment amount (rather than 20 percent of charges) and be subject to a cap per service equal to the inpatient deductible. This change would protect beneficiaries from excessive amounts of coinsurance and would make CAH cost sharing more consistent with Medicare cost sharing for outpatient services in other hospitals. If beneficiary coinsurance for outpatient services provided at CAHs had been set at 20 percent of the payment amount in 2022, with the amount per line item capped at the level of the inpatient deductible, beneficiary cost-sharing liability would have been about \$2.1 billion lower (60 percent lower), assuming no change in care patterns. If enacted, the recommendation would increase spending relative to current law by between \$2 billion and \$5 billion over one year and by between \$25 billion and \$50 billion over five years. ■

C H A P T E R

1

**Reforming physician fee
schedule updates and
improving the accuracy of
relative payment rates**

R E C O M M E N D A T I O N S

- 1-1** The Congress should replace the current-law updates to the physician fee schedule with an annual update based on a portion of the growth in the Medicare Economic Index (MEI) (such as MEI minus 1 percentage point).

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

.....

- 1-2** The Congress should direct the Secretary to improve the accuracy of Medicare's relative payment rates for clinician services by collecting and using timely data that reflect the costs of delivering care.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Reforming physician fee schedule updates and improving the accuracy of relative payment rates

Chapter summary

Every year, the Commission assesses the adequacy of fee-for-service (FFS) payments made under the Medicare physician fee schedule (PFS) and recommends an appropriate update to those payments in our annual March report to the Congress. As part of that process, the Commission considers beneficiaries' access to clinician care. For many years, the Commission has found that this access has been as good as, or better than, that of privately insured individuals; the share of clinicians who accept new Medicare patients has been comparable with the share who accept new privately insured patients; and the volume of and spending on fee schedule services per beneficiary has consistently grown. These trends coincide with the period from 2001 to 2020 during which growth in the Medicare Economic Index (MEI) (a measure of the growth in clinicians' input costs) exceeded payment-rate updates under the PFS by an average of just over 1 percentage point per year, suggesting that full MEI updates have not been necessary to maintain Medicare beneficiaries' access to care.

Nevertheless, the Commission is concerned about whether payment-rate updates under current law will remain adequate to ensure continued access to care in the future. Starting in 2026, payment rates will increase by 0.75 percent per year for qualifying clinicians participating in advanced alternative payment models (A-APMs) and by 0.25 percent for all other

In this chapter

- Background
- Historically, beneficiary access to clinician care has been comparable with the privately insured, indicating adequate payment rates
- Concerns about the adequacy of future payments to clinicians
- Reforming physician fee schedule updates
- Improving the accuracy of relative payment rates for fee schedule services
- Appendix: Simulations of illustrative options to redistribute relative value units for indirect practice expenses

clinicians. Meanwhile, clinicians' input costs, as measured by the MEI, are expected to increase by an average of 2.2 percent per year from 2025 through 2034—exceeding the growth in PFS payment rates by a greater amount than in the two decades from 2001 to 2020. This larger gap between input-cost and payment-rate growth could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program.

Alternative approach to updating PFS payment rates

In our March 2025 report to the Congress, the Commission recommended that the Congress should, for 2026, replace current-law updates for PFS services with a single update equal to MEI minus 1 percentage point. That recommendation applies only to one year—2026—but not future years. In contrast, this chapter addresses longer-term reforms to PFS updates. Specifically, this chapter contemplates what default updates should be for future years. Changes to default PFS updates would not obviate the need for continued monitoring of access but instead would set default updates at a level the Commission determines is adequate, in the aggregate, to ensure continued beneficiary access to care, given current knowledge. The Commission will continue to monitor trends in access to clinician care and, to the extent needed, recommend higher or lower updates in the future as part of its annual payment-adequacy analysis.

In our June 2024 report to the Congress, the Commission discussed an approach that would update PFS payment rates based on a measure of the growth in clinicians' input costs. Under this approach, the annual PFS updates specified in current law would be replaced with an update based on a measure of inflation below full MEI growth, such as MEI minus 1 percentage point. Based on historical evidence, such updates have been sufficient to maintain beneficiary access to care. In addition, they would:

- automatically adjust to changes in inflation;
- improve predictability for clinicians, beneficiaries, and policymakers;
- be simple to administer because they would apply across the board to all PFS services; and
- balance beneficiary access with beneficiary and taxpayer financial burden.

Given the Commission's concern about the adequacy of future PFS updates and the positive aspects of an update based on a portion of MEI, the Commission in this chapter recommends replacing the current-law updates to the PFS with an

annual update based on a portion of the growth in the MEI, such as MEI minus 1 percentage point. This recommendation should maintain FFS beneficiaries' access to care by maintaining or improving clinicians' willingness and ability to treat them. We expect the recommended updates would increase federal program spending by between \$15 billion and \$30 billion over five years relative to current law and would also increase beneficiary premiums and cost-sharing liabilities.

In designing the specific update, policymakers could consider a range of reasonable options, such as whether updates of MEI minus 1 percentage point should be paired with a minimum update floor (e.g., half of MEI growth or 0 percent) or update ceiling (e.g., 75 percent of MEI growth). Regardless of the particular approach, PFS rates would be updated each year based on some portion of MEI, consistent with historical evidence suggesting that updates of full MEI have not been necessary to maintain access to care.

Under the approach of updating PFS rates by a portion of MEI growth, the Commission did not address how the A-APM bonus should be treated. While the Commission maintains that incentivizing A-APM participation via differential payment-rate updates (such as 0.75 percent for A-APM participants and 0.25 percent for nonparticipants) is a flawed approach, we assert that A-APMs continue to show promise. Policymakers thus may choose to include some form of a bonus as an important component of payment for clinician services as they seek policy changes to improve A-APM design and performance.

Improving the accuracy of relative values under the fee schedule

While fee schedule updates are the main policy lever used to change aggregate spending on fee schedule services, relative value units (RVUs) determine how that spending is distributed among services and places of service. However, there are serious flaws in the way RVUs are calculated. These flaws likely lead to overpayment for some services and underpayment for others, which can have undesirable effects on the distribution of program spending, Part B cost sharing, and clinicians' decisions about how and where to practice medicine. These flaws may also create incentives for vertical consolidation between hospitals and clinicians.

Relative to current law, updating fee schedule rates by an amount similar to MEI minus 1 percentage point would substantially increase Medicare spending, which would magnify the effects of misvalued services. Higher spending

on PFS services would also increase the financial burden on taxpayers and beneficiaries through higher cost sharing and premiums. Therefore, an approach that updates fee schedule rates based on a portion of MEI should be coupled with improvements to the accuracy of relative valuations in order to address the problematic effects of misvalued services and help ensure that taxpayer and beneficiary funds are used judiciously.

The Commission has previously noted that some of the flaws in the way RVUs are calculated could be addressed by CMS collecting more timely, objective data on the relative resources that are needed to furnish clinician services. There are a number of approaches policymakers could take to further improve the relative valuation of services in tandem with reforming fee schedule updates. For example, Medicare could:

- **Pay more accurately for indirect practice expenses:** When a clinician service is furnished in a facility, Medicare generally includes payments for indirect practice expenses (i.e., overhead costs) in both the PFS rate and the payment to facilities (e.g., under Medicare's hospital outpatient prospective payment system). This arrangement assumes that all clinicians who furnish services at a facility should be compensated for the costs of maintaining an independent, freestanding office outside of the facility. However, an increasing portion of clinicians may pay little or no indirect practice expenses because they do not maintain an independent office or their overhead expenses are covered by the hospital that employs them (or owns their practice). In addition, some clinicians, such as surgeons, maintain an independent office, but their clinical office space may increasingly be used by other clinicians (who are also being paid for indirect practice expenses) while the surgeons are furnishing services at a facility. Since the PFS does not make these distinctions, Medicare on average likely overpays some clinicians for services furnished in a facility. Medicare's payment for indirect practice expenses could be better aligned with actual costs by incorporating data that reflect more up-to-date practice patterns.
- **Update the data used to calculate the aggregate allocation of RVUs:** The share of total RVUs allocated to clinician work, practice expenses, and malpractice insurance is based on cost data from 2006. Using more up-to-date data would produce RVUs that more accurately reflect how costs are distributed among the three RVU categories in a typical clinician practice. However, questions remain about the most appropriate data source to use

for this purpose and how to treat the expenses of clinicians whose practice expenses are covered by other entities, such as hospitals.

- **Address overvaluation of global surgical codes:** Current RVUs for 10-day and 90-day global surgical codes include values for postoperative visits that often do not occur, resulting in substantial overvaluation. Lowering these codes' relative values to reflect only services that are furnished or unbundling these codes into 0-day codes would improve payment accuracy.

This list is not exhaustive. Policymakers should consider a wide range of problems with valuation and recognize the need for flexibility when pursuing improvements. The Commission recommends that the Congress direct the Secretary to improve the accuracy of relative values for clinician services by collecting and using timely data that reflect the current cost of delivering care. This recommendation could improve care for beneficiaries by reducing incentives for clinicians to overprovide or underprovide certain services; it is not expected to affect total program spending because of the budget-neutral implementation required by statute. ■

Every year, the Commission assesses the adequacy of fee-for-service (FFS) payments made under the Medicare physician fee schedule (PFS) and releases the findings in our annual March report to the Congress. As part of that process, the Commission considers beneficiaries' access to care. For many years, the Commission has found that beneficiaries' access to care has been as good as, or better than, that of privately insured individuals; the share of clinicians who accept new Medicare patients has been comparable with the share who accept new privately insured patients; and the volume of and spending on fee schedule services per beneficiary has consistently grown. In 2024, answers to newly fielded questions in the Commission's annual beneficiary survey also indicated that Medicare beneficiaries' wait times for appointments with new clinicians are comparable with or better than the wait times for privately insured people.

But the Commission is concerned about whether payment-rate updates under current law will remain adequate to ensure continued access to care in the future. Under current law, growth in clinicians' input costs is projected to exceed the growth in PFS payment rates by a greater amount than in the two decades before the coronavirus pandemic. The larger gap between input-cost and payment-rate growth could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program. At the same time, ongoing issues with the calculation of Medicare's relative values for individual clinician services likely lead to relative overpayment for some services and underpayment for others, which can have undesirable effects on the distribution of program spending, beneficiary cost sharing, and decisions about how and where clinicians practice medicine.

In this chapter, we briefly describe the history of fee schedule updates to provide context for the current issues policymakers face and summarize findings on FFS Medicare beneficiaries' access to care in recent years. We then review some key concerns about current-law updates to the fee schedule and recommend replacing those updates with an annual update based on a portion of the growth in the MEI,

such as MEI minus 1 percentage point. Finally, we discuss flaws in the calculation of the fee schedule's relative value units (RVUs), which determine how spending is distributed among services and places of service, and make a recommendation to improve the accuracy of the RVUs by collecting and using timely data that better reflect the relative costs of delivering care.

Background

In 2023, Medicare paid for about 9,000 services under the PFS. To determine FFS Medicare payment rates under the PFS, CMS allocates a certain number of RVUs to each service in the fee schedule.¹ RVUs represent the relative time and resources needed to perform a given service and do not reflect the absolute cost of those services. These relative values are multiplied by the PFS's conversion factor (a national dollar amount equal to \$32.35 in 2025) to produce a total payment rate for each service.

In 2023, about 1.4 million clinicians, including physicians, advanced practice registered nurses (APRNs), physician assistants (PAs), therapists, chiropractors, and other practitioners, billed for services under the Medicare PFS. That year, the FFS Medicare program and its beneficiaries paid \$92.4 billion for PFS services, which represents just under 17 percent of total Medicare FFS spending.

The method for determining payment rates for clinician services and the way those rates are updated has evolved markedly since the Medicare program first came into existence.

Setting payment rates

When the Medicare program was first established in 1965, the program adopted a method of paying for physician services that many commercial insurance plans used at the time. Like these private sector plans, Medicare based payments for clinician services on customary, prevailing, and reasonable (CPR) charges submitted by physicians.

Problems with the CPR payment system quickly became apparent. Within specified limits, the Medicare program paid whatever prices physicians charged,

and Medicare beneficiaries generally would not move to another insurer or drop coverage if costs grew too high. In the years that followed, physicians sharply increased what they charged for services, as well as the volume of services furnished to Medicare beneficiaries (Physician Payment Review Commission 1987). As charges and payment rates steadily increased, so too did costs for taxpayers funding the program and for beneficiaries through higher cost sharing and premiums.

To address problems with the charge-based approach, the Omnibus Balanced Budget Act of 1987 required the Health Care Financing Administration (now CMS) to develop a fee schedule in which payment rates for physician services would be empirically based on the resources needed to furnish each service rather than what physicians charged for those services. This system came to be known as the Resource-Based Relative Value Scale (RBRVS). The RBRVS approach aims to assign each physician-furnished service a value that is relative to the value of every other physician service; the value of each service is measured in RVUs. The total RVU assigned to each Healthcare Common Procedure Coding System code is based on an assessment of the various resources that a typical practice requires when furnishing that service.

Each service's total RVUs are derived from three components that are each assigned their own relative values: clinician work, practice expense (PE), and malpractice (MP). The RVUs for clinician work are meant to reflect the relative levels of time, effort, skill, and stress associated with providing each service. The RVUs for PE are meant to reflect the relative costs of renting office space, buying supplies and equipment, and hiring nonpractitioner clinical and administrative staff. The RVUs for MP are meant to reflect the relative differences in premiums clinicians pay for medical malpractice insurance.

For most fee schedule services, there are generally two sets of RVUs for each service: one for services furnished in nonfacility settings (e.g., freestanding clinician offices) and one for services furnished in facilities (e.g., hospitals, skilled nursing facilities). PE RVUs are generally lower when services are furnished at a facility setting rather than a nonfacility setting because facilities receive separate payments to cover their practice expenses through other payment

systems (e.g., the hospital outpatient prospective payment system (OPPS)) and clinicians are assumed to use fewer of their own resources when services are furnished in a facility setting. RVUs for clinician work and MP are the same regardless of whether the service is furnished in a freestanding clinician office or a facility.

Under the RBRVS, the Medicare-allowed payment amount is determined by geographically adjusting each of the three national RVU components to reflect differences in local input prices (subject to certain restrictions, such as floors on certain payment adjustments), adding the geographically adjusted RVUs for the three components together and multiplying the total RVUs by a conversion factor, which is a national dollar amount.

Yearly changes in the conversion factor reflect two components: (1) a percentage specified in law (either through a formula or a fixed percentage) and (2) a percentage arrived at by CMS to ensure that any changes it makes to the set of codes available in the fee schedule and their relative values do not, in and of themselves, increase or decrease total PFS spending by more than \$20 million; this adjustment is referred to as CMS's "budget-neutrality adjustment" (see text box for more information on budget neutrality and conversion factors).

Updating payment rates each year

Once Medicare moved away from the charge-based method of paying clinicians, a mechanism for updating payment rates each year was needed to ensure that payment rates remained adequate to support beneficiary access to high-quality care. Medicare has used three approaches to update payment rates for clinician services: the volume performance standard (VPS), the sustainable growth rate (SGR), and the updates specified by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Under all three of these approaches, payment rates are updated each year by changing the fee schedule's conversion factor: Increasing the conversion factor by 1 percent, for example, results in an across-the-board 1 percent increase in payment rates, notwithstanding changes in the conversion factor due to a budget-neutrality adjustment. (A discussion of lessons learned from these policy approaches appears in the text box on pp. 20–21.)

Budget-neutrality adjustments and the conversion factor under the physician fee schedule

The physician fee schedule's (PFS's) budget-neutrality provision is a vital part of the annual update process that ensures that updating work relative value units (RVUs) does not, in itself, increase or decrease PFS spending. To ensure that changes to work RVUs do not increase or decrease PFS spending, CMS is required to adjust the conversion factor up or down.

Overview of the PFS budget-neutrality provision

Budget-neutrality adjustments under the PFS are intended to ensure that changes in medical practice, coding changes, new data on the relative value of services, or the addition of new services does not increase or decrease PFS spending. Changes that CMS makes, often based on recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), that result in an aggregate increase or decrease in PFS spending of more than \$20 million are required to be offset in a budget-neutral manner. For example, if CMS proposed increasing the work RVUs of a service that is projected to increase PFS spending by \$100 million in the upcoming year, then CMS reduces the conversion factor by an amount that is projected to decrease spending by \$100 million. If the projected effect is \$20 million or less, then no budget-neutrality adjustment is required.

Changes to the conversion factor as a result of the PFS budget-neutrality provision are driven by changes in work RVUs, not practice expense (PE) or malpractice (MP) RVUs. For example, if services' work RVUs increase, the total pools of PE and MP RVUs also increase to maintain the ratio of work RVUs to PE and MP RVUs. Therefore, to maintain budget neutrality with a higher number of work, PE, and MP RVUs, CMS adjusts the conversion factor down.

Changes to PE or MP RVUs do not result in changes to the conversion factor.² For example, changes to services' PE RVUs are made budget neutral by

adjusting PE RVUs up or down for other services rather than making a change to the conversion factor.

The PFS budget-neutrality provision does not apply to all services. Services that are novel, such as completely new types of services, are not subject to the PFS budget-neutrality provision when they are added to the PFS. Thus, novel services are permitted to increase spending without a budget-neutrality adjustment when the services are added to the PFS. Exempting novel services from budget neutrality encourages the adoption of new technology under the PFS. In contrast, existing services whose RVUs are revised and services that are newly unbundled and billable separately (e.g., certain care-coordination codes that were previously considered bundled with other evaluation and management codes) are subject to the budget-neutrality provision.

The PFS budget-neutrality provision's effect on the conversion factor

Changes in work RVUs are made budget neutral by adjusting the conversion factor up or down.³ On a utilization-weighted basis, work RVUs have tended to increase over time, and therefore offsetting reductions to the conversion factor have been made. Because the conversion factor is only one part of what determines a PFS service's payment rate (another part being the number of RVUs assigned to a given service), simply looking at changes in the conversion factor over time is not an accurate measure of the extent to which payment rates, in the aggregate, have increased or decreased over time or of changes in PFS spending, which are substantially affected by increases in the volume and intensity of PFS services over time.

Nearly all other Medicare payment systems have budget-neutrality provisions, and they accomplish the same basic objective—ensuring that changes in relative weights do not increase or decrease spending. However, PFS budget-neutrality

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Budget-neutrality adjustments and the conversion factor under the physician fee schedule (cont.)

adjustments to the conversion factor are often larger than in other payment systems, not because of differences in underlying objectives, but rather because of technical differences in how various payment systems deal with changes in work RVUs (in the PFS) and relative weights (in other payment systems).⁴ We compare the PFS with the hospital outpatient prospective payment system (OPPS) to demonstrate a key difference.

One key difference between the PFS and OPPS budget-neutrality adjustments is that the effects of changes in relative weights in the OPPS are not addressed through adjustments to the conversion factor. Under the OPPS, relative weights are recalculated annually using a combination of data from hospital cost reports and claims data. Using these data, CMS establishes relative weights on an annual basis; if one OPPS service becomes less (or more) expensive relative to a reference OPPS service (clinic visits), its relative weight goes down (or up). OPPS relative weights are also directly scaled to ensure that adjusting the relative weights does not result in overall spending increases or decreases. In contrast, clinicians do not submit cost reports, and under the PFS, work RVUs do not decrease (or increase) automatically in response to changes in other PFS services. For example, if CMS determines that work RVUs for some group of services merit

an increase, the work RVUs of other services do not automatically adjust (as the relative weights do under the OPPS). Instead, CMS reduces the PFS conversion factor to ensure overall budget neutrality.

The fact that the PFS budget-neutrality adjustment is used to account for the effects of changes in work RVUs, which can result in large adjustments relative to other payment systems, also makes it misleading to use changes in the PFS conversion factor as a measure of the increase or decrease in resources under the PFS or to compare the PFS conversion factor with the OPPS conversion factor. For example, when CMS increased the RVUs of evaluation and management office visits in 2021, the offsetting budget-neutrality adjustment to the conversion factor of -6.8 percent did not remove resources from the PFS; payments were only redistributed across different types of services. A more accurate measure of changes in the aggregate resources available under the PFS is total fee schedule spending per fee-for-service beneficiary, which reflects changes in RVUs, the conversion factor, and other factors, such as changes in the volume and intensity of services furnished. As seen in Figure 1-2 (p. 19) in this chapter, PFS spending per beneficiary has increased dramatically over time. ■

The VPS approach aimed to accomplish two main goals: (1) link updates in payment rates to growth in input costs (as measured by the MEI) and (2) restrain the growth in spending caused by increases in the volume and intensity of physician services delivered. In an attempt to target the policy's effects, the VPS used three conversion factors: one for surgical services, one for nonsurgical services, and one for primary care services. As time went on, however, clinicians and policymakers grew increasingly dissatisfied with the way the VPS operated. Since the VPS's spending targets were based in part on actual growth in the volume and

intensity of physician services minus the performance standard factor, the formula created continuous pressure to reduce volume and intensity. However, since the targets were determined at the national level, individual clinicians had very weak incentives to reduce their own volume and intensity. In addition, the VPS's annual updates for each type of service were volatile and markedly diverged over time.

In 1997, the Congress replaced the VPS with the SGR method of annually updating payment rates in the PFS. The spending target formula for the SGR was similar

to the one used for the VPS; the major difference was that the SGR's formula allowed for growth in volume and intensity based on real growth in gross domestic product (GDP) rather than historical volume and intensity growth (minus a performance standard). Another important difference between the two methods was that the SGR's spending targets were cumulative over time, while the VPS's spending targets were not. In the first years of the SGR system, actual expenditures did not exceed spending targets because volume did not grow faster than GDP. Therefore, updates to the PFS in the early years of the SGR system were at or above the MEI. However, beginning in 2001, actual cumulative expenditures exceeded allowed targets, and the discrepancy continued to grow each year, resulting in a series of prescribed multiyear cuts (due to the SGR formula) in order to recoup the difference. The SGR's prescribed cuts were implemented in 2002; after that, the Congress passed a series of bills to override the SGR-specified fee schedule reductions.

In 2015, MACRA repealed the SGR formula and established a schedule of fixed annual updates to the PFS's payment rates coupled with incentives to perform well on quality measures or participate in A-APMs that create incentives for clinicians to improve the quality of the care they provide and/or reduce spending on their care. Under MACRA's original framework, payment rates were to be updated by 0.5 percent annually from July 2015 through December 2019, by 0 percent from 2020 to 2025, and by 0.75 percent for qualifying clinicians in A-APMs and 0.25 percent for all other clinicians starting in 2026 (Figure 1-1, p. 14).

These fixed updates were coupled with (1) an annual 5 percent bonus for clinicians who participate in A-APMs, available from 2019 through 2024, and (2) an annual performance-based payment adjustment to payment rates (which could be negative, neutral, or positive) for non-A-APM clinicians under the Merit-based Incentive Payment System (MIPS). Subsequent legislation amended MACRA's fixed updates, providing a 0.25 percent update in 2019 instead of 0.5 percent, and made temporary increases to the fee schedule's payment rates in 2021 through 2024. These temporary increases differ from traditional updates in that they each apply for one year only and are not built into subsequent years' base payment rates.

Historically, beneficiary access to clinician care has been comparable with the privately insured, indicating adequate payment rates

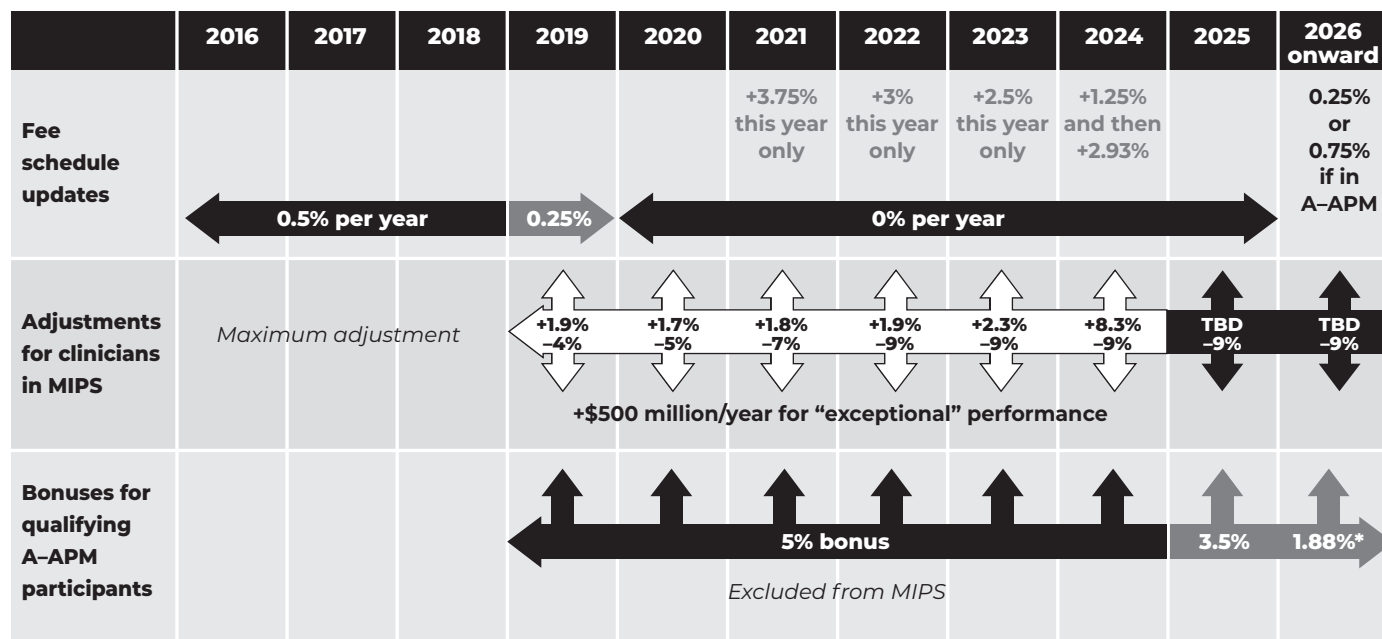
Every year, the Commission assesses the adequacy of payments made under Medicare's PFS and releases the findings in our annual March report to the Congress. As part of that process, the Commission assesses beneficiaries' access to care. For many years, the Commission has found that beneficiaries' access to care has been comparable with, or better than, that of privately insured individuals; the share of clinicians who accept new Medicare patients has been comparable with the share who accept new privately insured patients; and the volume of and spending on fee schedule services per beneficiary has grown. In 2024, newly fielded questions from the Commission's annual beneficiary survey also indicate that Medicare beneficiaries' wait times for appointments with new clinicians are comparable with or better than the wait times for privately insured people. Longer-term measures of access to care, such as applications to medical school, first-year enrollment in medical school, growth in the number of APRNs and PAs, and clinician incomes, have also remained positive.

Survey data suggest beneficiaries' access to care is comparable with that of privately insured individuals

The Commission sponsors an annual survey of Medicare beneficiaries ages 65 and over and privately insured individuals ages 50 to 64. The goal of surveying these two groups is to identify whether any problems that Medicare beneficiaries have in accessing care are confined to that population (which could suggest issues with Medicare's payment rates) or are also experienced by other patients (which could suggest larger issues in the health care sector). Over two decades, our survey has found that Medicare beneficiaries' access to care is comparable with, or better than, that of privately insured people. For example, among survey respondents in 2024 who had received health care in the past year, a greater share of Medicare beneficiaries was satisfied with their ability to find health care providers who accepted their insurance (97 percent) compared with privately insured people (93 percent) (Medicare Payment Advisory Commission 2025).⁵ These

FIGURE 1-1

Statutorily specified updates to physician fee schedule payment rates, payment adjustments, and bonuses under MACRA and subsequent legislation



Note: MACRA (Medicare Access and CHIP Reauthorization Act of 2015), MIPS (Merit-based Incentive Payment System), TBD (to be determined), A-APM (advanced alternative payment model). MIPS payment adjustments rounded to the nearest tenth of a percent. Fee schedule updates for 2021 through 2024 apply for one year only and were not incorporated into the following year's conversion factor. In 2024, fee schedule rates were updated by 1.25 percent through March 8, 2024, and then were instead updated by 2.93 percent from March 9, 2024, through December 31, 2024. These one-year-only updates and other changes (shown in gray) were made after the passage of MACRA. MIPS adjustments to payment rates can be positive, neutral, or negative. MACRA set maximum and minimum MIPS adjustments. The highest MIPS adjustments in 2025 and beyond are not yet known. MIPS adjustments and the A-APM participation bonus apply for only one year at a time and are not built into subsequent years' payment rates.

* The A-APM bonus is worth 1.88 percent in 2026 but is not available in subsequent years.

Source: MedPAC analysis of MACRA and subsequent legislation.

data are consistent with findings from beneficiary focus groups the Commission conducts every year across cities and rural areas. Focus-group interviews generally find that Medicare beneficiaries report high satisfaction with their insurance coverage. For example, in 2024, the vast majority of Medicare beneficiaries in our focus groups rated their coverage “excellent” or “good” (NORC at the University of Chicago 2024).

In 2024, our survey began asking respondents to quantify wait times for appointments with clinicians. We found that the number of weeks Medicare beneficiaries reported waiting for appointments with

new clinicians was comparable with or better than the wait times reported by privately insured people. For example, in 2024, 34 percent of Medicare beneficiaries waited two weeks or less for an appointment with a new primary care provider compared with 27 percent of privately insured people ages 50–64. We found similar results for specialist appointments: In 2024, 33 percent of Medicare beneficiaries waited two weeks or less for an appointment with a new specialist compared with 28 percent of privately insured people ages 50–64. On the other end of the distribution, we found that 18 percent of Medicare beneficiaries and 22 percent of privately insured people waited more than

eight weeks for an appointment with a new primary care provider (not a statistically significant difference). Sixteen percent of Medicare beneficiaries and 22 percent of privately insured people waited more than eight weeks for an appointment with a new specialist (Medicare Payment Advisory Commission 2025). While our analyses indicate that some beneficiaries wait a substantial amount of time for appointments, the fact that Medicare beneficiaries' wait times were comparable with or better than that of individuals with private insurance (which has far higher payment rates) suggests that higher Medicare payment rates would not have resulted in substantially shorter wait times.

Looking more broadly among Medicare beneficiaries who recently had an office visit scheduled after the beneficiary reached out to a doctor's office to set it up (and not just appointments with new clinicians), the Commission's analysis of CMS's 2022 Medicare Current Beneficiary Survey (MCBS) data found that nearly three out of four beneficiaries were seen in two weeks or less. Comparing these results with the Commission's analysis of wait times with new clinicians suggests that once beneficiaries find a new clinician and establish a care relationship with them, subsequent appointments may be easier to schedule.

The Commission also uses data from the MCBS and other surveys in its assessment of payment adequacy, which likewise have tended to conclude that Medicare beneficiaries have good access to care, as described below:

- The Commission's analysis of the 2022 MCBS found that a relatively small share (8 percent) reported experiencing trouble getting care in the past year—more often due to cost than to clinicians not accepting Medicare (Medicare Payment Advisory Commission 2025).
- The Medical Expenditure Panel Survey found that around age 65, when most people gain eligibility for Medicare, there are fewer reports of being unable to get necessary care and being unable to get needed care because of cost (Jacobs 2021).
- The National Health Interview Survey has found that delaying or forgoing needed care due to cost was more common among adults under the age of 65 than adults over 65 (National Center for Health Statistics 2021).

- The Behavioral Risk Factor Surveillance System survey found that, compared with people who have employer-sponsored or individually purchased health insurance, Medicare beneficiaries are more likely to have a personal physician, less likely to have medical debt, and more likely to be very satisfied with their care (Wray et al. 2021).

Clinicians accept Medicare at rates similar to those of commercial insurance

The Commission has found a substantial and growing difference between Medicare and commercial payment rates for clinician services. However, we have not found evidence that this payment differential impacts clinicians' willingness to accept new Medicare patients.

Using 2023 data from preferred provider organization (PPO) health plans that are part of a large national insurer, the Commission found that PPO payment rates for clinician services averaged 140 percent of Medicare's payment rates, with substantial variation across types of services (Medicare Payment Advisory Commission 2025). Other researchers have found similar ratios of commercial-to-Medicare payment rates for clinician services and have further explored the reasons for relatively high private-payer rates, such as increasing physician market power and vertical consolidation with hospitals (Congressional Budget Office 2022, KFF 2020). Further, the Commission has found that the difference between commercial and Medicare payment rates has widened over time. We found that, from 2011 to 2023, commercial PPO payment rates for clinician services increased from 122 percent of Medicare's payment rates to 140 percent of Medicare's rates (Medicare Payment Advisory Commission 2025).

Yet the share of clinicians who accept Medicare is comparable with the share who accept private health insurance. From 2014 to 2019, the share of nonpediatric office-based physicians who accepted Medicare was only 0 percentage points to 2 percentage points lower than the share who accepted private health insurance, according to the Centers for Disease Control and Prevention's National Electronic Health Records Survey (Ochieng et al. 2022). The 2021 National Ambulatory Medical Care Survey found that among the 94 percent of nonpediatric office-based physicians who reported accepting new patients, 89 percent said they accepted new Medicare patients and 88 percent said they

accepted new privately insured patients (Schappert and Santo 2023).

A 2022 American Medical Association (AMA) survey of clinicians in a wider range of clinical settings found that among nonpediatric physicians accepting new patients, 96 percent accepted new Medicare patients and 98 percent accepted new commercial insurance patients (American Medical Association 2023b). One specialty with notably low acceptance of Medicare was psychiatry. However, psychiatrists' low acceptance rate is not a Medicare-specific issue; other research has shown that psychiatrists are less likely to accept new patients using Medicare or commercial insurance (Bishop et al. 2014, Ochieng et al. 2022).

Looking from the perspective of patients trying to find a new provider, a 2023 KFF survey found that Medicare beneficiaries (enrolled in FFS Medicare or Medicare Advantage) were less likely than privately insured people to encounter providers who did not accept their insurance. Specifically, the survey found that 83 percent of Medicare beneficiaries said they had not encountered a doctor or hospital that was not covered by their insurance in the past year compared with 73 percent of people with employer-sponsored insurance and 57 percent of people with individual health insurance purchased through a Marketplace (Pollitz et al. 2023).

There are many reasons that clinicians may choose to accept FFS Medicare despite payment rates that are usually lower than commercial rates. A substantial share of most clinicians' patients are covered by Medicare, and if these clinicians opted to accept only commercially insured patients, they might not be able to fill their patient panels. In addition, almost all hospitals accept Medicare patients, and hospitals may expect their employed physicians to take Medicare patients given the important role these patients play in hospitals' mission and revenue streams. At the same time, though commercial rates may be comparatively high, commercial insurers often impose burdensome requirements on clinicians that take time to complete, such as requiring clinicians to appeal denied claims and complete insurers' prior authorization paperwork. A recent AMA survey found that physicians complete an average of 39 prior authorization requests per week, requiring 13 hours per week, and 40 percent of physicians have dedicated staff who work exclusively on completing prior authorizations (American Medical Association 2025). In contrast, FFS Medicare requires

prior authorization only for certain limited services and is known as a prompt payer since it is required to pay "clean" claims within 30 days of receiving a claim and must pay providers interest on any late payments. The relative lack of utilization management and the administrative simplicity of billing FFS Medicare may help offset the program's lower payment rates.

Volume and intensity of services delivered per beneficiary has increased

The Commission analyzes the volume and intensity of services delivered per beneficiary as an indirect measure of access. Changes in the volume and intensity of care can result from multiple factors, including changes in clinical practice patterns, changes in coding practices, movement of services from clinician offices to hospital outpatient departments, beneficiary health and disease prevalence, coverage of Medicare benefits (e.g., coverage of new provider types or services), changes in technology, selection into Medicare Advantage, and beneficiary preferences. Nonetheless, increases in the volume and intensity of care per beneficiary are a positive indicator that beneficiaries can access care.

Since 2000, the volume and intensity of clinician services furnished to beneficiaries—and the resulting payments that clinicians have received—have increased substantially. For example, from 2000 to 2017, the cumulative per beneficiary growth in volume and intensity of imaging services was 75 percent (Medicare Payment Advisory Commission 2019). The increase in volume and intensity of major procedures and evaluation and management (E&M) services over the period was somewhat lower but still considerable (47 percent and 45 percent, respectively). With the exception of a dip in utilization during the coronavirus pandemic, the volume of care that beneficiaries receive has continued to increase in more recent years (Medicare Payment Advisory Commission 2024b). For example, from 2022 to 2023, the average volume of services per FFS beneficiary increased by 5.4 percent (Medicare Payment Advisory Commission 2025).

Longer-term measures of access to care have remained positive

In the long term, access to health care also depends on the supply of clinicians. While less immediately related to PFS payment rates than our short-term measures of access, we review evidence on multiple measures of

clinician supply—clinician incomes, the number of applicants to and first-year enrollees in medical school, the increase in the number of APRNs and PAs, and the number of clinicians who bill the fee schedule.

Physicians' incomes are an important long-term indicator because declining incomes (either nominally or in real, inflation-adjusted terms) could dissuade some college students from entering the medical profession. Also, since the Commission lacks data that would allow us to calculate clinicians' all-payer profit margins from delivering services, we use clinician compensation data as a rough proxy for all-payer profitability. Similarly, a decrease in the number of medical school applicants or the number of clinicians billing the fee schedule could signal a declining interest in entering the medical field or treating Medicare beneficiaries, respectively.

Overall, our long-term measures of access to care are positive:

- Clinician incomes (including for physicians and other clinicians, such as nurse practitioners (NPs) and PAs) have kept pace with (or exceeded) inflation over the long term (Medicare Payment Advisory Commission 2024a).
- Growth in applications to and first-year enrollment in medical school has exceeded total U.S. population growth over a period of four decades and by a greater amount in the last decade. For example, from the 2013–2014 to the 2023–2024 academic years, first-year enrollment in medical schools increased by 2.3 percent per year while the total U.S. population grew by 0.6 percent per year (Medicare Payment Advisory Commission 2025).
- The number of APRNs and PAs, who represent an increasingly large share of the clinician workforce, has grown rapidly, suggesting robust interest in becoming an APRN or PA. For example, the number of certified PAs in the U.S. has quadrupled over the last two decades, increasing from about 43,500 in 2003 to 95,600 in 2013 to 178,700 in 2023 (National Commission on Certification of Physician Assistants 2023, National Commission on Certification of Physician Assistants 2014).
- The number of clinicians billing the fee schedule has increased substantially (due to rapid growth

among APRNs and PAs and modest growth among specialist physicians, while there has been slow or slightly negative growth among primary care physicians); the share of clinicians opting out of Medicare has remained very low; and the share of clinicians who are participating providers (meaning they cannot balance bill Medicare beneficiaries) has increased over time (Albanese 2023, Medicare Payment Advisory Commission 2024a).

(For more information on these measures, see the Commission's June 2024 and March 2025 reports to the Congress.)

Concerns about the adequacy of future payments to clinicians

The Commission's past assessments have generally indicated that Medicare beneficiaries have relatively good access to care. However, we are concerned about whether beneficiaries will maintain adequate access to care in the future since growth in clinicians' input costs is expected to exceed growth in Medicare PFS payment rates by a greater amount than it did in the two decades prior to the coronavirus pandemic. This larger gap could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program.

The impact of inflation on the future adequacy of PFS payment rates

MACRA has achieved one of its policy goals of stabilizing updates to fee schedule payment rates: Since MACRA was enacted, payment rates have been higher and more predictable than what would have occurred under the SGR. But recent increases in the costs of running clinician practices and projections of higher inflation over the next several years compared with the prepandemic period have led to concerns about the adequacy of current-law updates to fee schedule payment rates scheduled under MACRA.

The MEI measures annual changes in input costs for clinician services

The MEI is a measure of inflation that was originally used in the 1970s in Medicare's charge-based payment

system for clinician services to limit year-to-year payment increases. While Medicare no longer uses the MEI to increase (or limit) PFS payment rates, CMS still maintains the index for various other purposes.

The MEI measures the weighted average price change for various inputs involved in furnishing clinician services. Specifically, the MEI is a fixed-weight input price index composed of two broad categories—clinician compensation and practice expenses (which includes malpractice insurance). According to the 2017–based MEI, on average, clinician compensation accounts for 47.5 percent of the cost of furnishing clinician services and includes wages and benefits for physicians and other clinicians who bill the PFS directly (e.g., NPs and PAs). Practice expenses (including malpractice insurance) account for the remaining 52.5 percent. In the 2017–based MEI, CMS determined the distribution of expenses largely based on the U.S. Census Bureau’s Service Annual Survey (SAS), supplemented by several other data sources. The SAS provides annual nationwide estimates of revenue, expenses, and other measures for most traditional service industries (Census Bureau 2021).

The distribution of expenses is directly related to payments under the PFS. Later in this chapter, we discuss this relationship and CMS’s decision not to rescale fee schedule RVUs based on updated MEI data.

Once CMS establishes the distribution of expenses reflected in the MEI, the next step is to determine how the prices in each of the categories of expenses grow over time. To do so, CMS relies on a sample of commercial professional liability insurance carriers and three data sources from the U.S. Bureau of Labor Statistics to measure changes in the input costs of maintaining a physician office:

- the Employment Cost Index (ECI), which measures the change in the hourly labor cost to employers over time;
- the Producer Price Index, which measures the average change over time in the selling prices received by domestic producers for their output; and
- the Consumer Price Index (CPI), which measures the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services.

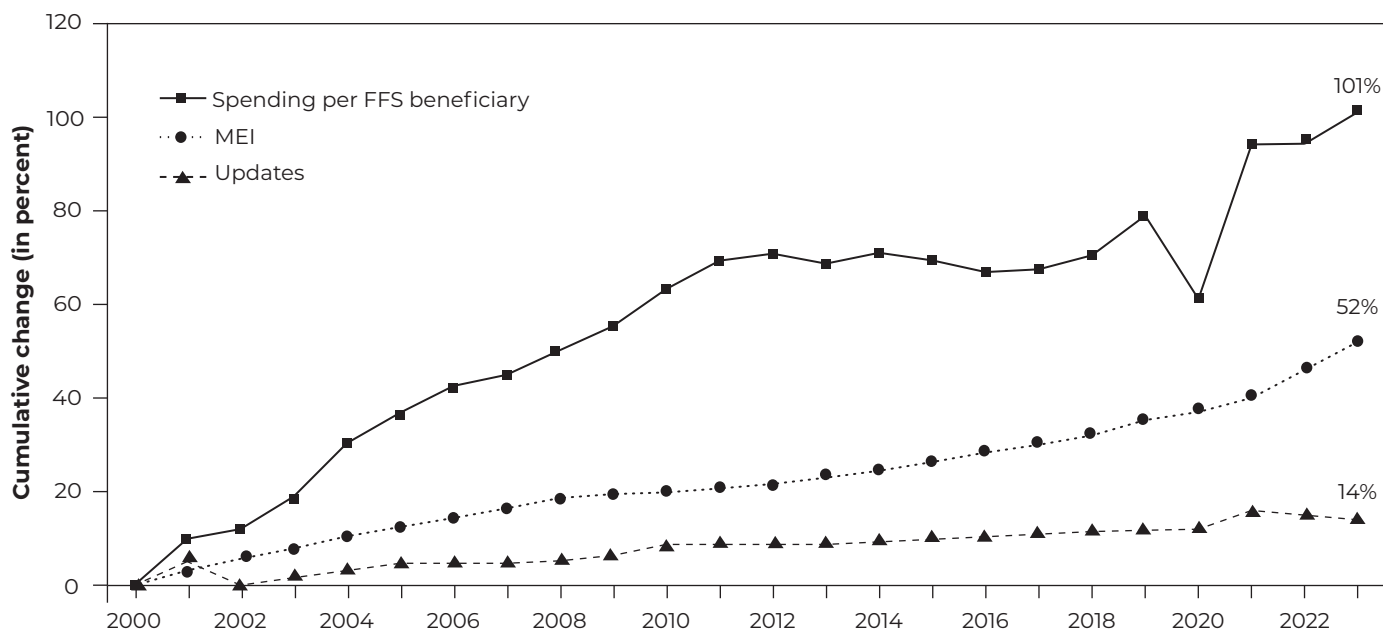
The decision about which price proxy to use is limited by available data and involves trade-offs. For example, in 2012, when considering the price proxy for clinician compensation, the Medicare Economic Index Technical Advisory Panel, established by the Secretary of the Department of Health and Human Services, sought an index that reflected a highly skilled occupational mix that was not heavily influenced by trends in actual physician wages that could create endogeneity or circularity concerns. The panel considered a broad index that included all private industry workers, for which the share of total employees who were physicians was only 0.6 percent. The panel also considered a slightly narrower index composed of professional workers, for which the share of total employees who were physicians was slightly higher at 4.0 percent. The panel recommended the slightly narrower index because it better reflected a more highly skilled mix of occupations and was still only minimally influenced by the actual wages of physicians (Berndt 2012).

Unlike many other market baskets used to update FFS Medicare payment rates, the MEI has long been adjusted to include a measure of productivity growth. Currently, the MEI includes an adjustment that reflects the 10-year moving average of private nonfarm business (economy-wide) total factor productivity. Therefore, reported MEI growth figures in this chapter include a built-in adjustment for productivity growth.

MEI growth has outpaced statutory fee schedule updates

MEI growth has consistently exceeded fee schedule payment-rate updates. From 2000 to 2023, the cumulative increase in fee schedule updates totaled 14 percent compared with MEI growth of 52 percent (Figure 1-2). The growing gap between statutory fee schedule updates and MEI growth means that Medicare payments per service (unadjusted for increases in intensity, coding, and other changes) have declined substantially in inflation-adjusted terms over time.

At the same time, the volume and intensity of clinician services delivered per beneficiary has increased, which has resulted in fee schedule spending per FFS beneficiary growing by 101 percent over the same time period.^{6,7} These data indicate that, even after adjusting for inflation, each FFS Medicare beneficiary generated more revenue for clinicians in 2023 than they did in

**FIGURE
1-2****Physician fee schedule spending per FFS beneficiary grew substantially faster than the MEI or fee schedule updates, 2000–2023**

Note: FFS (fee-for-service), MEI (Medicare Economic Index). The MEI measures the change in clinician input prices. MEI data are from the 2017–based MEI and include updated total factor productivity data that CMS released as part of the second quarter of 2024 market basket data. “Spending per FFS beneficiary” is based on incurred spending under the physician fee schedule. The graph shows updates to payment rates in nominal terms. Fee schedule updates do not include Merit-based Incentive Payment System adjustments or bonuses for participating in advanced alternative payment models. One-time payment increases of 3.75 percent in 2021, 3.0 percent in 2022, and 2.5 percent in 2023 are included in the update line and also impact spending per beneficiary.

Source: MedPAC analysis of Medicare regulations, CMS market basket data, and reports from the Boards of Trustees of the Medicare trust funds.

2000. Because increases in volume and intensity often increase costs (e.g., furnishing an additional service may require clinicians to purchase additional supplies, and a more intense service may require more clinician time), the growth in fee schedule spending per FFS beneficiary should not be interpreted as profit growth. Nonetheless, the substantial growth in volume and intensity (and the Commission’s broader finding that Medicare beneficiaries report relatively good access to care) suggests that below-MEI updates have not impeded access and that simply comparing changes in fee schedule updates with MEI growth is insufficient to capture changes over time in clinicians’ ability to provide services to Medicare beneficiaries.

Because the coronavirus pandemic and the associated relief funds that clinicians began receiving in mid-2020

make it more difficult to interpret how trends in access relate to PFS rates, we split evidence from more than two decades into two time periods—the two decades largely before the pandemic and 2021 and beyond.

On an annual basis, for the two decades from 2001 to 2020, MEI growth exceeded fee schedule updates by an average of just over 1 percentage point per year (1.6 percent vs. 0.6 percent annually).

From 2021 to 2023 (which was the most recent year of MEI data available at the time we conducted this analysis), MEI growth exceeded fee schedule updates by a greater amount than in the previous two decades. Over that period, MEI growth averaged 3.6 percent per year and PFS rates under MACRA were scheduled to receive no updates. However, the Congress provided

Lessons learned from past approaches to fee schedule updates

Looking back at events over the last 60 years, several lessons emerge about setting and updating Medicare's payment rates for clinician services. These lessons can be helpful in developing a new update policy going forward.

One important observation is that regardless of how fee schedule payment rates are set, the system has built-in features and incentives that can lead to increases in volume and intensity. If fee-for-service (FFS) Medicare payment rates are larger than the marginal costs of furnishing a service, a provider has a financial incentive to increase the volume of services furnished.⁸ Some studies have shown that increases in Medicare payment rates for clinician services, especially services that are considered discretionary, are correlated with increases in volume (Clemens and Gottlieb 2014). These increases, in turn, can cause spending to increase for both beneficiaries (in the form of higher cost sharing and premiums) and taxpayers (in the form of higher financing costs).

Since Medicare moved away from the charge-based payment approach, policymakers have used two strategies for controlling spending growth on fee schedule services. The first strategy was to establish formulaic spending targets where the size of annual conversion-factor updates was governed by whether actual spending was above or below the targets. The

volume performance standard (VPS) and sustainable growth rate (SGR) formulas both used this approach. A second strategy for controlling spending growth has been to set fixed payment-rate updates at less than input cost inflation. This approach was included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), along with incentives to participate in advanced alternative payment models (A-APMs).

The spending-target approach used by the VPS and SGR formulas was abandoned for a number of reasons. First, determining updates based on spending-target formulas can lead to highly variable updates from year to year. For instance, the SGR formula resulted in a 5.1 percent increase in payment rates in 2001, but, starting in 2002, the formula called for a series of annual reductions of 4 percent to 5 percent for a number of years. Beginning in 2003, the Congress passed a series of bills to override the SGR-specified fee schedule reductions. The primary rationale for overriding cuts called for by the SGR formula was a fear that allowing the scheduled reductions to take effect would cause physicians to reduce services provided to Medicare beneficiaries and that they would perhaps stop participating in the program (Boards of Trustees 2014, Medicare Payment Advisory Commission 2011c).

(continued next page)

one-time payment increases of 3.75 percent in 2021, 3.0 percent in 2022, and 2.5 percent in 2023.⁹ In addition, as part of a broader set of laws related to the coronavirus pandemic, clinician offices received billions of dollars in funding from sources outside of the fee schedule, such as payments through the Provider Relief Fund (PRF) and Paycheck Protection Program (PPP) loans. For example, as of December 2022, the Government Accountability Office found that clinicians and other health care practitioners

received \$12.7 billion through the PRF (Government Accountability Office 2023). Other research found that physician offices received more than \$17 billion in PPP loans through August 8, 2020 (Chen et al. 2022). PPP loans can be forgiven if applied toward approved expenses and if employment and compensation levels are maintained. As of December 2021, about 83 percent of PPP loans had been forgiven, in full or in part (U.S. Small Business Administration 2021).

Lessons learned from past approaches to fee schedule updates (cont.)

Importantly, the VPS and SGR formulas imposed incentives to reduce volume and intensity growth at the national level, but individual practitioners had almost no incentive to practice efficiently or look for ways to reduce the volume or intensity of services they delivered (Medicare Payment Advisory Commission 2011c). Because the formulas applied payment adjustments on an across-the-board basis, the approach neither rewarded individual clinicians who restrained unnecessary volume growth nor penalized clinicians who contributed most to inappropriate volume increases.

The second strategy for controlling spending, and the one used in MACRA, has been to make relatively low annual updates to the conversion factor and encourage clinicians to participate in A-APMs designed to increase incentives to provide efficient care. While relatively low legislatively specified updates do provide a measure of stability and can act to restrain spending growth, this approach does not respond to changing conditions such as high inflation. Concerns about low updates in current law relative to the higher inflation that began during the pandemic led the Commission to recommend that clinician payment rates be increased by a portion of MEI growth in its March 2023, 2024, and 2025 reports to the Congress (Medicare Payment Advisory Commission 2025, Medicare Payment Advisory Commission 2024b, Medicare Payment Advisory Commission 2023b).

Well-designed A-APMs are a key piece of the second strategy for controlling spending and improving incentives for providers to practice efficiently. The Commission maintains that A-APMs show promise, but it has been challenging to design voluntary A-APMs that maximize program savings (because of weak incentives for clinicians to reduce their spending in these models, for example). To date, evidence on the performance of A-APMs has been modest, though some models have produced gross savings (Congressional Budget Office 2023). The Commission made recommendations in June 2021 for how to improve A-APMs moving forward and will continue to monitor their implementation and performance (Medicare Payment Advisory Commission 2021).

The differential updates in MACRA based on A-APM participation are intended to incentivize clinicians to participate in A-APMs. However, the differential-update approach is flawed since it initially produces weak incentives and then will begin to produce strong incentives by creating a payment differential between clinicians who participate in A-APMs and those who do not, which could become untenably large. The Commission did not address how the A-APM bonus should be treated in this work. As A-APMs develop, the Congress may decide to incorporate a redesigned A-APM bonus payment to achieve its goals. ■

Beneficiaries' access to care remained comparable with private insurance enrollees' access over the pandemic and postpandemic period. However, the unprecedented nature of the coronavirus pandemic and the emergency funding that clinicians received over that period make it difficult to evaluate whether fee schedule updates that occurred during that period were sufficient to ensure access in the absence of emergency funding. Therefore, while updates of 1 percentage point per year below MEI growth from 2001 to 2020 did not undermine beneficiary access to care, we cannot

conclude that updates of substantially less than 1 percentage point below MEI (which occurred during the pandemic) would be sustainable over the long term.

MEI growth is projected to exceed fee schedule updates by more in the future than it has in the past

MEI growth was relatively low for two decades preceding the coronavirus pandemic, averaging 1.6 percent per year from 2001 to 2020. Beginning in 2021, MEI growth accelerated, reaching an annual

rate of 4.4 percent in 2022. MEI growth slowed to 4.0 percent in 2023, and CMS expects MEI growth to slow further in the coming years: 3.3 percent in 2024, 2.8 percent in 2025, and 2.3 percent in 2026.¹⁰ Despite this moderation, MEI growth is still projected to remain somewhat above the levels experienced in the two decades prior to the pandemic, averaging 2.2 percent per year from 2025 through 2034, about 0.6 percentage points higher than the two decades prior to the pandemic. In comparison, after a series of one-time payment-rate updates that were in place from 2021 to 2024 expired, aggregate updates have been flat from 2020 to 2025.¹¹ Starting in 2026, rates will increase by 0.75 percent per year for qualifying clinicians in A-APMs and 0.25 percent per year for clinicians not in A-APMs. As a result, the average annual difference between projected MEI growth and fee schedule updates from 2025 to 2034 is expected to be 1.5 percentage points for clinicians in A-APMs and 2.0 percentage points for clinicians not in A-APMs. Thus, while projecting future inflation rates is subject to substantial uncertainty, MEI growth is projected to exceed fee schedule updates by more than it did for the two decades from 2001 to 2020.

Clinicians' incentives to participate in A-APMs could diminish in the near term but become very large in the future

From 2019 to 2024, qualifying clinicians participating in A-APMs have received a bonus equal to 5 percent of their Medicare payments for fee schedule services. The bonus decreases to 3.5 percent in 2025 and 1.88 percent in 2026. In 2027 and beyond, there is no bonus (Figure 1-1, p. 14). Bonus payments are in addition to any shared savings payments or other payments that may be realized through participation in an A-APM.

Instead of using bonuses to incentivize participation in A-APMs, starting in 2026, fee schedule payment rates will increase by 0.75 percent per year for qualifying clinicians participating in A-APMs and by 0.25 percent for all other clinicians. These payment-rate differentials are set to continue each year in 2026 and beyond, so the cumulative effect starts out small and grows larger over time. For example, in 2027, A-APM clinicians' payment rates will be only 1 percent higher than those of other clinicians, but by 2045, that differential will be 10.5 percent. An incentive this large could be unwarranted and inequitable, especially if many clinicians continue to have limited access to A-APMs

due to their geographic location, medical specialty, or other circumstances.

Reforming physician fee schedule updates

Under current law, future fee schedule payment-rate updates are fixed in statute, set at relatively low levels compared with projected inflation, and provide inconsistent incentives for clinicians to participate in A-APMs. An alternative approach would be for the Congress to require CMS to update fee schedule rates based on some measure of the growth in the costs of running a clinician practice and design separate policies to create appropriately sized and structured incentives for clinicians to participate in A-APMs, which could involve bonuses or A-APM payments (e.g., shared savings) only. Here we discuss changes to the update but not the A-APM payments.

Under this approach, the dual physician fee schedule updates that are set to begin in 2026 based on A-APM participation would be replaced with a single update based on a portion of MEI growth, such as MEI minus 1 percentage point. (The MEI has a built-in adjustment for productivity. Therefore, the additional 1 percentage point below MEI is in addition to the standard productivity adjustment.) The objective of such an option is to set default updates at a level the Commission considers sufficient, in the aggregate, to ensure continued beneficiary access to care. Of course, setting default updates based on a portion of MEI growth would not negate the need for future monitoring of payment adequacy. The Commission would continue to monitor trends in access, inflation, volume of care, quality, and other indicators and, to the extent needed, recommend higher or lower updates in the future.

Three principles have guided the Commission's assessment of the adequacy of fee schedule updates: (1) payments should be sufficient to support beneficiary access to high-quality health care in an appropriate clinical setting; (2) payments should reflect efficient care delivery, thereby ensuring that the program's fiscal burden on beneficiaries and taxpayers is not greater than necessary; and (3) payments should give providers incentives to supply appropriate and equitable care.

Using these principles to craft an appropriate policy for updating PFS payment rates requires reviewing the available empirical evidence from the Commission's past assessments of access and related academic literature, as well as the Commission's judgment. To elucidate the rationale for a change in PFS update policy, we use an illustrative policy that would update rates at MEI minus 1 percentage point. We also discuss how various update floors and ceilings would affect such updates. Based on our review of the available evidence, an annual update of MEI minus 1 percentage point would be an appropriate default for fee schedule services, but policymakers may choose other reasonable alternatives. Regardless of the particular approach chosen, the critical concept is that fee schedule rates should increase based on some portion of the MEI since an annual full-MEI update could result in financial burdens that are larger than necessary for beneficiaries and the program.

MEI minus 1 percentage point could be implemented prospectively, as in most other FFS Medicare payment systems. For example, if MEI growth in the coming year is projected to be 4 percent, the update would be set at 3 percent (4 percent minus 1 percentage point). If the update were coupled with a floor of 0 percent, the update floor for the year would be 0 percent, so the actual update would be the higher of the two: 3 percent. In contrast, in a year in which the MEI is projected to grow by 0.5 percent, the MEI minus 1 percentage point calculation would result in an update of -0.5 percent, but the floor would set the actual update at 0 percent.

The Commission's preference for updating fee schedule rates based on inflation but below full MEI growth is based on several key factors:

- **It would automatically adjust to changes in inflation:** As demonstrated by the spike in inflation during the coronavirus pandemic, anticipating future rates of input cost growth for clinician practices is difficult. Therefore, setting default updates that change based on an objective measure of growth in practice costs (e.g., the MEI) would improve how well fee schedule updates match changes in the cost of running a clinician practice. Different formulations of sub-MEI growth updates would improve the responsiveness of fee schedule updates to actual inflation conditions relative to

current law. For example, an update of half of MEI would likely be adequate in the short term and, based on current CMS projections of MEI growth, in the long term as well.¹² However, if inflation in the long term is higher than currently projected by CMS, then updates of half of MEI might not be sustainable, based on historical evidence. For example, if MEI growth averaged 4 percent, an update of half of MEI would be 2 percent (2 percentage points below MEI growth). While annual updates of 2 percentage points below MEI growth might be sustainable, our analysis of past fee schedule updates allows us to conclude only that updates set at 1 percentage point below MEI growth are likely sustainable in the long term.

An update of MEI minus 1 percentage point could also be coupled with an update floor. If the update floor were set at half of MEI, updates would at least cover increases in practice costs on average (since practice expenses account for about half of the costs of running a clinician practice, according to the 2017-based MEI). If an update floor were set at 0 percent, updates could not be negative, which could otherwise occur during times of low inflation. For example, if updates of MEI minus 1 percentage point had been in place from 2001 to 2020, updates would have been negative in each of the four years from 2009 to 2012.¹³

An update of MEI minus 1 percentage point could also be coupled with an update ceiling to address a concern that, in periods of rapid inflation, the appropriate gap between MEI and updates necessary to maintain access may be greater than 1 percentage point. To illustrate the effect of such a policy, we use hypothetical values of MEI growth of 6 percent and an update ceiling of 75 percent of MEI growth. Under this scenario, an update of MEI minus 1 percentage point would result in an increase of 5 percent (6 percent - 1 percent) versus 4.5 percent with the illustrative ceiling in place (6 percent × 0.75). Such an update would still cover the growth in practice expenses and limit the financial burden on beneficiaries and taxpayers. From 2000 to 2023, a 75 percent ceiling would only once (in 2022) have reduced an update that was based on MEI minus 1 percentage point and, based on projections of MEI growth, would not affect such updates through 2034.¹⁴ Nevertheless,

a ceiling could be a useful policy tool to reduce unnecessarily high updates if MEI growth is higher than currently projected.

- **It would improve predictability for clinicians, beneficiaries, and policymakers:** Having updates that automatically adjust to the current inflation environment would allow clinicians to more reliably predict whether updates will keep pace with the costs of running their practices. Over time, greater predictability and stability may also help beneficiaries as clinicians maintain their practices (and access for beneficiaries) and more energy is focused on reforming care delivery rather than adequate updates. Appropriate default updates would also allow policymakers to focus on improving other aspects of the fee schedule rather than enacting numerous one-time or short-term patches to ensure that updates are adequate.
- **It should be sufficient, based on historical evidence, to maintain beneficiary access to care:** After factoring in a series of congressional patches to override fee schedule updates specified under the SGR, fee schedule updates averaged about 1 percentage point below MEI growth for the two decades preceding the coronavirus pandemic. Over that time, Medicare beneficiaries' access to care remained comparable with patients who had private insurance. This historical evidence suggests that updates of MEI minus 1 percentage point have been sufficient to maintain access to care. The addition of an update floor would make updates based on MEI minus 1 percentage point more generous during periods of low inflation. For example, from 2001 to 2020, updates averaged 1 percentage point below MEI growth. However, if an update policy of MEI minus 1 percentage point with a half of MEI floor were in place over that period, cumulative updates would have been 7 percentage points higher than actual fee schedule updates.¹⁵ This difference suggests that a policy that updated PFS payment rates by MEI minus 1 percentage point with a floor of half of MEI would be higher than what has occurred historically and that the method therefore errs on the side of slightly higher updates to ensure beneficiary access.
- **It would be simple to administer and apply to all PFS services:** An MEI-based update would be simple for CMS to administer and similar to other

FFS payment systems. The updates would also apply uniformly to all services (and therefore all clinician specialties).

- **It would balance beneficiary access with beneficiary and taxpayer financial burden:** Some physician organizations have called for annually updating PFS payment rates based on full MEI (American Medical Association 2023a). Our analysis suggests that doing so would likely increase Medicare and beneficiary spending beyond what is necessary to maintain access to care. In addition to creating a financial burden on taxpayers, unnecessarily increasing payment rates can be detrimental to beneficiaries' ability to afford (and therefore access) health care by raising their premiums and cost sharing. This burden may disproportionately impact subgroups of beneficiaries who, according to the Commission's analysis of CMS's 2022 Medicare Current Beneficiary Survey, are already more likely to report problems paying medical bills: FFS Medicare beneficiaries with no supplemental coverage, beneficiaries under the age of 65 (most of whom are disabled), and partial-benefit dually eligible beneficiaries (who do not qualify for the same Medicaid benefits that full-benefit dually eligible beneficiaries receive) (Medicare Payment Advisory Commission 2025). Given the relatively low current-law fee schedule updates, even updating rates below full MEI growth could substantially increase Medicare program and beneficiary spending.

RECOMMENDATION 1-1

The Congress should replace the current-law updates to the physician fee schedule with an annual update based on a portion of the growth in the Medicare Economic Index (MEI) (such as MEI minus 1 percentage point).

RATIONALE 1-1

Medicare lacks data on the costs and revenues associated with running clinician practices, which serve as the foundation of payment-adequacy analyses in other sectors, but the Commission has found that beneficiary access to clinician care has been as good as, or better than, that of privately insured individuals. However, MEI growth is projected

to exceed fee schedule updates by even more in the future than it has in the past. The Commission is therefore concerned about whether current-law payment-rate updates—which are fixed in statute without regard to inflation—will remain adequate to ensure continued access to care.

Because Medicare lacks data on clinician practice costs and revenues, it is difficult to determine sufficient updates. An update based on inflation growth—a feature that is common to many other Medicare fee schedules—would allow PFS rates to automatically adjust to changes in costs. However, inflation-based updates could increase Medicare’s payments for clinician services relative to current law, which could financially burden beneficiaries and taxpayers. Therefore, the Commission’s goal is to recommend a change to current-law updates that balances the goal of maintaining beneficiary access by ensuring that Medicare’s payments reflect trends in inflation growth with the desire to limit beneficiary and taxpayer financial burden.

The Commission maintains that the weight of the historical evidence on beneficiary access to care, clinicians’ acceptance of Medicare, rapid growth in fee schedule spending, and other metrics suggest that it is prudent to set updates based on a portion of MEI growth, such as MEI minus 1 percentage point, rather than full MEI growth. Sub-MEI growth in updates has been sufficient to maintain beneficiary access to care. Such updates would automatically adjust to changes in inflation; would improve predictability for clinicians, beneficiaries, and policymakers; would be simple to administer and apply to all PFS services; and would limit the financial burden on beneficiaries and taxpayers. The Commission will continue to monitor trends in access, inflation, volume of care, quality, and other indicators and, to the extent needed, recommend higher or lower updates in the future.

Policymakers may also wish to consider setting update floors and ceilings. Update floors could increase stability by ensuring that a default update of MEI minus 1 percentage point does not result in negative updates (in the case of a 0 percent update floor) or would at least cover the growth in overall practice expenses (if the floor were half of MEI since practice expenses account for about half the costs of running a clinician practice, according to the 2017-based MEI). Update

ceilings could address a concern that in periods of rapid inflation, the appropriate gap between MEI and updates necessary to maintain access may be greater than 1 percentage point. For example, if MEI were 6 percent, an update of MEI minus 1 percentage point would result in an increase of 5 percent (6 percent – 1 percent) versus 4.5 percent with an illustrative ceiling of 75 percent of MEI growth (6 percent $\times$ 0.75).

Under the approach of updating PFS rates by a portion of MEI growth, the Commission did not address how the A-APM bonus should be treated. While the Commission maintains that incentivizing A-APM participation through differential payment-rate updates (such as 0.75 percent for A-APM participants and 0.25 percent for nonparticipants) is a flawed approach, we assert that A-APMs continue to show promise. Policymakers thus may choose to include some form of a bonus as an important component of payment for clinician services as they seek policy changes to improve A-APM design and performance.

IMPLICATIONS 1-1

Spending

- We expect that the recommendation would increase federal program spending by between \$15 billion and \$30 billion over five years relative to current law.

Beneficiary and provider

- We expect that this recommendation would maintain FFS Medicare beneficiaries’ access to care by maintaining or improving clinicians’ willingness and ability to treat them.
- We expect that this recommendation would increase Part B premiums and coinsurance for Medicare beneficiaries.

Improving the accuracy of relative payment rates for fee schedule services

While fee schedule updates are the main policy lever used to change the aggregate value of fee schedule services, RVUs determine how that spending is distributed among services and places of service. In addition, other payers (including Medicaid) often base

Previous MedPAC recommendations on improving the way clinician services are valued

On numerous occasions, the Commission has expressed concerns about the way relative value units (RVUs) for clinician services are calculated and updated over time.

Of particular concern are issues related to data timeliness and accuracy and whether the current RVUs accurately reflect changes in the way medical care is organized and delivered. The Commission has also raised concerns about CMS's reliance on the Relative Value Scale Update Committee (RUC) to make recommendations on relative values. The RUC is a private entity that was formed in 1991 by the American Medical Association (AMA) and physician specialty societies. In addition to representatives from the AMA, 22 of the RUC's 32 members are appointed by major national medical specialty societies. (Four seats rotate on a two-year basis, with two reserved for representatives of primary care, one for an internal medicine subspecialty, and one for any other specialty not already represented at the RUC.) The RUC makes annual recommendations to CMS

on the relative values for new services, as well as for services that have been redefined. Under a specified review process, the RUC also reviews and makes recommendations on the relative values of existing services that may have become misvalued. As part of these processes, specialty societies survey clinicians and the RUC uses findings from those surveys to make recommendations to CMS about what relative values should be. CMS reviews and sometimes refines the RVUs recommended by the RUC.

In 2006 and 2011, the Commission made five recommendations for how the valuation process could be improved (Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2006).

The Commission recommended the following in 2006:

- The Secretary should establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the RUC.

(continued next page)

payments on fee schedule RVUs, so misvaluations can affect other parts of the health care system. The Commission has previously outlined flaws in the way RVUs are calculated. These flaws include use of outdated and/or inaccurate data, assumptions that certain services require more resources than they actually do, and double payment for certain costs (Medicare Payment Advisory Commission 2023a, Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2011a, Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2006).

Because overvalued services benefit more from higher across-the-board updates, larger fee schedule updates also magnify the effects of misvalued services, which include the underprovision of some services, the overprovision of others, and incentives for vertical

consolidation between hospitals and clinicians. These effects make relying on changes in fee schedule updates an inefficient, and potentially counterproductive, way to address relatively mispriced services. Instead, coupling any increase in updates with improvements to the accuracy of relative values would help address the effects of misvalued services and help ensure that taxpayer and beneficiary funds are used judiciously.

On several occasions, the Commission has made targeted recommendations to improve the processes and data used to set values for fee schedule billing codes. In 2006, the Commission recommended that CMS establish a standing panel of experts to help the agency identify overvalued services and review the billing-code values recommended by the American Medical Association/Specialty Society Relative Value Scale Update Committee (the RUC), which is

Previous MedPAC recommendations on improving the way clinician services are valued (cont.)

The group should include members with expertise in health economics and physician payment, as well as members with clinical expertise. The Congress and the Secretary should ensure that this panel has the resources it needs to collect data and develop evidence.

- The Secretary, in consultation with the expert panel, should initiate the five-year review of services that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may indicate changes in physician work.
- In consultation with the expert panel, the Secretary should identify new services likely to experience reductions in value. Those services should be referred to the RUC and reviewed in a time period specified by the Secretary.
- To ensure the validity of the physician fee schedule, the Secretary should review all services periodically.

The Commission recommended the following in 2011:

- The Congress should direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values. To help assess whether Medicare's fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years.

In the years since the Commission made these recommendations, CMS has been more active in revaluing certain codes, and the Congress has enacted legislation directing CMS to expand the scope of efforts to identify misvalued codes. That said, the agency has limited resources with which to collect additional data and conduct reviews. Reliance on data from outside organizations with a financial interest in payment rates can generate better data but bias valuations (Chan and Dickstein 2019). The agency has also not addressed changes such as growth in vertical consolidation. As such, deficiencies in the valuation process persist. ■

the main body that recommends relative values for fee schedule services to CMS (Medicare Payment Advisory Commission 2006) (see text box on the Commission's previous recommendations). And in 2011, the Commission recommended that CMS collect data on clinician work time, service volume, and practice expenses from a cohort of efficient practices and use the data to establish more accurate values for overvalued fee schedule services (Medicare Payment Advisory Commission 2011b).

Implementing our past recommendations would help to improve the data and valuation process, but the recommendations do not address some of the broader issues with the way RVUs are determined. In particular, valuations often do not fully reflect current practice

patterns or cost structures. They also largely have not accounted for changes in how medicine is organized, such as increases in the share of clinicians who are vertically consolidated with a hospital and how that affects their costs.

In this section, we present three examples of changes in payment policy and RVU valuation methodology that could address misvaluation issues:

- changing the allocation of indirect practice expenses to better reflect relative costs of facility-based clinicians;
- updating the allocation of RVU shares, which is currently based on 2006 MEI data, by using more up-to-date MEI data; and

- addressing relative values of global surgical codes, for which there is substantial evidence of overpayment.

The three policies discussed in this section are not an exhaustive list of ways that RVU valuation could be improved. There are numerous other issues with the way services are valued, and there is no one-size-fits-all solution. The Commission's goal is to use the examples described in this section to illustrate different approaches to improving the valuation of services and urge policymakers to address those issues in tandem with reforming fee schedule updates.

Changing indirect practice expenses to better reflect costs of facility-based clinicians

The physician fee schedule has two types of payment rates for clinician services: nonfacility and facility. When a service is furnished in a nonfacility setting, such as a freestanding office, the fee schedule payment includes payment for work, both direct and indirect PE, and MP. With the exception of global surgical codes, when a fee schedule service is performed in a facility setting, such as a hospital outpatient department or ambulatory surgical center, the PE portion of fee schedule RVUs is reduced so that it includes payment for work, indirect practice expenses (e.g., rent, utilities, and administrative staff), and MP, but it does not usually include payment for direct practice expenses (e.g., equipment and supplies).^{16,17} Medicare fees paid directly to the facility where the service was performed (e.g., OPPS payments) cover both the direct PE and the facility's indirect PE costs for each service.¹⁸ This arrangement assumes that facilities should be compensated for all of their costs (both direct and indirect) and that clinicians should be compensated for the indirect PE expenses of maintaining an independent, freestanding office outside of the facility.

Using an example of a widely used service (30- to 39-minute E&M office visit), Figure 1-3 shows which costs are included in payments made under the physician fee schedule (nonfacility and facility) and OPPS. As shown in the bar on the left side of the figure, when a service is furnished in a nonfacility setting, PFS payment includes payment for work, malpractice insurance, and both indirect and direct PE. As shown in the bar on the right side, when a service is furnished in a facility, PFS payments include work, malpractice

insurance, and indirect PE (but not direct PE), while the OPPS payment is for a combination of direct and indirect costs. In cases when clinicians practice exclusively or almost exclusively in a facility, or where a facility is financing indirect PE for clinicians, payment to both entities for indirect PE costs may be duplicative and unnecessary.

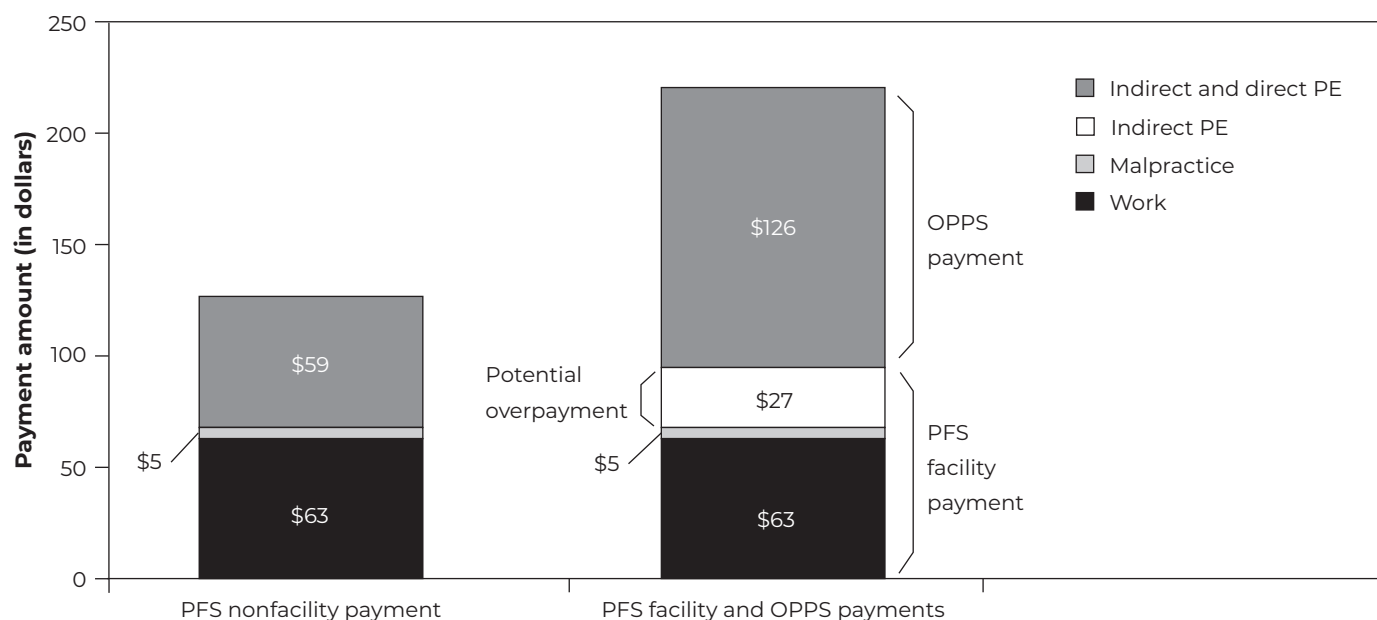
This approach to paying for services furnished in a facility is based on two key assumptions: (1) the facilities, not clinicians, are paying for direct costs incurred during the service (such as medical equipment), as well as indirect costs (such as maintaining the building and other operating expenses), so facilities should be compensated for both types of PE; and (2) even though some clinicians furnish most or even all of their services in a facility, they also need to be compensated for overhead costs related to maintaining a freestanding office.

When the RVU system was developed in the late 1980s, paying indirect PE for clinician services furnished in a facility was more empirically sound because fewer clinicians practiced exclusively in a hospital (or other facility), and few were financially affiliated with hospitals. Two trends have emerged that indicate that the relationship between clinicians and facilities has changed since then. First is the growth in the number of facility-based clinicians who practice exclusively, or almost exclusively, in a facility setting. This trend can be seen in the increasing number of hospitalists who follow patients admitted to a hospital rather than clinicians who split time between seeing patients in an office and facility. The second trend is a steady increase in the portion of physicians who are employed by a hospital or work in a practice that is owned by a hospital.

One way to gauge whether clinicians maintain independent offices is to use CMS claims data to measure what percentage of each clinician's total services was furnished in a facility. Table 1-1 (p. 30) shows the percentage of clinicians from different specialties that furnish 90 percent or more of their services in a facility setting. The table lists nine specialties in which at least 60 percent of the clinicians who billed Medicare furnished 90 percent or more of their services in facility settings. These findings suggest that some specialists are practicing exclusively, or almost exclusively, in facility settings and may not

**FIGURE
1-3**

Payments under the physician fee schedule and outpatient prospective payment system for an E&M office visit in 2024



Note: E&M (evaluation and management), PFS (physician fee schedule), OPPS (outpatient prospective payment system), PE (practice expense). The terms "facility" and "nonfacility" refer to the setting in which a service is performed. Examples of facility settings include hospital outpatient departments, hospital inpatient departments, and ambulatory surgical centers. Examples of nonfacility settings include clinician offices, retail health clinics, and urgent care centers. Figure based on 2024 payment rates for Healthcare Common Procedure Coding System code 99214 (30- to 39-minute evaluation and management visit for an established patient) and ambulatory payment classification 5012.

Source: National Physician Fee Schedule Relative Value File; Addendum A: OPPS APCs for calendar year 2024.

maintain an independent office. While these data can provide a sense of the prevalence of the share of clinicians who are practicing predominantly in a facility, it is important to note that many facility-based clinicians may have separate offices where administrative costs are not financed by the facility. In other cases, facility-based clinicians may not maintain a separate office, but administrative expenses like billing and scheduling are not financed by the facility.

In addition, studies have found that a growing number of clinicians have a financial affiliation with hospitals (Burgette et al. 2021, Nikpay et al. 2018, Wachter and Goldman 2016). Affiliation arrangements can vary, but according to a survey administered by the AMA, a growing percentage of physicians are in practices that

have some form of hospital ownership or are employed by a hospital, while the percentage of physicians in practices that are independent of a hospital has been shrinking (Kane 2023). Table 1-2 (p. 30) summarizes the results of this survey over the 2012 to 2022 period.

While the AMA's survey broadly indicates that a growing portion of physicians have a financial affiliation with a hospital, there is not a definitive data source that shows whether a given clinician is financially affiliated. Researchers have used various methods for determining financial affiliation, including a recent study that measured vertical integration between physicians and hospitals using a combination of data sources, including CMS records, survey responses, and Internal Revenue Service data (Luo et al. 2024).

**TABLE
1-1****Share of clinicians who furnish a majority of their services in facility settings, by selected specialties, 2023**

Clinician specialty	Clinicians furnishing 90 percent or more of services in facility settings
Hospitalist	95.3%
Emergency medicine	91.2
Critical care (interventionalist)	84.6
Hospice and palliative care	81.2
Pathology	70.6
Hematology	67.2
Infectious disease	65.5
Interventional radiology	65.2
Radiation oncology	63.8

Note: Clinician specialties include those in which at least 60 percent of clinicians furnished 90 percent or more of their services in a facility setting.

Source: MedPAC summary of Actuarial Research Corporation analysis of 2023 Medicare claims data.

How practice expense RVUs are calculated

In 2023, approximately 46 percent of total fee schedule payments were for the PE component (physician work accounted for roughly 50 percent and malpractice insurance about 4 percent) (Figure 1-4). PE RVUs are designed to reflect two different types of practice

expenses: direct and indirect. Direct practice expenses include three types of input costs: nonpractitioner clinical labor (e.g., nursing staff), medical supplies, and medical equipment. Indirect practice expenses include administrative costs, rent, office supplies, and information technology. In 2023, indirect PE accounted

**TABLE
1-2****A growing share of physician practices have a financial affiliation with a hospital**

Practice ownership structure	Percentage of physicians	
	2012	2022
Wholly owned by physicians (private practice)	60.1%	46.7%
Direct hospital employee/contractor	5.6	9.6
At least some hospital ownership	23.4	31.2
Wholly owned by hospital	14.7	20.1
Jointly owned by physicians and hospital	6.0	6.7
Unknown, either wholly or partly owned	2.6	4.5
Wholly owned by nonprofit foundation	6.5	5.2
Private equity	N/A	4.5
Other	4.4	2.6

Note: N/A (not available). Other arrangements include managed care organizations. Components may not sum to totals due to rounding.

Source: Kane 2023.

for about \$31 billion in total fee schedule payments (just over one-third of total payments), and direct PE represented about \$11 billion.

The current PE cost-allocation methodology is complex and rests on a number of assumptions about how costs are allocated and the relationship between work and PE costs. Figure 1-5 (p. 32) walks through the process used to calculate PE RVUs.

The first step in the process for calculating PE RVUs is to set the overall pools for PE RVUs and MP RVUs. A given year's total PE pool is calculated as the product of that year's total work RVU pool and the ratio of the previous year's total PE RVUs to total work RVUs. In practice, this process results in pools of work, PE, and MP RVUs that generally align with the cost-share ratios indicated by the MEI.¹⁹

Next, the total PE pool is divided into two parts: direct costs (e.g., equipment, supplies, and nonphysician clinical labor) and indirect costs (e.g., administrative overhead). This split is based on the weighted sum of specialty-specific direct and indirect costs per hour. Because the shares of direct and indirect costs within the overall pool of PE RVUs are fixed, any changes to either direct or indirect costs become a zero-sum game within that component of PE. In other words, if the indirect PE allocation increases for certain services, indirect PE for other services will decrease so that total indirect PE RVUs across all services do not change. Similarly, a change to service-level direct costs would lead to reallocation of direct PE RVUs for all services.

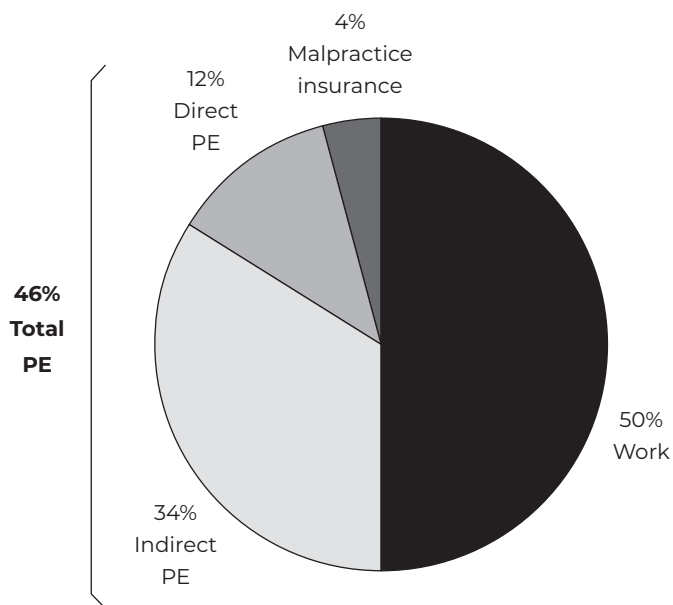
Service-level PE RVUs are then assigned. Direct PE RVUs are allocated to reflect variation in costs for each service using sample data to estimate expenses for equipment, medical supplies, and nonphysician clinical labor.²⁰ Since by definition indirect costs cannot be measured at the service level, the indirect PE pool is allocated according to a formula that takes into account each service's direct PE RVUs and work RVUs (or clinical labor when there is no physician work component), adjusted for specialty-level differences in reported indirect costs.

Policy approaches for reducing PE for certain services when furnished in a facility

Growth in the portion of clinicians who are facility based or in financial affiliation between clinicians and

FIGURE 1-4

Distribution of physician fee schedule spending, by type of RVU, 2023



Note: RVU (relative value unit), PE (practice expense).

Source: MedPAC summary of Actuarial Research Corporation analysis of 2023 Medicare claims and payment data. Percentages in the figure reflect the actual distribution of RVUs in 2023 and do not match cost shares from 2006 MEI due to year-to-year changes in service volume and other factors.

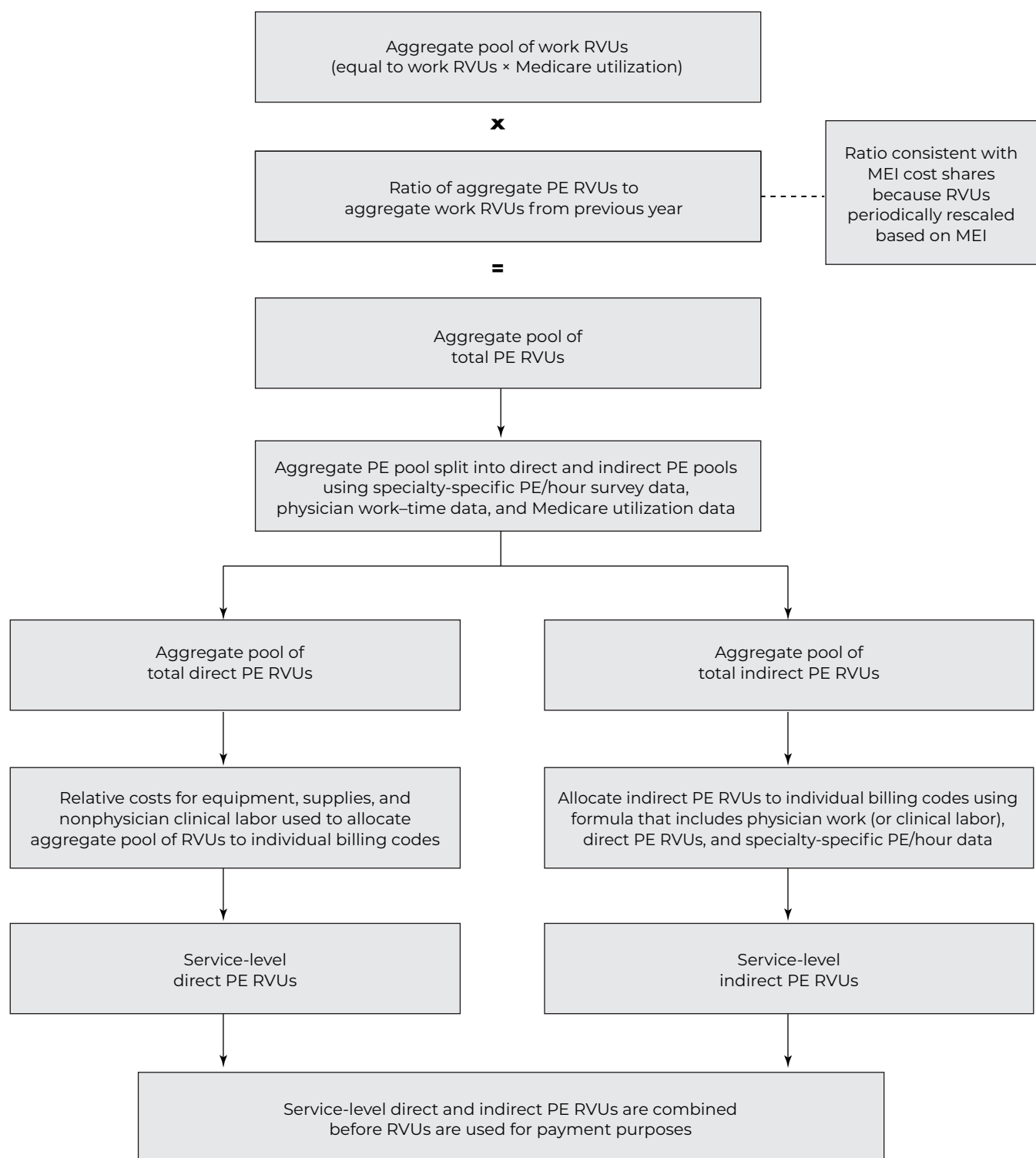
hospitals suggests that assumptions that all physicians are maintaining an independent office may no longer be valid. For clinicians who furnish most of their services in a facility or are in practices owned by a hospital, Medicare is paying the clinician for indirect practice expenses that may not exist or are being paid as part of the program's facility payment.

When the PFS makes indirect PE payments for services delivered in a facility and performed by clinicians who are not maintaining or financing a separate office, there are several implications:

- For facility-based clinicians who do not maintain a separate office, these payments can result in payment of overhead costs for an office that does not exist.

**FIGURE
1–5**

How practice expense RVUs are valued



Note: RVU (relative value unit), PE (practice expense), MEI (Medicare Economic Index).

Source: MedPAC summary of PE valuation process.

- For clinicians who are employed by a facility or work for a practice that is owned by a facility, the fee schedule's approach can result in payment for the same indirect costs (i.e., administrative overhead) twice—through both the PFS and the hospital OPPS.
- Because indirect PE RVUs are allocated according to a fixed pool of total PE RVUs, overpaying for indirect costs for some services furnished in a facility effectively reduces PE RVUs for other services, including all services furnished in an office.

Ideally, policies to reduce or eliminate fee schedule indirect PE RVUs for facility services should be targeted toward clinicians who do not pay indirect PE costs because they do not maintain or finance a separate practice. There are several approaches that could be used to identify circumstances in which indirect PE RVUs should be reduced or eliminated to address the potential overpayment. Medicare claims data could be used to determine whether a given clinician primarily practices in a facility or a service is furnished primarily in a facility, or a combination of both. Appendix 1-A (p. 42) presents simulated changes in RVUs and total spending using four claims-based approaches to identify circumstances in which indirect PE could be reduced. Alternatively, data about facility employment status and the financial relationship between clinicians and facilities could be used, although these data are not currently available for every clinician who bills the fee schedule.

Because of the zero-sum nature of allocating PE RVUs, addressing inaccuracies resulting from the current valuation rules would result in a redistribution of payments across the fee schedule and differential impacts across clinicians. The impact of each scenario depends on where individual clinicians furnish services and what kinds of services they deliver. In general, in the policy scenarios presented in the appendix to this chapter, clinicians who perform services in facilities (where current payment rules likely result in some overpayment of indirect PE) would see revenue declines. In contrast, revenue would increase for clinicians who perform services in nonfacility settings. For services commonly furnished in both settings, increased nonfacility payments could encourage clinicians to furnish more

services in a nonfacility setting and fewer in facilities. Reducing facility payments and increasing nonfacility payments could also reduce financial incentives for vertical consolidation between independent clinician practices and hospitals. The implications are less clear for reducing indirect PE for individual services that are furnished predominantly in facilities (e.g., emergency department services or major surgical procedures). The policy could encourage practices that are independent but provide services primarily in hospitals to financially integrate with a hospital. For these types of clinicians, the incentives would depend on the specifics of the policy.

Both rescaling RVUs based on updated MEI data (discussed in the next section) and changing indirect practice expenses to better reflect costs of facility-based or hospital-affiliated clinicians could have substantial impacts on the distribution of fee schedule payments. Depending on the mix and location of services that clinicians furnish, the combined effect of these policies could result in even larger changes than either policy in isolation. If both these policies were implemented, policymakers would need to be cognizant of the combined effects and would likely need to implement policies to limit the short-term impacts, such as transitioning to these policies over a period of multiple years. Using the updated MEI shares would be consistent with CMS's past practices and help keep the data underlying the fee schedule more up-to-date, while modifying the way that indirect costs are allocated represents an innovation in the PE methodology.

Overlap with site-neutral payment policies

The Commission has recommended reducing or eliminating the difference in total Medicare payments for certain services that can be performed in multiple settings (Medicare Payment Advisory Commission 2023a). This site-neutral approach is intended to reduce financial incentives to provide clinician services in facilities if they can be safely provided in an office. Since the total Medicare payments (including facility PFS and OPPS payments) for services furnished in a facility are generally larger than nonfacility PFS payments, the larger payments provide an incentive to furnish services in a facility. The OPPS payment for services subject to site-neutral adjustments would be reduced so that total Medicare payments are the same for the two settings. Effectively, this approach pays

the clinician for work, indirect PE, and malpractice costs and pays the hospital for the portion of practice expenses that are not included in the fee schedule's payment.

By reducing OPPS payments in this way, the site-neutral approach would accomplish some of the same goals as reducing or eliminating indirect PE RVUs for some clinician services furnished in a facility. To the extent that changes to indirect PE were implemented concurrently with site-neutral payments, total payments (PFS plus OPPS) would continue to be aligned across settings. However, the site-neutral policies that the Commission recommended in 2023 (and site-neutral proposals by others) would apply to only a portion of services that take place in a facility, whereas the clinician PE policy contemplated in this chapter could apply to a broader array of services. In addition, reducing indirect PE RVUs for some facility-based services would result in those RVUs being redistributed to other fee schedule services, thus increasing payment rates for other services.

The interaction between site-neutral and indirect PE policies would have important redistributive implications, but the presence of a site-neutral policy does not negate the justification for reductions in facility PE RVUs or vice versa. Thus, reducing PE RVUs for some facility-based services is consistent with the Commission's site-neutral policy and should be viewed as a complement to that policy rather than a replacement.

Updating the distribution of RVUs based on more up-to-date MEI data

In aggregate, total RVUs for work, PE, and MP are supposed to reflect the average distribution of these costs across clinician practices. The basis of this distribution has historically been the MEI. In other words, if the MEI indicates that clinician work accounts for half of the costs of running a typical clinician practice, then half of total RVUs should be associated with clinician work. Likewise, the share of total RVUs that are for PE and MP are guided by the distribution of costs indicated by the MEI.

CMS periodically rebases the MEI, which entails updating the base-year data used to establish the distribution of costs associated with furnishing clinician services. For example, CMS rebased the MEI in 1998 (moving the base year from 1992 to 1996), 2004

(moving the base year from 1996 to 2000), and 2011 (moving the base year from 2000 to 2006). In 2022, CMS again rebased the MEI (moving the base year from 2006 to 2017).

Traditionally, when CMS rebases the MEI, the agency rescales RVUs to match the distribution of expenses under the MEI. But in 2022, CMS revised and rebased the MEI using 2017 data but did not rescale the RVUs under the fee schedule. The agency delayed rescaling in light of the AMA's efforts to collect more up-to-date data on the costs associated with running a clinician practice and to promote stability and predictability within the fee schedule when data sources are updated (Centers for Medicare & Medicaid Services 2023, Centers for Medicare & Medicaid Services 2022). In the meantime, the distribution of RVUs under the fee schedule remains based on data reflecting physicians' practice costs in 2006.

In early 2025, the AMA conveyed a summary of the results of its most recent Physician Practice Information (PPI) survey to CMS and subsequently released the data publicly (American Medical Association 2024b). The PPI survey gathers information from physician practices and does not include data on certain other clinicians who bill the PFS.²¹ The most recent survey collected data for fiscal years ending on or after June 30, 2022, which means that practices could report data on fiscal years ending in 2022 or 2023 (Grau et al. 2024). The extent to which CMS will use these data to rebase the MEI or rescale RVUs under the fee schedule was unclear at the time this chapter was drafted, but such changes in the past have involved notice-and-comment rulemaking.

Over time, the shares of costs associated with work, PE, and MP have changed according to different iterations of the MEI and newly released AMA data. According to the MEI data, the share of costs associated with work declined from 1996 to 2017, falling from 54.5 percent to 47.5 percent (Table 1-3). However, the newly released AMA data suggest that the share of costs associated with work in 2022/2023 was 60.8 percent. Because PE accounts for most of the remaining costs, the trends for PE followed the opposite pattern—increasing from 42.4 percent to 51.1 percent in the MEI cost-share data from 1996 to 2017 and then declining to 37.0 percent according to the newly released AMA data. MP costs represent a small overall share of costs, and multiple data sources

**TABLE
1-3**

Estimated share of costs associated with work, practice expenses, and malpractice insurance, 1996–2023

Type of cost	Year of cost data				
	1996	2000	2006*	2017	2022/2023**
Work	54.5%	52.5%	50.9%	47.5%	60.8%
Practice expenses	42.4	43.7	44.8	51.1	37.0
Malpractice insurance	3.2	3.9	4.3	1.3	2.3

Note: Figures may not sum to 100 percent due to rounding. Cost shares for 1996 and 2000 were based on the American Medical Association's Socioeconomic Monitoring System Survey; cost shares for 2006 and 2022/2023 were based on the American Medical Association's Physician Practice Information Survey; cost shares for 2017 were based predominately on data from the U.S. Census Bureau's Services Annual Survey.

* The distribution of relative value units under the physician fee schedule is currently based on these data.

** These data are from the American Medical Association's recent Physician Practice Information survey and have not been incorporated into the Medicare Economic Index. These figures exclude expenses from certain practices consisting of clinicians who are not physicians, such as physical therapists. Data for such clinicians were collected in a separate survey, the Clinician Practice Information survey.

Source: MedPAC analysis of CMS regulations and American Medical Association data.

indicate that they have declined substantially as a share of overall costs since 2006 (Table 1-3).

The current distribution of RVUs under the fee schedule is based on cost-share data that are nearly two decades old. If RVUs were rescaled using more up-to-date data, the aggregate distribution of RVUs could change substantially. However, given that newer sources of data have found conflicting results, it is not clear how the distribution would change. Given the impact that rescaling RVUs can have on relative payment rates for fee schedule services, we provide an overview of the process CMS has used to rescale RVUs when new MEI data are incorporated. We then analyze the likely high-level impacts of such changes and discuss a few topics—the importance of incorporating more up-to-date data when establishing the distribution of RVUs, issues that may help explain the differences between the 2017-based MEI and the AMA's newly released data, and factors policymakers may want to consider when rescaling RVUs.

In the past, when rescaling RVUs under the fee schedule in response to new MEI data, CMS has:

- held the aggregate pool of work RVUs constant,
- increased or decreased the aggregate pools of PE and MP RVUs so that the distribution of RVUs matches the new MEI cost shares,

- increased or decreased the conversion factor so that any aggregate changes in the number of PE and MP RVUs is budget neutral, and
- allocated PE and MP RVUs to individual billing codes using the updated pools of RVUs.

To examine how the distribution of RVUs would have changed if CMS used the MEI cost weights from 2017 (instead of those from 2006), the Commission contracted with Actuarial Research Corporation (ARC).²² Following the process CMS has previously used to rescale RVUs, the pool of work RVUs would be unchanged, and ARC's simulation found that total PE RVUs across all settings would be about 18 percent higher, and total MP RVUs would be about 65 percent lower.²³ The reduction in MP RVUs would partly offset the increase in PE RVUs, but since the pool of PE RVUs is larger, the net change in total RVUs would be positive in aggregate. Therefore, to ensure that total fee schedule spending did not change, the increase in total RVUs would require a –5.4 percent budget-neutrality adjustment to the conversion factor.

Due to this budget-neutrality adjustment, overall spending would not change. However, on average, spending on nonfacility services would increase while spending on facility services would decrease because the increase in PE RVUs would be larger for services furnished in nonfacility settings. The difference results

from the fact that most facility PE RVUs do not include direct PE costs, so they experience smaller changes than nonfacility PE RVUs. Therefore, even though the direct and indirect pools grew by the same percentage, the service-level effects of the change in the two pools are different.

The simulation also found that the effect of using 2017 MEI cost shares would vary across types of service. For example, while total RVUs in all settings would be 5.5 percent higher for E&M office visits, they would be 12.3 percent higher for nonmajor vascular procedures; 9.1 percent higher for physical, occupational, and speech therapy; and 5.6 percent lower for major cardiovascular procedures. The variation across different services is largely a function of two factors: (1) the ratio of PE RVUs, MP RVUs, and work RVUs and (2) the ratio of facility and nonfacility services. Nonmajor vascular procedures tend to have relatively high PE RVUs, and most services are furnished in nonfacility settings, so those services would see large increases in total RVUs. Major cardiovascular procedures have relatively low PE RVUs (because these services are furnished in facility settings) and have relatively high MP RVUs, so using the updated MEI cost weights would lead to a substantial reduction in both total RVUs and payment rates. The impact on individual clinicians would depend on what services they furnish and where the services are furnished.

The AMA's newly released data were not available at the time ARC analyzed the effects of rescaling RVUs using the 2017-based MEI data. However, given our experience analyzing the effects of rescaling using the 2017-based MEI, the following high-level effects are likely if the 2022/2023 AMA data were used to rescale RVUs without any methodological changes regarding how the data would be incorporated. Compared with the 2006-based MEI, the AMA's newly released data suggest that work accounts for a higher share of the costs of running a clinician practice, with PE and MP accounting for lower shares. Because the aggregate pool of work RVUs would be held constant, we would expect the number of PE and MP RVUs to be reduced substantially to match the distribution of costs. To make those RVU reductions budget neutral, the conversion factor would then need to be increased. In contrast with the effects of rescaling RVUs to match the 2017-based MEI, we expect rescaling using the AMA's newly released data would, on average, decrease payment rates for services furnished in

nonfacility settings and increase rates for services in facility settings. We would also expect that services with relatively large PE costs, such as those requiring significant medical equipment or supplies, would experience payment-rate reductions while services with low PE costs would experience increases. A number of factors could change the ultimate clinician- and service-level impacts of incorporating the AMA's newly released data. For example, the new data on PE per hour collected in the AMA's survey could have substantial service-level effects above and beyond the effects of rescaling RVUs.

In general, the RVU system is more empirically sound if more timely data about cost shares are used to allocate RVUs, which underscores the importance of collecting up-to-date information on a regular basis. The problem with delaying the rescaling of RVUs to reflect more current data is that the costs of clinician practices have changed substantially since 2006. These changes include:

- increased vertical consolidation—including more hospital employment of clinicians (Capps et al. 2017, Nikpay et al. 2018);
- an increase in the percentage of physicians in large practices (50 or more physicians) and a decrease in the percentage of physicians in small practices (10 or fewer physicians) (Kane 2023);
- an increase in the number of NPs and PAs (AMN Healthcare 2023, Gallegos 2024);
- increases in operating costs due to increases in expenses like staff salaries and supplies (Medical Group Management Association 2023b);
- an increase in administrative costs associated with quality reporting and prior authorization (Casalino et al. 2016, Medical Group Management Association 2023a);
- technology-driven changes in costs, such as widespread adoption of electronic health record systems (Leventhal 2016); and
- changes in the medical malpractice market (Guardado 2022).

By not updating the distribution of RVUs to reflect these types of changes, Medicare could be underpaying for some services and overpaying for others.

Using up-to-date data on the distribution of costs is important for payment accuracy, but the 2017-based MEI data and the 2022/2023 AMA data suggest very different distributions of the costs of running clinician practices. Numerous timing and methodological differences likely contribute to these incongruous findings. One key underlying difference between the two data sources is how to treat PE associated with the increasing share of physicians who are employed by hospitals.

The 2017-based MEI relies on data from the U.S. Census Bureau's Services Annual Survey (supplemented by other data sources, such as the Bureau of Labor Statistics' Occupational Employment and Wage Statistics) to calculate the shares of clinician practice costs that are associated with work, PE, and MP. As part of this analysis, CMS intentionally excluded physicians who were directly employed in hospitals (and certain other facilities). CMS said that including costs for physicians who do not incur any operating expenses associated with running a practice, such as physicians who are directly employed by a hospital, would not be technically appropriate (Centers for Medicare & Medicaid Services 2022).

The AMA's newly released data come from its PPI survey. The PPI survey collected practice expense data from a sample of physician practices and practices that volunteered or were recruited to report their data.²⁴ Physicians who practiced in facilities and/or were directly employed by a hospital were included in the sample. To the extent that physicians' practice expenses were covered through other payment systems (e.g., the hospital inpatient prospective payment system, hospital outpatient prospective payment system), survey participants were instructed to exclude those expenses. Therefore, if a physician was employed by a hospital and most of their PE was financed by payments to the hospital or other facility, the expenses reported in the survey would mostly be associated with work and MP.

Therefore, the 2017-based MEI disproportionately includes situations in which the full array of the costs of running a clinician practice (including work, PE, and MP) is measured, whereas the PPI survey collected data from more practices in which some of the PE was borne by facilities.

The question of how to account for the PE of physicians who are employed by hospitals or practice predominantly in hospitals has become increasingly

important. Over time, there have been substantial increases in vertical consolidation and other changes in the practice of medicine (e.g., the shift from primary care physicians rounding on hospital inpatients to hospitalists performing those services). The underlying changes in the organization of medical practice suggest that any updates in the MEI shares used to rescale RVUs might be coupled with reforms regarding allocating practice expense RVUs to services furnished in facilities. The previous section of this chapter discusses some possible reforms concerning how indirect PE is allocated to account for facility-based services and/or clinicians (see p. 28).

At the time this chapter was written, we did not have sufficient information to judge the relative merits of updating MEI shares using the 2017-based MEI versus the newly released AMA PPI data. For example, releasing the PPI survey results by practice location (e.g., facility vs. nonfacility) and/or ownership categories could be useful since these characteristics appear to be a major factor driving the large differences from prior results and could inform changes in how these data are incorporated. Additional information on other technical matters could also be helpful in understanding the merits of using these data to revise MEI shares and in the broader PE RVU allocation process. For example, the difficulty in obtaining responses led to the PE per hour data being based on a small number of practices for some specialties, acceptance of practices that volunteered or were recruited to report their data, and physician-specialty categories being consolidated in certain circumstances (and not in others).²⁵ Low response rates are a common and increasing problem that affects many surveys and may suggest collecting data without regard to specialty or within broad specialty groups could improve the quality and feasibility of such data collection in the future, an option that other stakeholders have identified (Burgette et al. 2021).

Addressing issues with global surgical codes

Global surgical codes are single codes that are valued to include a procedure as well as pre- and postoperative visits related to the procedure when provided by the clinician who performed the procedure (or other clinicians in that practice) over a specified period of time. For the most part, global surgical codes cover care provided on the day of the surgical procedure plus

postoperative care furnished over the following 10- or 90-day period.²⁶ In 2023, these codes accounted for nearly half of the fee schedule's 9,000 billing codes, and Medicare's spending under the PFS and beneficiaries' spending amounted to about \$2.3 billion on 10-day codes and \$6.1 billion on 90-day codes (the combined amounts represent about 10 percent of total fee schedule spending). About 300 global codes account for 94 percent of spending on 10-day global codes and 72 percent of spending on 90-day global codes (Crespin et al. 2021).

Determining RVUs for global surgical codes involves making assumptions about the number and intensity of postoperative visits a patient typically receives from the rendering clinician over the 10- or 90-day period. These assumptions are informed by provider surveys administered by the RUC. Unless there is a transfer of care, any postoperative visits furnished by other providers are not included in the global codes but are paid separately on a FFS basis. In some cases, follow-up visits assumed in the global payment are simply not occurring. In other cases, a follow-up visit is furnished by a clinician not involved with the procedure, which means that Medicare is essentially paying twice for the same visit (once to the clinician who performed the procedure and once to the provider who furnished the postoperative visit). Both of these situations represent overpayments by Medicare.

Studies have found large differences between the number of postoperative visits that the fee schedule assumes clinicians will deliver after a surgical procedure and the number they actually deliver. In 2012, the Department of Health and Human Services' Office of Inspector General (OIG) sampled 300 global surgical codes and found that for 165 of those codes, the relative values used by Medicare included too many postoperative visits (Office of Inspector General 2012).²⁷ More recently, a landmark study by RAND found that, at most, only 17 percent of the postoperative visits assumed in 10-day global surgical codes were actually provided, and only 47 percent of postoperative visits assumed in 90-day global surgical codes were provided (Crespin et al. 2021).²⁸ These findings suggest that RVUs for 10- and 90-day surgical codes are too high, and thus Medicare beneficiaries are overpaying for these services. Because RVUs are calculated on a budget-neutral basis, overpaying for one group of services reduces payment rates for all other services.

The Commission has historically expressed support for episode-based payment approaches. In 2022, it expressed support for a national episode-based payment program to complement any similar programs established by accountable care organizations (Medicare Payment Advisory Commission 2022). When implemented effectively, episode-based payments can encourage efficient use of resources and act to restrain spending during each episode. One of the most important features of effective bundled-payment programs is accurate pricing of the surgical and postsurgical costs included in the bundled payment. Global surgical codes have the potential to encourage efficient provision of postsurgical care and restrain spending, but evidence indicates that valuations of these codes are systemically too high. This misvaluation results in overpayments and undermines the effectiveness of global payments in restraining spending.

Strategies for improving the accuracy of global payments

Improving the accuracy of payment rates for global surgical codes could be done in two ways. One approach is to convert all 10- and 90-day global codes to 0-day codes. The 0-day code would include all services provided on the day of a procedure, and clinicians would bill separately for each postoperative visit. The second approach is to retain the global codes but base payment rates on more accurate data about the number of visits that are actually provided by rendering clinicians during the postoperative period. Implementing either approach would represent a substantial improvement from the current situation of assuming that too many postoperative visits take place.

Implementing either of these options would address current payment inaccuracies by reducing payment for global services. Without legislation directing otherwise, these reductions would be redistributed to other fee schedule services to maintain budget neutrality, which would result in payment increases for all services other than global surgical services.

Convert 10- and 90-day global codes to 0-day codes

Under this approach, CMS would stop paying for postoperative visits that do not occur by replacing 10- and 90-day global surgical codes with 0-day

global codes—meaning the clinician who performed a surgical procedure would receive a lump-sum payment for all services provided on the day of a procedure (including pre- and postoperative visits provided that day) but all pre- and postoperative visits provided on other days would be billed on a FFS basis (Medicare Payment Advisory Commission 2014).

In the agency's 2015 proposed rule, CMS proposed converting all 10-day global surgical codes to 0-day global codes in 2017 and all 90-day global surgical codes to 0-day global codes in 2018 (Centers for Medicare & Medicaid Services 2014). The RUC expressed concerns about this change, arguing that changing 4,200 codes would take more time than CMS envisioned and that backing out postoperative visits from code values (which CMS had proposed doing) would yield “inappropriate” work RVUs for some procedures, with nearly half of minor and major surgical procedures having work RVUs that reflect a low intensity (American Medical Association 2015). The RUC and AMA also pointed out that converting global surgical codes to 0-day codes could result in an increase in postoperative E&M visits being billed under the fee schedule. Given these concerns, CMS could instead ask the RUC to propose new values for 0-day global codes. Given the large number of 10- and 90-day global codes to be revalued, the RUC could revalue codes in tranches—for example, prioritizing those 10- and 90-day codes that generate the largest amount of spending and/or are billed most frequently (Medicare Payment Advisory Commission 2024a).

Another concern raised by stakeholders is that while converting all global codes to 0-day codes would decrease beneficiary cost-sharing liability for the procedure itself, beneficiaries would face cost-sharing liability for each follow-up visit (to the extent that they occur). Currently, beneficiaries pay a single cost-sharing bill covering all of the care that is expected to be provided by the clinician who furnishes their procedure during a global period, so beneficiaries cannot currently lower their cost-sharing liability by skipping a postoperative visit offered by that clinician.

These risks are likely outweighed by the benefits of converting 10- and 90-day global surgical codes to 0-day codes. An advantage of this policy for beneficiaries is that, on net, their cost-sharing liability

would decrease in most cases because they would pay for fewer postoperative visits than they are currently billed for under 10-day and 90-day global surgical codes. Clinicians other than proceduralists would also benefit from this policy since payment rates for other services would increase to offset the decrease in payments for global surgical codes. Further, Medicare would stop overpaying clinicians who provide fewer postoperative visits than are assumed in surgical global codes and stop underpaying clinicians who provide more of such visits. Medicare would also stop double-paying for postoperative visits in instances when the clinician who performed a procedure is paid for postoperative visits through the global surgical code but another clinician (e.g., a primary care provider) is also paid for postoperative care through separately paid E&M office visits.

Ultimately, a provision in MACRA prevented CMS from converting 10- and 90-day global surgical codes to 0-day global codes. This MACRA provision also directed the agency to collect data on the actual number of visits furnished during global periods (no later than 2017) and to use these data to appropriately value surgical services (in 2019). In accordance with this MACRA provision, CMS collected no-pay claims data starting in 2017 from practices in nine states, documenting the provision of postoperative visits after selected procedures. The agency released findings from analyses of these data but did not revalue these codes; instead, it asked the public for input on the optimal way to use the findings about postoperative visits to revalue global surgical codes (Crespin et al. 2021). After reviewing the comments it received, CMS announced that it anticipated continuing to assess and develop an approach to revalue global surgical codes (Centers for Medicare & Medicaid Services 2019).²⁹

Revalue global codes Another option for improving the accuracy of 10- and 90-day global surgical codes is to retain the current episode durations of global surgical codes but revalue the codes' RVUs to reflect the actual average number of postoperative visits provided.

RAND explored revaluing global surgical codes by comparing the number of postoperative visits reported on the claims with the expected number of visits used for valuation (Mulcahy et al. 2021). Their study found that revaluing global codes by removing work RVUs,

physician time, and direct PE inputs for visits that were assumed but not provided would reduce total RVUs for global surgical codes by 28.5 percent. RAND estimated that the net reduction across all RVUs would be 2.6 percent, which would have the effect of increasing payment rates for other codes to maintain budget neutrality. When including the budget-neutrality adjustment, RAND estimated total Medicare payments for certain surgical specialties would decline by up to 18 percent, while payments to specialties such as primary care would increase by just under 3 percent.

Recommendation

An important goal of the fee schedule is to ensure that relative values for clinician services approximate the relative costs of the efficient provision of care. Misvaluations create inappropriate incentives for care delivery and vertical consolidation between clinicians and hospitals.

Taking steps to ensure that RVUs are as accurate as possible is a desirable policy on its own merits, but it is even more important when coupled with a policy to increase conversion-factor updates. Over time, compounded across-the-board increases in payment rates can magnify the clinical and market distortions that misvalued codes can create.

RECOMMENDATION 1-2

The Congress should direct the Secretary to improve the accuracy of Medicare's relative payment rates for clinician services by collecting and using timely data that reflect the costs of delivering care.

RATIONALE 1-2

The fee schedule's RVUs determine how payments are distributed among services and places of service. However, there are flaws in the way RVUs are calculated that likely lead to overpayment for some services and underpayment for others. The misvaluation of RVUs thus can have undesirable effects on the distribution of program spending, beneficiary cost sharing, and clinicians' decisions about how and where to practice medicine. RVU misvaluation may also create incentives for vertical consolidation between hospitals and clinicians. At the same time, other payers (including Medicaid) often base payments on fee schedule RVUs, so

misvaluations can affect other parts of the health care system.

The fee schedule's RVUs are misvalued in several ways. For example, with the growth in facility-based clinicians and vertical consolidation, some practice expenses may no longer exist (e.g., freestanding offices), and facilities are increasingly paying for indirect practice expenses that used to be financed by clinicians. Since Medicare pays both clinicians and facilities for indirect practice expenses—most frequently through both the physician fee schedule and the hospital OPPS—in circumstances where clinicians do not maintain or finance a separate office, Medicare may be overpaying for these costs.

Also contributing to misvaluation is the use of data from 2006 to allocate total RVUs across work, practice expenses, and malpractice expenses. Using more up-to-date data would help ensure RVUs more accurately reflect how costs are distributed between the three RVU categories, although there are questions about the source of these data and how to account for the growth of hospital-based clinicians.

Another example of misvaluation relates to global surgical codes. Substantial evidence indicates that, in aggregate, billing clinicians do not furnish as much postoperative care as is assumed by the RVUs for global surgical codes, meaning that in many cases, Medicare is paying for visits that are not occurring.

All three examples raise important issues about valuation, but there are numerous other concerns about potentially misvalued services. Because overvalued services benefit more from higher across-the-board updates, larger fee schedule updates magnify the effects of misvalued services. Therefore, any increase in updates should be coupled with improvements to the accuracy of relative values to help ensure that taxpayer and beneficiary funds are used judiciously.

Given the complex nature of the relative value system, the Commission's recommendation is broad, urging policymakers to consider a wide range of problems with valuation and recognizing that flexibility will be needed when pursuing improvements. In addressing those problems, policymakers should direct the Secretary to develop data-driven policies that fully

and accurately reflect practice costs, changes in practice patterns, financial relationships between clinicians and hospitals, and other reasons that relative values may be misvalued.

IMPLICATIONS 1-2

Spending

- No effect on total program spending is expected due to the required budget-neutral implementation.

Beneficiary and provider

- This recommendation could benefit beneficiaries by reducing incentives for clinicians to overprovide or underprovide certain services. It could have redistributive effects on payments to providers. ■

1-A

APPENDIX

Simulations of illustrative options to redistribute relative value units for indirect practice expenses

To get a sense of the impact of reducing or eliminating indirect practice expense (PE) in certain circumstances, the Commission contracted with Actuarial Research Corporation (ARC) to conduct several simulations. Each simulation is based on different approaches to identifying clinicians or services for which indirect PE for facility services could be reduced or eliminated. It is important to emphasize that the identification approaches presented below are meant to be illustrative and provide a measure of how relative value units (RVUs) and fee schedule spending could be affected if a given policy were adopted. None of the approaches presented here should be viewed as a Commission recommendation or endorsement.

Three of the approaches described below would require creating a second type of facility RVU in which indirect PE would be reduced or eliminated for clinicians or services that meet specified criteria. Another approach would be to change the way facility PE RVUs are calculated so that the valuation of facility services better reflects the practice expenses that clinicians actually pay.

While all four approaches described below have their drawbacks, there are also drawbacks to maintaining the status quo. To the degree that the fee schedule is relatively overpaying for indirect PE, fee schedule spending is maldistributed toward facility-based clinicians and away from all other clinicians. Because the total pool of PE RVUs is constant, reducing or eliminating indirect PE RVUs for facility-based clinicians would have the effect of increasing PE RVUs for clinicians who do not practice at facilities. At a high level, the combination of decreasing PE RVUs for facility-based clinicians and increasing RVUs for all other clinicians could reduce the financial incentives for clinicians and facilities to vertically consolidate.

- **Reduce or eliminate indirect PE RVUs for services furnished by facility-based clinicians.** This approach would reduce physician fee schedule (PFS) indirect facility PE payments for services provided by clinicians who furnish most or all of their services in a facility. This approach would be based on the presumption that facility-based clinicians do not need to maintain separate offices and that fees paid to the facility would cover overhead costs for these clinicians. Medicare claims could be used to identify facility-based

clinicians. For instance, indirect PE could be reduced for clinicians who furnish a specified portion of their services (e.g., at least 90 percent) in a facility setting.

Using claims data to identify facility-based clinicians would be relatively straightforward, but there are some potential drawbacks to this approach. For instance, the determination of which clinicians are considered facility based is likely to be sensitive to the threshold used to make that determination. For some specialties, using a threshold of 90 percent of facility services could result in many more clinicians being considered facility based than if a threshold of 100 percent were used. In addition, many clinicians who predominantly work in a facility are not actually employed by a facility and incur some indirect PE costs, which would no longer be paid by the fee schedule. In these circumstances, completely eliminating indirect PE could make it difficult for clinicians who are not employed by a facility to maintain an independent office and could incentivize them to consolidate with facilities. One way to address this concern would be to reduce, but not eliminate, indirect PE so that facility-based clinicians who have independent offices would still receive some payment for indirect PE under the fee schedule.

- **Reduce indirect PE RVUs for services that are predominantly performed in a facility setting.** Instead of reducing indirect PE for clinicians who primarily practice in a facility, this approach would target indirect PE reductions at services that are primarily performed in a facility. For instance, a service that is performed more than 90 percent of the time in a facility such as a hospital could have its indirect PE RVU reduced or eliminated. This approach would focus PE reductions on facility-based services, such as emergency department services. Unreduced indirect PE payments would be made for office-based services, such as most outpatient evaluation and management (E&M) visits, even if many of those services are furnished in a facility. This approach could be combined with the facility-based clinician approach discussed above so that reductions in indirect PE would affect only services that are primarily performed in a facility when furnished by clinicians who primarily practice in the facility (i.e., indirect PE would be reduced for services that are performed more than 90 percent of the time in a facility when provided

by clinicians who perform more than 90 percent of their services in a facility).

A service-based approach to reducing indirect PE suffers from some of the same drawbacks as the clinician-based approach. Identifying facility-based services would be sensitive to the thresholds used to make that determination. Reducing or eliminating facility indirect PE payments for certain services assumes that all clinicians who perform those services (regardless of their affiliation with the facility) do not need the indirect PE payments. A service-based approach is also bound to exclude services furnished by some facility-based clinicians, resulting in potential overpayment of indirect PE when billed by those clinicians. A hybrid approach (based on information about both clinicians and services) may be more accurate than either approach on its own, but it would still be subject to judgment calls about what thresholds should be used and payment cliffs between clinicians who are subject to the payment reduction and all other clinicians.

- **Reduce or eliminate indirect PE RVUs for facility services furnished by clinicians who are financially affiliated with a hospital.** Concerns have been raised that for some services performed in a facility, Medicare may be paying for the same indirect practice costs to both the clinician and the facility. Given the growth in hospital-employed clinicians and hospital-owned physician practices, this concern is primarily raised about services furnished in hospital outpatient departments. A policy that would reduce or eliminate indirect PE for clinicians who are financially affiliated with a hospital is based on the premise that hospitals receive payments for indirect practice expenses through the outpatient prospective payment system and the hospital is likely paying overhead costs for employed clinicians, as well as clinicians who are part of hospital-owned practices. (PE payments would not be reduced for services furnished in nonfacility settings even if a clinician is financially affiliated with a hospital because the hospital does not receive any indirect PE payments for those services.)

A drawback of this approach is that it is difficult to identify which clinicians are affiliated with

a hospital. The financial relationship between clinicians and hospitals is not always obvious, and CMS does not currently collect comprehensive data on these relationships. To address this difficulty, new data could be collected about the financial relationships between clinicians and facilities. Alternatively, clinicians who are affiliated with a hospital could indicate the relationship on claims, just as they indicate whether a service has been furnished in a facility or not. Under either approach, it would be important to clearly and accurately define who is considered a hospital-affiliated clinician. In addition, the financial relationships between hospitals and hospital-owned practices vary significantly, so the hospital may not finance indirect PE for hospital-affiliated clinicians in all cases.

- **Change the way practice expense is calculated.** Without new data collection, claims-based approaches to identifying facility-based services and facility-based clinicians would be imprecise and lead to false positives and false negatives. An alternative way of addressing concerns about overpayment of indirect PE would be to change the way PE RVUs are calculated. Under the current methodology, the indirect PE for each service is calculated using a weighted average of per hour costs among the specialties that typically perform that service. The per hour cost data that are currently used to calculate RVUs are from survey data that are almost 20 years old and do not reflect how PE costs have changed because of the increased number of clinicians who practice primarily in a facility (in some cases because they are financially affiliated with a hospital).

RAND has explored numerous alternatives to the current PE RVU allocation methodology, including updating the practice survey data (or collecting alternative data) to account for differences in costs across various practice characteristics such as those with facility- and nonfacility-based clinicians (Burgette et al. 2020). Alternatively, RAND has suggested removing specialty-specific cost measures as part of the PE valuation process and focusing instead on characteristics of the services themselves. For example, if a particular specialty's indirect PE is higher than average due to the costs associated with housing a

large piece of medical equipment, such costs could be tied directly to the utilization of the equipment rather than being accounted for, indirectly, at the specialty level (Burgette et al. 2021). Some have also argued that the PE allocation methodology could account for differences in practice size because there is evidence that larger practices may be able to reduce the marginal cost of certain expenses (e.g., electronic health records systems) through economies of scale (Burgette et al. 2018). Relatedly, the trend toward larger practices and increasing numbers of nurse practitioners (NPs) and physician assistants (PAs) may result in changes in indirect PE due to more efficient use of office space. Some clinicians in larger practices who perform procedures in a facility, such as surgeons, may share clinical space with other clinicians (e.g., NPs and PAs) who see patients in that space while the surgeons are furnishing services in a facility rather than leaving the space unused.

Impact of eliminating indirect PE RVUs using claims-based approaches

Policies to reduce or eliminate indirect PE RVUs for certain services would affect how total RVUs (and therefore Medicare spending) are distributed. Because total indirect PE RVUs are allocated from a fixed pool of total indirect PE RVUs, reductions in indirect PE RVUs for some services would result in a redistribution of PE RVUs among the entire indirect PE pool. Since the policies discussed in this section are designed to reduce indirect PE RVUs for certain services performed in a facility, nonfacility RVUs would tend to increase, as would PE RVUs for facility services that are not subject to reductions in indirect PE.

To gauge the effect that these types of changes would have, we simulated the impact on PFS RVUs and spending under three claims-based approaches for identifying services and clinicians for which indirect PE could be eliminated for facility services.³⁰ Under these policies, a third place of service would be created in the fee schedule (in addition to nonfacility and facility), which would be facility payments that do not include payment for indirect PE. Our policy simulations would eliminate indirect PE RVUs when a given service is performed in a facility and (1) the service is furnished in a facility 90 percent or more of the time, (2) the service is provided by a clinician who is furnishing 90 percent

or more of all their services in a facility, or (3) the service meets the criteria for both simulations 1 and 2 (i.e., the service is provided by a clinician who furnishes at least 90 percent of their services in a facility and is furnished at least 90 percent of the time in a facility).

These simulations show that, even when limited to a narrow set of services and clinicians, a substantial amount of fee schedule spending for indirect PE is mistargeted. In the first simulation, we found that fee schedule spending for services that met our inclusion criteria totaled \$19.8 billion in 2024. About \$14.3 billion and \$10.5 billion met our inclusion criteria in our second and third simulations, respectively. Of those totals (which include payments for work, PE, and malpractice (MP)), about \$4.5 billion, \$3.4 billion, and \$2.4 billion, respectively, was associated with indirect PE and was redistributed in our simulation.

Table 1-A1 (p. 46) shows the projected effect of changes in total PFS spending for each of three scenarios by broad type of service category and the setting for those services. Among all services, aggregate spending would not change because reductions in indirect PE RVUs would be redistributed to other services to maintain the size of the existing pool of indirect PE RVUs. As a result, spending on services furnished in nonfacility settings would increase to varying degrees under every scenario. Conversely, spending on services furnished in facilities decreases under almost every scenario. Medicare spending on each service and type of service (both increases and decreases) would also vary under each scenario. For instance, under the first scenario, total spending on other procedures would increase by 1 percent: Spending on these services in the nonfacility setting would increase by 6 percent and decrease by 12 percent when furnished in a facility. The variation in spending changes would be larger among more specific groups of services. For instance, under the third scenario (providers and services both equal to or greater than 90 percent in facility), spending would increase most for pulmonary function tests (11 percent), nursing facility services (9 percent), and non-oncologic injections and infusions (7 percent). Payments would decline most for observation-care services (-14 percent), emergency department services (-12 percent), and hospital inpatient services (-10 percent) (data not shown).

**TABLE
1-A1**

Simulated impact of indirect PE RVU policy scenarios on total Medicare spending, by type of service and setting

		Percent change in total fee schedule spending			
Type of service	Setting	Services ≥90% in facility	Providers ≥90% in facility	Providers and services both ≥90% in facility	Nonfacility services, facility-based providers
All services	Both settings	0%	0%	0%	0%
All services	Nonfacility	7	4	2	1
All services	Facility	-11	-6	-4	-2
E&M	Both settings	0	0	0	0
E&M	Nonfacility	9	6	1	2
E&M	Facility	-14	-10	0	-4
Major procedures	Both settings	-12	-2	-2	1
Major procedures	Nonfacility	7	2	1	1
Major procedures	Facility	-18	-3	-3	1
Other procedures	Both settings	1	1	1	1
Other procedures	Nonfacility	6	2	1	1
Other procedures	Facility	-12	-4	-1	0
Treatments	Both settings	1	0	0	1
Treatments	Nonfacility	1	0	0	1
Treatments	Facility	-1	1	0	1
Imaging	Both settings	4	1	0	1
Imaging	Nonfacility	4	1	0	1
Imaging	Facility	1	0	0	0
Tests	Both settings	5	3	1	1
Tests	Nonfacility	6	3	1	1
Tests	Facility	3	2	1	0

Note: PE (practice expense), RVU (relative value unit), E&M (evaluation and management). The terms “facility” and “nonfacility” refer to the setting in which a service is performed. Examples of facility settings include hospital outpatient departments, hospital inpatient departments, and ambulatory surgical centers. Examples of nonfacility settings include clinician offices, retail health clinics, and urgent care centers. Estimated changes in spending include the effects of redistributing indirect PE RVUs within the indirect PE pool, as well as small adjustments to the conversion factor needed to maintain budget neutrality.

Source: MedPAC summary of Actuarial Research Corporation analysis of 2023 Medicare claims data.

Reducing indirect practice expense RVUs among codes that are not inherently facility based when provided by facility-based clinicians

One criticism of using claims to identify hospital-affiliated clinicians is that some services, such as emergency department or hospital inpatient E&M visits, must be done in a facility. Thus, relying on the place of service to identify hospital-affiliated clinicians

could flag some clinicians as hospital affiliated who are not. While many clinicians who perform services that are inherently facility based are employed by hospitals (and their indirect PE payments could therefore be duplicative), we ran a simulation that examined the magnitude of indirect PE associated with services that can be performed in both facility and nonfacility settings. To do so, we eliminated (and redistributed) indirect PE for facility services furnished by clinicians

that performed 90 percent or more of their services in a facility setting but only for services that were not considered inherently facility based.³¹

We examined this approach in the fourth simulation, in which we found that fee schedule spending for services that met these criteria totaled \$3.8 billion in 2024. Of that total, more than \$1 billion was associated with indirect PE and was redistributed in our simulation. This approach would have the largest effect on E&M services. According to our simulations, facility spending for all E&M services would decrease by 4 percent and nonfacility E&M spending would increase by 2 percent; overall spending on E&M services would not change. Such a policy to reduce (and redistribute) indirect PE only from services that are not inherently facility based is too narrow to address the broader issue of indirect PE for all hospital-affiliated clinicians because many services with potentially duplicative indirect

PE payments are always or commonly performed in a facility (e.g., inpatient E&M visits). However, such a policy would be directionally consistent with a broader solution and may be more practicable to implement with current data.

Future research could build off this work and seek to analyze the redistributive effects of reducing or eliminating indirect PE for facility services furnished by hospital-affiliated clinicians, who could be identified through a tax ID method used by Luo and colleagues (Luo et al. 2024). Regardless of any potential identification strategies researchers implement, CMS would need accurate and up-to-date information for every clinician that identifies whether they are affiliated with a hospital. Reducing indirect PE for hospital-affiliated clinicians and increasing PE for clinicians in private practice could reduce incentives for providers to consolidate with hospitals. ■

Endnotes

- 1 Our count includes unique Healthcare Common Procedure Coding System codes for which Medicare made at least one payment during the year. We treat codes that have modifiers as a single code, and we do not include codes that clinicians could have billed for but did not.
- 2 One exception to this general rule is when RVUs are rescaled in response to new Medicare Economic Index data. We discuss this issue further in the chapter.
- 3 At various points in the past, CMS has implemented the PFS budget-neutrality provision by directly reducing services' work RVUs or by applying a budget-neutrality adjuster to work RVUs (i.e., work RVUs did not change but the payment for work RVUs was reduced). However, stakeholders objected to such adjustments on the basis that they undermined the relativity of the PFS and caused confusion with other payers who rely on RVUs established by Medicare. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required CMS to implement the PFS budget-neutrality provision through the conversion factor.
- 4 For example, from 2020 to 2025, the average budget-neutrality adjustment under the PFS was twice as large as the average OPFS budget-neutrality adjustment. Over the same period, the PFS budget-neutrality adjustment was 1.0 percent or higher (in absolute-value terms) in three out of six years compared with only once under the OPFS.
- 5 In addition, among beneficiaries who had received health care, a greater share of Medicare beneficiaries was satisfied with their ability to find health care providers that had appointments when they needed them (88 percent) compared with privately insured people (79 percent).
- 6 We considered calculating Medicare spending per clinician over time, but such a statistic would be difficult to interpret appropriately. For example, our data include only FFS beneficiaries, but actual total spending per clinician depends on the mix of patients seen by clinicians (e.g., FFS Medicare and Medicare Advantage (MA) patients). Therefore, because MA enrollment has increased rapidly over time, calculating FFS spending per clinician would be artificially depressed. Further, interpreting spending per clinician is made more difficult by the changing mix of clinicians, such as the increasing number of NPs and PAs over time.
- 7 Especially during the second half of this period, the growth in PFS spending per beneficiary was restrained by the shift of services from clinician offices to hospital outpatient departments. While this trend increases Medicare's total spending generated by PFS services (PFS spending plus associated hospital outpatient spending), it makes PFS payments lower than they otherwise would be because of Medicare's payment rules.
- 8 Likewise, if payments do not cover the marginal cost of furnishing a service, a provider has a financial incentive to furnish fewer such services.
- 9 The Congress also provided one-time payment increases in 2024 of 1.25 percent from January 1, 2024, through March 8, 2024, and 2.93 percent from March 9, 2024, through December 31, 2024. Because the 2021 to 2024 payment-rate increases were one-time-only updates, their effects do not cumulate over time.
- 10 MEI-growth data included in this chapter differ from data published in physician fee schedule rules because of timing differences. MEI-growth data included in this chapter reflect the MEI growth that occurred or is projected to occur in a given year. In contrast, MEI-growth data in fee schedule rules reflect the most recently available actual historical data at the time of publication. For example, the final rule for payment year 2025 uses MEI growth from the second quarter of 2024 (i.e., actual historical MEI growth from the third quarter of 2023 to the second quarter of 2024). MEI growth reported in this chapter for 2025 is based on projected MEI growth from the fourth quarter of 2025 (i.e., projected MEI growth from the first quarter of 2025 to the fourth quarter of 2025). We also incorporate a productivity adjustment to match the period from which MEI growth was analyzed.
- 11 Over this period, the conversion factor declined primarily because CMS increased the RVUs for many E&M services and created a new add-on code. These increases required offsetting decreases in the conversion factor to remain budget neutral. The underlying updates over this period, excluding temporary payment increases, were 0 percent.
- 12 Using CMS projections of MEI growth as of the third quarter of 2024, the average annual fee schedule update from 2025 to 2034, if updates were based on MEI minus 1 percentage point rather than half of MEI, would be 1.2 percent instead of 1.1 percent.
- 13 This statement is based on actual MEI data published by CMS in 2024. Results may have been different if updates were set prospectively based on projected MEI growth.
- 14 This analysis is based on actual or projected MEI growth (including a productivity adjustment) that occurred in a

calendar year, using the most recently available market basket data at the time we wrote this report.

- 15 The higher cumulative payment rate results from half of MEI being higher than MEI minus 1 percentage point in 16 out of the 20 years from 2001 to 2020.
- 16 Direct PE is included in facility PE RVUs for some services. Most of these services are global surgical codes, which include direct PE for postoperative visits assumed to take place during the global payment period (even though substantial evidence suggests that many of these visits do not actually take place). Direct PE is also included in facility payments for several dozen nonglobal Healthcare Common Procedure Coding System codes to account for nonphysician clinical labor related to activities that take place outside the facility, such as quality-assurance activities, discharge management, and postprocedure services.
- 17 Reduction of indirect PE for facility services applies to most fee schedule services. However, some services, such as “incident to” services and physical therapy services, have special payment rules.
- 18 Payments for continuing medical education (CME) expenses are included in the PFS’s indirect PE RVUs but are not included in the facility fee (e.g., under the OPPS). If PFS PE RVUs for facility services are adjusted to exclude other types of indirect PE, consideration should be given to how to compensate clinicians for expenses related to CME.
- 19 MEI cost shares and the pools of RVUs may not match exactly due to year-to-year changes in service volume and other factors.
- 20 Nonphysician clinical labor includes registered nurses, medical technicians, and similar clinical staff. It does not include APRNs and PAs, who are included in the work component of RVUs.
- 21 Practices were included in the PPI survey only if they employed at least one physician (Whicher et al. 2025). Data on other practices, such as physical therapy practices, were collected in a separate survey—the Clinician Practice Information survey. A summary of the results of this survey was also released in 2025 (American Medical Association 2024a).
- 22 This analysis is based on the same data and methodology used to develop fee schedule RVUs for 2024.
- 23 Under statute, the total RVUs for a given service may not decline by 20 percent or more in a single year. This provision had a minimal impact on the results of this simulation.
- 24 A total of 380 physician practices responded to the AMA’s PPI survey. Of those, 327 practices responded based on being part of the original survey design, and 53 practices were not: 36 practices that volunteered their data (and completed the survey), 6 practices that the AMA recruited to pretest the survey, and 11 practices that were identified as part of a separate survey and subsequently completed the PPI survey (Grau et al. 2024). The 53 practices were allowed to submit their data in response to difficulty obtaining completed surveys, especially in certain specialties. According to the AMA, at the department level, the volunteer, pretest, and data from the other survey accounted for 11 percent of the 831 departments, 11 percent of the 18,086 physicians in those 831 departments, and, when weighted, 7 percent of the physician population.
- 25 The PPI survey response rate was calculated using the following formula: response rate = number of completed interviews / (number of cases in the sample – estimated number of ineligible cases). The AMA assumed that practices that did not click on the link for the survey were ineligible. Using this assumption, the response rate was 6.8 percent (Grau et al. 2024).
- 26 A number of 0-day global surgical codes include services during the procedure service date but not postsurgical visits related to the procedure. For 0-day codes, CMS generally does not allow providers to bill a separate E&M visit on the same day that a procedure is furnished.
- 27 The study also found that 46 codes included fewer postoperative visits than had been assumed. Among the remaining 89 codes, either payment rates reflected the actual number of postoperative visits or OIG was unable to determine whether the number of postoperative visits was accurate.
- 28 We report results of a sensitivity analysis by RAND that was restricted to the subset of clinicians who billed for any postoperative visits during 90-day global periods. We report these results rather than RAND’s main results because some specialty societies contend that the reason some clinicians did not bill for any postoperative visits was that their billing system did not allow them to submit the 99024 no-pay billing code that was used by RAND to identify postoperative visits (American Academy of Facial Plastic and Reconstructive Surgery et al. 2022). However, we caution that it is also possible that some clinicians did not report any postoperative visits because they did not provide any. The results we report should therefore be interpreted as conservative and possibly overrepresenting how many postoperative visits were provided.

29 In the 2025 final rule, CMS continued to assess how to improve Medicare's payment policies for global surgical codes. The agency finalized changes that are intended to obtain information and allow for more accurate payment to reflect the time and resources spent on postoperative care associated with global surgical services. Specifically, CMS expanded the use of a modifier for clinicians who intend to perform only the surgical portion of a global surgical service and added a new add-on code to be billed by clinicians who do not perform the surgical procedure within a global package but provide a related postoperative visit during the global period. These policies are not intended to address the overvaluation of global surgical codes discussed in this chapter.

30 Certain codes required special rules in the simulations. The professional component of codes in which the technical and

professional components can be paid separately (mainly imaging studies and tests) were exempted from reductions in indirect practice expense. We implemented this rule so that, regardless of where the professional component was performed, our simulations comport with a CMS policy that the professional and technical component RVUs sum to the total RVUs when both components are combined into one payment. Indirect PE for global surgical codes were only partially reduced because some indirect PE is included in follow-up visits that can occur in a nonfacility setting rather than a facility setting. Carrier-priced codes are excluded because information about indirect PE is not available.

31 We defined services as inherently facility based if 90 percent or more of volume was provided in a facility.

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C H A P T E R

2

Supplemental benefits in Medicare Advantage

Supplemental benefits in Medicare Advantage

Chapter summary

In addition to covering basic Part A and Part B services, Medicare Advantage (MA) plans may provide “supplemental” benefits to their enrollees, such as reduced cost sharing for Part A and Part B services, reduced Part B and Part D premiums, enhanced Part D benefits, and other benefits not covered under fee-for-service (FFS) Medicare such as dental, vision, or hearing services (non-Medicare services). These supplemental benefits, which are intended to provide more generous coverage and better financial protection for MA enrollees, are a defining feature of MA, but relatively little is known about the use of the benefits and the costs associated with them.

The majority of the supplemental benefits provided by MA plans are financed by the rebates that plans receive from Medicare. Medicare spending on plan rebates has increased sharply in recent years. Our analysis shows that, in 2025, Medicare will pay MA plans approximately \$86 billion in rebates—or about \$2,530 per enrollee (roughly 17 percent of Medicare’s payments to MA plans)—to provide supplemental benefits, up from \$21 billion (or about \$1,160 per enrollee) in 2018.

According to their 2025 bid projections, plans expect to use about \$39 billion (of the total \$86 billion, equivalent to about \$100 per member per month (PMPM)) to provide non-Medicare services to their enrollees and

In this chapter

- Background
- Marked growth since 2018 in the rebates that finance MA supplemental benefits
- Conventional MA plans and SNPs report using rebates very differently
- Little is known about use of supplemental benefits
- Supplemental benefits: Cost-sharing and premium reductions
- Supplemental benefits: Non-Medicare services
- The role of vendors, community-based organizations, and vertically integrated entities
- Appendix: Additional information about supplemental benefits

about \$27 billion (\$64 PMPM) to reduce enrollees' cost sharing for Medicare-covered services (such as doctors' visits). Though plans' bids indicate how they intend to use rebate dollars, projections may vary from actual experience, and little is known about how MA rebate dollars are actually spent. Because Part D benefit enhancements and Part D and Part B premium reductions are adjudicated directly between CMS and MA plans, there is less uncertainty about plans' spending for these supplemental benefits. For 2025, we estimate that MA plans will use about \$15 billion of the rebates they receive from Medicare to enhance Part D benefits and reduce Part D premiums (equivalent to about \$37 PMPM), and they will use about \$5 billion (\$10 PMPM) to reduce their enrollees' Part B premiums.

Different types of MA plans tend to offer different types of supplemental benefits. Conventional MA plans (i.e., nonemployer, non-special-needs plans) typically allocate the largest share of their rebate dollars to reducing enrollee cost sharing for Part A and B services. In contrast, special-needs plans (SNPs) report allocating a small share of their rebates to reducing cost sharing because most of their enrollees are dually eligible for Medicare and Medicaid and so will have their out-of-pocket (OOP) costs covered by Medicaid and other programs. Instead, SNPs allocate most of their rebate dollars to the provision of non-Medicare services.

In recent years, CMS and the Congress have gradually increased plans' flexibility in the types of supplemental benefits that can be offered, and plans can now target supplemental benefits to enrollees with a particular health status or disease state. Plans also can provide supplemental benefits that are not primarily health related to chronically ill enrollees; these benefits—which include services like meals, nonmedical transportation, and pest-control services—are known as special supplemental benefits for the chronically ill (SSBCI).

These new flexibilities, combined with the growth in rebate dollars, have allowed MA plans to significantly expand the number of supplemental benefits they offer. Across almost every type of supplemental benefit, our analysis of benefits offered by plans finds that the share of MA enrollees in plans offering these benefits has increased since 2018. Many plans offer supplemental benefits as “combination benefits,” in which enrollees are provided with a “flex card” that can be used to pay for a number of different services. Growth in the share of SNP enrollees in plans offering the newer forms of benefits has been particularly dramatic. According to plans' bid data, SNPs now intend to devote

more rebate dollars to other non-Medicare services than to dental, vision, hearing, and transportation benefits combined.

As Medicare spending for MA supplemental benefits grows, it becomes increasingly valuable for policymakers to fully understand their use. CMS requires MA organizations to submit encounter records for all health care items and services, including supplemental benefits, provided to their enrollees. Accordingly, MA encounter data should be the most detailed source of information for assessing MA enrollees' use of services. However, the Commission has found that encounter data for some MA plans and for some services (including inpatient, home health, and skilled nursing facility services) are incomplete. And to the best of our knowledge, no studies have used encounter data to assess MA enrollees' use of supplemental benefits—likely because the reliability of the data has been unclear.

Indeed, until 2024, the system that CMS used to collect encounter records was not configured to accept records for dental services. For this report, we used data from the Medicare Current Beneficiary Survey (MCBS) to assess how enrollees use and pay for dental care. We found that between 2017 and 2022, just over half of non-dually eligible MA enrollees who had dental coverage through their MA plan visited the dentist during the year. These enrollees paid for a considerable portion of their dental expenses OOP, but the percentage decreased over time, falling from 61 percent in 2017 to 35 percent in 2022. In both 2017 and 2022, a small share of non-dually eligible MA enrollees reported difficulty accessing dental care due to cost. For most of the outcomes we assessed, trends for FFS beneficiaries without a form of dental coverage followed a directional trend similar to that of MA enrollees with dental coverage. However, FFS beneficiaries without a form of dental coverage paid for a significantly larger share of their dental care OOP. The similar trends in dental utilization for MA and FFS beneficiaries suggest that the recent decline in OOP costs for non-dually eligible MA enrollees cannot be attributed entirely to growth in MA supplemental benefits. Other underlying factors may also have played a role. Without further analysis, it is difficult to assess the extent to which the changes observed for MA enrollees are due to changes in MA supplemental benefits, to broader changes affecting the Medicare population as a whole, or to other changes such as the composition of the MA population. Survey data, however, offer limited insight into how MA enrollees use and pay for dental care, underscoring the need for better encounter data pertaining to the services.

We analyzed encounter data for 2021 to assess whether plans are submitting records for other supplemental benefits and whether the submission rates are suggestive of problems with the reliability of the data. Our analysis is a preliminary and exploratory first step toward using encounter data to assess the use of supplemental benefits. As such, we did not attempt—at this stage—to measure utilization rates or draw conclusions about access or value based on our findings. Instead, we focused on assessing whether plans are submitting records and characterizing the potential uses or limitations of the data.

We identified significant limitations to using the encounter data to assess supplemental benefits. First, as noted above, few encounter records have been collected for dental services, which is one of the largest categories of supplemental benefits. Second, MA plans have reported that the supplemental-benefit encounter records that they do submit are incomplete because of confusion about reporting requirements and how to populate the records for services that do not have well-established procedure codes. Third, the encounter data system does not contain a way to distinguish which records are for basic or supplemental services or for optional or mandatory supplemental benefits.

Nevertheless, for some services—particularly vision and hearing services—plans experience fewer technical limitations to submitting the data. We found that for these services, MA plans are submitting records and that the submission rates follow patterns in line with what can reasonably be expected based on survey data about MA enrollees' use of vision and hearing services. This is an encouraging sign that indicates that it may be feasible to use encounter data to explore MA enrollees' use of supplemental vision and hearing benefits. For other types of supplemental benefits, however, we found few encounter records, and the submission rates were well below the utilization rates suggested by survey data. Considering the well-documented data limitations and the discrepancies between encounter data and other sources, we can conclude that—for most supplemental benefits other than vision and hearing services—the encounter data are insufficient for characterizing enrollees' use of the benefits.

In 2024, CMS began implementing a series of actions to improve and increase the amount of data that plans report regarding utilization of and spending for supplemental benefits. The new data-reporting requirements will address some, but not all, of the data limitations that hinder our ability to assess how MA enrollees use supplemental benefits and how much plans spend on the

benefits, and it will be several more years before the full range of data are available for analysis.

In addition to assessing the data pertaining to MA enrollees' use of supplemental benefits, we provide information about how MA plans administer supplemental benefits. Because many supplemental benefits are nonmedical, MA organizations (MAOs) often contract with third parties such as businesses or community-based organizations to provide or administer the benefits. Medicare does not collect information about the entities with which MAOs contract. To better understand how supplemental benefits are administered, we reviewed the websites of MAOs and entities that administer MA supplemental benefits. Several themes emerged from our review. First, we found that many MAOs contract with dental and/or vision insurers that manage the supplemental dental and vision benefits on behalf of the MA plan, although some insurers manage the benefits themselves or have acquired organizations that manage the benefits on their behalf. Second, we found that MAOs often contract with for-profit vendors to provide nonmedical supplemental benefits. Plans may also contract with community-based organizations, though information about these arrangements was harder to find. Third, we found that MAOs frequently administer supplemental benefits through entities with which the insurer is vertically integrated and that several of the large MAOs have acquired or developed subsidiary businesses that specialize in providing services that can be offered as supplemental benefits. We also found several instances in which MAOs structure their supplemental benefits to be provided exclusively by providers owned by the plan's parent organization.

Altogether, our review of numerous data sources pertaining to MA supplemental benefits reveals a fundamental lack of transparency about how often enrollees use the benefits and plans' spending for the benefits. The data that Medicare collects are currently insufficient for examining the use of most of these benefits. The lack of reliable data makes it difficult to answer many important questions about how the rebates Medicare pays to MA plans are used. For example, we do not know how much plans spend on each type of benefit, which enrollees use each benefit (and how frequently), or whether service use differs by such factors as age, sex, race, disability status, and geographic area. The Medicare program currently relies on competition between insurers to incentivize plans to offer benefits that enrollees will value and use. But, because of different challenges in the program, including the complexity of the choice environment and the absence of reliable data,

it is unclear to what extent supplemental benefits address enrollees' needs or affect outcomes. Without reliable information about how the benefits are used or administered, it is difficult for policymakers to assess the adequacy of the access provided or to know whether the spending provides good value to enrollees and the taxpayers who fund the program. Better information could be used to help beneficiaries navigate the options available to them and could help policymakers identify ways of making the program work more efficiently. ■

The Medicare Advantage (MA) program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional fee-for-service (FFS) Medicare program. MA plans are required, with few exceptions, to cover all Part A and Part B services to which Medicare beneficiaries are entitled.¹ MA plans may also provide their enrollees with “supplemental” benefits such as reduced cost sharing for Part A and Part B services, reduced Part B and Part D premiums, enhanced Part D benefits, and coverage of non-Medicare services (services not covered under FFS Medicare, such as dental, vision, and hearing services). For beneficiaries, a primary trade-off in choosing between MA and FFS is access to the supplemental benefits that plans provide versus a broader choice of providers and minimal utilization management in FFS.

The Commission has noted that supplemental benefits are intended to provide more generous coverage and better financial protection for MA enrollees. Supplemental benefits may provide MA enrollees with access to important services not covered by Medicare or address health-related challenges beneficiaries face, but little is known about enrollees’ use of the benefits. The Medicare program currently relies on competition between insurers to incentivize plans to offer benefits that enrollees will value and use, but evidence regarding the extent to which supplemental benefits address enrollees’ needs or affect outcomes is lacking and the reliability of the data Medicare collects about the benefits has not been well explored. Without reliable information about how the benefits are used or administered, it is difficult for policymakers to assess the adequacy of the access provided or to know whether the spending provides good value to enrollees and the taxpayers who fund the program. Better information could be used to help beneficiaries navigate the options available to them and could help policymakers identify ways of making the program work more efficiently.

CMS requires MA organizations (MAOs) to submit encounter records for all health care items and services, including supplemental benefits, provided to their enrollees. Accordingly, MA encounter data should be the most detailed source of information for assessing MA enrollees’ use of services. However, the Commission has found that encounter data for some MA plans and for some services (including inpatient,

home health, and skilled nursing facility services) are incomplete. The Commission has not previously assessed encounter data for MA supplemental benefits.

In this chapter, we explore trends in the rebates paid to MA plans to finance the provision of supplemental benefits, measure the premium and cost-sharing reductions provided as supplemental benefits, chart changes in the types of benefits plans offer enrollees, and analyze MA encounter data to better understand the data and their potential utility for measuring enrollees’ use of supplemental benefits. Because encounter data for dental services are unavailable, we also use data from the Medicare Current Beneficiary Survey (MCBS) to assess how enrollees use and pay for dental care. For assessing vision and hearing benefits, we use encounter data because there are well-defined procedure codes that should make it possible for plans to submit encounter records related to the services. For other non-Medicare services that are commonly offered as supplemental benefits, we analyze the encounter data and outline the data limitations that hinder our ability to reliably assess enrollees’ use of the services. Last, we provide information about how MA plans are administering supplemental benefits and the entities with which plans are partnering to provide the services.

Background

MA supplemental benefits can be organized into four broad categories: reduced cost sharing for Part A and Part B services, reduced Part B premiums, enhanced Part D benefits (including reduced Part D premiums), and coverage of non-Medicare services (services not covered under FFS Medicare, such as dental, vision, and hearing services). Plans have flexibility regarding which supplemental benefits they offer and the generosity of the coverage. The Congress and CMS have gradually expanded the types of supplemental benefits that MA plans can offer and how the benefits can be offered.

Supplemental benefits in MA are financed primarily by rebates

MA plans primarily finance the provision of supplemental benefits using “rebates” that are added to the capitated payments they receive to cover basic

Medicare benefits. The rebate amount a plan receives is determined by Medicare's payment formula for MA plans and depends on how the plan's bid compares with a county-specific payment benchmark, as well as on a plan's star rating.

Organizations seeking to offer MA plans submit bids representing the dollar amount that the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average spending risk.² Plans' bids are compared with a benchmark amount that is based on the projected costs of providing Part A and Part B services to FFS beneficiaries in the county; the benchmark is the maximum amount Medicare will pay for an MA plan to provide Part A and Part B benefits.³ If a plan's bid is below the benchmark, its payment rate is its bid plus a share of the difference between the plan's bid and the benchmark (as low as 50 percent but typically either 65 percent or 70 percent, depending on a plan's quality ratings). The added payment to the plan, based on the difference between the bid and the benchmark, is referred to as the "rebate." Plans are required to use the rebate to provide supplemental benefits. For 2025, almost 100 percent of plans bid below their benchmarks and received rebates to offer supplemental benefits.⁴

Plans have the option of offering more supplemental benefits than what can be covered by the rebate they receive from Medicare. In such cases, plans typically charge enrollees additional premiums to cover the costs of providing the benefits. This arrangement rarely takes place: In an analysis of plans' bid data for 2022, the Government Accountability Office (GAO) found that 83 percent of MA plans, enrolling 86 percent of MA enrollees, expected to finance supplemental benefits solely with rebates; for special-needs plans (SNPs), the share was even higher, at 96 percent (Government Accountability Office 2023).⁵ In other words, the supplemental benefits offered by MA plans are primarily financed by the rebates the plans receive from Medicare.

Medicare has gradually expanded the types of supplemental benefits that MA plans can offer

MA plans' supplemental benefits are intended to provide more generous coverage and better financial protection for MA enrollees (Medicare Payment Advisory Commission 2024b). The supplemental

benefits that MA plans may offer fall into four broad categories: reduced cost sharing for Part A and Part B services, reduced Part B premiums, enhanced Part D benefits (including lower premiums), and coverage of non-Medicare services (services not covered under FFS Medicare, such as dental, vision, and hearing services). Plans have flexibility regarding which supplemental benefits they offer and the generosity of the additional coverage. Each category is subject to some limitations, but—over time—CMS and the Congress have gradually increased plan flexibility and expanded the types of supplemental benefits that MA plans can offer and how the benefits can be offered.

Cost-sharing reductions

MA plans have the flexibility to develop their own cost-sharing rules instead of using those applied under FFS Medicare. However, plans are subject to limitations intended to guard against the use of benefit designs that might discriminate against beneficiaries who are sicker by charging high cost sharing for the services those enrollees are likely to use. Plans must abide by these rules but may charge cost sharing below the minimum required levels. Some of the limitations apply to overall cost sharing, while others apply to cost sharing for particular services.⁶

The level of overall cost sharing that plans can impose is constrained in two ways. First, plans must ensure that their cost sharing for all Part A and Part B services is, in aggregate, at least actuarially equivalent to FFS cost sharing. To maintain actuarial equivalence, any increase in cost sharing for some services must be offset by lower cost sharing for other services. Second, MA plans must provide an annual cap on enrollees' out-of-pocket (OOP) spending for in-network services, known as a maximum out-of-pocket (MOOP) limit.⁷

In addition to the limits on aggregate cost sharing, plans must also comply with a complex set of limits on the cost sharing they can charge for certain service categories (Medicare Payment Advisory Commission 2023). Conceptually, there are three major types of service-specific limits:

- Services for which plans cannot charge more in cost sharing than FFS Medicare does. This limit applies to such major categories as inpatient care, skilled nursing facility (SNF) care, dialysis, and Part B drugs.

- Services for which plans can charge more than FFS does but are subject to some specified limit. This limit applies to categories such as physician services.
- Services for which plans cannot charge more than 50 percent in coinsurance or an actuarially equivalent copayment. This general limit applies to any categories, such as outpatient hospital services, for which CMS does not have any specific limits on cost sharing.

Some of these limits—such as the prohibition on charging higher cost sharing than FFS for dialysis, SNF care, or Part B drugs—are specified in law. CMS also has the authority to put cost-sharing limits on other services to prevent plans from using benefit designs that the agency considers discriminatory. For example, CMS added cost-sharing limits for rehabilitation services, starting with the 2020 plan year, and has indicated that it may add a limit for ambulance services in the future (Centers for Medicare & Medicaid Services 2022b). MA enrollees may also pay cost sharing for non-Medicare services that their plan offers as supplemental benefits; CMS does not set limits on the cost sharing that can be charged for these services, and the cost sharing enrollees pay for them does not count toward the MOOP limit.⁸

Altogether, plans can charge less in overall cost sharing than would be charged under FFS as long as their benefit design complies with the limitations described above. For plans providing more generous coverage than would be provided under FFS, the difference between the two amounts is treated as a supplemental benefit.

Enhanced Part D benefits and Part B premium reductions

All beneficiaries enrolling in Medicare Part B, regardless of their decision to receive benefits through FFS Medicare or MA, are required to pay the Medicare Part B premium.⁹ However, MA plans may pay a portion of their members' Part B premium as a supplemental MA benefit. Beneficiaries may face an additional premium to enroll in Part D; MA prescription drug plans (MA-PDs), which provide integrated Part C and Part D coverage under the same plan, can also reduce or eliminate the Part D premium as a supplemental MA benefit. Further, MA-PDs may provide additional Part D benefit

enhancements as a supplemental benefit, such as reduced cost sharing or coverage of additional drugs.

For plans reducing their enrollees' Part B premium, CMS limits the amount by which the premium can be reduced; the maximum reduction is generally equal to the Part B premium for the year preceding the contract year (although this rule is typically not binding since very few plans offer full Part B–premium reductions).¹⁰ For plans reducing or eliminating the Part D premium for their enrollees, the maximum reduction is based on the Part D premium for that plan, and the plan cannot reduce the total Part D premium below zero.

Coverage of non-Medicare services

MA plans may offer coverage of non-Medicare services (those not covered under FFS Medicare) as a supplemental benefit. Plans' ability to offer these benefits has always been subject to limitations that specify the types of benefits that can be offered and the types of enrollees who can receive them. For many years, two key requirements were that the benefits had to be (1) "primarily health related," meaning that their main purpose was "to prevent, cure, or diminish an illness or injury," and (2) "offered uniformly to all enrollees" (Centers for Medicare & Medicaid Services 2016). These requirements had prevented plans from providing benefits that were not directly health related but that could address other enrollee needs (such as in-home supports for people with functional limitations) and from targeting benefits to specific types of enrollees (such as those with a particular health condition).

Policymakers have taken several steps in recent years to loosen those requirements:

- In 2018, CMS broadened its definition of "primarily health related" to include services that address physical impairments, lessen the functional or psychological impact of injuries, or reduce avoidable health care utilization (Centers for Medicare & Medicaid Services 2018c). Under this new definition, plans can provide services such as in-home support services and home modifications. This change took effect in 2019.
- At the same time, CMS modified the uniformity requirement to let plans target supplemental benefits to enrollees with a particular "health

status or disease state” (Centers for Medicare & Medicaid Services 2018d). Plans that choose to target benefits in this manner must ensure that all enrollees with the targeted health status or disease state are treated in the same manner. This change also took effect in 2019.

- The Bipartisan Budget Act of 2018 gave plans the flexibility to provide to chronically ill enrollees supplemental benefits that “have a reasonable expectation of improving or maintaining the health or overall function” and do not have to be primarily health related. These benefits are known as special supplemental benefits for the chronically ill (SSBCI). Plans can use this authority to cover services such as meals, food and produce, nonmedical transportation, and pest-control services (Centers for Medicare & Medicaid Services 2019b). This change took effect in 2020.
- In 2017, the Center for Medicare & Medicaid Innovation (the CMS Innovation Center) started a demonstration called the Medicare Advantage Value-Based Insurance Design (VBID) Model that let participating plans offer a wider range of supplemental benefits and target them to certain types of enrollees. The demonstration evolved over time and the types of benefits that were initially permitted only under the VBID model were later permitted more broadly under the policy changes listed above, which gave plans some of the same flexibilities. For example, beginning in 2017, plans participating in the VBID model were permitted to target supplemental benefits to enrollees with certain clinical conditions; this flexibility was extended to non-VBID plans (under the SSBCI policy described above) beginning in 2020. However, the demonstration was distinctive because it provided the only way for plans to target supplemental benefits to beneficiaries based on socioeconomic status instead of chronic illness or disease state and to reduce or eliminate cost sharing for Part D drugs.¹¹ The VBID demonstration began with nine MA organizations in seven states; it was incrementally expanded to additional states in subsequent years and was expanded by law to all states beginning in 2020. In 2024, CMS announced that it would terminate the demonstration at the end of 2025, citing “substantial and unmitigable costs to the Medicare Trust Funds,” driven by faster

risk-score growth and higher Part D expenditures (Centers for Medicare & Medicaid Services 2024e, Centers for Medicare & Medicaid Services 2023c).

As a result of these changes, the types of supplemental benefits that MA plans can offer to their enrollees has widened. Table 2-A1 of the appendix (p. 119) lists examples of the supplemental benefits MA plans may offer.

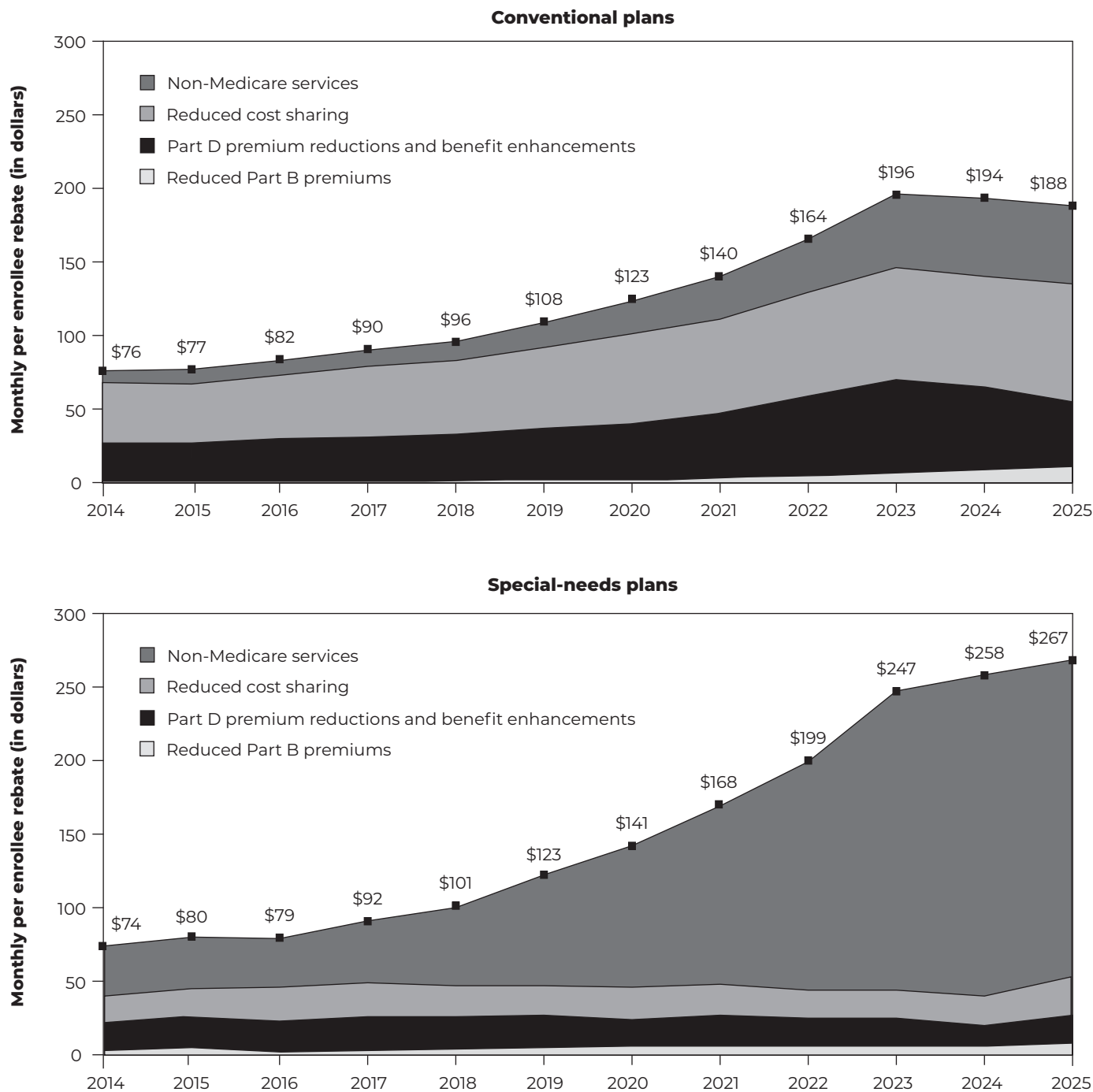
Marked growth since 2018 in the rebates that finance MA supplemental benefits

The rebates that Medicare pays to MA plans have grown significantly in recent years. The average rebate paid to conventional MA plans (i.e., nonemployer, non-special-needs plans) nearly doubled on a nominal basis between 2018 and 2025: Rebates rose from \$96 per member per month (PMPM) in 2018 to an all-time high of \$196 in 2023; they then declined slightly to \$188 PMPM in 2025 (Figure 2-1). For special-needs plans (SNPs), the average rebate is significantly higher—\$267 PMPM in 2025—and has increased in every year since 2016. In 2025, Medicare will pay MA plans (including both conventional plans and SNPs) approximately \$2,530 per enrollee per year to provide supplemental benefits. The increase in the average rebate per member, combined with rapid MA enrollment growth, has resulted in a significant increase in the amount Medicare spends on rebates. In 2018, Medicare paid MA plans (including conventional plans, SNPs, and employer plans) an estimated \$21 billion in rebates (roughly 10 percent of payments to MA plans in that year); in 2025 the program will spend approximately \$86 billion (or 17 percent of MA payments) on rebates (Figure 2-2, p. 68).¹²

Conceptually, the rebates paid to MA plans were originally intended to be a form of shared savings in which plans would be rewarded for providing Medicare benefits at a lower cost than would have been the case under FFS.¹³ However, the Commission’s previous work has shown that elements of MA payment policy have resulted in benchmarks that are higher than the expected costs of the MA population (Medicare Payment Advisory Commission 2025). Because plan bids are meant to reflect plan costs and because

**FIGURE
2-1**

Monthly MA rebates have nearly doubled since 2018; plans allocate a significant share of rebates to non-Medicare services

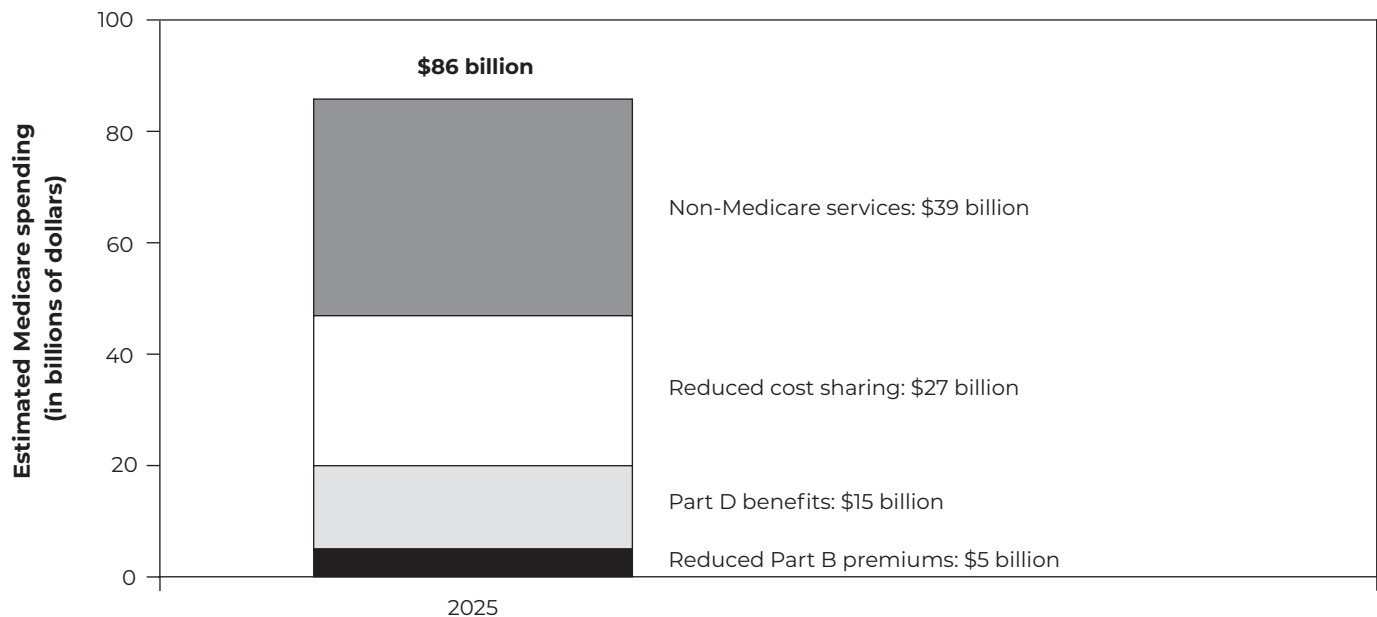


Note: MA (Medicare Advantage). MA plans must report in their bids how much of their rebate they plan to allocate to reduced Part B premiums, reduced cost sharing, Part D benefits, and non-Medicare services, but these projections may not reflect actual use. "Conventional plans" excludes employer group plans, special-needs plans, and plans that do not offer Part D coverage. "Special-needs plans" excludes employer group plans, non-special-needs plans, and plans that do not offer Part D coverage. The plan rebate is the per beneficiary per month amount that the plan offers as premium-free extra benefits. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of MA bid data.

**FIGURE
2-2**

Medicare will spend an estimated \$86 billion on MA rebates in 2025



Note: MA (Medicare Advantage). In the bids they submit to CMS, MA plans must report how much of their rebate they plan to allocate to reduced Part B premiums, reduced cost sharing, Part D benefits, and non-Medicare services. These projections may not reflect actual use. Rebates paid to nonemployer plans were estimated using rebate amounts from MA bids and monthly enrollment data for nonemployer plans. Rebates for employer plans were estimated using the same method CMS uses to determine employer-plan payment rates, in which the difference between the county-specific benchmark and base payment rate for employer plans (based on the average bid-to-benchmark ratio for nonemployer plans in the payment quartile of the county) is multiplied by the plan-specific rebate percentage (based on the plan's star rating) and the risk score.

Source: MedPAC analysis of MA bid data, 2025.

rebates are a share of the difference between plan bids and benchmarks, inaccurate benchmarks can increase the rebates plans receive. Our previous work has shown that the difference between benchmarks and plan bids has widened over time, thereby increasing rebates. The extent of this effect varies across MA organizations but has become particularly pronounced for some plans. One potential implication of this effect is that a large portion of the rebates Medicare pays to MA plans may be financed by additional program spending and not by savings derived from plan efficiencies. Additionally, because MA rebates are paid from the Medicare trust funds, they are partially financed by Part B premiums collected from all beneficiaries (including those in FFS Medicare). The Commission estimates that Part B premiums will finance about \$13 billion of MA rebates in 2025, with nearly \$6 billion coming from FFS beneficiaries who do not have access to the supplemental benefits financed by the rebates.¹⁴

Conventional MA plans and SNPs report using rebates very differently

In the bids they submit to CMS, MA plans must report how much of their rebate they plan to allocate to each type of supplemental benefit: reducing enrollees' cost sharing, reducing enrollees' Part B or Part D premiums, enhancing Part D benefits, or covering non-Medicare services. Plans are required to allocate the full value of the total rebate to at least one of the supplemental-benefit categories. Plans' rebate allocations are a projection of how the plan anticipates rebate dollars will be used but might not reflect actual use. For example, consider a hypothetical plan that prospectively allocates half of its rebate to reducing cost sharing and half to covering non-Medicare services: If the plan's members use more Medicare-

**TABLE
2-1**

Conventional MA plans report allocating the largest share of rebate dollars to reducing cost sharing; SNPs report allocating the largest share to covering non-Medicare services, 2025

Category	Distribution of allocated rebate							
	Total		Benefit expenses		Administrative costs		Profit margin	
	Dollar	Percent	Dollar	Percent	Dollar	Percent	Dollar	Percent
Conventional MA plans	\$188	100%	\$173	92%	\$14	7%	\$2	1%
Reduced Part A and Part B cost sharing	80	43	71	89	8	10	1	1
Non-Medicare services	53	28	47	88	6	11	1	1
Reduced Part B premium	11	6	11	100	—		—	
Part D benefits	44	23	44	100	—*		—*	
<i>Reduced basic premium</i>	15	8	15	100	—*		—*	
<i>Enhanced coverage</i>	29	15	29	100	—*		—*	
Special-needs plans	\$267	100%	\$233	87%	\$22	8%	\$12	5%
Reduced Part A and Part B cost sharing	26	10	22	86	2	9	1	5
Non-Medicare services	215	80	184	86	20	9	11	5
Reduced Part B premium	8	3	8	100	—		—	
Part D benefits	19	7	19	100	—*		—*	
<i>Reduced basic premium</i>	11	4	11	100	—*		—*	
<i>Enhanced coverage</i>	8	3	8	100	—*		—*	

Note: MA (Medicare Advantage), SNP (special-needs plan), N/A (not applicable). MA plans must report in their bids how much of their rebate they plan to allocate to reduced Part B premiums, reduced cost sharing, Part D benefits, and non-Medicare services, but these projections may not reflect actual use. "Conventional plans" excludes employer group plans, special-needs plans, and plans that do not offer Part D coverage. "Special-needs plans" excludes employer group plans, non-special-needs plans, and plans that do not offer Part D coverage. The plan rebate is the per beneficiary per month amount that the plan offers as premium-free supplemental benefits. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. No rebate dollars used to reduce Part B premiums can be apportioned for administrative costs or profit. Components may not sum to totals due to rounding.

* Because Part D premiums typically reflect some amount of administrative costs and profit for the Part D plan, some of the rebate dollars allocated to the reduction of Part D premiums are also devoted to administrative costs or profits, though less directly.

Source: MedPAC analysis of MA bid data, 2025.

covered services than the plan anticipated and use fewer non-Medicare services than anticipated, the distribution of actual spending by the plan would skew toward greater spending on cost-sharing reductions relative to the distribution suggested by the allocations reported in the bid. As a result, we are able to summarize how plans allocate (i.e., expect to use) their rebates but know considerably less about how the funds are ultimately used.

Plans that use rebate dollars to lower cost sharing for basic Medicare services or to provide non-

Medicare benefits apportion some of the rebate to their administrative costs and margin (positive or negative).¹⁵ As shown in Table 2-1, in 2025, conventional plans intend to allocate about 8 percent and SNPs intend to allocate about 13 percent of their rebate to such purposes. In 2025, as in most previous years, conventional MA plans allocated the largest share of their rebate dollars to reducing cost sharing for Part A and Part B services. Because this cost sharing is often already covered for SNP enrollees, SNPs have always allocated the largest share of their rebates to

covering non-Medicare services. However, between 2018 and 2023, both conventional plans and SNPs sharply increased the share of rebate dollars allocated to coverage of non-Medicare services; both types of plans have continued to allocate a significant portion of rebates to those services in recent years.

Reduced cost sharing

In 2025, as in most previous years, conventional MA plans allocated the largest share of their rebate dollars (43 percent) to reducing cost sharing for Part A and Part B services (Table 2-1, p. 69). In contrast, SNPs allocated a small share of their rebate (10 percent) to reducing cost sharing.¹⁶ Because most of their enrollees (about 90 percent) are dually eligible for Medicare and Medicaid, many OOP costs for these beneficiaries are already covered by other programs: Medicaid covers Part A and Part B cost sharing and pays the Part B premium in most cases, and Medicare's Part D low-income subsidy typically covers the premium and all or most cost sharing for prescription drug coverage. As a result, SNPs have less reason than conventional plans to use their rebates to cover these costs.

Enhanced Part D benefits and Part B premium reductions

MA plans also provide financial protections by allocating rebate dollars to reducing basic Part D premiums and enhancing Part D benefits, and reducing Part B premiums. Specifically, plans can use rebate dollars to lower the basic Part D premium or can reduce the premium enrollees pay for enhanced Part D benefits (such as lower cost sharing or coverage of additional drugs).¹⁷ Part D premium reductions are strategically important for plans because low premiums are an effective way to attract enrollees. In interviews with MedPAC staff, MA actuaries and plan representatives have shared that Part D premium reductions are a first-order consideration with regard to how rebate dollars are allocated. In 2025, conventional MA plans allocated 23 percent of their rebate dollars to Part D benefits. MA plans may also use rebates to reduce the standard Medicare Part B premium for their enrollees. However, this arrangement is less common and plans typically devote a small share of rebate dollars (6 percent among conventional plans in 2025) to such reductions.¹⁸ Conventional plans allocate more rebate dollars to reducing Part D premiums (consistent with the lower

share of LIS enrollees receiving premium assistance through Part D in those plans). Part B premium reductions are primarily concentrated in the plans receiving the largest rebates, suggesting that plans appear to prioritize Part D premiums, cost-sharing reductions, and coverage of non-Medicare services over Part B premium reductions.

Coverage of non-Medicare services

In recent years, plans have allocated a large share of their rebates to the provision of non-Medicare services (Figure 2-1, p. 67). The share of rebates allocated to these types of benefits grew dramatically between 2018 and 2023, but it has leveled off somewhat in recent years. Nevertheless, plans continue to anticipate using a large share of rebate dollars for non-Medicare services. Across all MA plans, the share of rebates allocated for coverage of non-Medicare services doubled between 2018 and 2025—rising from roughly 20 percent to 40 percent—largely driven by the increase in the share of non-Medicare services for SNPs. In 2025, on an annual basis, conventional MA plans and SNPs allocated about \$636 and \$2,580 in rebates per enrollee, respectively, to coverage of non-Medicare services (figures based on total rebate, including administrative costs and profit margin).

For conventional MA plans, the share of rebates allocated to non-Medicare services rose from 15 percent in 2019 to 28 percent in 2025. In total since 2014, according to plans' bid projections, more than 40 percent of the growth in conventional plans' rebates has been allocated to non-Medicare services. SNPs have always allocated a larger share of their rebates to covering non-Medicare services—56 percent, on average, between 2014 and 2018—but the share for these plans has also risen since 2019: In 2025, SNPs allocated 80 percent of their rebates to non-Medicare services. Since 2014, nearly all of the growth in SNP rebates has been allocated to these benefits.

The increase in the share of rebate dollars allocated for coverage of non-Medicare services coincides with a period of rapid rebate growth. The fact that plans allocated a larger share of each marginal rebate dollar to these benefits (instead of to cost-sharing reductions) could reflect that cost sharing is an important utilization-management tool for plans and could indicate that there are limits to the extent to which plans are willing to reduce enrollee cost sharing.

Other factors, such as the expansion in 2019 and 2020 of the types of benefits MA plans could offer and how they could be targeted to enrollees, could also have contributed to the increase.

Little is known about use of supplemental benefits

Little is known about the extent to which MA enrollees use the many supplemental benefits available to them. For many of the benefits, the data that Medicare collects are insufficient for examining the use of the services. The lack of reliable data makes it impossible to answer many important questions about how the rebates that Medicare pays to MA plans are used. For example, we do not know how much plans spend on each type of benefit, which enrollees used each benefit (and how frequently), or whether service use differs by such factors as age, sex, race, disability status, and geographic area. Without this information, GAO has noted, it is difficult to determine whether the benefits improve MA enrollees' health (Government Accountability Office 2023). As such, policymakers do not have good information about whether the spending provides good value to MA enrollees and the taxpayers who fund the program. Part B and Part D premium reductions are the two categories for which we can be most sure of enrollees' use of the benefits because the reductions are adjudicated automatically between CMS and plans offering the benefits. For cost-sharing reductions and coverage of non-Medicare services such as dental care, however, current data sources do not provide reliable information.

Before 2024, Medicare primarily collected information about supplemental benefits from MA plans in three datasets: plan benefits data, bid data, and encounter data. Each of these has significant limitations for analyzing the use of such benefits.

- **Plan benefit data.** MA plans are required to submit information to CMS about the benefits they cover and the structure of that coverage (e.g., deductible amount, use of copayments or coinsurance, requirements for referral or prior authorization), but the data do not include any information about enrollees' use of the benefits or plans' spending for them. The data are published concurrent with the year in which the coverage applies. The data include

information about what benefits each plan offers, including information about supplemental benefits, and CMS lists nearly 100 supplemental benefits that plans may offer, grouped into approximately 14 service categories (e.g., inpatient hospital benefits, dental services). CMS also provides an option for plans to enter additional benefits beyond those listed in the submission form.

- **Bid data.** As part of the annual bidding process, MA plans submit utilization and spending information, aggregated to the plan and service-category level. The primary function of the bid data is facilitation of the MA bidding process, not oversight of supplemental-benefit use and delivery. As such, the data (appropriately) include information that is necessary for monitoring plan bids and exclude other information that would be useful for overseeing the delivery and use of supplemental benefits. However, we can use the bid data to glean some insights about plans' spending on supplemental benefits.¹⁹ The data are reported using broad service categories (e.g., dental, vision, hearing, transportation, and "other supplemental benefits"). For each service category, MA plans report how much they spent (on a per member per month (PMPM) basis) during the preceding year (referred to as the "base period"). Plans also submit projections of their expected costs for each broad service category in the upcoming year. Those projections, along with a set of other factors, determine the plan's bid for the year.^{20,21}

Of the roughly 14 service categories in which plans can offer supplemental benefits, only four are separately and distinctly reported in bid data: dental, vision, hearing, and transportation services. Information for other supplemental benefits is either reported under a broad category (e.g., "other non-Medicare services") or combined with information about Medicare-covered services (e.g., additional days of inpatient hospital care provided as a supplemental benefit is reported under the "inpatient hospital" category, along with information about Medicare-covered hospital stays) (Centers for Medicare & Medicaid Services 2023b). This aggregation severely limits the extent to which bid data can be used to comprehensively assess supplemental-benefit use or spending.

- **MA encounter data.** CMS requires MA organizations to submit encounter records for all health care items and services, including supplemental benefits, provided to their enrollees.²² Accordingly, MA encounter data should be the most detailed source of information for assessing MA enrollees' use of services. However, the Commission has found that the encounter data that plans have submitted to date are incomplete and cannot be used for many analyses (the Commission is actively exploring whether there are targeted analyses for which the data can be used) (Medicare Payment Advisory Commission 2024a).²³

Several factors limit the possibility of using encounter data to assess supplemental-benefit utilization. One limitation is that, up until 2024, the Encounter Data Processing System (EDPS) that CMS uses to collect encounter records from MA plans was not configured to accept dental claims (Centers for Medicare & Medicaid Services 2024h).²⁴ As a result, the encounter data cannot be used to assess dental services, yet plan bids show that dental is a major category of supplemental benefits. A second limitation is that, although MA plans have long been required to submit encounter records for supplemental benefits, CMS did not provide instructions for submitting records for supplemental benefits for years prior to 2024 (Centers for Medicare & Medicaid Services 2024h). GAO has previously reported that this lack of guidance, along with technical limitations of the EDPS, has resulted in confusion among MA plan officials about whether and how to submit encounter records for supplemental benefits (Government Accountability Office 2023). See the text box on using encounter data to assess use of MA supplemental benefits for more information (pp. 96–99).

As a result of these limitations, it is unclear to what extent encounter data could be used to assess MA enrollees' use of supplemental benefits. In this chapter, we explore whether there are certain categories of supplemental benefits for which it may be feasible to use encounter data to assess utilization of the services. Our preliminary analysis of encounter data for 2021 (the latest data available at the time of our analysis) suggests that the encounter data for vision and hearing services

may be usable, but the data for other supplemental benefits appear to be incomplete.

New data submission requirements for 2024 will provide more information about supplemental benefits

In 2024, CMS began implementing a series of actions to improve and increase the amount of data that plans report regarding use of and spending for supplemental benefits. The changes include:

- **Dental encounter records.** Beginning in 2024, the EDPS—which plans use to submit encounter records to Medicare—was updated to accept submission of encounter records for supplemental dental benefits.
- **Encounter records for other non-Medicare services.** In 2024, CMS issued new guidance for how encounter records for supplemental benefits should be submitted to the EDPS, including a supplemental-benefit indicator that can be used to identify encounter records for supplemental benefits and a set of “default” codes that are to be used to report items or services for which a typical diagnosis, procedure, and/or revenue code does not apply (Centers for Medicare & Medicaid Services 2024c). CMS also provided instructions for submitting information about supplemental benefits that do not produce the same types of utilization data as medical services (e.g., fitness benefits or over-the-counter (OTC) debit cards).

Encounter data could, in theory, also be a vehicle for collecting information about how much plans and enrollees spend on services. Such information could be used to assess the reductions in cost sharing that MA plans provide; however, the payment-related fields of the encounter data are incompletely populated and of unknown reliability. This shortcoming is not addressed in CMS's recent changes.

- **Plan-level use and spending data.** Starting with the 2024 plan year, as part of the Part C Reporting Requirements (generally used to monitor plans), CMS began requiring MA plans to report aggregated information about their enrollees' use of supplemental benefits and their spending on those benefits (Centers for Medicare & Medicaid Services 2024g). Plans will be required to report:

- the number of enrollees eligible for the benefit,
- the number of enrollees who used the benefit at least once,
- the total instances of utilization among eligible enrollees,
- the median number of utilizations among enrollees who used the benefit at least once,
- the total net amount incurred by the plan to offer the benefit,
- the type of payment arrangement(s) the plan used to implement the benefit (e.g., capitation, flat fee),
- how the plan accounts for the cost of the benefit (how the plan determines and measures administrative costs, costs to deliver, and any other costs the plan captures), and
- the total out-of-pocket cost per utilization for enrollees who used the benefit.

The data will be reported for approximately 100 supplemental benefits spread across 14 categories, including dental, vision, hearing, transportation, and SSBCI (Centers for Medicare & Medicaid Services 2024g). These new data should provide an overarching view of use of and spending for supplemental benefits. However, the utility of the new data will be somewhat limited because the data will be reported at the MA plan level, so it will not be possible to assess which enrollees within a plan are using the benefits. That level of aggregation will limit the types of analysis that can be conducted; for example, without knowledge of who used a benefit, it is difficult to assess how the use of the benefit relates to the individual's medical or social needs. This limitation leaves a general lack of transparency about who is using supplemental benefits, whether the benefits are being accessed by beneficiaries who could most benefit from them, and the value of the benefits for beneficiaries and taxpayers. We anticipate that the data for 2024 will be available for analysis sometime in the second half of 2025 or in 2026.

- **Detailed medical loss ratio data.** MA plans are required to maintain a medical loss ratio (MLR) of

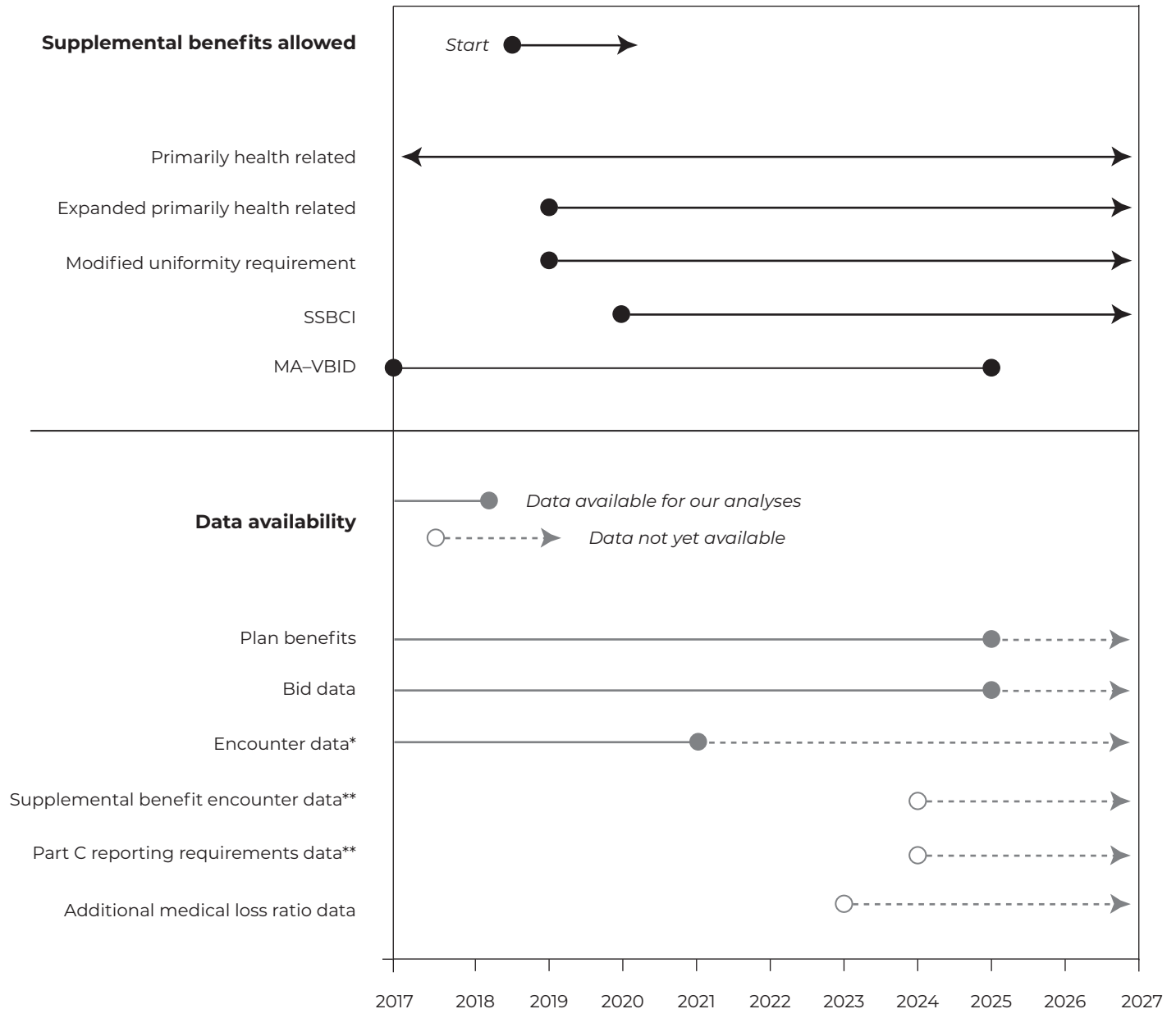
85 percent (42 CFR Sec. 422.2410(b)).²⁵ To monitor and enforce this requirement, CMS collects data from MAOs about their revenues and expenditures in each plan year. The amount of detail that CMS collects for such purposes has fluctuated over time. Starting with plan-year 2023, CMS began requiring MA plans to report additional detail about their expenditures on supplemental benefits as part of the required data. MAOs are required to report, for each contract, their expenditures for 16 different MA supplemental benefits (each separately reported), as well as their expenditures for SSBCI and “all other primarily health related supplemental benefits” (18 total reporting categories). The data are collected toward the end of the calendar year following the contract year (i.e., data pertaining to 2023 are collected at the end of 2024), and the time it takes to make the data publicly available varies. The additional details collected for 2023 were not available at the time of our analysis. This information will provide a better understanding of MAOs' spending on supplemental benefits but will be limited by the fact that the information will be reported at the contract level.

Altogether, the new data-reporting requirements will address some, but not all, of the data limitations that hinder our ability to assess how MA enrollees use supplemental benefits and how much plans spend on the benefits. Due to lags between when the data are collected, reported, and made available to researchers, it may be several more years before the full range of data are available for analysis. Figure 2-3 (p. 74) illustrates the time frames in which information about MA benefits is available and how the schedule limits our analysis of supplemental benefit use. Note that, at the time of our analysis, the most recently available encounter data were for 2021. Our analysis of plan bids and benefit data suggests that spending for supplemental benefits has grown significantly since 2021 and that the types of benefits being offered to MA enrollees have expanded in the intervening years.

Until better data are available, we must rely on existing data sources to try to understand MA enrollees' use of supplemental benefits. In the rest of this chapter, we analyze plan benefit data to assess trends in the types of benefits MA plans offer to their enrollees. Where possible, we also assess sources of

FIGURE
2-3

Lags in data availability hinder analysis of supplemental benefit utilization



Note: SSBCI (special supplemental benefits for the chronically ill), MA (Medicare Advantage), VBID (Value-Based Insurance Design). CMS broadened its definition of “primarily health related” and relaxed the requirement that benefits be offered uniformly to all enrollees beginning in 2019, expanding the types of supplemental benefits that plans could offer and enabling plans to target supplemental benefits to particular groups of enrollees. The Bipartisan Budget Act (BBA) of 2018 gave plans the flexibility to provide supplemental benefits that are not primarily health related to chronically ill enrollees (known as “special supplemental benefits for the chronically ill”). This change took effect in 2020. In 2017, the Center for Medicare & Medicaid Innovation (the CMS Innovation Center) started a demonstration called the Medicare Advantage Value-Based Insurance Design (MA-VBID) Model that lets participating plans offer a wider range of supplemental benefits and target them to certain types of enrollees. The model was initially limited to a small number of insurers offering plans in seven states. The BBA of 2018 expanded the model to all states starting in 2020. In 2024, CMS announced that the model will cease at the end of 2025.

* Before 2024, the Encounter Data Processing System used to collect encounter data from plans was not configured to accept data on the use of supplemental dental benefits.

** Points indicate the measurement years for which the plans are required to begin reporting and do not reflect delays between the measurement year and the year in which the data are available for analysis.

Source: MedPAC analysis of MA policies and data resources.

information about MA enrollees' use of the benefits. For dental benefits, because encounter data are not available, we analyze data from the MCBS. For other benefits, we conducted an analysis of the data to explore the extent to which the data can be used to assess the use of supplemental benefits.

Supplemental benefits: Cost-sharing and premium reductions

MA plans can use the rebates they receive from Medicare to reduce cost sharing and Part B and Part D premiums for their enrollees. In this section, we use plans' bid data to summarize the services for which MA plans report reducing cost sharing and the availability of premium reductions. Complete and accurate MA encounter data would be the best vehicle for collecting information about the cost sharing paid by MA enrollees; unfortunately, the cost-sharing fields in the encounter data are incompletely populated and of unknown reliability. In lieu of reliable claims-level information, we must use the information from plans' bid data, which include plans' estimates of cost sharing for broadly defined service categories reported on a per member per month (PMPM) basis. As such, bid data cannot be used to assess what enrollees actually pay or which enrollees benefited from plan-provided cost-sharing reductions, but bid data can provide an aggregated view of how plans anticipate using rebate dollars allocated for cost-sharing reductions. The premium reductions that plans provide as supplemental benefits are used equally by all enrollees in a plan and so do not produce (or require) utilization data like those required for understanding the use of other supplemental benefits.

Reduced cost sharing for Part A and Part B services

Reduced cost sharing for Part A and B services is one of the most common MA supplemental benefits: Nearly all conventional MA plans allocate a portion of rebate dollars to reducing the amount enrollees pay OOP for care. In 2025, conventional MA plans allocated more of their rebate to reducing cost sharing (43 percent) than to any other category of supplemental benefits (Table 2-1, p. 69). Those dollars can be used both to reduce the amount enrollees pay for particular services

and to finance the MOOP limit plans are required to offer.²⁶ Understanding how much MA enrollees pay for care is important for several reasons. First, it is important to assess whether plans are adhering to Medicare's cost-sharing rules for MA plans. Second, beneficiaries who are choosing between FFS Medicare (with the potential purchase of a Medigap plan) and MA could use the information to inform their decision.²⁷ Third, lessons from MA could provide insights into how to improve the cost-sharing structure of FFS Medicare.

In contrast with other types of supplemental benefits, there is little question as to whether MA enrollees use the cost-sharing reductions that MA plans offer as supplemental benefits. Because the reductions are often applied to commonly used services and are adjudicated at the point of service, most MA enrollees who use at least one Medicare-covered service during the year are likely to use at least one service for which cost sharing under their plan is lower than what they would have paid if they had been enrolled in FFS Medicare without another form of coverage (such as Medigap). In addition, all enrollees who reach the MOOP limit that plans are required to provide can be considered to have "used" the benefit. However, the number of enrollees affected by the cost-sharing reductions in any given plan depends on the types of services for which the plan chooses to reduce cost sharing and the types of services that enrollees use. Unfortunately, inadequate data limit our ability to assess the cost sharing paid by MA enrollees: No publicly available resources contain reliable claim- or beneficiary-level cost-sharing information. MA encounter data would be the best vehicle for collecting information about cost sharing, but the cost-sharing fields in the data are incompletely populated and of unknown reliability.²⁸ In lieu of reliable claims-level information, we must use information from plans' bids, which include financial projections for the plan.

In their bids, plans estimate the amount that they anticipate their enrollees will pay in cost sharing for Medicare-covered services in the upcoming year (reflecting the combined effects of the required MOOP limit in MA, plans' benefit design decisions, plans' use of rebates, and plans' expectations about the services enrollees will use). The bid pricing tool that CMS uses to collect bids automatically calculates an estimate of

the actuarially equivalent amount of cost sharing that would be charged for Medicare-covered services if the same population were enrolled in FFS Medicare (without an additional form of coverage, such as Medigap). The actuarial-equivalence calculations hold utilization constant and do not reflect the possibility that beneficiaries would likely use services differently if charged different cost sharing. The net difference between a plan's cost sharing for Medicare-covered services and the estimated amount in FFS (for enrollees without an additional form of coverage) is considered a supplemental benefit that can be financed using the plan's rebate (if the cost sharing under the plan is lower, which is generally the case). Because the calculations in the bid pricing tool are made separately for each service category, we can gain a rough sense of the service categories for which plans expect to use relatively more rebate dollars to reduce enrollees' cost sharing.

Table 2-2 shows conventional plans' estimates of the cost-sharing reductions their members will experience in 2025, expressed on a PMPM basis. The table also shows MedPAC's estimates of the per unit cost-sharing reductions that enrollees might experience when using a particular service (estimated using the PMPM cost-sharing reduction and the utilization rates that plans report in their bids). We focus on the cost-sharing reductions provided by conventional plans because enrollees in those plans are less likely to be dually eligible, and are therefore less likely to have help from Medicaid paying their cost sharing. Further, because SNPs devote a smaller portion of their rebates to reducing cost sharing (due to the high percentage of enrollees who are dually eligible), cost-sharing reductions in MA are concentrated in conventional plans. To provide a sense of the relative cost of each type of service, we also show an estimate of the "allowed amount," which is the plan's negotiated payment rate for the service—typically shared between the plan and the enrollee through cost sharing.²⁹ The reductions shown in the table reflect the combined effects of the required MOOP limit in MA, plans' benefit design decisions, and plans' use of rebates. Because the bid pricing tool does not account for the fact that roughly 85 percent of FFS enrollees have another form of coverage that reduces their out-of-pocket costs, the data indicate how plans estimate that rebate dollars will be distributed across service categories but do not reflect how enrollees' true OOP costs in MA differ from

the amount they might have paid if they enrolled in FFS Medicare and purchased an additional form of coverage (Medicare Payment Advisory Commission 2024b). In 2025, conventional plans project that cost sharing for Medicare-covered services for their members will be lower than the amount those members would be expected to face if they were in FFS Medicare without another form of coverage for almost all service categories.³⁰ The two exceptions are ambulance and home health services. CMS does not impose a service-specific limit on cost sharing for ambulance services in MA, so plans are subject to the general rule that they cannot charge more than 50 percent in coinsurance or an actuarially equivalent copayment for the services (CMS has previously contemplated adding a service-specific cost-sharing limit for ambulance services (Centers for Medicare & Medicaid Services 2022b)). For home health, FFS Medicare does not charge cost sharing, while some MA plans do.

Looking across service categories, on a PMPM basis, conventional plans anticipate that (in 2025) the largest reduction in cost sharing will be for professional services such as primary care and specialty visits—a reduction of \$32 PMPM, or roughly 13 percent of the allowed amount (the negotiated payment rate between the plan and the provider). Because the actuarially equivalent cost sharing in FFS Medicare would be roughly 20 percent, this reduction equates to the MA plan reducing the cost sharing by slightly more than half (relative to FFS Medicare without additional coverage).³¹

PMPM estimates, however, do not account for the fact that not all enrollees will use certain services during the year. To better convey how cost-sharing reductions may affect certain MA enrollees, we recalculated the cost-sharing reductions on a "per unit" basis using the plans' projections of utilization for each service category (Table 2-2).³² On a per unit basis, we estimate that conventional plans expect the largest cost-sharing reductions per service to be for outpatient surgical visits, with a reduction of roughly \$342 per visit (or about 12 percent of the allowed amount per visit). Ultimately, though, the total value of cost-sharing reductions for any given enrollee depends on the mix of services they use, the amount of a service they use, whether they receive the services within their plan's network, and other aspects of their plan's benefit design. For example, some plans apply service-specific

**TABLE
2-2**

Conventional plans' estimates of MA cost-sharing reductions vary by service category, but effects on enrollees depend on the services used, 2025

Service category ^a	Unit	Average cost-sharing reduction relative to FFS Medicare without additional coverage		Average allowed amount ^b		Reduction as percentage of allowed amount	
		PMPM	Per unit of service	PMPM	Per unit of service	PMPM	Per unit of service
Inpatient facility	Days	\$5	\$66	\$280	\$3,137	2%	2%
Skilled nursing facility	Days	3	57	34	633	9	9
Home health ^c	—	0	—	24	—	-1	—
Ambulance	Trips	-1	-50	14	679	-7	-7
DME ^d	—	1	6	20	105	5	6
Outpatient, emergency	Visits	5	104	46	996	10	10
Outpatient, surgery	Visits	11	342	90	2,839	12	12
Outpatient, other	Visits	9	17	124	233	8	7
Professional	Visits	32	20	254	157	13	13
Part B drugs	Scripts	9	53	97	588	9	9

Note: MA (Medicare Advantage), FFS (fee-for-service), PMPM (per member per month), DME (durable medical equipment). "Conventional plans" excludes employer group plans and special-needs plans. Positive numbers indicate that estimated cost sharing in MA is lower than the estimated cost sharing in FFS without additional forms of coverage; negative numbers indicate that MA cost sharing is higher than in FFS without additional forms of coverage. All dollar figures are rounded to the nearest dollar. Plan bids include estimates of the amount that the plan will spend PMPM on cost-sharing reductions for their enrollees, by service category, but these projections may not reflect actual plan spending. The reductions shown in the table reflect the combined effects of the required maximum out-of-pocket limit in MA, plans' benefit design decisions, and plans' use of rebates. The figures shown here include the cost-sharing reductions offered by plans that charge a Part C (MA) premium; for those plans, the cost-sharing reductions may be financed partially by Part C premiums paid by enrollees. To estimate per unit cost-sharing reductions, we calculated total plan spending on cost-sharing reductions as the product of the PMPM rate and the plan's projected membership for the year, divided by the number of plan-estimated units (units are typically visits, trips, or days, calculated as the plan-estimated utilization rate times the number of members). Estimates for each service category are based on data only for plans that reported data using the most common reporting unit for the category.

^a The bid pricing tool that plans use to submit bids includes 11 Medicare-covered service categories. We excluded the "other Part B services" category because there is variation in whether plans report data in the category.

^b The allowed amount is the plan's negotiated payment rate for the service, typically shared between the plan and the enrollee through cost sharing.

^c We do not calculate per unit amounts for home health because we have previously found that plans appear to use different units when reporting home health utilization in their bids (Medicare Payment Advisory Commission 2024a).

^d The DME service category includes DME, prosthetics, and certain diabetes-related products. The unit used to report DME products in the bid pricing tool is most commonly listed as "other."

Source: MedPAC analysis of MA bid data.

deductibles or use tiered cost sharing that varies based on the provider delivering the services. As such, these figures can give only a rough impression of cost sharing in MA, and data limitations prevent us from being able to reliably assess how variation in cost sharing within and across MA plans affects MA enrollees.

MA plans generally operationalize cost-sharing reductions through changes to their benefit design—dialing up or down the amount of cost sharing charged

to enrollees for specific services. However, since 2021, CMS has permitted plans to use an additional method—referred to as a "reduction in cost sharing" benefit, or RICS—to deliver further cost-sharing reductions for their enrollees. Under a RICS benefit, the plan designates a list of services and a monetary limit; plan enrollees can use the RICS benefit to cover cost-sharing expenses for any of the plan-designated services, up to the limit set by the plan. Typically, the benefit is delivered using a prefunded debit card

provided to the enrollee. For enrollees, the RICS may provide an attractive mix of flexibility and extra financial protection. For plans, the RICS benefit may be appealing because it can be simpler to administer for certain types of services because the plan's financial liability can be capped at a plan-designated limit and because the plan can design the benefit to encourage use of services that it views to be of higher value.

The share of MA enrollees in conventional plans that offered the RICS benefit rose from 1 percent in 2021 to a peak of 12 percent in 2023. Since then, the percentage has declined; in 2025 only 6 percent of conventional plan enrollees were in a plan offering a RICS benefit. In the initial years of the benefit, plans mostly allowed enrollees to use the benefit to pay only for dental services or only for dental, vision, and hearing services. More recently, plans have granted enrollees more flexibility, allowing them to use the benefit on Medicare-covered services (such as doctors' visits) in addition to supplemental benefits. In 2025, about 20 percent of plans offering a RICS benefit allow their enrollees to use the benefit to reduce or cover cost sharing for essentially any of the major Medicare-covered service categories; roughly half allow the benefit to be used only for cost sharing for Medicare-covered services, one-third allow use for both Medicare and non-Medicare services, and the remainder allow use for only non-Medicare services.³³ The average estimated monthly limit for 2025 was \$36, a significant decrease from \$81 in 2021 when the benefit was first offered.³⁴ Plans offering RICS in 2025 typically projected similar cost-sharing levels (excluding the effects of the RICS) to plans not offering RICS and allocated a similar percentage of their rebate to the traditional forms of cost-sharing reduction (i.e., using the benefit design), suggesting that the RICS benefit is being offered as an additional form of cost-sharing assistance for enrollees rather than as a substitute for lowering cost sharing through the benefit design.

Part B and Part D premium reductions

MA plans commonly use rebate dollars to reduce or eliminate Part D premiums for their members; some plans also offer reduced Part B premiums (though this choice is less common). In 2025, nearly 100 percent of eligible Medicare beneficiaries (those with Part A and Part B coverage) have access to at least one conventional MA plan (i.e., excluding SNPs

and employer group plans) that includes Part D drug coverage and charges no Part C or Part D premium (enrollees still pay the Medicare Part B premium) (Medicare Payment Advisory Commission 2025).

In contrast to cost-sharing reductions and coverage of non-Medicare services, estimating enrollees' use of premium reductions is relatively straightforward because the premium reductions are adjudicated automatically between CMS and the plans, requiring no action by the enrollees. About 76 percent of MA enrollment in 2025 is projected to be in the "zero-premium" plans that include Part D coverage and charge no Part C or Part D premium. Ninety-nine percent of beneficiaries have access to plans that offer some reduction in the Part B premium; about 32 percent of 2025 conventional plan enrollees were projected (in plan bids) to be in these premium-reduction plans, and the average monthly premium reduction was \$44 (the monthly Part B premium for 2025 was \$185) (Centers for Medicare & Medicaid Services 2024b).

Using data from plans' bids, in which plans report the amount of MA rebate used to reduce Part D or Part B premiums, it is possible to estimate total Medicare spending on premium reductions and MA enrollees' financial savings on premiums. Using rebate data for 2025, we estimate that Medicare will pay MA plans (via rebates) about \$20 billion to reduce Part D and Part B premiums and enhance Part D benefits for their enrollees (about \$15 billion of which was for Part D premium reductions and benefit enhancements).

Supplemental benefits: Non-Medicare services

In recent years, plans have allocated (in their bid projections) a growing share of MA rebates to the provision of non-Medicare services, such as dental, vision, and hearing services. For many years, when CMS required that supplemental benefits be primarily health related, dental, vision, and hearing services were among the most common supplemental benefits. As described earlier, significant policy changes have gradually expanded the types of benefits that plans may offer. As a result, plans are gradually covering a larger number of non-Medicare services. According to CMS,

over 99 percent of MA plans offered at least one such benefit in 2022, and the median number of benefits offered was 23; dental, vision, hearing, and fitness benefits were the most common (Centers for Medicare & Medicaid Services 2024g).

Figure 2-4 (p. 80) uses the projections from plans' bid data to assess which non-Medicare services plans expect to spend the most delivering (on a PMPM basis). Plan projections are reported using highly aggregated categories: Projected spending for dental, vision, hearing, and transportation benefits are reported separately; spending for all other non-Medicare services is reported in a pair of catch-all categories. As such, we are unable to break out the spending for services like gym memberships or OTC cards. The data show that, in 2025, conventional plans prioritize using rebate dollars to provide dental benefits while SNPs prioritize other types of benefits (such as OTC items, food and produce, or flexible-benefit cards).³⁵ Although dental benefits accounted for a smaller percentage of SNPs' estimated spending, because total SNP rebates are so much larger than those of conventional plans, SNPs projected spending more than conventional plans on dental benefits (about \$26 PMPM, versus \$19 for conventional plans). SNPs expected to spend considerably more (roughly \$130 PMPM, versus \$14 PMPM in conventional plans) on other types of supplemental benefits. SNPs' projected spending for these services has grown substantially over the last five years, and SNPs now report spending more than twice as much on these benefits as they do on all other non-Medicare services combined (including dental, vision, hearing, and transportation benefits).

Enrollment in plans offering supplemental dental, vision, and hearing coverage has increased since 2014

Dental, vision, and hearing benefits are among the most commonly offered supplemental benefits and have been allowed under CMS rules for many years. These benefits address health challenges that many seniors face as they age and for which there is limited coverage under traditional FFS Medicare (see text box for more information on supplemental benefits, pp. 81–83). As shown in Figure 2-4 (p. 80), these benefits continue to constitute a majority of conventional plans' reported projected spending on non-Medicare services each year: In 2025, conventional MA plans estimated

that dental, vision, and hearing benefits would account for about 53 percent of plan spending on non-Medicare benefits, up from 35 percent in 2014 (2014 data not shown). For SNPs, growth in the projected spending on newer types of benefits has outpaced spending on dental, vision, and hearing services. Projected SNP spending on dental, vision, and hearing services—as a share of total non-Medicare benefit spending—fell from 43 percent to roughly 20 percent between 2014 and 2025, despite rising in nominal dollar terms from \$12 to nearly \$40 PMPM (2014 data not shown).

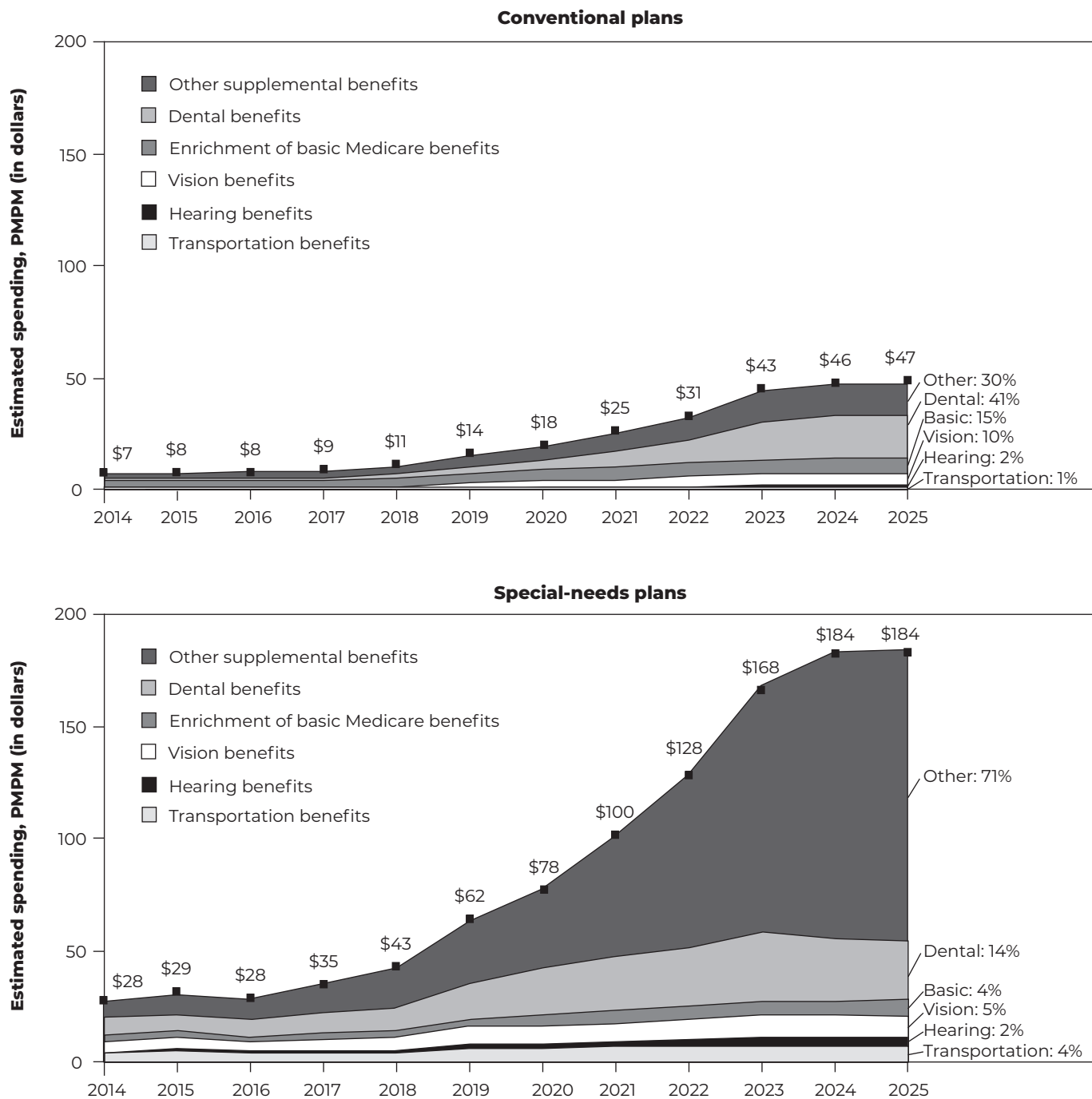
We analyzed plan benefit-package data for 2014 through 2025 to assess how the percentage of MA enrollees in plans offering supplemental dental, vision, and hearing services has changed over time. Enrollment in such plans could change because the number of plans offering the benefit changed, because enrollees selected plans that offered the coverage, or both. The share of MA enrollees in conventional plans that offer these benefits has increased significantly since 2014. In SNPs, the share of enrollees in such plans has long been higher than in conventional plans and has been more stable over time, but the services offered within each benefit have shifted gradually in the direction of covering more types of services.

Efforts to summarize and compare MA supplemental benefits are complicated by the fact that plans' coverage of the services can vary in many ways. For example, plans can choose which types of dental, vision, or hearing services they cover. In 2024, for instance, CMS required plans to provide information about whether and how they cover 11 distinct subcategories of dental services, 6 subcategories of hearing services, and 7 subcategories of vision services.³⁶ Plans decide whether they will cover none, some, or all of these services. The Medicare Plan Finder tool uses a checkmark to indicate which benefit category (e.g., dental, vision, and/or hearing) each plan covers, but plans receive a checkmark if they cover any (at least one) service in one of the relevant subcategories for the benefit. For example, a plan that covers only routine hearing exams would receive a checkmark for providing hearing benefits, as would a plan that covers hearing exams, fittings and evaluations for hearing aids, and the hearing aids themselves.

Even when MA plans cover a particular benefit, they may limit the number and type of services that

FIGURE
2-4

Plans project that a majority of rebate-financed spending on non-Medicare services is for dental and other types of benefits, 2014–2025



Note: PMPM (per member per month). "Conventional plans" excludes employer group plans and special-needs plans. "Special-needs plans" excludes employer group plans and non-special-needs plans. "Other supplemental benefits" includes benefits such as fitness benefits, over-the-counter items, and special supplemental benefits for the chronically ill. Figures represent plans' projected spending PMPM for each service category (these projections may not reflect actual plan spending), excluding amounts financed by Part C premiums paid by Medicare Advantage enrollees. Figures are based on the enrollment-weighted national average. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of MA bid data.

Supplemental benefits may address health and social needs faced by many Medicare beneficiaries, but evidence on outcomes is lacking

Medicare Advantage (MA) supplemental benefits have the potential to address challenges that many Medicare beneficiaries face. For example, a significant percentage of Medicare beneficiaries report having dental, vision, or hearing difficulties. These challenges generally increase with age but are also common for beneficiaries under age 65, who are typically eligible for Medicare due to a disability. Supplemental benefits may also address health-related social needs that affect many Medicare beneficiaries, such as food insecurity or transportation difficulties. However, evidence regarding the extent to which supplemental benefits address enrollees' needs or affect their health outcomes is lacking. Focus groups and surveys of beneficiaries suggest that beneficiaries appreciate having access to supplemental benefits, but the findings from such studies do not shed light on whether the benefits meet beneficiaries' needs or provide good value relative to their cost.

Dental, vision, and hearing challenges faced by Medicare beneficiaries

A significant percentage of Medicare beneficiaries report having vision-, hearing-, or dental-related difficulties. Nearly all Medicare beneficiaries (over 94 percent) report having vision problems, and roughly 46 percent report using a hearing aid or having trouble hearing (Centers for Medicare & Medicaid Services 2022a). One analysis of the 2016 MCBS found that, among beneficiaries 65 and older, more than half of beneficiaries with vision problems also reported having some degree of hearing impairment (Assi et al. 2022). At the same time, according to the Medicare Current Beneficiary Survey (MCBS), about 15 percent of Medicare beneficiaries living

in the community have trouble eating solid food because of dental problems (Centers for Medicare & Medicaid Services 2025a). Approximately 7 percent have chronic tooth pain, while nearly 17 percent have lost (or had removed) all of their natural teeth. For all three measures of oral health, beneficiaries under 65 are substantially more likely to report having difficulties than other beneficiaries: Nearly 30 percent of these enrollees report having difficulty eating solid foods due to trouble with their mouth or teeth, and roughly a quarter report having chronic tooth or jaw pain (Centers for Medicare & Medicaid Services 2021a, Centers for Medicare & Medicaid Services 2020a). Supplemental benefits are one way that MA plans and enrollees may seek to address enrollees' vision, hearing, and dental needs. However, to date, there is relatively limited evidence about the effects of supplemental benefits on the vision, hearing, and dental outcomes of MA enrollees.

Medicare beneficiaries also face health-related social needs

Health outcomes can be affected by nonmedical aspects of life such as access to adequate housing, transportation, or nutrition. People's health-related social needs (HRSN) are shaped by social determinants of health (SDOH), which are the conditions and environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes.

Evidence from the MCBS and other sources suggests that a significant percentage of Medicare beneficiaries face HRSN. Roughly 14 percent of Medicare beneficiaries living in the community

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enrollees can receive and the maximum amount the plan will spend on the benefit. Service-specific quantity limits are particularly common for routine, relatively low-cost services where plans typically do not require cost sharing. For more complicated dental, hearing, and

vision services, plans typically use other mechanisms such as cost sharing, deductibles, or maximum coverage limits to control spending. In 2024, among conventional plans, spending limits were used by nearly 90 percent of plans with dental benefits, roughly 40

Supplemental benefits may address health and social needs faced by many Medicare beneficiaries, but evidence on outcomes is lacking (cont.)

report having trouble getting to places such as doctors' appointments. About 18 percent do not drive or have given up driving, and about 23 percent report asking others for rides (Centers for Medicare & Medicaid Services 2024a). Seventeen percent of beneficiaries are food insecure, meaning that in the last year there was a time in which their food did not last and they had no money to buy more (12.5 percent), they skipped or reduced the size of their meals to stretch their food supplies (6.3 percent), they ate less because they did not have enough money for food (6.1 percent), they did not eat because they did not have enough money for food (3.1 percent), or they could not afford a balanced meal (12.3 percent) (Centers for Medicare & Medicaid Services 2024a). For both transportation difficulties and food insecurity, beneficiaries under 65 reported significantly more challenges than the overall Medicare population.

Compared with fee-for-service (FFS) Medicare, MA plans and entities operating under alternative payment models such as accountable care organizations (ACOs) have more flexibility and incentives to address the HRSN of their patients or enrollees. Capitated payments under MA provide incentives for plans to consider patient health more holistically as a way of managing spending or improving quality scores, which can mean attending to enrollees' social needs. MA supplemental benefits—particularly the special supplemental benefits for the chronically ill, which plans have had the option to offer since 2020—are one route through which plans can attempt to address those needs. In interviews with researchers, officials from MA plans have reported an increasing interest in addressing members' HRSN, but perspectives have varied as to whether and how to do so (Thomas et al. 2019).

In a previous analytic cycle, MedPAC contracted with L & M Policy Research to conduct a literature review and interview stakeholders about steps that health care providers, payers, and other organizations have taken to address SDOH (L & M

Policy Research 2023).³⁷ The literature review found that, although many organizations are working to address SDOH, there is a great deal of heterogeneity among interventions, and objective evaluations of the interventions are limited. The most common types of interventions addressed by the studies included in our literature review involved coordination of care (i.e., connecting at-risk patients with various social and medical services), food insecurity and nutrition, and housing needs. Most interventions in the literature were associated with improvements in some measures, but others showed mixed or inconclusive results. Altogether, there is strong evidence that SDOH and the HRSN that stem from them can create health challenges, but whether MA plans can design and implement interventions that meet those needs and whether such interventions are an efficient way to improve health outcomes or reduce overall spending remains a question.

Beneficiary perspectives on supplemental benefits

Because MA supplemental benefits are intended to address important challenges facing beneficiaries, we reviewed sources of information on enrollees' perspectives on the benefits. Evidence from the Commission's annual beneficiary focus groups and surveys conducted by other researchers generally suggests that beneficiaries appreciate having access to supplemental benefits, but their perspectives vary regarding the importance of the benefits (relative to other aspects of their coverage). In MedPAC's annual beneficiary focus groups, MA enrollees have tended to say that supplemental benefits are nice to have access to but were not the primary factor affecting their coverage decisions (NORC at the University of Chicago 2024, NORC at the University of Chicago 2023). For example, one beneficiary stated, "I just started getting [the supplemental benefit] last year. It was an added benefit, and it is a nice feature, but it wouldn't be the decision-maker for me." Another noted, "It

(continued next page)

Supplemental benefits may address health and social needs faced by many Medicare beneficiaries, but evidence on outcomes is lacking (cont.)

didn't factor into choosing the plan. . . . I don't take many over-the-counter [drugs] because of all the prescriptions I take. So we struggle to use even half of [the supplemental over-the-counter card value] every quarter." Among dually eligible MA enrollees, very few reported considering supplemental benefits when selecting a plan, instead prioritizing coverage of their prescription drugs and primary care providers. Some enrollees, however, weighed supplemental benefits more highly: One (non-dually eligible) MA enrollee said that "every year when the book or the email comes as to how the benefits are going to change, I just go right to there and say which one's better [for me]? . . . Whatever gives me the most [supplemental benefits]." Dually eligible enrollees who considered supplemental benefits when making enrollment decisions reported that they valued the card-based benefits that can be used to pay for over-the-counter (OTC) items, copays, and other items. For example, one enrollee reported that "now [the MA plan is] offering \$157 in terms of food, the OTC benefit. That's [a] huge attraction." Some MA enrollees mentioned liking the dental, vision, and hearing benefits and that the inclusion of those benefits had led them to choose MA over FFS Medicare (NORC at the University of Chicago 2023).

The extent to which MA enrollees in our focus groups used their supplemental benefits varied. One beneficiary reported that they signed up for MA to specifically to "get all the benefits they could get" but had not used any dental, vision, hearing, or gym benefits since enrolling (NORC at the University of Chicago 2024). Of beneficiaries with access to a gym benefit, a subset of enrollees reported using the benefits; some rural participants noted that the gyms covered by the benefit were too far away (NORC at the University of Chicago 2023). Some participants also described using their transportation benefits: "[When I switched to] Medicare Advantage . . . they asked me, 'Do you want transportation?' I'm like, 'Sure, is it free?' and he said yes, so I'm like, OK, I can get a ride to the doctor and back" (NORC at the University of Chicago 2023). Participants living in urban areas reported using

the transportation benefit to see their preferred provider, and some reported using the benefit to travel farther to be seen at larger academic medical centers. Rural beneficiaries had fewer experiences with supplemental transportation benefits, but a few had used the services, one with mixed satisfaction. These perspectives are generally in line with other studies that have asked beneficiaries about their views of supplemental benefits.

One study by the Commonwealth Fund asked Medicare beneficiaries how important, if at all, was access to extra benefits beyond doctor and hospital coverage (Commonwealth Fund 2025b). Across all Medicare beneficiaries, 83 percent considered supplemental benefits to be important; the share was higher among MA enrollees, with 89 percent of enrollees considering the benefits important (compared with 74 percent among FFS beneficiaries).³⁸ However, other surveys by the Commonwealth Fund have found that MA enrollees ranked supplemental benefits as less important than getting high-quality care, having access to providers, and having low out-of-pocket costs (Commonwealth Fund 2024). The survey also asked enrollees about their use of supplemental benefits. Across multiple types of benefits, use was higher among beneficiaries who considered the benefits to be important: Roughly 73 percent of MA enrollees who considered supplemental benefits important reported using any of the benefits, while 47 percent of those who did not think the benefits were important reported any use.

Altogether, findings from beneficiary focus groups and surveys suggest that MA enrollees appreciate having access to supplemental benefits, but that use of the benefits is varied. The variability highlights the need for better data regarding enrollees' use of supplemental benefits. Otherwise, it is impossible to know whether supplemental benefits are being used to meaningfully address enrollees' needs and whether the value they provide is commensurate with the high levels of program spending going toward them. ■

percent of plans with hearing benefits, and essentially all plans with vision benefits.³⁹ In addition to spending and quantity limits, plans can use networks to restrict coverage to providers (such as dentists or audiologists) with which the plan contracts; there are no network-adequacy requirements for supplemental benefits, and limited participation by providers could limit enrollees' ability to access the benefits.

Altogether, although we are able to broadly characterize the percentage of MA enrollees who are in plans that offer some level of coverage for dental, vision, hearing, and other benefits, the data mask considerable variation in the nature of the coverage being provided.

Most MA enrollees have some dental coverage, but plans' offerings may vary widely, and relatively little is known about enrollees' use of dental benefits

Our analysis of plan benefit data found that 90 percent or more of MA enrollees are in plans that offer some coverage of dental services, but plans have significant discretion regarding what dental services they cover, and available data do not enable us to know what specific services or procedures may be covered (plan benefits data indicate the subcategories of dental care for which plans offer any coverage but do not indicate which specific procedures or services within the subcategory are—or are not—covered). Plans also have discretion over the level of cost sharing required for dental services, the dentists included in the plan's network, whether prior authorization or referral is required for coverage, and the amount of financial protection provided. The coverage limitations that plans apply can have important implications for enrollees, but beneficiaries might not have sufficient information with which to evaluate the dental coverage offered by different plans.

The system that CMS uses to collect encounter data was not configured to accept dental claims until 2024, so relatively little is known about how much enrollees use dental benefits. MA plans project significant spending on dental benefits, constituting a significant gap in our knowledge of how rebates and supplemental benefits are used. MedPAC's analysis of data from the MCBS found that between 2017 and 2022, more than half of non-dually eligible MA enrollees with dental coverage through their MA plan visited a dentist during the year. MA enrollees paid much of their

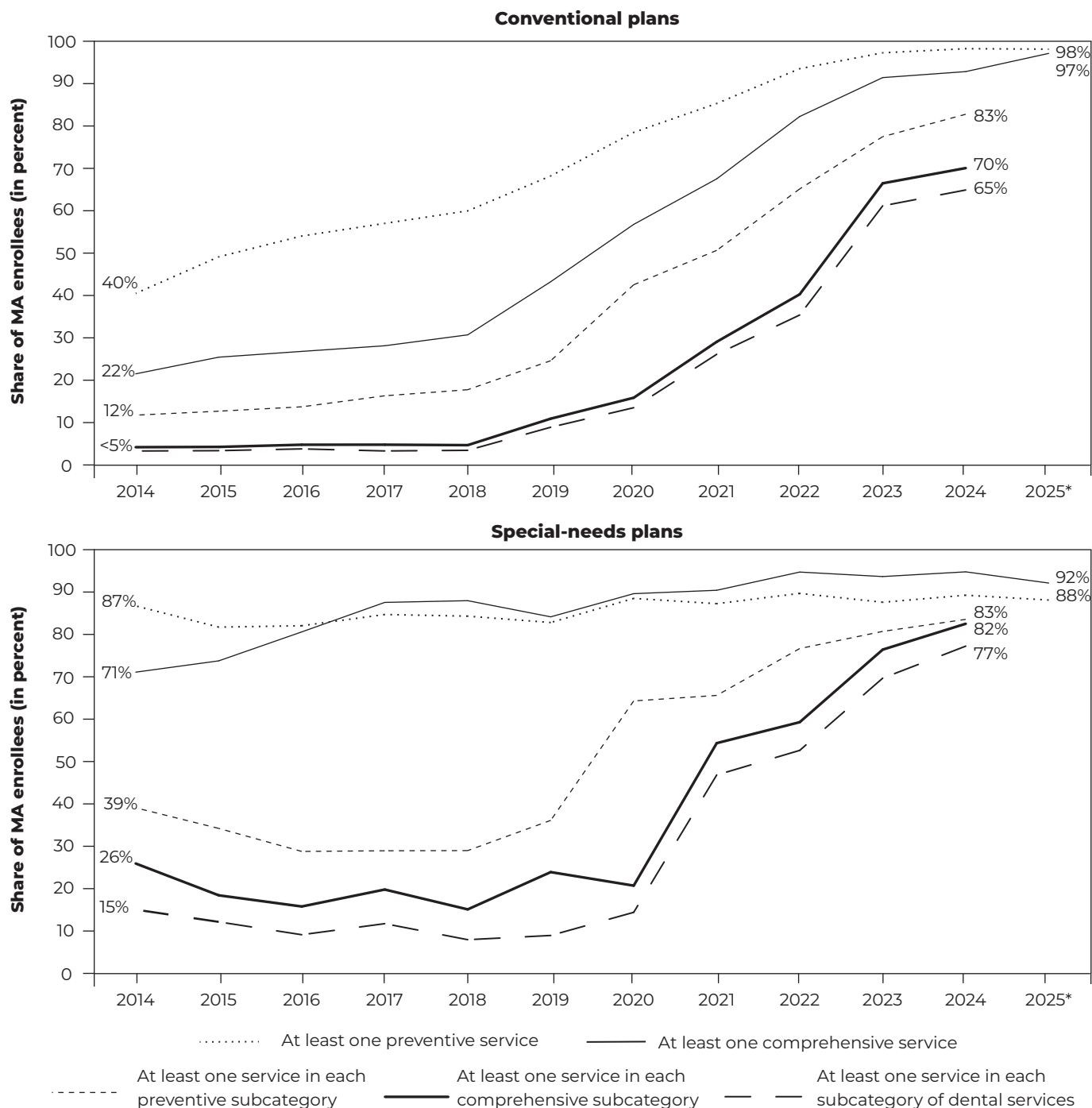
dental expenses OOP, but—for non-dually eligible MA enrollees—the percentage decreased over time, from 61 percent in 2017 to 35 percent in 2022. In both 2017 and 2022, a small share of MA enrollees reported difficulty accessing dental care due to cost. Still, the large decline in OOP costs for non-dually eligible MA enrollees suggests that supplemental dental benefits may have provided increased financial assistance for MA enrollees over the period, but other factors may also have played a role. Further analysis is needed to assess how much the changes observed for MA enrollees are due to changes in supplemental benefits, to broader changes affecting the Medicare population as a whole, or to changes such as the composition of the MA population.

Enrollment in plans offering dental benefits

FFS Medicare generally does not cover dental services like routine cleanings, tooth extractions, or dentures. Some dental services, however, can be covered if they are directly related to a covered medical service or if they require an inpatient admission (Centers for Medicare & Medicaid Services 2021c). Beginning in 2023, FFS Medicare's coverage expanded to include additional clinical scenarios in which Medicare will pay for dental services (Freed et al. 2024). However, these expansions are modest and will impact a relatively small number of Medicare beneficiaries (Freed et al. 2024). MA plans offering supplemental dental benefits can provide a range of services not covered by FFS Medicare. Up until 2025, the dental services that MA plans cover as supplemental benefits were generally subdivided into two categories of services: preventive and comprehensive. Preventive services were subcategorized into oral exams, prophylaxis (cleaning), fluoride treatment, and dental X-rays. Comprehensive services were subcategorized into nonroutine services, diagnostic services, restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery, and other services. Beginning in 2025, CMS reorganized the subcategories of dental services and stopped distinguishing between preventive and comprehensive services. To show trends in dental benefit offerings for 2014 through 2025, we categorized as preventive dental services (for 2025) all of the dental service subcategories that have historically been categorized as preventive services (oral exams, cleanings, fluoride treatments, and X-rays) (Figure 2-5). We categorized all other subcategories of dental services for 2025 as comprehensive services.

**FIGURE
2-5**

MA enrollment in plans offering some degree of preventive and comprehensive dental coverage has increased, 2014-2025



Note: MA (Medicare Advantage). "Conventional plans" excludes employer group plans and special-needs plans. "Special-needs plans" excludes employer group plans and non-special-needs plans. Figure shows the share of MA enrollees in plans that cover at least one service in the given category; plan-specified coverage limits may apply. Beginning in 2025, CMS reorganized how plans report the dental services they cover and stopped distinguishing between preventive and comprehensive services. To show how dental benefits in 2025 compare to those offered in prior years, we categorized oral exams, cleanings, fluoride treatments, and X-rays (which CMS has historically categorized as preventive services) as preventive dental services for 2025; we categorized all other subcategories of dental services for 2025 as comprehensive services.

* We exclude subcategory detail for 2025 because CMS reorganized how dental services are reported beginning in 2025.

Source: MedPAC analysis of MA bid data.

Our analysis of plan benefit data found that the share of MA enrollees in plans offering some coverage of dental services has risen significantly since 2017. Other analyses of plan benefit data have found similar results (McCormack and Trish 2023). In 2025, more than 95 percent of MA enrollees in conventional plans are in plans that cover at least one preventive dental service or at least one comprehensive service (Figure 2-5, p. 85). Roughly 68 percent of conventional plan enrollees in 2025 are in plans that offer coverage of at least one service in all four subcategories of preventive services—down from over 80 percent in 2024. In 2024, roughly 70 percent of conventional plan enrollees were in plans that covered at least one service in each subcategory of comprehensive services. In 2025, at least 70 percent of conventional plan enrollees are in plans that cover at least one diagnostic, restorative, endodontic, or periodontic service—services that were categorized as comprehensive services prior to CMS’s reorganization of how dental services are reported. However, CMS’s new taxonomy includes several new dental service subcategories, with new detail about services like removable prosthodontics (dentures), dental implants, and orthodontics. Fewer conventional plan enrollees are in plans offering these subcategories of benefits (69 percent, 16 percent, and 8 percent, respectively). Given the change in reporting detail, subcategory detail for 2025 is excluded in Figure 2-5.

For enrollees in SNPs, the share of enrollees in plans covering at least one preventive service or one comprehensive service has long been higher than in conventional plans, and in 2025, nearly 90 percent of SNP enrollees are in plans that cover at least one preventive service, and more than 90 percent are in plans that cover at least one comprehensive service. Some SNP enrollees may have access to Medicaid-covered dental services, which could result in differences between the dental benefits offered in conventional MA plans and SNPs. The share of SNP enrollees in plans covering services in all subcategories of preventive or comprehensive dental services has risen sharply since 2018, such that in 2024, roughly three-quarters of SNP enrollees were in these plans. Similar to conventional plans, the change in reporting requirements makes it difficult to characterize how coverage of comprehensive dental services in SNPs changed between 2024 and 2025. However, in 2025, at least three-quarters of SNP enrollees are in plans that

cover at least one diagnostic, restorative, endodontic, or periodontic service (which were categorized as comprehensive services prior to the reporting change). For the new, more detailed dental service subcategories, 83 percent of SNP enrollees are in plans that offer some coverage of dentures, 26 percent are in plans offering some coverage of dental implants, and 14 percent are in plans offering some coverage of orthodontics.

Supplemental dental benefits vary across plans

MA plans have significant discretion regarding what dental services they cover as part of their supplemental benefits and the nature of the coverage. This discretion allows plans to tailor their benefit packages to include services that are attractive to members but may also make it difficult for beneficiaries to understand how coverage varies across plans.

As described above, the services that MA plans cover as supplemental benefits were generally subdivided into two categories of services prior to 2025: preventive services (made up of four subcategories) and comprehensive services (made up of seven subcategories). (CMS stopped distinguishing between preventive and comprehensive services beginning in 2025; however, it remains useful to understand the distinction because studies from earlier years use it to characterize MA plans’ dental benefits.) In the benefit data they report to CMS, plans indicate—for each subcategory of services—whether they cover at least one service in the subcategory. The data do not enable us to know whether the plans cover all services in the subcategory or just some. Plans also have discretion over other important features of the supplemental dental benefits they offer, including the level of cost sharing, which dentists to include in the plan’s network, and whether prior authorization or referral is required for coverage. Further, plans can implement benefit limits that cap the amount of financial protection provided under the plan.

Because plans have discretion over the design of the supplemental dental benefit they offer, there is wide variation across plans in the form and generosity of the coverage. In a review of the dental benefits offered by MA plans in 2023, researchers found that, of MA plans that offered dental coverage as a mandatory supplemental benefit (i.e., those that included the

coverage in the base benefit package for all enrollees), only 8.4 percent offered coverage that met the researchers' definition of "comprehensive" dental coverage (not to be confused with comprehensive services discussed above) (Simon et al. 2025).⁴⁰ The study also showed that, although most seniors (66 percent) live in a county in which at least one MA plan offers a comprehensive dental benefit, only 4 percent of MA enrollees are enrolled in such plans.

The coverage limitations that MA plans apply can have important implications for beneficiaries. An analysis of 2019 MCBS data and plan benefit data found that (when controlling for individual- and county-level covariates) enrollees in HMOs were 7 percentage points more likely to report unmet dental needs and 4.4 percentage points more likely to report unmet dental need due to cost than enrollees in PPOs (Nasseh et al. 2025). Enrollees in plans requiring prior authorization for preventive services and those in plans covering only preventive dental services were more likely to report unmet dental needs (differences of 4.5 percentage points and 12 percentage points, respectively) than those in other plans offering dental benefits. Benefit limits were also found to be correlated with rates of unmet need: Enrollees in plans with no benefit limit reported rates of unmet dental need that were 12.4 percentage points lower than those in plans with an annual benefit limit of \$500 or less. Higher benefit limits were associated with lower rates of unmet need due to cost and higher probabilities of having a dental visit. Enrollees in plans that required cost sharing for comprehensive services were less likely to visit a dentist within the year. Although this study was cross-sectional and cannot establish the causal effects of plan characteristics on dental utilization, it illustrates the variability of dental benefits across MA plans and is suggestive of the potential implications for enrollees. The coverage decisions also affect plans' financial liability for dental care: Previous work by GAO has shown that MA plans covering a larger number of dental services projected spending more on dental services (Government Accountability Office 2023).

The Medicare Plan Finder indicates which MA plans offer supplemental dental benefits with a checkmark. However, dental coverage configurations are far more complex than the Plan Finder would suggest. Plans receive a checkmark if they cover at least one

dental service; a plan that covers only one annual cleaning would receive a checkmark for providing dental benefits, as would a plan that covers all dental services. This lack of specificity raises concerns about whether enrollees are given sufficient information with which to evaluate the dental coverage offered by different plans. Multiple sources suggest that MA enrollees have difficulty understanding the limits of the dental coverage provided by MA plans. In interviews with GAO, stakeholders have reported that "dental is the supplemental benefit on which [advocacy groups] receive the most complaints, often about plans' limits on what or how much is covered. The [stakeholder] said enrollees might complain because, although they were able to get a cleaning and X-rays, they also need dentures or implants" (Government Accountability Office 2023). The Commission has previously contemplated the merits of standardizing the supplemental dental, vision, and hearing benefits that plans can offer, but has not—as of 2025—made recommendations on the topic (Medicare Payment Advisory Commission 2023).

Survey data provide a limited view of how MA enrollees use and pay for dental services

Despite the growing enrollment in plans offering dental benefits in MA, relatively little is known about the extent to which enrollees use the benefits. MA encounter data should be the most detailed source of information about MA enrollees' use of services, but the EDPS that CMS uses to collect encounter data was not configured to accept dental claims until 2024. Thus, we do not have reliable encounter data with which to analyze how MA enrollees use and pay for dental services.⁴¹

In the absence of reliable encounter data, we used data from the MCBS to assess dental utilization and spending among MA enrollees. The survey data provide a limited, overarching view of dental use and spending. One limitation, for example, is that the survey data count dental visits regardless of whether they were covered by insurance (such as through an MA supplemental dental benefit) or paid for OOP. Some MA enrollees may have dental coverage through Medicaid or private insurance. To better understand the role of MA supplemental dental benefits, we analyzed the data for MA enrollees for whom MA was their only form of dental coverage. Specifically, we limited our analysis to

**TABLE
2-3****Non-dually eligible Medicare beneficiaries' use of and spending for dental services: Findings from an analysis of MCBS data from 2017 and 2022**

Outcome	MCBS year		Percentage change
	2017	2022	
Percentage of non-dually eligible beneficiaries with a dental visit during the year			
FFS beneficiaries with no dental coverage	51%	61%	20%
MA enrollees with dental coverage through their MA plan	56	57	2
Medicare beneficiaries with a private source of dental coverage	78	82	5
Total dental spending by non-dually eligible beneficiaries			
FFS beneficiaries with no dental coverage	\$580	\$861	48%
MA enrollees with dental coverage through their MA plan	521	892	71
Medicare beneficiaries with a private source of dental coverage	1,028	940	-8
Percentage of dental spending paid out of pocket by non-dually eligible beneficiaries			
FFS beneficiaries with no dental coverage	90%	96%	6%
MA enrollees with dental coverage through their MA plan	61	35	-43
Medicare beneficiaries with a private source of dental coverage	52	49	-6
Percentage of non-dually eligible beneficiaries who had trouble accessing dental care due to cost			
FFS beneficiaries with no dental coverage	6.8%	3.6%	-47%
MA enrollees with dental coverage through their MA plan	7.3	4.0	-45
Medicare beneficiaries with a private source of dental coverage	2	2	0

Note: MCBS (Medicare Current Beneficiary Survey), FFS (fee-for-service), MA (Medicare Advantage). Figures for beneficiaries with private dental coverage include data for FFS beneficiaries and MA enrollees with a private source of coverage, the majority of whom are in FFS Medicare. Calculations were made on unrounded data.

Source: MedPAC analysis of Medicare Current Beneficiary Survey data, 2017–2022.

community-dwelling Medicare beneficiaries who were enrolled in MA for 12 months of the year and reported having dental insurance through their MA plan. We limited our analysis to nonemployer coordinated-care plans (HMOs and PPOs) that provided dental benefits consistently across the plan's service area.⁴² To provide additional context, we include results for Medicare beneficiaries (in MA or FFS) who reported having a privately purchased source of dental coverage and for FFS Medicare beneficiaries who reported having no source of dental coverage. We excluded results for beneficiaries who were dually eligible for Medicare and Medicaid because changes in states' Medicaid coverage of dental services during the period make it difficult to disentangle the potential effects of supplemental benefits from other factors.

We found that between 2017 and 2022, more than half (56 percent) of non-dually eligible MA enrollees who had dental coverage through their MA plan visited the dentist in any given year (Table 2-3). The share using dental services was relatively similar in the two years we analyzed. Average dental spending by the enrollees in our sample increased over the study period, rising from \$521 in 2017 to \$892 in 2022. The share of dental expenses paid OOP by non-dually eligible MA enrollees decreased over time, falling from 61 percent in 2017 to 35 percent in 2022. In both 2017 and 2022, a small share (less than 10 percent) of MA enrollees reported difficulty accessing dental care. For respondents who report that there was a time in the last year in which they did not receive needed dental care, the MCBS asks what the reasons

Studies assessing how Medicare beneficiaries use and pay for dental care

Numerous studies have used survey data to assess how Medicare Advantage (MA) enrollees use and pay for dental care. Our review of more than a dozen studies found that roughly 40 percent to 60 percent of MA enrollees use dental services in a year.⁴³ Surveys have generally found that MA enrollees pay for a significant share of their dental spending out of pocket. Despite methodological differences, the results were relatively consistent across the studies we examined. However, it is important to note that the share of MA enrollees in plans offering supplemental dental coverage increased rapidly between 2018 and 2023, the period encompassing many of the studies (McCormack and Trish 2023). As such, results from a prior period might not be reflective of recent trends.

Roughly half of MA enrollees visit a dentist in a year, with non-dually eligible enrollees more likely to receive care

Research drawing from four nationally representative surveys suggests that between 40 percent and 60 percent of MA enrollees visit the dentist in any given year, and that dually eligible enrollees are generally less likely (than non-dually eligible enrollees) to have had a visit in the last year. The most recent data on MA dental-service utilization comes from a 2023 survey conducted by the Commonwealth Fund, which found that 42 percent of MA enrollees reported using dental benefits in the past year (Commonwealth Fund 2025b). Other studies, using Medicare Current Beneficiary Survey (MCBS) data from earlier years, have found similar rates of use. For example, in an analysis of the 2021 MCBS, CMS found that 55 percent of non-dually eligible enrollees in MA plans offering dental coverage had at least one dental visit during the year, and one-third of dually eligible enrollees with dental coverage through MA had a visit (Centers for Medicare & Medicaid Services 2021d). An analysis of 2019 MCBS data found that between 40 percent and 50 percent of MA enrollees

in plans offering supplemental dental coverage had a visit in the year. An analysis of 2016 MCBS data found that 55 percent of non-dually eligible MA enrollees who were in plans offering supplemental dental coverage (and 27 percent of dually eligible Medicare beneficiaries with dental coverage) saw a dentist in the year (Nasseh et al. 2025, Willink et al. 2020). Evidence from a study that used (pooled) Medical Expenditure Panel Survey (MEPS) data for 2010 through 2021 found similar use rates: In that study, 47 percent of MA enrollees received any dental care in the year (Simon and Cai 2024). Over the study period, the estimated percentage of MA enrollees with a dental visit rose from less than 45 percent in 2010 to slightly more than 50 percent in 2021.

Across most studies, utilization among low-income or dually eligible enrollees was generally lower than use among higher-income groups. In the Commonwealth Fund survey, the share of enrollees reporting use of dental benefits in the past year ranged from 40 percent to 50 percent for all income and racial or ethnic groups; among beneficiaries with incomes below \$100,000, the share of beneficiaries using dental care was positively associated with higher incomes (Commonwealth Fund 2025b). In CMS's analysis of 2021 MCBS data, one-third of dually eligible MA enrollees in plans offering dental coverage saw a dentist in the year; another analysis of the 2019 MCBS (also conducted by CMS) found similarly low percentages among dual-eligible enrollees (Centers for Medicare & Medicaid Services 2021b, Centers for Medicare & Medicaid Services 2021d). One study, which used pooled data from the Health and Retirement Study for 2014 to 2020, estimated that among MA enrollees ages 65 to 70 who were likely to be eligible for Medicaid and who lived in Medicaid-expansion states, roughly 69 percent had a dental visit in the last two years (Elani et al. 2024). The higher percentage of enrollees using dental care in this study may be related to the longer (two-year) time frame.

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Studies assessing how Medicare beneficiaries use and pay for dental care (cont.)

All of the studies we reviewed found that most dental utilization is for preventive services. Analysis of the MCBS and MEPS suggests that roughly 20 percent to 30 percent of MA enrollees had a nonpreventive visit in the year (Centers for Medicare & Medicaid Services 2021d, Simon and Cai 2024). A study by the actuarial firm Milliman analyzed claims from 2021 through 2023 for 1.1 million MA enrollees enrolled in plans that provided supplemental dental coverage and found that approximately 70 percent of dental claims were for preventive services (Wix and Fontana 2024).

MA enrollees' out-of-pocket spending for dental services

Several studies using data from the MCBS and MEPS have found that MA enrollees pay for a sizable fraction of their dental care out of pocket (OOP). For example, a study that used both MEPS and MCBS data for 2017 through 2021 found that OOP costs for non-dually eligible MA enrollees accounted for about 60 percent of their total dental spending (Cai et al. 2025). A different study of (pooled) MEPS data for 2010 through 2021 found that OOP costs accounted for roughly 62 percent of MA enrollees' total dental costs (Simon and Cai 2024). An earlier study of the 2016 MCBS found that OOP costs accounted for approximately 76 percent of overall dental spending for MA enrollees with dental coverage (Willink et al. 2020).

These results are difficult to square with the cost-sharing structures that MA plans report using for their supplemental dental benefits. For example, a recent analysis of 2023 MA plan benefit files found that roughly 35 percent of plans required no cost sharing for preventive services (Nasseh et al. 2025). For more than 60 percent of plans, the maximum cost sharing for nonpreventive services averaged (across all nonpreventive services) less than 30 percent. Several factors may contribute to the disconnect between what appears to be low cost sharing among MA plans and the high OOP costs reported in survey data.

First, the survey data capture all dental visits regardless of whether the visit was covered by insurance. Many MA plans cover only certain dental services delivered through in-network providers; beneficiaries using noncovered services or who choose to visit an out-of-network dentist (or who have trouble finding an in-network dentist) might face higher cost sharing.⁴⁴ The Government Accountability Office has reported that MA enrollees frequently report difficulty understanding the limits of the dental coverage provided by MA plans (Government Accountability Office 2023). Second, many plans apply benefit limits that cap the plan's liability for dental benefits. Beneficiaries who reach the benefit limit could face high OOP costs, despite being enrolled in a plan that charges low cost sharing below the benefit limit. In 2023, more than three-quarters of MA plans used a limit of at least \$1,500 (Nasseh et al. 2025). MedPAC's analysis of the MCBS found that the share of dental expenses paid OOP by non-dually eligible MA enrollees fell from 61 percent in 2017 to 35 percent in 2022 (see Table 2-3, p. 88). Given that MA plans have rapidly expanded their dental coverage in recent years (see Figure 2-5, p. 85), some of the higher OOP costs reported in the literature may be due to the use of data from earlier years.

A small share of MA enrollees report cost-related barriers to accessing dental care

Both the MCBS and the MEPS ask beneficiaries about their ability to access needed dental services and—for those experiencing access issues—the extent to which cost was a barrier to getting care. Results from multiple studies using various data sources show that most MA enrollees do not face cost-related difficulties accessing needed dental care.⁴⁵ Multiple analyses of MCBS have found that roughly 10 percent to 15 percent of MA enrollees had a time in which they could not get needed dental care (Centers for Medicare & Medicaid Services 2020a, Nasseh et al. 2025). Additional studies have found that, among enrollees experiencing difficulties accessing care, cost was a common barrier: Overall,

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Studies assessing how Medicare beneficiaries use and pay for dental care (cont.)

roughly 10 percent of MA enrollees reported that cost-related issues were a reason for not being able to get needed dental care (Gupta et al. 2024a, Hames et al. 2024, Nasseh et al. 2025). However, none of the studies we reviewed provided information about the dental needs of the enrollees who reported cost-related issues and the types of services they had difficulty accessing. Additionally, many of the studies use data from earlier years, in which dental benefits may not have been as expansive as they are today.

Dually eligible enrollees and individuals with low incomes are more likely to report cost-related access difficulties (Centers for Medicare & Medicaid Services 2020a, Gupta et al. 2024a). One study found that, among non-dually eligible MA enrollees who had no stand-alone dental coverage, roughly 11 percent reported unmet dental need due to cost. Enrollees with incomes below 200 percent of the poverty line, however, were 6 percentage points more likely to report cost-related barriers than other enrollees (Gupta et al. 2024a).

In addition to reporting access issues, some MA enrollees also report delaying dental care due to cost concerns. A study of MEPS data for 2018 through 2021 (pooled) found that 16 percent of MA enrollees delayed any dental care due to cost; results from earlier years analyzed in the same study suggest that beneficiaries are less likely to delay care they deem “necessary”: From 2010 to 2017, roughly 5 percent of respondents reported delaying necessary dental care (Simon and Cai 2024). A different study that focused on non-dually eligible MA enrollees found that roughly 10 percent of those enrollees delayed dental care in the year, and 6 percent delayed care due to cost (Cai et al. 2025). Evidence suggests that dually eligible enrollees may be more likely to delay care due to cost: A study that used data from the 2019 the National Health Interview Survey found that nearly 28 percent of low-income MA enrollees (those with incomes below 200 percent of the federal poverty line) reported delaying dental care due to cost (Agarwal et al. 2022).

The limitations of studies comparing use of dental care in MA and fee-for-service Medicare make it difficult to assess the effects of MA supplemental dental benefits

Many of the studies analyzing how MA enrollees use and pay for dental care have compared the utilization and spending of MA enrollees with that of beneficiaries in fee-for-service (FFS) Medicare. Many of the comparisons do not account for important differences between the MA and FFS populations, such as demographic and socioeconomic differences. However, access to dental coverage and use of dental services vary widely by income level and dual-eligibility status and across racial and ethnic groups (Centers for Medicare & Medicaid Services 2021d, Centers for Medicare & Medicaid Services 2019a). Thus, it is important to keep these variations in mind when comparing patterns of dental use for MA and FFS beneficiaries. Compared with beneficiaries in FFS Medicare, a higher proportion of MA enrollees are Black or Hispanic or have relatively low incomes (Ochieng et al. 2024). Further, among MA enrollees, Black enrollees, enrollees with low incomes, and enrollees without a college degree have been shown to be more likely to enroll in plans offering supplemental dental benefits (Gupta et al. 2024b).⁴⁶ This nonrandom sorting of beneficiaries into different programs and different types of dental coverage makes it difficult to disentangle whether lower or higher utilization in MA or FFS is due to enrollees’ dental coverage or to other factors.

Among the studies that do account for such differences, few account for the fact that, though many FFS Medicare beneficiaries do not have any form of dental insurance, some beneficiaries obtain coverage through employer-sponsored/retiree benefits or through privately purchased stand-alone dental plans. Beneficiaries who are dually eligible for Medicare and Medicaid may, in some states, have coverage through their state’s Medicaid program. The comprehensiveness of coverage provided through each of these

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Studies assessing how Medicare beneficiaries use and pay for dental care (cont.)

sources varies, as does the extent to which MA and FFS enrollees have coverage through any of the sources. Medicare beneficiaries who obtain private dental coverage (most of whom are in FFS Medicare) likely pay premiums for that coverage. The cost of those premiums is generally not reflected in the measures of OOP costs assessed in the studies comparing dental care in MA and FFS. In contrast, many MA enrollees have access to some level of supplemental dental benefits with no additional associated premium. Plans can charge premiums for dental coverage, use the rebates they receive from Medicare in lieu of premiums, or use a mix of premiums and rebates to finance dental benefits. Plans use rebates to finance essentially all mandatory supplemental benefits (i.e., those that are automatically included in the plan's benefit package); MA enrollees purchasing optional supplemental dental benefits must pay a premium for that coverage. This dynamic complicates interpretation of studies that compare OOP dental costs for MA and FFS beneficiaries. Further, because most studies of dental-care utilization

among Medicare beneficiaries use a cross-sectional study design, the studies can generally be used to characterize how beneficiaries in the two programs use dental care but cannot shed light on important questions such as whether supplemental dental coverage in MA improves access to dental care relative to the care that similarly situated individuals would have received had they enrolled in FFS (or vice versa).

Altogether, though numerous studies using data from four nationally representative surveys have assessed how MA enrollees use and pay for dental care, the studies provide limited insight into the effects of the dental benefits that MA plans provide as supplemental benefits. These limitations highlight the importance of having reliable encounter data for MA dental benefits. The encounter-data updates that CMS implemented for 2024 (discussed on p. 72) are an important step in this direction, but we do not expect those data to be available for analysis until 2026 or 2027. ■

were for not getting the care. In 2022, roughly 4 percent of non-dually eligible MA enrollees reported not receiving dental care because of cost, down from 7 percent in 2017.⁴⁷

Our analysis of the data for 2017 and 2022 provides a snapshot of how MA enrollees used and paid for dental services in two years that bookend a period of rapid growth in MA supplemental benefits. The analysis is descriptive, and we did not attempt to quantify what fraction of the difference between 2017 and 2022 is attributable to changes in MA supplemental benefits. Other dynamics, such as changes in the composition of the MA population or broader trends in the overall Medicare population, could also play a role in how things changed over time.

To contextualize how the experience of MA enrollees compared with that of other Medicare beneficiaries, we looked at the data for Medicare beneficiaries (in

MA or FFS Medicare) who had a private source of dental coverage, as well as for FFS beneficiaries who were not dually eligible and lacked dental coverage. The trends for these groups may provide some information about underlying changes in how Medicare beneficiaries were using dental coverage over this period. For most of the outcomes we assessed, the trend for FFS beneficiaries without a form of dental coverage followed a directional trend similar to that of MA enrollees: The share visiting a dentist increased, dental spending increased, and rates of cost-related access issues fell (Table 2-3, p. 88). FFS beneficiaries paid for a significantly larger share of their dental care OOP. Between 2017 and 2022, the OOP trend for FFS beneficiaries and MA enrollees trended in opposite directions. For FFS beneficiaries without coverage, the OOP share rose from 90 percent to 96 percent between 2017 and 2022. For MA enrollees, the OOP share declined (from 61 percent to 35 percent for non-dually eligible enrollees). The similar trends in dental

utilization for MA and FFS beneficiaries suggest that the differences between the 2017 and 2022 OOP point-in-time estimates cannot be attributed entirely to growth in MA supplemental benefits; the large decline in OOP costs for non-dually eligible MA enrollees suggests that supplemental dental benefits may have provided increased financial assistance over the period, but other underlying factors may also have played a role. Without further analysis, it is difficult to assess the extent to which the changes observed for MA enrollees are due to changes in MA supplemental benefits, due to broader changes affecting the Medicare population as a whole, or due to other changes such as the composition of the MA population.

Our results are consistent with a number of other studies that have used the MCBS and other surveys to assess how MA enrollees use and pay for dental care. See the text box about studies assessing how Medicare beneficiaries use and pay for dental care for more information about other studies.

Most MA enrollees are in plans offering some coverage of vision and hearing services; preliminary analysis suggests it may be feasible to use encounter data to assess use of the benefits, though limitations remain

Our analysis of plan benefit data shows that more than 90 percent of MA enrollees are in plans that offer some coverage of vision and hearing services. Research on MA enrollees' use of these services has been relatively limited, however, and prior studies have relied primarily on survey data. To the best of our knowledge, no studies have used encounter data to assess MA enrollees' use of vision and hearing services—likely because the reliability of the data has been unclear. To explore what the data contain and identify potential uses of the data, we analyzed encounter data for 2021 to assess whether plans are submitting records for the services. Although there are many limitations to how the data can be used and interpreted, we found that the vast majority of plans offering vision and hearing benefits reported encounter records pertaining to the services. For vision and hearing exams, eyewear, and hearing aids, the percentage of MA enrollees with corresponding encounter records appears to be in the range suggested by survey data. This is an encouraging sign that it may be feasible to use encounter data to explore MA enrollees' use of supplemental vision and hearing benefits.

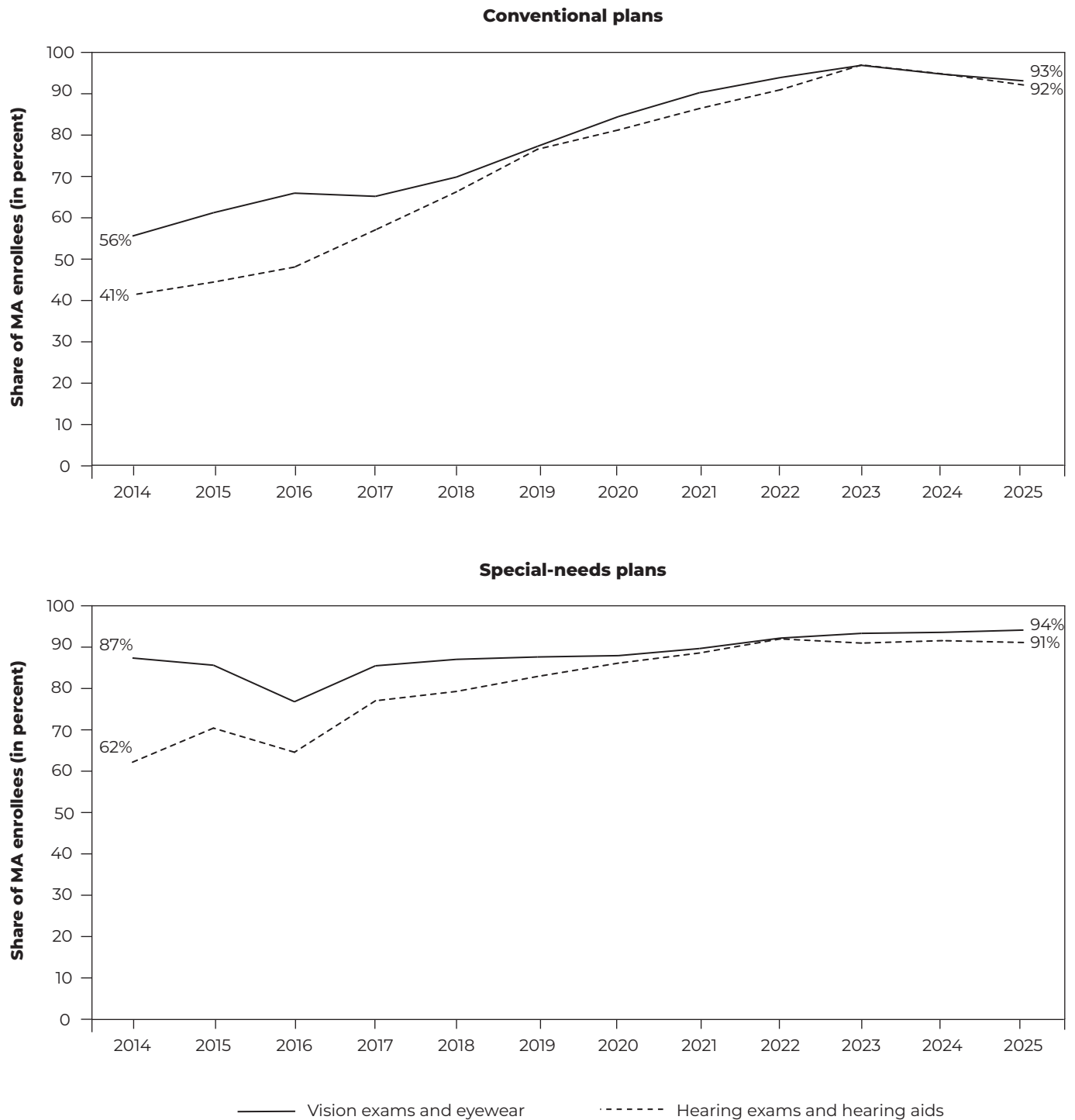
Enrollment in plans offering vision and hearing benefits

Traditional FFS Medicare generally does not cover routine eye exams, eyeglasses for day-to-day use, or contact lenses (Centers for Medicare & Medicaid Services 2021c). There are a few services, though, that Medicare will cover for certain populations, such as annual eye exams for diabetic retinopathy in people with diabetes and annual glaucoma screenings for people deemed at high risk for developing the disease (Centers for Medicare & Medicaid Services 2021c). MA plans offering supplemental vision benefits can cover eye exams and eyewear (including glasses and/or contacts) for their enrollees. Among enrollees in conventional MA plans, most enrollees—nearly 95 percent—are in plans offering coverage for eye exams and eyewear (Figure 2-6, p. 94). The share of enrollees in such plans rose significantly, from 56 percent to 93 percent, between 2014 and 2025. For SNPs, the share of enrollees in plans offering both eye exams and eyewear has historically been higher than in conventional plans, but rates for the two plan types were relatively comparable in 2025.

FFS Medicare also does not cover hearing aids or exams for hearing aid fittings. In limited circumstances, hearing and balance exams can be covered if they are related to or being used for diagnosis of a medical condition, and annual audiologist visits can be covered if related to diagnostic or nonacute hearing conditions (Centers for Medicare & Medicaid Services 2021c). MA plans can offer enhanced coverage of Medicare-covered hearing benefits, as well as routine hearing exams, fittings and evaluations for hearing aids, and/or hearing aids. Plans have discretion over which types of hearing aids they cover (e.g., inner ear, outer ear, or over the ear) and which providers are covered by the benefit. As with dental and vision benefits, the share of enrollees in plans offering these benefits has risen since 2014 (Figure 2-6, p. 94). The share of enrollees in conventional MA plans offering coverage for both hearing exams and hearing aids rose from roughly 41 percent to 92 percent between 2014 and 2025. For SNPs, the share of enrollees in plans offering exams and hearing aids has also risen—from 62 percent to 91 percent between 2014 and 2025. For SNPs, the share of enrollees in plans offering exams and hearing aids has also risen—from 62 percent to over 90 percent between 2014 and 2024.

**FIGURE
2-6**

MA enrollment in plans offering vision and hearing benefits has increased



Note: MA (Medicare Advantage). “Conventional plans” excludes employer group plans and special-needs plans. “Special-needs plans” excludes employer group plans and non-special-needs plans. Figure shows the share of MA enrollees in plans covering at least one service in the service category; plan-specified coverage limits may apply.

Source: MedPAC analysis of MA bid data.

MA enrollees' use of vision and hearing benefits

As with dental benefits, relatively little is known about the extent to which MA enrollees use the supplemental vision and hearing benefits offered by MA plans. Survey data provide some insights regarding the percentage of MA enrollees who use vision or hearing services in any given year—although the extent to which enrollees use their plan benefits to pay for their vision and hearing care is unclear. Surveys also find that use of hearing services is generally lower than use of vision services, as is to be expected based on the relative prevalence of vision and hearing needs among the Medicare population. In contrast to dental services, CMS's encounter data systems have always been configured to accept encounter records for vision and hearing services. Further, there are well-established procedure codes that MA plans should be able to use to report on their enrollees' use of these services. However, little is known about the extent to which MA plans are submitting encounter records for supplemental vision and hearing benefits and the reliability of the data. We analyzed encounter data for 2021 and found that MA plans are submitting records for vision and hearing services. Our findings suggest that, although the data have many limitations, it may be possible to use the encounter data to answer some questions about the use of vision and hearing services in MA.

Survey data provide a limited view of MA enrollees' use of vision and hearing services Evidence from multiple studies suggests that between 40 percent and 60 percent of MA enrollees use vision services in any given year. A survey by the Commonwealth Fund found that 41 percent of MA enrollees reported using vision benefits in the past 12 months (Commonwealth Fund 2025b). Use rates were considerably higher among the under-65 population: 80 percent of MA enrollees under age 65 reported using vision benefits (Commonwealth Fund 2025a). For the overall Medicare population, other studies have found higher utilization rates than those reported in the Commonwealth Fund survey—generally indicating that between 50 percent and 60 percent of MA enrollees used vision services in the year (Cai et al. 2025, Hames et al. 2024, Willink et al. 2020).

As with dental care, survey data suggest that MA enrollees pay for a significant portion of their vision care—between 60 and 70 percent—OOP (though one study found that the share paid OOP was lower

(29 percent) for optometry visits than for glasses (72 percent)) (Cai et al. 2025, Willink et al. 2020). Estimates vary of how frequently MA enrollees experience cost-related difficulties accessing vision care. One study that used 2018 and 2019 MCBS data found that, overall, only 4 percent of MA enrollees experienced cost-related access issues (Gupta et al. 2024a). However, that study and others have found that enrollees with lower incomes and enrollees under age 65 have more issues accessing vision care. One study found that, among enrollees age 65 and older with incomes below 200 percent of the federal poverty line, two-thirds reported delaying an eye examination due to cost (Agarwal et al. 2022). The Commonwealth Fund survey found that a quarter (26 percent) of MA enrollees under age 65 reported experiencing cost-related barriers to vision care (Commonwealth Fund 2025a).

For hearing services, research suggests that, compared with dental and vision services, the share of MA enrollees using services is relatively low. This finding is likely due—at least in part—to differences in beneficiaries' need for the services and their propensity to seek hearing care. Overall, roughly 8 percent of MA enrollees report using hearing services in a year (Commonwealth Fund 2025b, Willink et al. 2020). MA enrollees under age 65 were more likely to use hearing care; the Commonwealth Fund survey found that roughly one-third of MA enrollees under 65 used hearing care in the last year (Commonwealth Fund 2025a). Among MA enrollees under 65 who did not receive hearing services in the year, 8 percent cited cost as the primary reason for not getting care (Commonwealth Fund 2025a). An analysis of the 2018 MCBS by KFF found that MA enrollees who used hearing care paid (on average) \$763 OOP for the services—roughly \$220 less than beneficiaries in FFS Medicare (not controlling for differences between the two populations) (Freed et al. 2021).

Using encounter data to assess MA enrollees' use of supplemental vision and hearing benefits To the best of our knowledge, no studies have used encounter data to assess MA enrollees' use of vision and hearing services—likely because the reliability of the data has been unclear. To explore what the data contain and to identify potential uses of the data, we analyzed encounter data for 2021 to assess whether plans are submitting records for the services and whether the

Using encounter data to assess use of Medicare Advantage supplemental benefits

Federal regulations require Medicare Advantage (MA) plans to submit encounter records for all items and services provided to their enrollees, including items and services provided as supplemental benefits (42 CFR Sec. 422.310(b)). However, in assessing the encounter data for basic Medicare services (including inpatient, home health, and skilled nursing facility services), the Commission has previously found that the encounter data that plans have submitted to date are incomplete and cannot be used for many analyses (Medicare Payment Advisory Commission 2024a). (The Commission is actively exploring whether there are targeted analyses for which the data can be used.) The Commission has not previously assessed encounter data for MA supplemental benefits.

Limitations of relying on encounter data to assess use of supplemental benefits

There are several reasons to expect that the encounter data that plans submit for supplemental benefits do not provide complete information about enrollees' use of the benefits.

- **Limitations of the MA encounter data system.**

Until 2024, the Encounter Data Processing System (EDPS) that CMS uses to collect encounter records from MA plans was not configured to accept dental claims (Centers for Medicare & Medicaid Services 2024h). As a result, the encounter data cannot be used to assess utilization of supplemental dental benefits and we exclude dental benefits from our analysis.

- **Confusion about reporting requirements.** The Government Accountability Office (GAO) has reported confusion among MA organizations (MAOs) about the reporting requirements for MA supplemental-benefit encounter data (Government Accountability Office 2023). Although federal regulations have long required MA plans to submit encounter records for all items and services provided to their enrollees (including

items and services provided as supplemental benefits), CMS's Encounter Data Submission and Processing Guide has previously limited the requirement to submit encounter records for supplemental services to those for which the plan had sufficient data to populate an encounter record (Centers for Medicare & Medicaid Services 2025b). In interviews with officials from MAOs, GAO found that MAOs' understanding of the reporting requirements varied: Officials for several organizations stated that encounter record submission was required for only some supplemental benefits, officials from one other organization stated that they were not required to submit records for any supplemental benefits, and officials from another organization stated that encounter records were required for all services. The plan representatives reported submitting encounter records in accordance with their understanding of the requirements.

- **Challenges with procedure codes.** The system that CMS uses to collect encounter data from MA plans requires that each record have a procedure code—either a Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) code (Government Accountability Office 2023). Because some MA supplemental benefits are nonmedical (e.g., rent and utility subsidies), there are not procedure codes corresponding to all the benefits that plans might offer. In such cases, prior to 2024, it was not possible for plans to submit an encounter record for such services. In interviews with GAO, officials from MAOs described examples of such situations: Officials from one organization described “us[ing] a general procedure code for submitting encounter data on their supplemental benefit that provides deliveries of fruit and vegetables to enrollees because there was not an applicable procedure code” (Government Accountability Office 2023). In other instances, procedure codes might exist for the service, but

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Using encounter data to assess use of Medicare Advantage supplemental benefits (cont.)

plans might refrain from using the codes due to confusion about whether the code appropriately aligned with the benefit the plan provided (Government Accountability Office 2023). Plan officials described this challenge to GAO, stating that “there is a procedure code for an annual gym membership, but [the plan] did not know how to use that procedure code to report utilization” (Government Accountability Office 2023).

- **Insufficient data collected from supplemental-benefit vendors.** MAOs often contract with third-party vendors or community-based organizations to provide supplemental benefits to their enrollees (for details, see the section “Supplemental benefits: Vendors, community-based organizations, and vertically integrated entities,” p. 110). In such arrangements, MAOs report that the data they receive from vendors are limited and sometimes do not have sufficient detail with which to submit an encounter record for the services provided (Government Accountability Office 2023).

CMS made changes to address several of these challenges starting in 2024 (see p. 72 for an overview of those changes).

MedPAC’s assessment of MA encounter data for supplemental benefits

We analyzed MA encounter data for 2021 to assess whether MAOs are submitting encounter records for supplemental benefits. Because there are not standardized code sets that pertain to MA supplemental benefits, we worked with our staff physician to develop lists of HCPCS and CPT codes that may pertain to MA supplemental benefits. We relied on descriptions of the benefits provided by CMS to develop our code lists, which are available in the appendix to this chapter (p. 118) (Centers for Medicare & Medicaid Services 2019b, Centers for Medicare & Medicaid Services 2018c, Centers for Medicare & Medicaid Services 2016). We then assessed the number of beneficiaries for whom an

encounter record was submitted using one of the codes in our code list. We excluded chart reviews from our analysis to avoid double counting services that were reported in both an encounter record and a chart-review record. In addition, for our analysis of vision and hearing benefits, we limited our analysis to nonemployer HMO and PPO plans with at least 1,000 enrollees to ensure that the plans we assessed were large enough to have a reasonable likelihood of including enrollees that used the benefits of interest.

Limitations of our analysis

There are significant limitations to what can be assessed using encounter data for 2021 (some of which will be addressed by CMS’s recent encounter data changes).

- **Identifying procedure codes and the corresponding benefit:** Because there are no instructions or standards regarding which HCPCS or CPT codes refer to which supplemental benefit, it is difficult to know (in some instances) to which supplemental benefit an encounter record might relate. For example, a record with a code of S5170 (home-delivered prepared meal) could relate to either a supplemental benefit that provides meals on a temporary basis (e.g., following an inpatient admission) or the special supplemental benefit for the chronically ill that provides meals beyond a limited basis.
- **Distinguishing between mandatory and optional supplemental benefits:** MA plans can offer supplemental benefits on a mandatory or optional basis. Mandatory supplemental benefits are automatically included as part of the benefit package for all enrollees in a plan, and plans can use rebates to finance the benefits. Optional benefits are not automatically included in a plan’s benefit package; instead, enrollees have the option of paying an additional premium to access the benefits. Plans cannot use rebates to finance optional supplemental benefits. A study

(continued next page)

Using encounter data to assess use of Medicare Advantage supplemental benefits (cont.)

by Milliman found dental benefits to be the most commonly offered optional supplemental benefit, followed by vision and hearing benefits (Friedman and Yeh 2021).⁴⁸ No Medicare enrollment data provide information about which MA enrollees purchase optional supplemental benefits; thus, for plans that offer optional supplemental benefits, we were unable to differentiate between encounter records related to mandatory or optional benefits. Some MA plans offer dental, vision, and/or hearing services on both a mandatory and optional basis. In such instances, it is typical for a plan to include a basic version of the benefit as a mandatory supplemental benefit and offer an optional benefit (sometimes referred to as a “rider”) that enrollees seeking additional coverage can purchase for an additional premium.

- **Inability to assess data completeness:** Another limitation is the absence of another, independent data source with which to compare the encounter records we identified. Given the barriers to encounter data submission (described previously),

it is reasonable to conclude that the encounter data we assessed cannot provide a complete picture of MA enrollees’ use of supplemental benefits. As such, we did not attempt to measure utilization rates or draw conclusions about access or value based on our findings. Instead, our focus was on assessing whether plans are submitting records and characterizing the potential uses or limitations of the data.

- **Inability to assess which records are for covered services:** In some cases, it is difficult to distinguish between encounter records for basic and supplemental Medicare benefits. For example, dental services are generally not covered by Medicare but may be covered in some circumstances. Similarly, Medicare does not generally cover eyeglasses but does cover them after cataract surgery. The encounter data we used in our analysis do not include a mechanism for distinguishing between basic and supplemental services in such instances. However, this issue likely affects a relatively small number of records

(continued next page)

submission rates suggest problems with the reliability of the data. The text box “Using encounter data to assess use of Medicare Advantage supplemental benefits” discusses our analytic approach as well as the barriers and limitations to using the data. This analysis is a preliminary and exploratory first step toward using encounter data to assess the use of supplemental benefits. As such, we did not attempt—at this stage—to measure utilization rates or draw conclusions about access or value based on our findings. Instead, our focus here is on assessing whether plans are submitting records and characterizing the potential uses or limitations of the data.

MA encounter data for supplemental vision and hearing benefits

We first looked to see if MA plans that offered vision or hearing coverage as mandatory supplemental benefits submitted any records for those services, to check that plans were generally able to submit records for these services. We found that the vast majority of plans offering the benefits reported at least one record that contained a vision- or hearing-related Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Nearly all plans (more than 95 percent) that covered vision

Using encounter data to assess use of Medicare Advantage supplemental benefits (cont.)

given the relatively narrow scope of vision and hearing coverage in FFS Medicare in 2021.

In other cases, the encounter records we identify might include some noncovered services for which the plan did not make payment. MA plans are required to submit encounter records for all items and services delivered to MA enrollees, regardless of whether the plan made payment to the provider for the services. Accordingly, the encounter data may include records for claims that were not covered (i.e., were denied). For example, enrollees who received a noncovered hearing or vision service or who visited a provider outside of the plan's network might have an encounter record for the visit but might have paid for the services OOP. However, plans can generate encounter records only if they receive any claim information from the provider or enrollee. If an enrollee purchases glasses or hearing aids (both of which are available over the counter) and does not attempt to use

their insurance, the purchase will not be reflected in the encounter data. Thus, encounter data are not a reliable way to identify all of the enrollees who wear glasses or use hearing aids. Further, some items (such as hearing aids) might not be purchased every year. Because we looked at only one year of data, our analysis captures only records for enrollees who received the item or service in the year of analysis and will not reflect the fact that some enrollees may have used the benefits in a previous year.

Given the significant barriers to reliably measuring utilization rates using encounter data, we focused first on assessing whether plans are submitting encounter records for supplemental benefits, the percentage of enrollees who had records for supplemental benefits submitted, and whether the submission of encounter records aligns with the benefits offered by the plan. ■

exams, eyewear, or hearing exams as a mandatory supplemental benefit submitted at least one encounter record corresponding to the relevant benefit; 85 percent of plans that offered coverage of hearing aids submitted at least one corresponding record. These high rates suggest that plans are generally able to submit encounter records for vision and hearing services and that they use the procedure codes we identified for each type of service.

We next assessed—for each type of vision and hearing benefit—the percentage of enrollees for which plans submitted an encounter record corresponding to the covered benefit. We refer to this percentage as the “submission rate.”

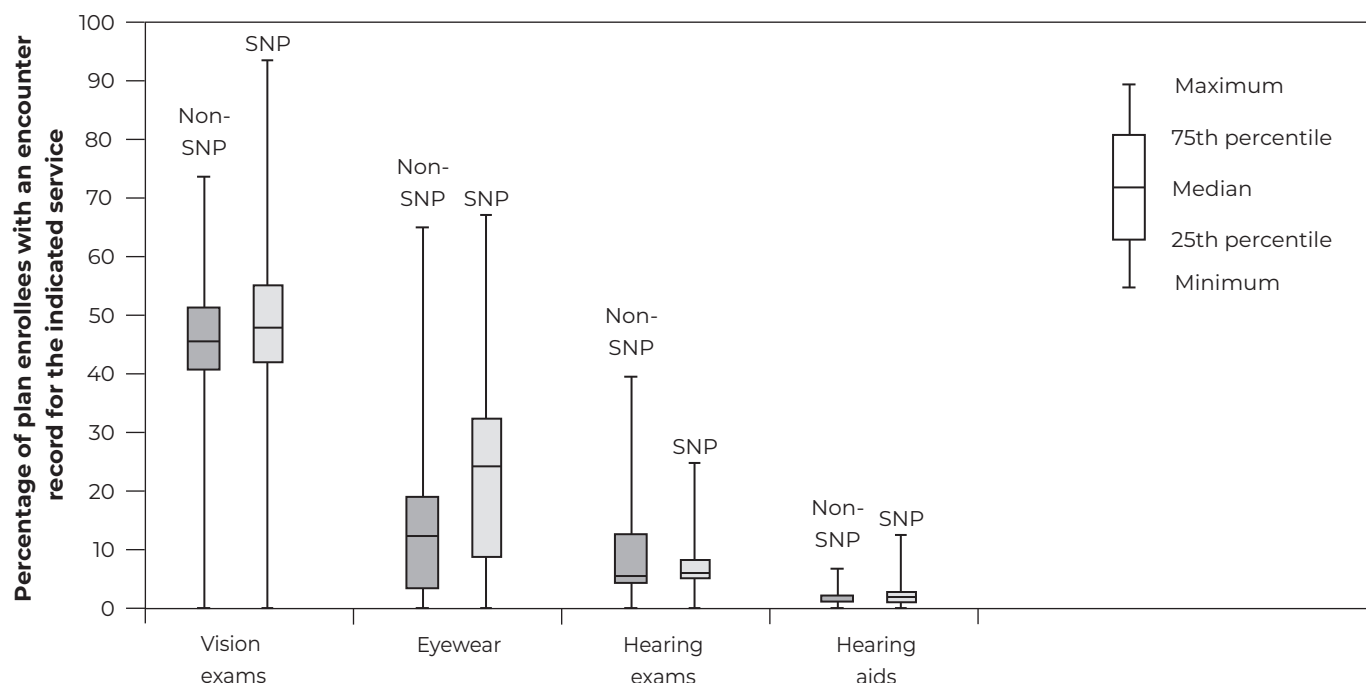
The submission rates for vision and hearing services varied widely across plans, with some plans submitting

no records and some submitting records for a large number of the plan's enrollees (Figure 2-7, p. 100). Figure 2-7 illustrates the range of submission rates; the figure is enrollment weighted so as to better reflect the submission rates of the plans that MA enrollees are in. (Enrollment weighting means that the boxes of the box-and-whisker plot represent the submission rates of plans enrolling 50 percent of MA enrollees. The horizontal line within each box—representing the median of the distribution—divides the distribution in half: Half of MA enrollees are in plans with submission rates below the level indicated by the line, and half are in plans with submission rates above that level.)

The submission rate for plans offering vision exams as a mandatory supplemental benefit ranged from 0 percent to 75 percent among conventional plans and

**FIGURE
2-7**

The share of MA enrollees with a vision or hearing encounter record varied widely across plans, 2021



Note: MA (Medicare Advantage), SNP (special-needs plan). Figure includes only nonemployer coordinated-care plans with at least 1,000 enrollees. Distributions are enrollment weighted such that the median value represents the central enrollee rather than the central plan.

Source: MedPAC analysis of MA plan benefits data and MA encounter data for 2021.

from 0 percent to 96 percent among SNPs. Roughly half of MA enrollees in both conventional plans and SNPs were in plans with submission rates between 40 percent and 60 percent; this range aligns with the findings from surveys (described above) which have generally found that somewhere between 40 percent and 60 percent of MA enrollees use vision services within the year.

The submission rates for eyewear-related encounter records were generally lower than the rates for vision exams, as is to be expected (not all enrollees who get an exam will need glasses, and not all enrollees who get glasses will replace them in every year). In conventional plans, the median submission rate was 14 percent of enrollees, and for SNPs the median submission rate was 23 percent. These rates mean that half of MA enrollees in plans offering eyewear benefits were in plans that submitted records for less than a quarter (and for

conventional plans, less than a fifth) of their enrollees. Because analyses of survey data have tended not to report on the percentage of people purchasing new glasses in a year, it is difficult to determine whether these submission rates are suggestive of incomplete data or in line with expected rates.

As we would expect based on survey data, rates of submitting encounter data for hearing services were generally lower than for vision services. For hearing exams, the median submission rates were 5 percent and 6 percent for conventional plans and SNPs, respectively; for hearing aids, the median submission rates were 1 percent and 2 percent, respectively. These rates appear to be in the range of the rates found in survey data (though slightly lower; survey data suggest that about 8 percent of MA enrollees use hearing services in a year). As with eyewear, enrollees might not replace their hearing aids each year, and survey data

do not shed light on the question, so it is difficult to conclude whether the submission rates we observed are suggestive of incomplete data. At this stage, we can conclude only that a large number of MA plans have submitted encounter records that likely pertain to supplemental vision and hearing benefits. This finding is an encouraging sign that it may be feasible to use encounter data to explore MA enrollees' use of supplemental vision and hearing benefits.

MA plans increasingly offer other types of supplemental benefits, but encounter data are currently inadequate for assessing utilization

In addition to dental, vision, and hearing services, MA plans are increasingly offering an array of other non-Medicare services such as transportation assistance, fitness benefits, meal-delivery services, OTC items, social support services, and subsidies for rent and utilities. The proliferation of these types of benefits has, to some extent, been facilitated by legislative and regulatory changes implemented over the last decade. The growth in MA rebates has likely been an accelerant, providing plans with additional funds to use on supplemental benefits. Despite their increasing prevalence, little is known about MA enrollees' use of these newer types of benefits. Our analysis of encounter data for 2021, presented below, suggests that the data are inadequate for assessing utilization, making it difficult to determine whether the benefits provide good value to Medicare and the taxpayers who fund the program.

MA plans have long been allowed to offer, as supplemental benefits, non-Medicare services other than dental, vision, and hearing benefits. For many years, the additional benefits were required to be “primarily health related,” meaning that their main purpose had to be “to prevent, cure, or diminish an illness or injury” (Centers for Medicare & Medicaid Services 2016). This definition included dental, vision, and hearing services, but also included enhanced or expanded coverage of Medicare-covered services (e.g., additional days of inpatient care), health-related transportation services, fitness benefits, acupuncture, enhanced disease-management services, bathroom safety devices, posthospitalization meals, OTC items, and other benefits (see Appendix 2-A for additional examples). Beginning in plan-year 2019, CMS broadened its definition of “primarily health related”

to permit additional services that address physical impairments, lessen the functional or psychological impact of injuries, or reduce avoidable health care utilization (Centers for Medicare & Medicaid Services 2018c). Under this new definition, plans can provide services such as adult day-care services, home-based palliative care, in-home support services, or support for caregivers of enrollees (see Appendix 2-A for additional examples). Further, starting in 2020, the Bipartisan Budget Act of 2018 gave plans the flexibility to provide chronically ill enrollees with supplemental benefits that “have a reasonable expectation of improving or maintaining the health or overall function” and do not have to be primarily health related. These benefits are known as special supplemental benefits for the chronically ill (SSBCI). Plans can use this authority to cover services such as meals, food and produce, nonmedical transportation, and pest-control services (Centers for Medicare & Medicaid Services 2019b) (see Appendix 2-A for descriptions of the services plans can offer as SSBCI).

MA plans have an incentive to experiment with offering the new categories of supplemental benefits, and the benefits play an important role in the MA marketplace. Studies have found that enrollees consider supplemental benefits when picking an MA plan and gravitate toward plans offering the benefits (Freed et al. 2023, Gupta et al. 2024b, Zhao et al. 2021). For example, one recent study examined differences between plans that gained or lost enrollment during the 2022 open enrollment period (Cates et al. 2022). Among conventional MA plans, those gaining enrollment offered certain supplemental benefits—dental coverage, eyeglasses or contacts, hearing aids, and an allowance for OTC items—more often than other plans, and their coverage of those benefits tended to be more generous than the coverage for plans that lost enrollment (plans gaining enrollment also tended to have lower premiums and lower copayments for primary care visits). Other studies have demonstrated that supplemental benefits may play a role in attracting different groups of enrollees, shifting the enrollment mix of MA plans, though the direction and strength of such effects likely depends on the supplemental benefit being assessed (Cooper and Trivedi 2012, Tucher et al. 2024a). One study found that adoption of newer forms of supplemental benefits was associated with improved ratings on the MA Consumer Assessment of Healthcare Providers and Systems (MA-CAHPS); plans

have a strong incentive to keep their members satisfied and to increase their MA-CAHPS rating because it is one of the measures used to calculate the star ratings that factor into the formula used to determine plan payments (Tucher et al. 2024b). Additionally, some have speculated that supplemental benefits may be a mechanism through which MA plans can address social determinants of health, thereby improving beneficiaries' access to care and lowering health care costs. Given the data limitations discussed throughout this chapter, such claims are hard to evaluate at this time (Government Accountability Office 2023).

Enrollment in plans offering primarily health-related supplemental benefits has increased unevenly since 2018

Although MA plans have the flexibility to cover a wide range of non-Medicare services as supplemental benefits, they have typically favored some benefits over others. Figure 2-8 shows how the share of enrollees in plans offering various primarily health-related (i.e., non-SSBCI) benefits has changed since 2018. The figure shows the 15 most commonly available benefits in 2025 (ranked by the percentage of enrollees in plans offering the benefit and excluding dental, vision, hearing, and SSBCI benefits). (Many MA plans offer other primarily health-related benefits, but a relatively small share of total MA enrollment was in such plans in 2025.) In 2025, the four most common benefits (other than dental, vision, and hearing benefits) were fitness benefits (e.g., gym memberships), annual physical exams, OTC drugs and items, and meals. More than half of MA enrollees are in plans that offered each of these benefits in 2025. SNPs are particularly likely to offer the benefits, and more than 90 percent of SNP enrollees were in plans offering a fitness, OTC, and/or transportation benefit in 2025 (data not shown). The percentage of MA enrollees in plans offering OTC items and/or meals has expanded significantly since 2018: The share of MA enrollees in plans that offer OTC benefits rose from 48 percent to 84 percent over the 2018 to 2025 period, and the share enrolled in a plan offering meals rose from 23 percent to 73 percent. Some benefits are offered less frequently, however. For example, less than half of MA enrollees are in plans offering acupuncture, health education, additional sessions of smoking cessation counseling (beyond those covered under Medicare), or nutritional or dietary counseling benefits. For a small

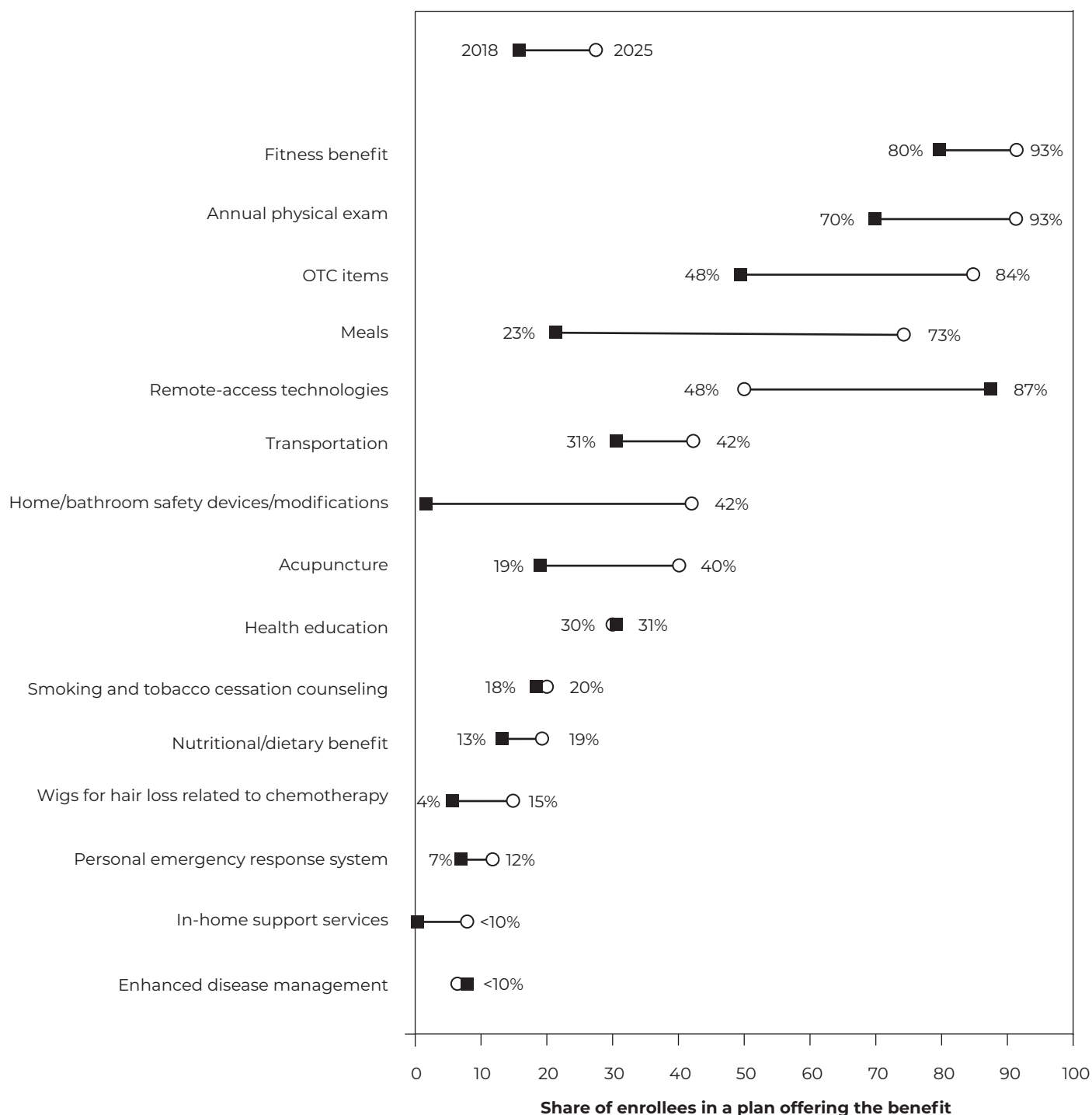
number of benefits, the share of enrollees in a plan offering the benefit has decreased since 2018. The most notable change has been for remote-access technology benefits, a decrease that may be associated with the expanded coverage of telehealth in FFS Medicare.

The share of MA enrollees in plans offering non-primarily health-related supplemental benefits has grown since 2020

Beginning in 2020, as required by the Bipartisan Budget Act of 2018, MA plans were given the ability to offer non-primarily health-related items or services to chronically ill enrollees, so long as there is a “reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee” (Centers for Medicare & Medicaid Services 2019b). These benefits are required to be targeted to MA enrollees who (1) have one or more comorbid and medically complex chronic conditions that are life threatening or significantly limit the overall health or function of the enrollee; (2) have a high risk of hospitalization or other adverse health outcome; and (3) require intensive care coordination. MA plans determine which of their enrollees meet this definition, and CMS requires that the plans document how they make such determinations. CMS provides examples of benefits that meet the SSBCI “reasonable expectation” requirement, but plans can also propose other benefits (see Appendix 2-A for examples). Due to concerns about whether the benefits offered as SSBCI are meeting the requirement, starting in 2025, CMS began requiring MA organizations to develop and maintain “bibliographies of relevant research studies or other data” to demonstrate that benefits offered as SSBCI meet the “reasonable expectation” criteria (Centers for Medicare & Medicaid Services 2024g). MA plans participating in the MA-VBID model demonstration are also permitted to offer non-primarily health related benefits but have additional flexibility to target the benefits to enrollees on the basis of socioeconomic status (Centers for Medicare & Medicaid Services 2020b). Beginning in 2025, plans participating in the demonstration are required to offer at least two supplemental benefits intended to address enrollees' health-related social needs (the benefits can be primarily health related or non-primarily health related but must relate to food and nutrition, transportation, or housing and living environment) (Centers for

**FIGURE
2-8**

The share of MA enrollees in plans offering primarily health-related supplemental benefits has expanded significantly since 2018, 2018–2025



Note: MA (Medicare Advantage), OTC (over the counter). Includes conventional plans and special-needs plans; excludes employer group plans. Figure shows the share of MA enrollees in plans offering any mandatory coverage of the service; plan-specified coverage limits may apply. Figure shows the 15 most commonly offered benefits (ranked by percentage of MA enrollees in plans offering the benefit); dental, vision, hearing, and special supplemental benefits for the chronically ill are excluded.

Source: MedPAC analysis of MA plan benefits data.

Medicare & Medicaid Services and Center for Medicare & Medicaid Innovation 2023).

Plans have gradually expanded their coverage of non-primarily health-related supplemental benefits. The benefits are particularly common among SNPs: As shown in Figure 2-9, the most common of these benefits in 2025 are food and produce, and “general supports for living,” which may include plan-provided housing support, plan-provided housing consultations, subsidies for rent or assisted living communities, and subsidies for utilities (Centers for Medicare & Medicaid Services 2019b). In contrast, a relatively low share of enrollees in conventional MA plans are in plans that offer these benefits.

A significant share of MA plans offering non-primarily health-related benefits do so through the MA-VBID model demonstration (ATI Advisory 2023). This is especially true for D-SNPs: In 2025, the MA-VBID model is the predominant pathway by which D-SNPs will offer non-primarily health-related supplemental benefits (Friedman et al. 2024). However, because CMS has announced that the MA-VBID model demonstration will end at the end of 2025, this pattern is likely to change in future years.

Several factors might explain the somewhat limited enrollment among conventional plan enrollees in plans offering SSBCI and other “newer” supplemental benefits (e.g., those available under the CMS’s expanded definition of primarily health related). First, plans must use rebate dollars to finance any new benefits, and they may be reluctant to pare back longer-standing benefits. This reluctance could lead plans to gradually add newer benefits over time as rebates increase. Second, plans have an incentive to offer supplemental benefits with broad appeal, and they may determine that the newer benefits are less attractive, on balance, than the more traditional benefits. (Since eligibility is tied to specific health conditions, the share of enrollees who qualify for SSBCI will typically be smaller than the share who qualify for more traditional benefits, and beneficiaries may have difficulty determining whether they would qualify.) This may partially explain the higher prevalence of non-primarily health-related benefits among D-SNPs; because all D-SNP enrollees meet the low-income requirement, D-SNPs participating in the MA-VBID demonstration can make the benefits available to essentially all enrollees in the plan. Finally,

plans may need time to develop the infrastructure to offer some of the newer benefits, such as finding a suitable vendor for delivering food and produce and prepared meals (Kornfield et al. 2021).

MA plans often administer supplemental benefits through combination benefits and flex cards

Since 2021, it has become increasingly common for MA plans to offer supplemental benefits as “combined” supplemental benefits, in which enrollees can select services from a plan-provided list. To manage their spending on the services, plans can set guardrails on how such benefits are used by:

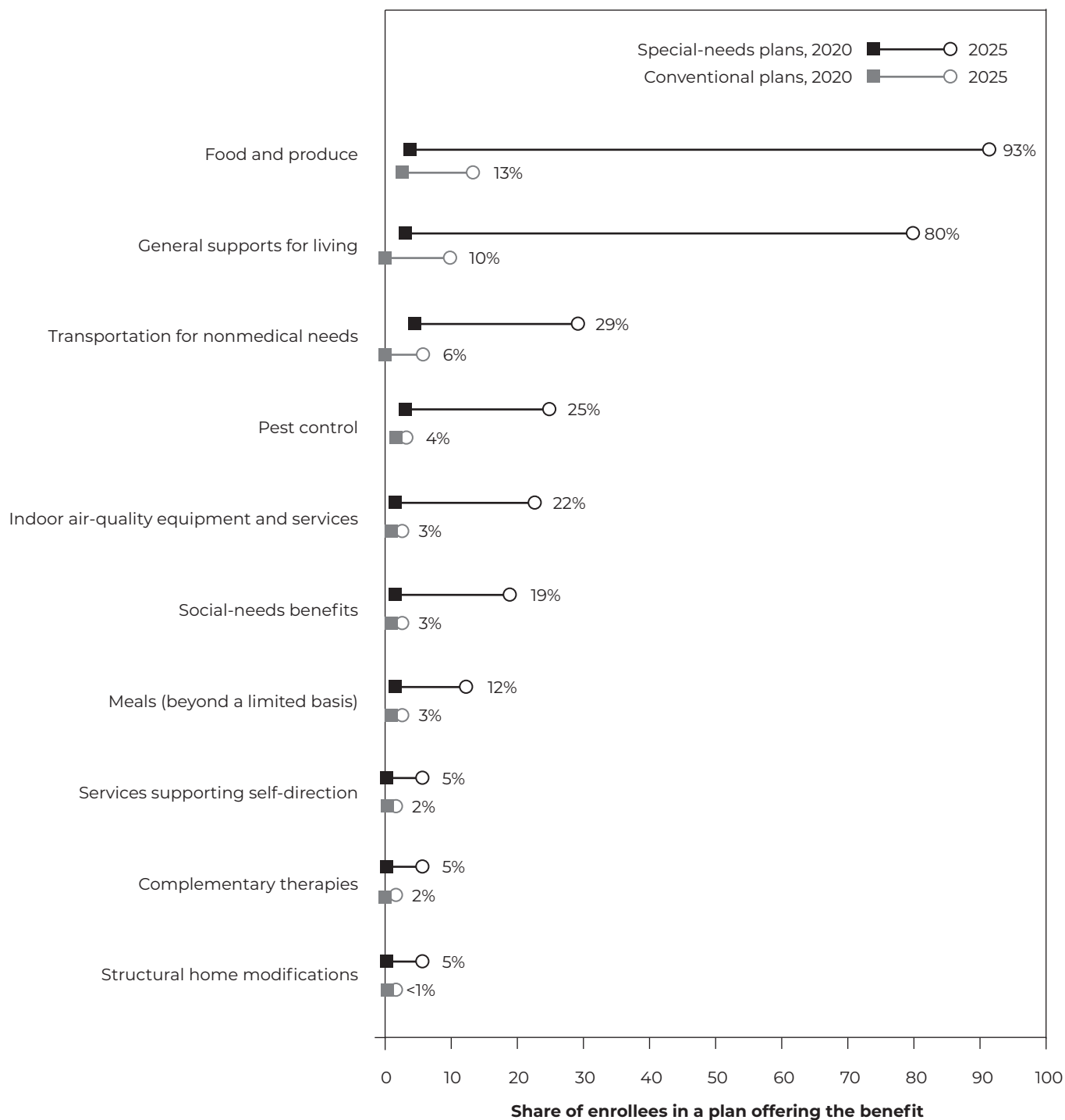
- limiting the type and number of benefits an enrollee can select and requiring the enrollee to select the benefits from a plan-provided list in advance of coverage;
- setting a monetary limit on the value of the coverage;
- limiting the number of visits, uses, or trips (in the case of transportation benefits) that can be covered by the benefit; and
- defining a time period in which the benefits can be used (e.g., annually, semiannually, quarterly).

The benefits are often delivered in the form of a prefunded debit card, sometimes referred to as a “flex card,” but they can also be delivered by having enrollees select items from a plan-provided list or through a catalog, managed through a reimbursement system or traditional claims processing. Table 2-4 (p. 106) shows the share of enrollees in plans offering at least one combination benefit (plans can offer up to five distinct combinations of benefits per plan).⁴⁹ The table also shows the average estimated annualized benefit limit (i.e., the maximum amount the plan will make available to the enrollee under the combined benefit on an annual basis) for several commonly offered benefit combinations.⁵⁰

We found that the spending limits for combination benefits, which plans report in the plan benefit-package data they submit with their bids, have increased significantly for certain combinations over the five years that plans have been permitted to offer such benefits. For some (but not all) combinations, spending limits in 2025 are below the levels for

FIGURE
2-9

The share of MA enrollees in plans offering non-primarily health-related supplemental benefits has expanded since 2020, 2020-2025



Note: MA (Medicare Advantage). "Conventional plans" excludes employer group plans and special-needs plans. "Special-needs plans" excludes employer group plans and non-special-needs plans. Figure shows the share of MA enrollees in plans offering any mandatory coverage of the service, including benefits provided as special supplemental benefits for the chronically ill or through the MA-VBID model; plan-specified coverage limits may apply.

Source: MedPAC analysis of MA plan benefits data.

**TABLE
2-4****MA plans have increasingly been delivering supplemental benefits using flex cards and other flexible benefit arrangements, 2021-2025**

	2021	2022	2023	2024	2025
Share of enrollees in plan offering a combined benefit					
Conventional plans	4%	12%	25%	45%	54%
SNPs	6	48	62	86	92
Share of enrollees in an uncapped combined benefit					
Conventional plans	3%	7%	<1%	<1%	4%
SNPs	5	9	<1	<1	<1
Average annualized spending limit in capped combined benefit plans					
Combination includes only dental and vision or hearing services	\$387	\$757	\$709	\$810	\$745
Conventional plans	387	838	641	646	733
SNPs	N/A	523	869	1,165	787
Combination includes only an OTC benefit and SSBCI items or services	447	980	1,314	1,508	989
Conventional plans	55	248	376	452	365
SNPs	513	1,417	1,595	1,798	1,289
All other combinations that include an OTC benefit	719	518	557	687	879
Conventional plans	915	426	472	320	288
SNPs	325	768	831	1,341	1,522

Note: MA (Medicare Advantage), SNP (special-needs plan), N/A (not applicable), OTC (over the counter), SSBCI (special supplemental benefits for the chronically ill). "Conventional plans" excludes employer group plans and special-needs plans. "Special-needs plans" excludes employer group plans and non-special-needs plans. "Combined benefit plans" excludes "dental-only" plans in which the plan offers only dental services under the combination benefit. Dollar amounts are not adjusted for inflation. We estimate the annualized limit for each plan by scaling the value of the benefit according to the time and dollar limits applied by each plan. For example, for a plan using a limit of \$100 per quarter, we would calculate an annualized limit of \$400. Flex cards are prefunded debit cards through which plans can administer benefits that are offered under a combined benefit configuration.

Source: MedPAC analysis of MA plan benefits data.

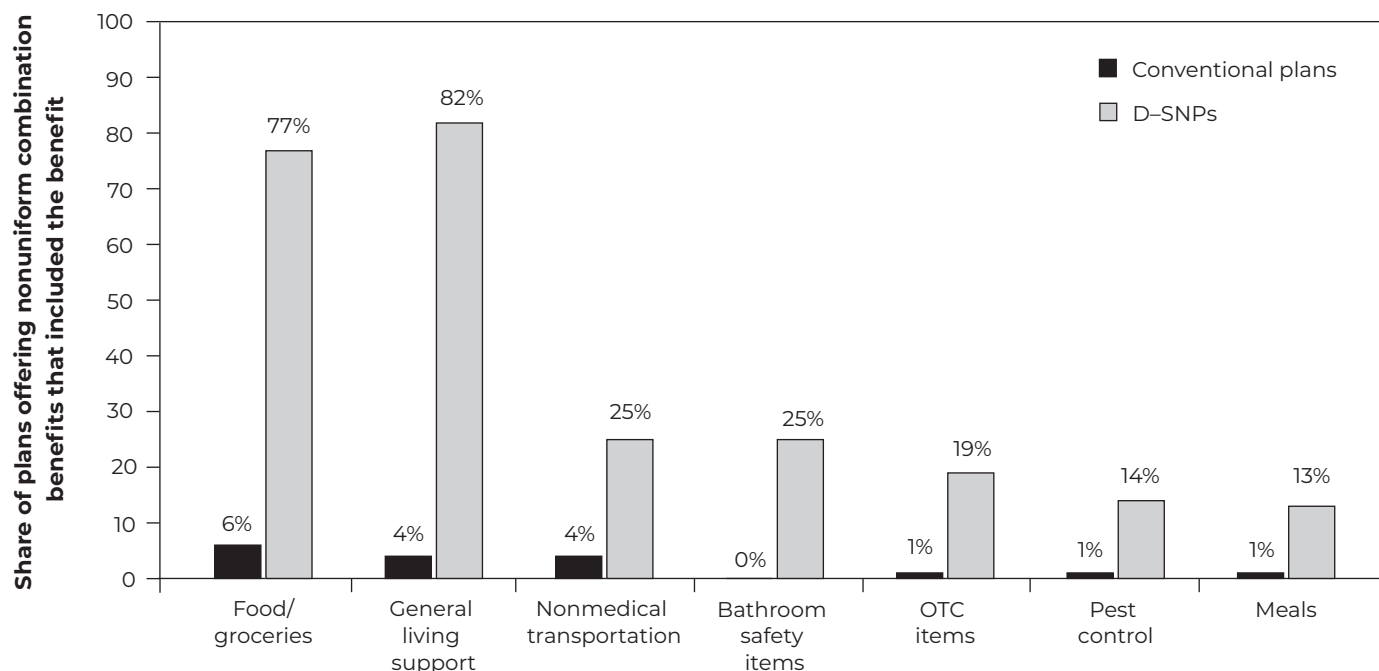
2024; nevertheless, spending limits for almost all combinations remain well above their 2021 level. For example, the estimated annualized limit for combinations that include only dental and vision and/or hearing benefits roughly doubled from \$387 in 2021 to \$745 in 2025.

Some combinations of benefits are more frequently offered than others. In 2024, 41 percent of MA plans offered combination benefits that included OTC items as a possible use; 31 percent included an option to

use the benefit for home and bathroom safety devices and modifications; and roughly a quarter included "nonuniform" benefits (i.e., those targeting a subset of MA enrollees as SSBCI, benefits offered under the MA-VBID demonstration, or benefits offered under the uniform flexibility rules) (Yeh and Yen 2024). These benefits are particularly common among dual-eligible special-needs plans (D-SNPs), with more than half of D-SNP enrollees in plans that include either OTC items or nonuniform benefits in a combination benefit (Friedman et al. 2023). In 2024, roughly 10 percent of

**FIGURE
2-10**

Plans offering combination benefits frequently allow enrollees to use the benefits for food and other basic cost-of-living expenses, 2024



Note: D-SNP (dual-eligible special-needs plan), OTC (over the counter). "Conventional plans" excludes employer group plans and special-needs plans. "Special-needs plans" excludes employer group plans and non-special-needs plans. "Nonuniform" benefits include special supplemental benefits for the chronically ill, benefits targeted to groups of enrollees under the MA Value-Based Insurance Design demonstration, and benefits offered under CMS reinterpretation of the uniformity requirement (Centers for Medicare & Medicaid Services 2018d). Food/grocery benefits may include items such as (but not limited to) produce, frozen foods, and canned goods. Tobacco and alcohol are not permitted (Centers for Medicare & Medicaid Services 2019b). "General living support" benefits "may be provided to chronically ill enrollees if the benefit has a reasonable expectation of improving or maintaining the health or overall function of the enrollee" and may include plan-sponsored housing consultations and/or subsidies for rent or assisted living, and/or subsidies for utilities such as gas, electricity, and water (Centers for Medicare & Medicaid Services 2019b).

Source: MedPAC recreation of Figure 6 from Yeh and Yen (2024).

all MA plans offered a combination plan that included only OTC and nonuniform benefits. Figure 2-10 shows the most common benefits offered within the nonuniform benefits category for such plans in 2024. Common benefits included support for purchasing food/groceries and "general living support," which can include subsidies for rent and/or subsidies for utilities such as gas, electricity, and water.⁵¹ As shown in Table 2-4, we estimate that, in 2025, the average amount available to eligible enrollees in SNPs offering an OTC/SSBCI-only combination benefit is approximately \$1,300 (for the year), down from about \$1,800 in 2024 (our estimates are similar to other published estimates) (Yeh and Yen 2024).

Limited evidence about MA enrollees' use of SSBCI and other non-Medicare services

Relatively little comprehensive or generalizable research exists about the extent to which MA enrollees use supplemental benefits other than dental, vision, or hearing services. Most available evidence comes from broad surveys or from analyses conducted by MA plans. A survey by the Commonwealth Fund asked MA enrollees about their use of common supplemental benefits (but did not ask whether respondents were in a plan that offered the benefit) (Commonwealth Fund 2024). The survey found that 69 percent of enrollees used at least one supplemental benefit (including dental, vision, or hearing benefits); 13 percent used

a transportation benefit; 19 percent used a gym membership; 46 percent used an OTC allowance; 12 percent used a grocery allowance; and 2 percent used a meal-delivery benefit.

One plan sponsor, Elevance Health, has released several internally conducted analyses of its enrollees' use of supplemental benefits. The first analysis compared characteristics of enrollees who used supplemental benefits and those who did not for a sample of about 860,000 MA enrollees in 2022 (Elevance Health 2023). For 6 of the plan's 42 supplemental benefits (nurse hotline, nutrition consultations, nutrition therapy services, orthotics, telemonitoring, and transitional-care services), the plan did not have the available data to report utilization. For the remaining 36 benefits that were assessed, most enrollees used 2 or fewer of the benefits (not all 36 benefits were available in each plan, and the way benefits were offered could vary across plans). Although some benefits have restricted availability, the plan did not identify the share of enrollees eligible for each benefit or which benefits were used most frequently. Among the plan's non-dually eligible enrollees, 25 percent did not use any of the 36 supplemental benefits, the majority (52 percent) used 1 or fewer benefits during the year, and 86 percent used 3 or fewer benefits. Among the plan's dual-eligible enrollees, 17 percent did not use any of the 36 supplemental benefits, 36 percent used 1 or fewer benefits, and 76 percent used 3 or fewer benefits. The plan did not report what share of enrollees used any specific benefit, including benefits that are intended to address social determinants of health.

A second analysis conducted by Elevance Health assessed health care utilization rates of MA enrollees who used at least 1 of 36 supplemental benefits in either 2021 or 2022 using a sample that included 1.3 million supplemental-benefit utilizers, roughly 398,000 nonutilizers, and matched cohorts drawn from the FFS population (Elevance Health 2024). The study used propensity-score matching and a difference-in-difference design to attempt to measure the incremental effect of using supplemental benefits.⁵² This method aims to control for differences between the MA and FFS populations so that differences in utilization can be attributed to the use of supplemental benefits. However, the study does not present evidence to show that the baseline utilization rates of the matched groups were similar, which makes

it difficult to determine whether results are due to the use of supplemental benefits or underlying differences between the two groups; the study's authors acknowledge that unmeasured confounding factors could affect their results. In addition, the study matches individuals in MA to individuals in FFS with similar hierarchical condition category (HCC) risk scores (though did not require an exact match). The Commission has previously found that individuals in MA have higher risk scores, on average, due to more exhaustive reporting of diagnostic codes in MA (Medicare Payment Advisory Commission 2024b). As a result, the study may have matched MA enrollees with FFS individuals who have comparatively more intense health care needs despite having similar risk scores, which could lead the study to overstate the effects of supplemental benefits.⁵³ The study found that individuals who used supplemental benefits had different patterns of health care use than nonusers, but due to the study's limitations, it is difficult to draw conclusions about the findings.

One trade association examined data in 2020 for 30,000 MA enrollees in a regional plan who had access to the OTC benefit. That analysis found that 33 percent of eligible beneficiaries in 2020 used the OTC benefit, which provides an allowance for beneficiaries to receive specified nonprescription items from pharmacies (Consumer Healthcare Products Association 2021). Additionally, one analysis of a posthospitalization meal-delivery benefit found that roughly 57 percent of eligible patients accepted or received the benefit; some eligible patients did not receive the benefit because the plan's case managers had difficulty contacting the patient, the patient said they already had help with meals or were able to prepare meals themselves, or the patient declined the meals with no reasons provided (Nguyen et al. 2023). Altogether, the limited evidence that is available from surveys and other studies provides little insight into MA enrollees' use of supplemental benefits and leaves basic questions unanswered.

Current MA encounter data are insufficient for assessing use of many supplemental benefits

MA encounter data should be the most detailed source of information about the services that MA enrollees use, but no research has yet explored whether the data can provide information about enrollees' use of

non-Medicare services. As discussed in the text box on using encounter data to assess use of MA supplemental benefits (pp. 96–99), confusion among MA plan officials about if and how to submit encounter records for some services suggests that the data are likely incomplete for some services and some plans. However, the potential strengths or weaknesses of the data have not previously been well documented. To fill this gap and to explore whether there are services for which the data might be used, we analyzed encounter data for 2021. The 2021 data were the most recent data available at the time of our analysis. However, for some types of supplemental benefits (e.g., SSBCI), 2021 was one of the first years in which plans could offer the benefits. As such, utilization may have been low, and plans and supplemental benefit vendors may still have been developing their processes for collecting and reporting data for such benefits.

One major barrier to using the encounter data to analyze non-Medicare services is the absence of standardized procedure codes corresponding to the benefits that plans offer. (This barrier should be addressed by CMS's updated guidance for 2024 encounter data, but those data are not yet available for analysis.) We used descriptions of supplemental benefits published in CMS guidance and worked with our staff physician to identify CPT and HCPCS codes that could plausibly relate to these types of supplemental benefits (see Table 2-A3 for a list of the codes we used in our analysis, pp. 122–123). Table 2-5 (p. 111) shows, for each non-Medicare service that we assessed, the percentage of MA enrollees in plans that offered the benefit on a mandatory basis in 2021, the number of codes we used to analyze the benefit, and the percentage of MA enrollees in plans offering the benefit who had an encounter record that contained at least one of the codes we linked to the benefit.

We found encounter records for each of the types of supplemental benefits we assessed. However, because some of the codes we used can refer to Medicare-covered services, we are unable to confirm that all of the records we found represented utilization of a supplemental benefit (Table 2-A3 in the appendix indicates relative frequencies of the codes we identified in our searches, pp. 122–123). The percentage of unique enrollees who had at least one encounter record that included one of the codes we looked for ranged from less than 1 percent (for many benefits) to just over 50

percent (for annual physical exams). For most benefits, however, the share of enrollees in plans that offered the benefit who also had a corresponding encounter record was relatively low. For 16 of the 18 benefits we analyzed, fewer than 10 percent of enrollees in plans offering the benefits had corresponding encounter records.

Because we do not have a way to assess the completeness of the data, it is difficult to know whether this measure provides a reliable signal about the extent to which MA enrollees use the supplemental benefits available to them. If the data are incomplete, the utilization we identified may be a lower bound on the true level of utilization; on the other hand, if the procedure codes we used include some services that were not actually supplemental benefits, the utilization we identified could overstate the use of some benefits. Of the benefits we assessed, transportation benefits were the only category for which the percentage of enrollees with an encounter record was roughly in line with the rate suggested by survey data: We found that about 20 percent of enrollees in plans offering transportation benefits had a corresponding encounter record, which is slightly higher than the percentage of survey respondents who reported getting transportation help from their plan in a 2023 survey by the Commonwealth Fund (Commonwealth Fund 2024). For many of the other benefits, the percentage of enrollees with encounter records differs considerably from survey results. The surveys discussed previously found that between one-third and two-thirds of enrollees with access to OTC benefits used the benefit (Commonwealth Fund 2024, Consumer Healthcare Products Association 2021, Elevance Health 2023). However, only 7 percent of enrollees in plans with access to an OTC benefit in our analysis had a corresponding encounter record. For meal- and food-related benefits, the surveys suggest that somewhere between 2 percent and 33 percent of enrollees in plans offering a grocery benefit used it (Commonwealth Fund 2024, Elevance Health 2023). We found that less than 1 percent of enrollees in plans offering such benefits had a corresponding encounter record. For gym memberships and fitness benefits, the Commonwealth Fund survey found that 19 percent of enrollees used the benefit, but less than 1 percent of enrollees in plans with fitness benefits had corresponding encounter records in our analysis (Commonwealth Fund 2024).

Altogether, considering the well-documented data limitations and the discrepancies between encounter data and other sources, we can conclude that—for most supplemental benefits other than vision and hearing benefits—the encounter data are insufficient for characterizing enrollees’ use of the benefits. Given the considerable amount of Medicare spending going toward these benefits in the form of MA rebates, the lack of transparency around use of the benefits is concerning.

The role of vendors, community-based organizations, and vertically integrated entities

Just as little is known about MA enrollees’ use of supplemental benefits, relatively little is known about how MAOs administer the benefits. Because many supplemental benefits are nonmedical, MAOs often contract with third parties such as businesses or community-based organizations to provide or administer the benefits. Medicare does not collect information about the entities with which MAOs contract. To better understand how supplemental benefits are administered, we reviewed the websites of MAOs and entities that administer MA supplemental benefits (see methods text box, p. 112).

Several themes emerged from our review. First, we found that many MAOs contract with dental and/or vision insurers that manage the supplemental dental and vision benefits on behalf of the MA plan, although some insurers manage the benefits themselves or have acquired organizations that manage the benefits on their behalf. Second, we found that MAOs often contract with for-profit vendors to provide nonmedical supplemental benefits. Plans may also contract with community-based organizations, though information about these arrangements was harder to find. Third, we found that MAOs frequently administer supplemental benefits through entities with which the insurer is vertically integrated and that several of the large MAOs have acquired or developed subsidiary businesses that specialize in providing services that can be offered as supplemental benefits. We also found several instances in which MAOs structured their supplemental benefits to be provided exclusively by providers owned by the plan’s parent organization.

Supplemental dental and vision benefits are often administered through external dental and vision insurers

Many of the MAOs we reviewed arranged for their supplemental dental and vision benefits to be administered by dental or vision insurance companies that specialize in administering insurance benefits for a specific category of services. In addition to managing dental or vision supplemental benefits for MA plans, these organizations sometimes offer stand-alone dental or vision insurance plans in the commercial market or contract with employers to provide ancillary dental or vision benefits. Most of the MAOs we reviewed contracted with at least one of these types of entities. The companies can provide a range of services for MA plans, such as organizing networks of clinicians (e.g., dentists, audiologists, or opticians), processing claims, negotiating payment rates or discounts, confirming enrollees’ eligibility for coverage, and ensuring compliance with regulations. Some companies may also take on risk for the benefit(s) they manage, but the prevalence of risk-sharing arrangements is unclear.

For dental benefits, many of the MAOs we reviewed contracted with one of several large dental insurers that offer dental plans in multiple markets across the country. For both vision and hearing benefits, the entities listed as managing the supplemental benefits on behalf of MAOs were often parts of large, vertically integrated organizations that manufacture eyewear or hearing aids, own optometry or audiology practices, and operate retail businesses oriented toward selling eyewear or hearing aids (EssilorLuxottica 2025, EyeMed 2025, Mark Farrah Associates 2023, Vision Service Plan 2025a). Some of the hearing-oriented entities that we identified most frequently in our review are owned by a hearing-aid manufacturer that also owns several hearing-related retail chains and online stores (WS Audiology 2025). Another hearing-oriented company used by several of the MAOs we reviewed is owned by an organization that operates a suite of companies that specialize in administering supplemental benefits on behalf of managed care plans, including hearing benefits, vision services, OTC items, meals and groceries, nutrition counseling, transportation, personal emergency response services, and wellness kits (Hearing Review 2020, NationsBenefits 2025a).

Several of the large MAOs included in our review have established or acquired dental-, vision-, or

**TABLE
2-5****A small share of MA enrollees have encounter records that might correspond to supplemental benefits, 2021**

Supplemental benefit	Number of CPT or HCPCS codes assessed	Percentage of MA enrollees in plans that offered the benefit*	Percentage of enrollees in plans that offered the benefit who had a corresponding encounter record
Fitness benefit	10	91%	<1%
Annual physical exam	26	88	51
OTC items	66	82	7
Food			
Meals (limited duration)	7	56	<1
Food and produce (SSBCI)	7	9	<1
Meals (SSBCI)	7	7	<1
Transportation	97	46	20
Acupuncture	6	26	1
Home modifications			
Home and bathroom safety devices and modifications	74	8	5
Structural home modifications (SSBCI)	5	<1	7
Personal emergency response system	3	24	3
Health education	31	32	<1
Smoking and tobacco cessation	14	20	3
Nutrition/dietary counseling	7	15	1
Wigs for chemotherapy hair loss	1	4	<1
In-home support service	127	8	2
Medical nutritional therapy	2	6	<1
Enhanced disease management	16	6	<1

Note: MA (Medicare Advantage), CPT (Current Procedural Terminology), HCPCS (Healthcare Common Procedure Coding System), OTC (over the counter), SSBCI (special supplemental benefits for the chronically ill). Excludes chart-review encounter records. See appendix for a list of the codes we used to identify each type of supplemental benefit.

* Includes plans offering the supplemental benefits on a mandatory basis.

Source: MedPAC analysis of MA plan benefit data and MA encounter data, 2021.

hearing-oriented companies and now manage the benefits “in house.” For example, UnitedHealthcare has acquired several companies that now operate as UnitedHealthcare subsidiaries and administer supplemental dental, vision, and hearing benefits for UnitedHealthcare’s MA plans (Baltimore Sun 2021, EPIC Hearing Healthcare 2025, United Healthcare 2025a, United Healthcare 2025b, UnitedHealth Group 2019). All three subsidiaries also manage the supplemental

benefits of other MAOs (Blue Shield California 2025, MercyOne 2024, Trinity Health Plan of Michigan 2025). Other MAOs, including Humana and Capital Blue Cross, have made similar acquisitions (Capital Blue Cross 2025, CompBenefits 2010).⁵⁴ However, not all of the MAOs we reviewed listed a third-party entity as managing their dental, vision, or hearing benefit—perhaps because the benefit manager was not listed (or we were not able to identify it) or because some organizations manage the

Methods used to identify and learn about how MA supplemental benefits are administered

To better understand how supplemental benefits are being administered, we reviewed the websites of a nonrandom sample of Medicare Advantage organizations (MAOs) and collected information about the entities with which plans are contracting. Our sample included a mix of large for-profit organizations that offer plans nationally, nonprofit organizations, regional organizations, and provider-owned organizations.⁵⁵ We reviewed the websites in January 2025. Information about supplemental-benefit vendors—when it was available at all—was sometimes found in the “Evidence of Coverage” documents that plans are required to provide to members, but information was sometimes listed elsewhere on the plan’s website (for example, some organizations posted “vendor information sheets” while others had a page of their website dedicated to supplemental benefits).

After reviewing MAO websites to identify the entities with which plans partner, we visited the websites of the entities listed by MAOs to collect information about their business models, how they market their services to MAOs, their ownership structure and financial relationships, and other information. We also conducted an internet search to identify additional organizations that market themselves as providing MA supplemental benefits and conducted a similar review of those organizations. Information about the entities that administer supplemental benefits was limited. As such, our findings can provide illustrative examples of how some MAOs administer supplemental benefits but might not be representative of the industry as a whole. ■

benefits internally.⁵⁶ Altogether, we found that MAOs used a variety of approaches to administer dental, vision, and hearing benefits. Although our review suggested that partnerships with dental or vision insurers are common, existing data sources do not enable us to quantify which types of relationships are most prevalent.

MAOs often contract with vendors or community-based organizations to administer nonmedical supplemental benefits

We found that MAOs frequently contract with vendors (typically for-profit entities) to administer nonmedical supplemental benefits such as meals, transportation, and in-home supports and services. Nearly all of the MAOs included in our review contracted with at least one such vendor. Most of the vendors we identified specialized in providing one type of MA supplemental benefit. However, many of the plans we reviewed administered at least one supplemental benefit through

a prepaid debit card, such as an “OTC card” or flex card. Because flex cards can be used by enrollees to pay for an array of supplemental benefits (defined by the plan), the vendors that administer the cards were often listed in plan documents as the vendor for multiple supplemental benefits. Some vendors operate businesses related to multiple supplemental benefits and offer a flex card as the mechanism through which the benefits are financed and/or accessed. For example, one company offers a flex card that enrollees can use to purchase OTC products, groceries, nonemergency transportation, meals, and exercise kits—all provided through subsidiaries of the company administering the card (MA plans using the vendor can decide which of the benefits their members can access) (NationsBenefits 2025a).

The parent organizations of some MAOs own or operate businesses that administer OTC cards and flex cards. For example, CVS Health owns OTC Health Solutions, which offers a platform through which

MAOs can administer a flex card or OTC benefit (OTC Health Solutions 2025a, OTC Health Solutions 2025b). The platform includes a mobile application and online portal through which MA enrollees can browse a catalog of OTC items (including CVS Health products) and order them for home delivery or pickup at a CVS retail location; the flex card can be used at CVS retail locations as well as other plan-specified locations. Similarly, UnitedHealth Group, through its subsidiary Optum, owns HealthyBenefits+ and Solutran, which offer MAOs a platform for administering OTC and flex-card benefits (Healthy Benefits 2025, Solutran 2025). The MA plans owned by these parent organizations typically administer supplemental benefits through the related subsidiary. Many of the other MAOs in our review also used these companies to administer their OTC or flex-card benefits.

We found several additional instances of MA plans administering supplemental benefits through entities owned by the plan's parent organization. The Commission has previously reported that vertical integration of MAOs has increased since 2022, as measured by the share of MA expenses paid to related parties during a year (Medicare Payment Advisory Commission 2025). Payments from MA plans to related subsidiaries providing supplemental benefits are one potential source of vertical integration. However, due to data limitations, we are unable to quantify the extent to which payments to supplemental-benefit vendors have contributed to the increase in vertical integration and cannot determine what share of rebate dollars are paid to vertically integrated entities.

Information about the role of community-based organizations was harder to find on plan websites

MAOs may also partner with nonprofit community-based organizations (CBOs) to provide supplemental benefits.⁵⁷ However, information about partnerships with CBOs was difficult to locate on plan websites. Perhaps MAOs did not list (or we could not find) the names of CBOs with which they partner, or perhaps they did not partner with CBOs for the benefits we reviewed. To better understand the role of CBOs in providing supplemental benefits, we reviewed case studies and academic studies that described MAOs partnering with CBOs. We found a relatively limited set of case studies, which described partnerships between

MAOs and Meals on Wheels, the YMCA, a nonprofit organization that provides home-based nursing care, Area Agencies on Aging, and other nonprofits (Aging and Disability Business Institute 2022, Aging and Disability Business Institute 2021, Aging and Disability Business Institute 2019, Better Medicare Alliance 2016).

One annually conducted survey of CBOs found that a growing share of them are partnering with MAOs. The survey—which included Area Agencies on Aging, Centers for Independent Living, and other CBOs—found that the share of organizations contracting with MAOs rose from 16 percent in 2021 to 21 percent in 2023 (Kunkel and Lackmeyer 2024).⁵⁸ Older adults and people with disabilities were the populations most often served through the partnerships, and case-management/care-coordination services were the most frequently provided services.⁵⁹ Several of the less frequently provided services (reported by about one-third of survey respondents) are services that MAOs can offer as supplemental benefits, including nutrition programs, home-care services, caregiver support and training, medical and nonmedical transportation, and environmental modifications. See the text box on factors affecting MAOs' decisions about how to administer supplemental benefits (pp. 114–117).

Vertical integration and the lack of transparency around supplemental benefits

Our review found that some MAOs administer supplemental benefits through entities with which the insurer is vertically integrated or with which the plan has a financial interest. On the one hand, this type of integration may enhance coordination of services; on the other, the integration makes it difficult to understand whether the rebates that fund supplemental benefits are being used efficiently. As described earlier in this section, UnitedHealthcare and several other large insurers own subsidiary businesses that administer supplemental dental, vision, or hearing services for the company's MA plans. Additionally, several of the large insurers own subsidiary organizations that administer card-based supplemental benefits. Further, some MAOs require beneficiaries to access supplemental benefits from entities owned by the same parent organization as the plan. For example, several of the large health systems that offer MA plans require that their enrollees access

Factors affecting Medicare Advantage organizations' decisions about how to administer supplemental benefits

Because many supplemental benefits are nonmedical, Medicare Advantage organizations (MAOs) often contract with third parties such as businesses or community-based organizations to provide or administer the benefits. In interviews with MA plan leaders and other stakeholders, researchers have explored how MAOs are choosing to administer supplemental benefits (Baehr et al. 2024, Crook et al. 2019, Durfey et al. 2022, NORC at the University of Chicago 2021, Thomas et al. 2019, Urban Institute 2019). The interviews have found that MAOs typically partner with third-party entities—often vendors or community-based organizations (CBOs)—to provide access to the new benefits. In addition, stakeholders have described the characteristics they value and look for in potential partners (Durfey et al. 2022, Thomas et al. 2019). These attributes include:

- alignment of organizational goals;
- the ability to provide data showing a positive impact on health outcomes, quality of care, or return on investment;
- operational capacity to work with MA plans and scale service delivery; and
- other factors such as expertise, experience providing the services, familiarity with local communities, and strong positive relationships in those communities.

Across multiple studies, stakeholders have described how challenges relating to these factors have hindered MAO–CBO partnerships and favored partnerships with vendors or larger (regional or national) organizations. In our review of plan websites, we found many instances of MAOs contracting with vendors and little information about MAO–CBO partnerships. We found that the vendors we reviewed advertised themselves as being highly focused on plan-aligned goals, provided quantitative information about the effects of their

services, and emphasized their ability to work with MA plans and scale delivery.

MA supplemental-benefit vendors heavily advertise their ability to achieve plan goals

The vendors we identified through our review seemed purpose-built to partner with MAOs: Vendors' websites emphasized their capacity to address nearly all of the themes that researchers have found to be important to health plans.

Alignment of organizational goals

In their interviews with researchers, officials from MA plans stated that they prioritize partnerships in which the partner and the MAO have shared goals (Durfey et al. 2022, Thomas et al. 2019). Multiple interviewees identified improved star ratings and enrollment as important goals for the plans.⁶⁰ Similarly, a survey by the actuarial firm Wakely found that MAO leaders ranked improving clinical outcomes, improving star-rating measures, and attracting or retaining new members as “very important” considerations in their decision-making about supplemental benefits (Baehr et al. 2024). Researchers have noted that, unlike vendors, CBOs often have their own goals, which might not align with that of an MA plan, and may be “concerned that partnering with health care organizations can lead to a loss of autonomy and to an overmedicalization of their goals and services” (Durfey et al. 2022, Taylor and Byhoff 2021). In contrast, we found that supplemental-benefit vendors often advertised their alignment with plans' goals—particularly their ability to help plans lower costs and increase revenue.

Most of the vendor websites we explored advertised their ability to keep a plan's members healthy and reduce their health care costs. In addition, many vendors were specific about how their services could improve financial performance for MAO partners—particularly through membership growth and retention, improved star ratings, and improved

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Factors affecting Medicare Advantage organizations' decisions about how to administer supplemental benefits (cont.)

risk scores. For example, one of the most widely used vendors of fitness benefits advertises its ability to help MA plans achieve “high member acquisition,” “high member retention,” and “lower health care cost claims” (SilverSneakers 2025). A company that administers a flex card and other supplemental benefits advertises its ability to provide “targeted interventions driving CAHPS [Consumer Assessment of Healthcare Providers and Systems] and STARS improvement” as well as its ability to “help support HEI [Health Equity Index] capture and connect members to SDOH [social determinants of health] programs” (NationsBenefits 2025b).⁶¹ A company managing vision benefits for MA plans claimed that “not offering the right vision plan can lead to missed opportunities to improve member health, satisfaction, HEDIS [Healthcare Effectiveness Data and Information Set] scores and star ratings, growth, retention and profitability” (Vision Service Plan 2025b). Two vendors providing food-related supplemental benefits advertised their ability to improve health outcomes, lower medical costs, improve quality or star ratings, and increase enrollment (FarmboxRx 2025, GA Foods 2025). One of the meal-delivery vendors also advertised that it could help plans with “accurate and timely risk score coding.”

Vendors providing in-home supplemental benefits emphasized their ability to identify members' diagnoses and boost star ratings. For example, one company that provides in-home health risk assessments advertises that its employees “know how to look for and document member issues beyond the screening(s) they perform” (HealPros 2025).⁶² Another offers an in-home visit “designed to optimize chronic condition recapture rate and quality gap closure” as well as telehealth “assessments that address HEDIS and Star Gap measures to optimize reimbursement and value-based payment potential” (Medigence Health 2025).⁶³ One company, owned by a large national insurer, advertises that its services “provide timely

and valuable diagnostic screenings . . . [that] are crucial for meeting quality measures and improving health plan member satisfaction scores. They also positively impact star ratings. Accurate coding and documentation are key for appropriate reimbursement” (Signify Health 2025). And one care-coordination vendor described itself as “the sole care coordination program focused on Quality Stars and Risk Adjustment” (Porter 2024). The company provides MA enrollees with a “comprehensive in-home assessment [that] addresses quality and risk adjustment first.” The company touts its ability to “identify and address risk-adjustable conditions and novel HCCs [hierarchical condition categories]” alongside its ability to coordinate care.

Operational capacity to work with MA plans and scale service delivery

In interviews with researchers, officials from MA plans described seeking partners that have “infrastructure aligning with that of MA plans,” meaning the operational capacity to comply with CMS rules and regulations, work within the MA bidding cycle, and understand the competitive pressures facing MAOs. For example, researchers have reported that CBOs “may have limited experience and capacity to contract with health insurance plans” because they “may not meet the liability insurance requirements to contract with plans or may not have the technical capacity to receive, store, and share any health-related information on beneficiaries in a manner required by Health Insurance Portability and Accountability Act (HIPAA) regulations” (Crook et al. 2019). Some interviewees stated that a lack of “plan literacy” on the part of CBOs can be a barrier to partnership, while another pointed out that MA plans and CBOs often have “business models and missions [that] are inherently different” (Durfey et al. 2022).

In contrast, the vendors identified through our review of plan websites foregrounded their understanding of MA regulatory, operational, and

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Factors affecting Medicare Advantage organizations' decisions about how to administer supplemental benefits (cont.)

business considerations. Vendors touted their ability to handle members' data appropriately and comply with CMS regulations. They also advertised their services as being highly customizable in order to meet the varying needs and interests of different MAOs. Considering the value that plans place on finding partners that have “aligned infrastructure,” it is perhaps less surprising that entities owned and operated by MA parent organizations have been able to develop businesses that are widely used by MA plans to administer supplemental benefits.

Officials from MAOs also cited the ability to scale services to wider geographic areas as an important capacity for potential partners. MAOs are required to offer supplemental benefits uniformly within a given plan's service area. CBOs often serve a more limited service area and may struggle to meet the needs of an MAO partner. Some CBOs have overcome this obstacle by forming “networks” of CBOs that together cover a larger service area (ATI Advisory 2020). Some vendors take a similar approach, serving as “aggregators” that develop, through subcontracts with locally operating businesses or nonprofits, networks of providers that can deliver supplemental benefits across a wider service area (ATI Advisory 2020, NORC at the University of Chicago 2021).

The work of assembling such networks can be significant and might deter plans from partnering with local, independent CBOs. By contrast, the vendors we reviewed emphasized their ability to scale and provide consistent service across large geographic areas. Researchers have reported that “some health plans report that it is easier to contract with national umbrella organizations because they can scale benefits more effectively, take advantage of more advanced contracting capabilities, or ensure high levels of liability coverage required under corporate risk management policies” (NORC at the University of Chicago 2021).

Ability to provide data showing a positive impact on health outcomes, quality of care, or return on investment

MAO officials have also stated that they value having data about how a potential partner can help them achieve their goals (Durfey et al. 2022). This capacity may be increasingly important because, beginning in 2025, CMS is requiring MAOs to maintain “bibliographies” that demonstrate that benefits offered as special supplemental benefits for the chronically ill (SSBCI) have a reasonable likelihood of maintaining or improving the health of their enrollees (Centers for Medicare & Medicaid Services 2024g). Researchers have interviewed MA

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hearing or vision benefits through providers that are affiliated with the health system. For example, some plans offered by an MAO that is owned by a large health system cover hearing aids only if they are furnished by audiology clinics owned by the health system (Select Health 2024).

Vertical integration can create opportunities to coordinate services and deliver benefits more efficiently. However, when an MA plan contracts with an owned subsidiary to deliver supplemental

benefits, or when the benefits are required to be delivered through owned providers, there is also an opportunity for the parent organization to retain a larger fraction of each dollar flowing through the supply chain as profit. Plans receiving a rebate from Medicare to finance supplemental benefits typically allocate some fraction of the rebate to administrative costs and profits. The remainder is paid to entities that provide the supplemental benefits to MA enrollees; some of the payment is used to cover that entity's

Factors affecting Medicare Advantage organizations' decisions about how to administer supplemental benefits (cont.)

plan officials about the evidence they use to make decisions about supplemental benefits and found that MA decision-makers typically rely on multiple data sources to determine how to target benefits to MA enrollees, that gaps in evidence hinder decision-making about newer “non-primarily health-related” supplemental benefits, and that some MAOs conduct their own research to fill gaps in knowledge (Shields-Zeeman et al. 2022).

On the websites of the vendors we reviewed, we noted that many provided quantitative information about the services they provide and how their services may relate to MAO goals. The statistics frequently relate to member-satisfaction surveys, membership growth or retention, improvements in health outcomes, or reductions in medical costs. However, much of the evidence we found on plan or vendor websites was cross-sectional and did not provide strong evidence of the causal effects of the interventions on health, enrollment patterns, quality of care, or other outcomes. Recent academic research has assessed the effects of MA supplemental-benefit adoption on patterns of plan disenrollment and plan-satisfaction ratings. One study showed that plan adoption of supplemental benefits (either primarily health-related benefits or special supplemental benefits for the chronically ill (SSBCI)) was not associated with the rate of plan disenrollment (for both dually and non-dually

eligible beneficiaries) (Tucher et al. 2025). Another study found that adopting both a primarily health-related benefit and an SSBCI benefit was associated with slightly higher plan-satisfaction ratings (as measured using the MA-CAHPS); adopting just one of the two benefit types had no significant effect (Tucher et al. 2024b). Nevertheless, vendors may be providing their own data to plans in an effort to demonstrate their potential value, and those data may pertain to outcomes that are of significant interest to the plans. CBOs, on the other hand, might prioritize alternative measures of success and “may not necessarily have previously needed to provide evidence of the population health or financial impact of their services to medically oriented health care entities,” making them a potentially less attractive partner to MAOs (Durfey et al. 2022).

Altogether, our findings—considered in the context of previous research—provide some insight as to how MAOs might be making decisions about the entities with which they partner to administer supplemental benefits. Multiple factors suggest that operational considerations and business incentives may lead plans to favor partnerships with vendors or other large organizations over partnerships with local, independent CBOs, which might have competing goals and operational differences that hinder partnerships with MAOs. ■

administrative costs and profit margin. A vertically integrated entity could therefore capture a larger fraction of each rebate dollar by paying an owned entity to administer supplemental benefits on behalf of the plan. The data that MA plans are currently required to report to Medicare provide no information about the administrative costs or profits of third-party entities delivering MA supplemental benefits. Patterns of high spending and low use could be a sign that the benefits are not being administered efficiently or that

program spending is being captured by entities in the supply chain. The lack of transparency, combined with the high levels of vertical integration we observed in a sample of MAOs, underscores how little is known about enrollees' use of supplemental benefits. ■

2-A

APPENDIX

Additional information about supplemental benefits

**TABLE
2-A1****Examples of supplemental benefits**

Service category	Examples
Supplemental benefits meeting CMS's original definition of "primarily health related"	
Extensions of covered Medicare benefits	Additional days of inpatient acute care, inpatient stay upgrades, additional days of inpatient psychiatric care, additional days of SNF care, SNF stay with waived hospital-stay requirement
Dental	Oral exams, prophylaxis (cleanings), fluoride treatment, dental X-rays, diagnostic dental services, restorative dental services, endodontics, periodontics, extractions, prosthodontics
Vision	Routine eye exams, contact lenses, eyeglasses (lenses and/or frames)
Hearing	Routine hearing exams, fitting/evaluation for hearing aids, hearing aids
Other	Acupuncture, bathroom safety devices, fitness benefits, enhanced disease management, health education, in-home safety assessments, meals (needed due to an illness and offered for a limited duration), OTC items, personal emergency response system, medication reconciliations, remote-access technologies, telemonitoring services, transportation related to health care needs, wigs for hair loss related to chemotherapy, worldwide coverage
Supplemental benefits meeting CMS's expanded definition of "primarily health related"	
Other	Adult day care services, home-based palliative care, in-home support services, support for caregivers of enrollees, medically approved non-opioid pain management, stand-alone memory fitness benefit, home and bathroom safety devices and modifications, transportation to additional health-related locations, OTC benefits
Special supplemental benefits for the chronically ill (SSBCI)	
Other	Complementary therapies, food and produce, meals (beyond limited basis), pest control, transportation for nonmedical needs, indoor air quality equipment and services, social-needs benefit, services supporting self-direction, structural home modifications, general supports for living

Note: SNF (skilled nursing facility), OTC (over the counter). This list is not exhaustive of the supplemental benefits MA plans can offer. Prior to 2020, MA supplemental benefits were required to be "primarily health related," which CMS originally defined as benefits for which the primary purpose is "to prevent, cure, or diminish an illness or injury" (Centers for Medicare & Medicaid Services 2016). Beginning in 2019, CMS broadened its definition to permit services that address physical impairments, lessen the functional or psychological impact of injuries, or reduce avoidable health care utilization (Centers for Medicare & Medicaid Services 2018c). Services that met the original definition continue to be permitted under the expanded definition. Beginning in 2017, MA plans participating in the MA Value-Based Insurance Design Model demonstration were permitted to target supplemental benefits to certain categories of enrollees (Centers for Medicare & Medicaid Services 2018b). Beginning in 2019, the ability to target supplemental benefits to clinically specific groups of enrollees was extended to all plans (Centers for Medicare & Medicaid Services 2018d). Beginning in 2020, all plans were granted the option to provide "non-primarily health-related" supplemental benefits that "have a reasonable expectation of improving or maintaining the health or overall function" for chronically ill enrollees, known as special supplemental benefits for the chronically ill (SSBCI) (Centers for Medicare & Medicaid Services 2019b).

Source: MedPAC summary of CMS guidance documents.

**TABLE
2-A2****CMS descriptions of special supplemental benefits for the chronically ill (cont. next page)**

Benefit	Description
Complementary therapies	Complementary therapies offered alongside traditional medical treatment may be offered as non–primarily health-related SSBCI. Complementary therapies must be provided by practitioners who are licensed or certified, as applicable, in the state in which they practice and are furnishing services within the scope of practice defined by their licensing or certifying state. Alternative therapies that are considered primarily health related may be offered by an MA plan as a non-SSBCI benefit.
Food and produce	Food and produce to assist chronically ill enrollees in meeting nutritional needs may be covered as SSBCI. Plans may include items such as produce, frozen foods, and canned goods. Tobacco and alcohol are not permitted.
General supports for living	General supports for living such as housing may be provided to chronically ill enrollees if the benefit has a reasonable expectation of improving or maintaining the health or overall function of the enrollee. General supports for living may be provided for a limited or extended duration as determined by the plan. The benefit may include plan-sponsored housing consultations and/or subsidies for rent or assisted living communities. Plans may also include subsidies for utilities such as gas, electric, and water as part of the benefit.
Indoor air quality equipment and services	Equipment and services to improve indoor air quality, such as temporary or portable air-conditioning units, humidifiers, dehumidifiers, High Efficiency Particulate Air filters, and carpet cleaning, may be covered as SSBCI. Plans may also include installation and servicing of equipment as part of the benefit.
Meals (beyond limited basis)	Meals are considered a primarily health-related benefit (i.e., non-SSBCI) when provided to enrollees for a limited period immediately following surgery or an inpatient hospitalization or due to a chronic illness (so long as the meals are needed due to an illness, are consistent with established medical treatment of the illness, and are offered for a short duration). Meals may be offered beyond a limited basis as a non–primarily health-related benefit; meals may be home delivered and/or offered in a congregate setting.
Pest control	Pest-eradication services that are necessary to ensure the health, welfare, and safety of a chronically ill enrollee. Services may include pest-control treatment(s) or products that may assist the enrollee in the pest eradication (e.g., traps, pest-control sprays, cleaning supplies).
Services supporting self-direction	Services supporting self-direction allow enrollees to have the responsibility for managing all aspects of health care delivery in a person-centered planning process; while such services are a non–primarily health-related benefit, they may have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee. Plans may provide services to assist in the establishment of decision-making authority for health care needs (e.g., power of attorney for health services) and/or may provide education such as financial literacy classes, technology education, and language classes. Interpreter services may also be provided to enrollees to facilitate encounters with health care providers. Primarily health-related education and/or medical nutrition therapy services that are primarily health related may be offered by an MA plan as non-SSBCI supplemental benefits.
Social-needs benefits	Access to community or plan-sponsored programs and events to address enrollee social needs, such as non–fitness club memberships, community or social clubs, park passes, and access to companion care, marital counseling, family counseling, classes for enrollees with primary caregiving responsibilities for a child, or programs or events to address enrollee isolation and improve emotional and/or cognitive function, are non–primarily health-related benefits that may be covered as SSBCI.

**TABLE
2-A2**

CMS descriptions of special supplemental benefits for the chronically ill (cont.)

Benefit	Description
Structural home modifications	Structural modifications to the home that may assist with the chronically ill enrollee's overall function, health, or mobility are permitted if those items and services have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee (e.g., widening of hallways or doorways, permanent mobility ramps, easy-to-use doorknobs and faucets).
Transportation for nonmedical needs	Transportation to obtain nonmedical items and services, such as for grocery shopping, banking, and transportation related to any other SSBCI, is a non-primarily health-related benefit. Such transportation may be reimbursed, arranged, or directly provided by an MA plan as a SSBCI.

Note: MA (Medicare Advantage), SSBCI (special supplemental benefit for the chronically ill). CMS provides MA plans with these examples of non-primarily health-related supplemental benefits (known as special supplemental benefits for the chronically ill, or SSBCI). This list is not exhaustive of the SSBCI that plans can offer. Plans participating in the MA Value-Based Insurance Design (MA-VBID) Model are granted additional flexibility to target non-primarily health-related supplemental benefits to enrollees on the basis of socioeconomic status (Centers for Medicare & Medicaid Services 2020b).

Source: MedPAC reproduction of CMS guidance documentation (Centers for Medicare & Medicaid Services 2019b). Descriptions of some benefits have been edited to remove detail not relevant to a general audience.

**TABLE
2-A3****CPT and HCPCS codes for analysis of other supplemental
benefits in 2021 MA encounter data (cont. next page)**

Supplemental- benefit category	HCPCS and CPT codes (percentage of enrollees with an encounter record for the category who had an encounter record for that code)
Fitness benefit	S9970 (83%), S9451 (10%), A9300 (7%), 97170 (<1%), 97169 (<1%), 97005 (<1%), 97172 (<1%), 97171 (<1%)
Annual physical exam	G0439 (72%), 99397 (28%), G0438 (12%), 99396 (4%), 99387 (2%), 99401 (1%), 99386 (1%), 99395 (<1%), 99402 (<1%), 99385 (<1%), S0612 (<1%), 99429 (<1%), 99403 (<1%), 99404 (<1%), S0610 (<1%), S0613 (<1%), 99411 (<1%), 99412 (<1%), 99391 (<1%), 99394 (<1%), 99381 (<1%), 99393 (<1%), 99384 (<1%), 99392 (<1%), 99383 (<1%), 99382 (<1%)
OTC items	A9270 (77%), A6402 (7%), A6446 (5%), A4927 (4%), T4535 (3%), A6449 (2%), A9150 (2%), A4554 (2%), A6219 (2%), T4541 (2%), A4670 (1%), T4527 (1%), A6454 (1%), T4526 (1%), A6457 (1%), A6443 (1%), T4528 (1%), T4537 (1%), A4930 (1%), T4523 (1%), T4522 (1%), A6441 (1%), T4524 (<1%), A6220 (<1%), A6452 (<1%), A6450 (<1%), A6448 (<1%), A6445 (<1%), A6413 (<1%), A6403 (<1%), A6453 (<1%), T4544 (<1%), A6442 (<1%), T4543 (<1%), T4525 (<1%), A4553 (<1%), A6447 (<1%), T4540 (<1%), A9286 (<1%), A6455 (<1%), T4539 (<1%), T4521 (<1%), A6451 (<1%), A4928 (<1%), S5199 (<1%), A4663 (<1%), A6218 (<1%), A6221 (<1%), A6444 (<1%), T4542 (<1%), A9153 (<1%), A4660 (<1%), A4931 (<1%), A6404 (<1%), T4534 (<1%), T4536 (<1%), A9152 (<1%), T4533 (<1%), T4530 (<1%), T4529 (<1%), S0197 (<1%), T4532 (<1%), T4531 (<1%), T4538 (<1%), A9180 (<1%), T4545 (<1%)
Meals (limited basis)	S5170 (83%), S9977 (17%), S9433 (<1%), A0190 (<1%), A0210 (<1%), S9435 (<1%), S9434 (<1%)
Meals (beyond a limited basis) (SSBCI)	S5170 (73%), S9977 (29%), A0190 (<1%), S9433 (<1%)
Food and produce (SSBCI)	S5170 (96%), S9977 (5%), S9433 (<1%), A0190 (<1%), S9435 (<1%)
Transportation	A0425 (78%), A0427 (51%), A0429 (32%), A0428 (20%), A0100 (16%), P9604 (8%), P9603 (6%), A0426 (4%), A0130 (4%), T2003 (4%), A0110 (3%), A0398 (2%), A0422 (2%), A0999 (2%), A0382 (2%), S0215 (2%), A0998 (2%), A0120 (2%), A0433 (1%), A0170 (1%), S0209 (1%), A0434 (1%), A0431 (1%), A0436 (1%), T2005 (1%), A0380 (1%), A0394 (<1%), A0200 (<1%), A0420 (<1%), A0888 (<1%), A0090 (<1%), T2049 (<1%), A0080 (<1%), A0432 (<1%), A0392 (<1%), A0396 (<1%), T2007 (<1%), A0430 (<1%), A0160 (<1%), A0435 (<1%), A0424 (<1%), A0390 (<1%), T2001 (<1%), S0207 (<1%), A0384 (<1%), T2002 (<1%), T2004 (<1%), A0140 (<1%), A0180 (<1%), S9992 (<1%), A0190 (<1%), S0208 (<1%), A0210 (<1%), A0021 (<1%), A0225 (<1%)
Transportation for nonmedical needs (SSBCI)	A0425 (78%), A0427 (44%), A0429 (28%), A0100 (20%), A0428 (17%), P9604 (13%), A0110 (11%), A0130 (4%), P9603 (4%), A0426 (3%), A0380 (2%), T2003 (2%), A0999 (1%), T2005 (1%), A0422 (1%), A0998 (1%), S0209 (1%), A0433 (1%), S0215 (1%), A0382 (1%), A0120 (1%), A0434 (1%), A0398 (1%), A0431 (1%), A0436 (1%), T2049 (<1%), A0080 (<1%), A0394 (<1%), A0420 (<1%), A0888 (<1%), A0090 (<1%), A0424 (<1%), A0160 (<1%), A0396 (<1%), A0432 (<1%), A0170 (<1%), A0200 (<1%), A0392 (<1%), A0435 (<1%), A0430 (<1%), A0390 (<1%), T2007 (<1%), S0207 (<1%), A0190 (<1%), T2001 (<1%), A0140 (<1%), S9992 (<1%), T2002 (<1%), T2004 (<1%), A0021 (<1%), A0384 (<1%)
Acupuncture	97810 (72%), 97811 (48%), 97813 (37%), 97814 (29%), 20560 (1%), 20561 (1%),
Home and bathroom safety devices and modifications	E0143 (52%), E0156 (21%), E0163 (15%), E0240 (10%), E0244 (7%), E0246 (7%), E0100 (5%), E0248 (3%), E0135 (3%), E0105 (3%), E0149 (3%), E0185 (2%), E0700 (2%), E0730 (2%), E0627 (1%), E0247 (1%), E0165 (1%), E0245 (1%), E0168 (1%), E0277 (1%), E0159 (1%), E0184 (1%), E0271 (1%), E0154 (1%), E0155 (1%), E0241 (<1%), E0147 (<1%), E0305 (<1%), S5165 (<1%), E0148 (<1%), E0272 (<1%), E0189 (<1%), E0310 (<1%), E0720 (<1%), E0191 (<1%), E0188 (<1%), E0731 (<1%), E0325 (<1%), E0210 (<1%), E0190 (<1%), E0243 (<1%), E0141 (<1%), E0186 (<1%), E0158 (<1%), E0144 (<1%), E0167 (<1%), E0130 (<1%), E0275 (<1%), E0274 (<1%), E0199 (<1%), E0215 (<1%), E0153 (<1%), E0196 (<1%), E0197 (<1%), E0140 (<1%), E0203 (<1%), E0315 (<1%), E0157 (<1%), E0605 (<1%), E0276 (<1%), E0326 (<1%), E0205 (<1%), E0280 (<1%), E0629 (<1%), E0170 (<1%), E0273 (<1%)

**TABLE
2-A3**

**CPT and HCPCS codes for analysis of other supplemental
benefits in 2021 MA encounter data (cont.)**

Supplemental- benefit category	HCPCS and CPT codes (percentage of enrollees with an encounter record for the category who had an encounter record for that code)
Structural home modifications (SSBCI)	E0246 (43%), E0241 (29%), E0243 (29%)
Personal emergency response system	S5161 (100%), S5160 (1%), S5162 (<1%)
Health education	98960 (52%), G0495 (25%), G0496 (8%), G0445 (5%), G0420 (4%), S9110 (3%), 99473 (1%), G0177 (1%), 99078 (1%), 98961 (1%), S9449 (1%), H0025 (1%), 98962 (<1%), S9446 (<1%), H2027 (<1%), S9441 (<1%), G0421 (<1%), S9445 (<1%), S9454 (<1%), H1010 (<1%), T1018 (<1%), S9443 (<1%), H1003 (<1%), T2013 (<1%), G9357 (<1%), S9436 (<1%), S9442 (<1%), S9444 (<1%), T1027 (<1%), T2012 (<1%)
Smoking and tobacco cessation	99406 (53%), 4004F (44%), 99407 (7%), 4000F (6%), 4001F (<1%), G9016 (<1%), D1320 (<1%), S4991 (<1%), S9453 (<1%), G0436 (<1%), S4990 (<1%), G0437 (<1%)
Nutrition/dietary counseling	97802 (71%), 97803 (36%), G0270 (10%), S9470 (6%), 97804 (2%), S9452 (1%), G0271 (<1%), D1310 (<1%), S9465 (<1%)
Wigs for chemotherapy hair loss	A9282 (100%)
In-home support service	S9131 (28%), S9123 (24%), S9129 (14%), T1019 (14%), T1030 (13%), S9500 (11%), S5125 (8%), S9122 (6%), S9501 (5%), S9127 (4%), S9502 (4%), S5131 (3%), S9128 (3%), S9343 (2%), S9124 (2%), T1031 (2%), S9328 (2%), S9342 (2%), S9374 (2%), T1001 (1%), S5498 (1%), S9494 (1%), S9379 (1%), S5116 (1%), S5102 (1%), T1028 (1%), S9338 (1%), S5135 (1%), S9503 (1%), S5501 (1%), S9542 (1%), S9366 (1%), S9348 (<1%), S5150 (<1%), S5130 (<1%), S9330 (<1%), T1005 (<1%), T1021 (<1%), S5502 (<1%), T1002 (<1%), S5517 (<1%), S9341 (<1%), T1004 (<1%), S5126 (<1%), S9490 (<1%), S9375 (<1%), S9373 (<1%), S9367 (<1%), S9504 (<1%), T2031 (<1%), T2030 (<1%), T1003 (<1%), S9097 (<1%), S9359 (<1%), S5105 (<1%), S9125 (<1%), T1020 (<1%), S9361 (<1%), S9363 (<1%), S9372 (<1%), S5109 (<1%), S9351 (<1%), S9365 (<1%), S5100 (<1%), S9340 (<1%), S5101 (<1%), S9347 (<1%), S5522 (<1%), S9346 (<1%), S5523 (<1%), S9364 (<1%), S5520 (<1%), S9529 (<1%), S9376 (<1%), S5521 (<1%), S9368 (<1%), T2033 (<1%), S5185 (<1%), S9370 (<1%), S9325 (<1%), S9326 (<1%), S9537 (<1%), S9590 (<1%), S5121 (<1%), S9329 (<1%), S5497 (<1%), S9331 (<1%), S9357 (<1%), T1000 (<1%), H0043 (<1%), S5110 (<1%), S5120 (<1%), S5136 (<1%), S9355 (<1%), S0271 (<1%), S5151 (<1%), S9212 (<1%), S9327 (<1%), S5111 (<1%), S5518 (<1%), S9214 (<1%), S9336 (<1%), S9339 (<1%), S9345 (<1%), S9353 (<1%), S9497 (<1%), S9560 (<1%), S9810 (<1%), T1022 (<1%)
Medical nutritional therapy	G0270 (98%), G0271 (4%)
Enhanced disease management	S9140 (75%), S0316 (7%), G2065 (7%), S0315 (4%), G2064 (4%), S0317 (2%), S0353 (2%), S0354 (1%), S0341 (1%), S0340 (<1%), S0311 (<1%), S9141 (<1%), S0280 (<1%), S0281 (<1%)

Note: CPT (Current Procedural Terminology), HCPCS (Healthcare Common Procedure Coding System), MA (Medicare Advantage), SSBCI (special supplemental benefits for the chronically ill), OTC (over the counter). Percentages may sum to more than 100 percent because an enrollee could have encounter records that use more than one of the relevant codes for the category. Codes for which we found no encounter records are not shown.

Source: MedPAC analysis of MA encounter data and interpretation of CMS descriptions of supplemental benefits (Centers for Medicare & Medicaid Services 2019b, Centers for Medicare & Medicaid Services 2018c, Centers for Medicare & Medicaid Services 2016).

Endnotes

- 1 These required services are referred to as “basic” services or “Medicare-covered” services, to distinguish them from the supplemental services that plans may provide that are not covered by traditional Medicare. We use the term “supplemental benefits” to refer to the full collection of additional benefits that MA plans may provide, following the term used in program guidance (42 CFR 422.102). These benefits are sometimes also referred to as “extra benefits” but should not be confused with the “supplemental” coverage that FFS beneficiaries can purchase through a Medigap plan.
- 2 Risk scores adjust a plan’s base rate to account for differences in expected beneficiary medical costs by increasing a plan’s payment rate for beneficiaries who are projected to have higher medical expenses and decreasing the payment rate for beneficiaries who are projected to have lower medical expenses.
- 3 Benchmarks are increased for plans with higher quality ratings.
- 4 In the rare circumstance where a plan’s bid is above the benchmark (after both have been adjusted to reflect a person of average risk), the plan’s base payment rate is set at the benchmark and enrollees must pay a premium (in addition to the usual Part B premium) equal to the difference.
- 5 Premiums for “optional” supplemental benefits that are not automatically included in the plan’s benefit package were excluded from the study’s calculations.
- 6 See the Commission’s June 2023 report to the Congress for additional detail on the limits placed on MA plans’ flexibility to use cost-sharing structures that differ from the cost-sharing rules used in FFS Medicare.
- 7 CMS calculates three types of limits using FFS spending data: A mandatory limit based on the 95th percentile of out-of-pocket FFS spending, a lower limit (known in earlier years as the voluntary limit) based on the 85th percentile of out-of-pocket FFS spending, and—starting in 2023—an intermediate limit. Plans have the flexibility to set their MOOP limit anywhere between \$0 and the mandatory limit. CMS encourages plans to have more-generous limits by allowing plans that are at or below the intermediate limit to charge higher cost sharing for certain services.
- 8 Cost sharing for supplemental benefits must be below 100 percent of the cost of the item or service; that is, the plan must incur a nonzero direct cost associated with the benefit (Centers for Medicare & Medicaid Services 2016).
- Plans have the option of setting a service-specific maximum OOP limit for the non-Medicare services they cover as supplemental benefits.
- 9 Medicaid pays the Part B premium for most dually eligible beneficiaries.
- 10 The Part B premium for the preceding year is used as the limit because plan bids are due in June of the year preceding the benefit year, before the actual Part B premium for the upcoming benefit year is announced. In 2025, for example, the maximum Part B premium reduction was \$174.70, equal to the Part B premium for 2024. In November, CMS announced that the Part B premium for 2025 would be \$185.00, meaning that enrollees in plans offering the maximum premium reduction would owe a Part B premium of about \$10 per month (Centers for Medicare & Medicaid Services 2024b, Centers for Medicare & Medicaid Services 2023a). Because the Part B premium generally increases from one year to the next, MA enrollees will typically owe some portion of the Part B premium, even in plans offering the maximum reduction. An additional implication of the limit is that MA enrollees will continue to be liable for the income-related portion of the premium and the Part B late-enrollment penalty (if applicable), regardless of any plan-provided premium reduction.
- 11 Plans participating in the VBIID demonstration could target beneficiaries who receive Part D’s low-income subsidy or who live in disadvantaged areas—as defined using the area deprivation index.
- 12 We estimate that Medicare will pay approximately \$72 billion and \$14 billion in rebates to nonemployer plans and employer plans, respectively, in 2025. Rebates paid to nonemployer plans were estimated using rebate amounts from MA bids and monthly enrollment data for nonemployer plans. Employer plans do not submit bids. Instead, starting in 2019, CMS began paying employer plans based on the bidding behavior of nonemployer plans in the prior year. Because employer plans are mostly preferred provider organizations (PPOs), their payment in 2025 largely reflects the average bidding behavior of nonemployer PPOs in 2024. We use employer-plan enrollment data for 2025 and apply 2025 employer-plan payment rates (adjusted to reflect recent employer-plan risk-score trends) to estimate Medicare’s payments to employer plans. Rebates for employer plans are estimated using the same method CMS uses to determine employer-plan payment rates, in which the difference between the county-specific benchmark and base payment rate for employer plans (based on the average bid-to-benchmark ratio for

- nonemployer plans in the payment quartile of the county) is multiplied by the plan-specific rebate percentage (based on the plan's star rating) and the risk score.
- 13 Title 42 USC 1395w-23 describes the rebate for plans “for which there are average per capita monthly savings described in Section 1395w-24(b)(3)(C) or 1395w-24(b)(4)(C).” Sections 1395w-24(b)(3)(C) and 42 USC 1395w-24(b)(4)(C) define “average per capita monthly savings” as the difference between the plan's risk-adjusted benchmark and bid.
 - 14 We estimate that total rebate spending for 2025 will be \$86 billion. Roughly 60 percent of Medicare payments to MA plans are made from the Part B Trust Fund, and beneficiary premiums finance roughly a quarter of Part B spending. Thus, roughly 15 percent (60 percent × 25 percent) of rebate spending is financed by beneficiary premiums. Roughly 15 percent of FFS enrollees are dually eligible and thus receive Part B premium assistance through Medicaid.
 - 15 Because Part D premiums typically reflect some degree of administrative costs and profit for the Part D plan, some of the rebate dollars allocated to the reduction of Part D premiums is also devoted to administrative costs or profits, though more indirectly. No rebate dollars used to reduce Part B premiums can be apportioned for administrative costs or profit.
 - 16 Across all nonemployer plans (i.e., conventional plans and SNPs) in 2025, plans allocated about \$100 per member per month (PMPM) to provide non-Medicare services, \$64 PMPM to reduce enrollees' cost sharing, \$37 PMPM to make Part D enhancements and premium reductions, and \$10 PMPM to reduce enrollees' Part B premiums.
 - 17 Part D benefit enhancements include things like lowering Part D cost sharing or providing coverage of additional drugs. Using rebate dollars for such enhancements is sometimes described as a reduction in Part D supplemental premiums because the rebate enables the plan to offer the enhancements without a commensurate increase in beneficiary premiums.
 - 18 In 2025, plans allocated more rebate dollars to Part B premium reductions than in previous years. This change is likely due primarily to changes to the structure of the Part D direct-subsidy amount, which may have resulted in plans overestimating the amount of Part C rebates needed for their target Part D premium. Part D–premium targets are initially calculated before plans know how much rebate funding they need to cover their target Part D premium (which is only known after Part D plans submit bids and CMS calculates the national average bid amount). After plans know how much they will need in rebates to cover their target Part D premium, plans reallocate their rebate to ensure that plan enrollees receive the full value of the rebate. However, CMS restricts changes in projected Part C margins that result from rebate allocations to an average of \$1 per member per month. If an MA plan overestimated the amount of Part C rebates needed for their Part D premium, they would likely need to reallocate rebate funding from the Part D–premium buydown to the Part B–premium buydown, the only rebate-funded benefit for which plans do not receive a margin.
 - 19 Plans' bid data must be certified by an actuary, they are subject to review and audit by CMS, and CMS requires that the base-period data match the MA organization's audited financial statements (Centers for Medicare & Medicaid Services 2023b). As such, they may be a reliable source of data for learning about utilization and spending in MA. However, because financial statements generally do not contain information about service use, the utilization rates reported in the data might not receive the same scrutiny and may not be as reliable as the report fields that describe the payments. We interviewed actuaries who prepare MA bids to learn more about the preparation of the data and gather their perspectives about the reliability of the data. They generally supported the view that the utilization rates reported in the bid data are a reasonable source of information about a plan's base-period experience because they are typically derived from the same claims data that are used to populate the payment fields; however, actuaries noted that different plans may use different methods to summarize and report utilization data.
 - 20 Other factors can include sales and marketing expenses, administrative costs, reinsurance costs, and profit margin (Centers for Medicare & Medicaid Services 2023b).
 - 21 In years prior to 2020, the bid pricing tool required plans to report the number of beneficiaries utilizing each category of service. However, CMS stopped collecting this information in 2020; as a result, the 2020 bids—reporting about use of services in 2018—are the last year of bid data that included this information.
 - 22 Federal regulations require MA plans to submit encounter records for all items and services provided to enrollees (42 CFR Sec. 422.310(b)), including items and services provided through supplemental benefits; however, prior to 2024, CMS's Encounter Data Submission and Processing guidance limited that requirement to supplemental services for which the plan has sufficient data to populate an encounter record (Centers for Medicare & Medicaid Services 2025b).
 - 23 In 2019, the Commission made a recommendation to improve the accuracy and completeness of MA encounter data that included the use of a payment withhold to give plans a

- financial incentive to submit more accurate and complete data (Medicare Payment Advisory Commission 2019). That work focused on encounter data for Part A and Part B services but would apply equally well to encounter data for supplemental benefits.
- 24 Prior to 2024, the EDPS was configured to accept encounter records that used the 837-I and 837-P claims formats. A few MA plans have submitted dental encounter records using these formats. However, most dental claims are adjudicated using the 837-D format, which the EDPS was not configured to accept until 2024, and plans have reported not submitting dental records before that time (Centers for Medicare & Medicaid Services 2025b, Centers for Medicare & Medicaid Services 2024d, Government Accountability Office 2023).
 - 25 The MLR is the minimum percentage of revenue that an insurer is required to spend on benefits for its members. An MLR requirement of 85 percent means that the insurer is required to spend at least 85 percent of its revenue on care for its enrollees and can use no more than 15 percent of its revenue for administrative costs and profit. MLR requirements for MA organizations are monitored at the contract level. The numerator of the MLR includes incurred expenses for members' medical claims, including both Medicare and non-Medicare services (i.e., basic and supplemental benefits).
 - 26 CMS generally expects MA plans to use their rebate dollars to cover expenses associated with the cap on enrollees' OOP costs. In 2025, plans project that their liability for the OOP cap will be \$14 per enrollee per month—equivalent to 7 percent of rebates and 1 percent of projected plan payments (Medicare Payment Advisory Commission 2025).
 - 27 Medicare also does not have comprehensive data about the effect of Medigap coverage, or other forms of secondary insurance, on the cost sharing paid by beneficiaries in FFS Medicare. FFS claims data contain information about the total cost-sharing liability for FFS beneficiaries but not whether the beneficiary or another party made the payment.
 - 28 The form CMS uses to collect encounter records includes fields that plans can use to report the amount they paid to providers as well as the enrollees' cost-sharing liability. The data collected in those fields are not included in the public versions of the encounter data available to researchers.
 - 29 The allowed amounts shown in the table are derived from plan bids and may reflect other spending for the service category, such as spending related to risk-sharing arrangements between plans and providers, in addition to the negotiated payment rate.
 - 30 For HMOs, the estimates are based on the cost-sharing amount charged for in-network services. For enrollees in preferred provider organizations (PPOs), the data reflect use of both in-network and out-of-network services; the difference between MA and FFS cost sharing for PPO enrollees may vary for in-network and out-of-network services.
 - 31 The actuarially equivalent amount for cost sharing for professional services in FFS Medicare is not exactly 20 percent because of the Part B deductible and special cost-sharing rules for certain services (e.g., certain preventive services).
 - 32 Plans can choose the unit of measure they use to report the data from a list of CMS-provided options. For example, roughly 90 percent of bids report the number of days of inpatient care for their members, while roughly 10 percent report the number of inpatient admissions. We included bids that used the most common unit for each category: days for inpatient and skilled nursing facility services; visits for home health care, outpatient, and professional services; trips for ambulance services; scripts for Part B drugs; and "other" for durable medical equipment.
 - 33 Many plans that offer a RICS benefit that can be used on most Medicare-covered services do not allow the benefit to be used to pay cost sharing for home health services.
 - 34 Plans can limit the RICS allowance that enrollees can access in a given period such as one year, six months, one month, or other. In 2025, most plans administer the RICS benefit using an annual or quarterly limit. We calculated the monthly limit for each plan by scaling the value of the benefit according to the time limit applied by each plan to calculate an annualized limit, then divided that figure by 12. For example, for a plan offering \$100 of RICS per quarter, we would calculate an annualized RICS of \$400 and a monthly limit of \$33.
 - 35 Some plans include more supplemental benefits in their benefit package than can be covered by the plan's rebate. Beneficiaries enrolling in those plans pay a premium to finance the portion of the supplemental benefits not covered by the rebate. Because our primary interest is in Medicare's spending for supplemental benefits, we estimate how much of the rebate is used to cover non-Medicare services and exclude amounts that are financed by enrollee premiums. The distribution of spending across non-Medicare service categories is based on plans' projections of all spending for non-Medicare services, inclusive of spending financed by enrollee premiums.
 - 36 Determining exactly what services an MA plan covers can be challenging, and beneficiaries will likely need to examine a plan's marketing or member materials, or contact a plan

- representative, to get an accurate picture. For example, when KFF tried to determine in 2021 whether a sample of 10 plans covered dentures (which are part of the “prosthodontics” category under comprehensive dental services), they had to examine each plan’s Evidence of Coverage document, which describes all of the services covered by the plan and is often more than 200 pages long (Freed et al. 2021).
- 37 The literature review included peer-reviewed studies, gray literature, and government reports that examine interventions intended to address social risks and the impact those programs had on health outcomes, utilization, and/or health expenditures. The review focused on interventions that include older Americans or Medicare beneficiaries in the U.S. The final review included 33 articles that cover a mix of social needs and types of interventions. Ten organizations conducting programs to address HRSN in the older adult population were also selected to participate in structured interviews. The interviewees represented three health care plans offering MA products, a Medicare ACO, three integrated health care systems (one of which has several ACOs), two organizations taking part in the Center for Medicare and Medicaid Innovation’s Accountable Health Communities model, and a state Medicaid agency.
 - 38 The survey asked FFS beneficiaries and MA enrollees, “How important to you, if at all, is having access to extra benefits beyond doctor and hospital coverage?” (Commonwealth Fund 2025b).
 - 39 See the Commission’s June 2023 report to the Congress (Chapter 3) for an in-depth description of the variation in benefit design for MA supplemental benefits (Medicare Payment Advisory Commission 2023).
 - 40 The study defined a “comprehensive dental benefit” as coverage that includes no coinsurance for preventive services, no prior authorization for preventive services, coverage of at least two dental cleanings per year, no referral required for preventive services, coverage of nonpreventive services, coverage of the full range of nonpreventive services (diagnostic, restorative, endodontic, periodontic, prosthodontic services, and extractions), a maximum annual benefit limit of no less than \$1,500, a maximum average coinsurance of 30 percent for nonpreventive services, and no additional premium for preventive and nonpreventive services. The criteria were intended to define a dental benefit that “represents parity with employer-sponsored [dental] plans” and were developed based on literature reviews, the authors’ expertise in the field of dental insurance, and consultation with government officials, academics, clinicians, and experts from the insurance industry.
 - 41 Comprehensive data regarding FFS beneficiaries’ use of dental services are also unavailable.
 - 42 MA plans are allowed to vary premiums, cost sharing, and supplemental benefits across parts of a plan’s service area, called “segments.” Each segment consists of at least one county, and benefits, premiums, and cost sharing must be the same within each segment (Centers for Medicare & Medicaid Services 2018a). Accordingly, MA enrollees in one segment of a plan’s service area may have access to different supplemental benefits than enrollees in another segment of the same plan. This variation is relatively rare, and most plans cover the same set of dental service categories across all plan segments.
 - 43 Several studies have used proprietary claims data to report on MA enrollees’ use of supplemental dental benefits, but it is unclear whether findings from those studies are representative patterns of use in MA overall. For example, a study by the actuarial firm Milliman analyzed 2018 claims for 1.9 million MA enrollees who were 65 or older and enrolled in plans that provided dental coverage as a mandatory benefit (meaning that the benefit was automatically included in the benefit package for all enrollees) (Wix and Fontana 2020). Roughly 8 million enrollees in 2018 were in conventional MA plans that offered some coverage of preventive dental services (Friedman and Yeh 2022). The study found that only 11 percent of enrollees had claims for preventive dental care (which the study defined as cleanings, oral exams, and periodontal cleanings) and another 1 percent had claims for some other type of dental care. The study did not indicate which dental services were covered by the unnamed MA insurer(s) that provided the claims data; the low utilization rates, especially for other types of dental care, could be because the plan(s) had limited coverage of those services. According to the study, low utilization could also have been due to enrollees being unaware of their plan’s dental benefits or enrollees finding that their dentist did not participate in the plan’s provider network. A later study, also by Milliman, reported that year-over-year rates of dental utilization in MA rose in 2022 and 2023, but the study did not report percentages for how many enrollees used dental services in those years (Wix and Fontana 2024). The study found that more than two-thirds of dental claims were for preventive services (e.g., oral exams and X-rays). The authors hypothesized that rising utilization rates could be related to plans covering a wider set of services over time, easing of benefit limits (e.g., limitations on how many visits are covered per year or how much the plan will spend for any given enrollee), an increase in the number dentists participating in MA dental networks, improved awareness by MA enrollees about dental benefits, and pent-up demand following the coronavirus pandemic.
 - 44 MA network-adequacy requirements do not apply to supplemental benefits.

- 45 The MCBS, the MEPS, and the National Health Interview Survey (NHIS) ask respondents about their access to dental care. The MCBS asks respondents if there was ever a time in the last year in which they could not receive needed dental care and, if so, what the reasons were for not getting the care. For survey years 2010 through 2017, the MEPS respondents were asked if they delayed any necessary dental care in the past year; for 2018 through 2021, respondents were asked if they delayed any dental care in the past year due to cost. The NHIS also asks about delaying care due to cost. The studies use different methods to define cost-related access problems. Some studies define “cost” as the respondent endorsing that “could not afford the cost” was a reason they could not get dental care. Other studies also include “didn’t want to spend the money” and “insurance did not cover [the] recommended procedures” in the definition.
- 46 These groups of enrollees were also more likely to enroll in plans offering supplemental vision benefits (Gupta et al. 2024b). Although White Medicare beneficiaries were more likely to have some form of private dental coverage, White beneficiaries were more likely overall to have no dental coverage due to a large share of Black and Hispanic beneficiaries having some amount of dental coverage through Medicaid or MA (Centers for Medicare & Medicaid Services 2021b).
- 47 We categorized the following responses as being cost related: “could not afford the cost,” “insurance did not cover the recommended procedures,” and “did not want to spend the money.” We did not count responses as being cost related if the respondent endorsed that they did not receive the care because they “did not think anything serious was wrong/expected dental problems to go away.”
- 48 Milliman’s analysis showed that in 2021, 37 percent of conventional MA plans offered comprehensive dental coverage as an optional supplemental benefit, and 28 percent offered optional preventive dental benefits. More than 95 percent of plans that offered any optional supplemental benefits offered optional comprehensive dental benefits. The share of plans offering optional preventive dental benefits has decreased over time as more plans include those as mandatory supplemental benefits.
- 49 Many plans provide a “dental-only” combination benefit that includes only dental services up to a plan-specified spending limit. Consistent with other analyses of MA plan benefit offerings, we exclude dental-only combination benefits in our summary of combination benefits (Yeh and Yen 2024).
- 50 We estimate the annualized limit for each plan by scaling the value of the benefit according to the time and dollar limits applied by each plan. For example, for a plan using a limit of \$100 per quarter, we would calculate an annualized limit of \$400.
- 51 CMS guidance documents state that food and produce—including but not limited to produce, frozen foods, and canned goods—may be provided as SSBCI to assist chronically ill enrollees in meeting nutritional needs; tobacco and alcohol are not permitted under the benefit (Centers for Medicare & Medicaid Services 2019b).
- 52 The propensity score used in the analysis included age; sex; race/ethnicity; CMS-HCC risk score; dual-eligibility status; residence in a rural area or primary care provider shortage area (from the Department of Health and Human Services’ Area Health Resources Files) and/or a food desert (defined using the U.S. Department of Agriculture’s Food Access Research Atlas); and a neighborhood-level measure of socioeconomic disadvantage.
- 53 A second shortcoming of using HCC risk scores to control for acuity in studies measuring health care utilization is that CMS’s HCC risk scores are designed to capture differences in health care spending, not utilization. The study did not assess whether the HCC risk scores are correlated with use of the services analyzed in the study.
- 54 We found that both UnitedHealthcare and Humana also partner with other independent companies to administer the benefits for some of their plans (Humana 2025, United Healthcare 2025c).
- 55 The organizations included in our review were Alignment Healthcare USA, Banner Health, Blue Cross Blue Shield of Michigan, Blue Cross and Blue Shield of North Carolina, California Physicians’ Service, Cambia Health Solutions, Capital Blue Cross, CareFirst, Centene, Cigna Group, Clover Health, CVS Health, Devoted Health, Elevance Health, Henry Ford Health System, Highmark Health, Horizon Mutual Holdings, Humana, Intermountain Health Care, Kaiser Foundation Health Plan, Marshfield Clinic Health System, Risant Health, SCAN Group, United Healthcare, UPMC Health System, and Trinity Health Plan.
- 56 One analysis of the dental insurance market showed that some of the parent organizations that offer MA plans may also offer dental plans, which suggests that the companies have the capacity to administer the benefits internally (Vujicic et al. 2018).
- 57 CMS defines CBOs as “public or private not-for-profit entities that provide specific services to the community, or targeted populations in the community, to address the health and social needs of those populations. They may include community-action agencies, housing agencies, area agencies on aging, centers for independent living, aging and disability

- resource centers, or other nonprofits that apply for grants to perform social services” (Centers for Medicare & Medicaid Services 2024f).
- 58 The survey found that 47 percent of CBOs in 2023 contracted with at least one health care entity (up from 38 percent in 2017) (Kunkel and Lackmeyer 2024). Medicaid managed care plans were the most common type of partnership among the surveyed organizations, followed by state Medicaid agencies, hospital or health systems, the Veterans Administration, commercial insurers, and then MAOs. On average, the surveyed CBOs reported having three to four active contracts with health care entities.
- 59 MA coordinated-care plans are required to “ensure continuity of care and integration of services through arrangements with contracted providers that include . . . [p]rograms for coordination of plan services with community and social services generally available through contracting or noncontracting providers in the area served by the MA plan, including nursing home and community-based services, and behavioral health services” (42 CFR Sec. 422.112(b)).
- 60 CMS uses a 5-star rating system to characterize MA plan performance (Medicare Payment Advisory Commission 2025). Star ratings are based on measures tied to clinical quality, administrative capability, and patient experience. Medicare currently collects close to 100 MA quality measures, over 40 of which are used to determine a star rating from 1 to 5 for each MA contract. These ratings are made available through the Medicare Plan Finder website to enable beneficiaries to compare across plans. Since 2012, the MA star-rating system has been the basis of the MA quality-bonus program, which increases benchmarks for MA contracts rated 4 stars or higher. The star rating also contributes to the level of rebate payments. Plans with higher star ratings retain a higher share of the difference between a plan bid and the benchmark when bids are below the benchmark.
- 61 “HEI” refers to the Health Equity Index, which CMS developed to encourage plans to address health disparities. The HEI is scheduled to be incorporated into 2027 MA star ratings (Centers for Medicare & Medicaid Services 2023d). In 2025, CMS announced that it plans to update the HEI reward to call it the Excellent Health Outcomes for All (EHO4all) reward (Centers for Medicare & Medicaid Services 2025c).
- 62 Health risk assessments are provided to Medicare beneficiaries as part of an annual wellness visit, and, for MA enrollees, health risk assessments are often provided during a plan-initiated home visit. The Commission has previously identified health risk assessments and in-home visits as mechanisms by which MA plans record more diagnoses for their members, thereby increasing risk scores and payments from Medicare (Medicare Payment Advisory Commission 2025). The Commission has previously shown that health risk assessments are often used to identify diagnosis codes that are not documented on subsequent encounters with providers. For example, for 2023, we found that diagnoses identified only through health risk assessments accounted for \$15 billion in payments to MA plans, or a little more than 3 percent of all payments to MA plans. About 80 percent of these payments were from health risk assessments conducted as part of an annual wellness visit or initial preventive physical examination, while the rest of these payments were from in-home health risk assessments. The Commission has previously reported that chart reviews and health risk assessments are opportunities to record diagnoses for MA enrollees that are not available in FFS Medicare; additional interactions with members through supplemental benefits may be another such factor.
- 63 “Star Gap measures” is a reference to the MA star-rating system and plans’ efforts to increase MA enrollees’ use of services that affect the plans’ star ratings by closing “gaps” between the observed and plan-targeted level of utilization for those services.

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C H A P T E R

3

**Examining home health
care use among Medicare
Advantage enrollees**

Examining home health care use among Medicare Advantage enrollees

Chapter summary

The Commission regularly examines fee-for-service (FFS) Medicare beneficiaries' spending on, and use of, health care services paid for by Medicare's FFS prospective payment systems and fee schedules. Home health is the most frequently used post-acute care (PAC) setting among FFS beneficiaries. The benefit covers treatment for beneficiaries needing skilled care in their home. It can be used after an acute care hospitalization or skilled nursing facility (SNF) stay, or without a prior institutional stay.

Many published studies have examined home health care use among Medicare Advantage (MA) enrollees, frequently with the goal of contrasting use with FFS beneficiaries. However, these studies have relied on data that have limitations for drawing nationally representative conclusions. Home health care use by MA enrollees is reported in the home health MA encounter data submitted by plans and in the Outcome and Assessment Information Set (OASIS) submitted by home health agencies (HHAs). Although CMS requires that both data sources be reported for all Medicare beneficiaries receiving home health care, prior Commission work has found that both data sets are incomplete. Combining these data sources allows for a more complete view of nationwide home health care use among MA enrollees than either data

In this chapter

- Background
- Methods for estimating home health care use by MA enrollees
- Probability of home health care use among Medicare beneficiaries
- Visits per beneficiary among Medicare home health care users
- Home health agencies treating Medicare beneficiaries
- Limitations of this analysis

source alone: Among MA enrollees with a home health encounter record or an OASIS record in 2021, 88 percent had both types of data, 7 percent had only a home health encounter record, and 5 percent had only an OASIS record.

Incorporating beneficiary, plan, and provider characteristics into the combined data and using multivariable regressions, we estimated the probability of home health care use among FFS and MA beneficiaries in 2021 and, conditional on home health care use, visits per beneficiary. We found that the overall rate of home health use among MA enrollees was slightly lower than among FFS beneficiaries (8.3 percent vs. 8.6 percent) after adjusting for beneficiary characteristics. However, there were differences depending on whether beneficiaries had an acute care hospitalization during the year. For those with a hospitalization, the adjusted probability of home health care use was 3.2 percent higher among MA enrollees than FFS beneficiaries (41.7 percent vs. 40.4 percent), which could suggest that home health care is sometimes used in MA as a substitute for other types of post-acute care, such as costlier SNF stays. Among beneficiaries without a hospital stay, the probability of home health care use was 13.7 percent lower among MA enrollees than FFS beneficiaries (3.7 percent vs. 4.2 percent), which could be related to plans' implementation of prior authorization and home health cost sharing (which do not exist in FFS) or to HHAs' preferences for admitting FFS beneficiaries.

We also examined total visits received by home health care users and found that enrollment in MA was associated with 2.1 (11 percent) fewer visits per beneficiary per year compared with FFS (18.2 vs. 20.4 visits per user), on average, after controlling for beneficiary characteristics, including functional and clinical health status derived from OASIS data. This difference in the number of visits per beneficiary was similar regardless of whether beneficiaries had a prior acute care hospital stay.

We examined how use of home health care differed among MA enrollees by plan attributes. We found that enrollment in plans with home health cost sharing was associated with both lower rates of home health care use and a lower average number of visits per user compared with enrollment in plans without home health cost sharing. Enrollment in preferred provider organization plans (vs. HMO plans) was associated with more visits per user but no change in the probability of any home health care use. We did not find any differences in the probability of home health care use for those enrolled in provider-sponsored plans relative to other types of plans, but we did find that

beneficiaries enrolled in provider-sponsored plans tended to have fewer visits in the year compared with those not enrolled in such plans.

The HHAs that treated higher shares of MA enrollees in 2021 tended to be larger than those treating lower shares of MA enrollees. Overall, fewer HHAs treated MA enrollees (4,600 HHAs treated at least 20 MA enrollees, while 7,000 HHAs treated at least 20 FFS beneficiaries). After controlling for the HHA treating the beneficiary, we found that home health users in MA received 1.8 fewer visits than those in FFS (similar to our estimate that does not control for which HHA treated the patients). This finding indicates that, even within the same HHA, MA enrollees received fewer visits, on average, than FFS beneficiaries.

We emphasize that it is not possible to draw conclusions on the appropriateness of care based solely on observing differences in use (and most of the differences we observed are relatively modest). Home health care is one component of the broader PAC landscape, and its use is likely affected by the availability of other PAC providers, as well as other factors such as types of MA plans, their provider networks, the supplemental benefits they offer, and the prior hospitalization (if there is one). Thus, overall PAC use among MA enrollees may differ from that of FFS beneficiaries in important ways that may not be apparent when examining a single sector. In future work, we plan to incorporate analyses of MA enrollees' use of other PAC settings (including SNFs and inpatient rehabilitation facilities). ■

Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to beneficiaries in their homes. To be eligible for Medicare’s home health benefit, beneficiaries must need part-time (fewer than eight hours per day) or intermittent skilled care to treat their illnesses or injuries and must be unable to leave their homes without considerable effort. Most fee-for-service (FFS) Medicare beneficiaries receive home health care after an acute inpatient hospitalization or skilled nursing facility (SNF) stay, but home health care can also occur without a prior institutional stay. In 2023, about 2.7 million FFS Medicare beneficiaries received home care, and the program spent \$15.7 billion on home health care services under the home health prospective payment system (PPS) (Medicare Payment Advisory Commission 2025).

Many published studies have examined home health care use among Medicare Advantage (MA) enrollees, frequently with the goal of contrasting use with FFS beneficiaries. However, these studies have relied on data that have limitations for drawing nationally representative conclusions. Home health care use by MA enrollees is reported in the home health MA encounter data submitted by plans and in the Outcome and Assessment Information Set (OASIS) submitted by home health agencies (HHAs). Although CMS requires that both data sources be reported for all Medicare beneficiaries receiving home health care, prior Commission work has found that both data sets are incomplete (Medicare Payment Advisory Commission 2024a).

In this chapter, we report the results of an analysis of home health utilization by MA enrollees using a data set that combines encounter and OASIS data. We examine how home health care use varies by beneficiary, plan, and provider characteristics. We apply multivariable regression analyses to explore how use of home health care differs by relevant MA plan characteristics and by MA versus FFS after adjustment for beneficiary demographics and functional clinical health status (when available). We also describe the HHAs that treat Medicare beneficiaries and examine how they differ by the share of their Medicare patients who are covered by MA. Where relevant, we include information we obtained from speaking with the leadership of a few large HHA chains.¹ During these discussions, we asked

the HHA representatives about their experiences treating MA enrollees and working with MA plans.

This chapter examines only home health visits that are part of the home health benefit, as reported by plans and HHAs. MA enrollees may receive other services, depending on their MA plan, that are external to the Medicare home health care benefit but may be similar to aspects of the benefit (such as certain types of in-home health care that some plans offer as supplemental benefits). With the information available, it is not possible to draw conclusions on the appropriateness of the amount of care delivered. Further, home health care is just one component of the broader post-acute care (PAC) landscape and is affected by the availability and use of other types of PAC providers, such as skilled nursing facilities (SNFs). In future work, we plan to explore MA enrollees’ use of other PAC providers such as SNFs and inpatient rehabilitation facilities (IRFs).

Background

Medicare beneficiaries enrolled in Part A and Part B may choose to receive benefits from private MA plans instead of traditional FFS Medicare. MA plans must cover Part A and Part B services but can also offer supplemental benefits to enrollees and may use alternative payment models and care-management techniques to manage service use and steer enrollees to preferred providers (MA plans may contract with a subset of providers, subject to certain network adequacy requirements). The Commission has long been interested in better understanding the services used by MA enrollees. Such information is critical to overseeing Medicare’s payments to MA plans—which reached \$494 billion in 2024—and to ensuring that Medicare beneficiaries enrolled in MA plans (now more than half of eligible beneficiaries) receive the full Medicare benefit (Medicare Payment Advisory Commission 2024b). Better understanding of service use by MA enrollees could help improve MA payment policy, facilitate comparison with FFS Medicare, and generate new policy ideas that could be applied across the entire Medicare program.

Several recent studies have examined MA enrollees’ home health care use, mostly with the goal of

comparing use and outcomes with those of FFS beneficiaries. Most studies rely on home health assessment data collected on OASIS, which must be submitted by HHAs for all Medicare patients (see below for further information on OASIS collection) (Burke et al. 2024, Kim et al. 2025, Loomer et al. 2021, Skopec et al. 2020). However, while OASIS data can provide information on the use of home health care, these data do not contain information on home health visits provided during an episode of care. To assess home health visits, some studies use proprietary claims for a subset of MA enrollees using home health care. Prusynski et al. (2024) used data on home health services provided by a large nonprofit HHA, and Casebeer et al. (2022) reported on the home health services provided to beneficiaries enrolled in Humana plans, which covered about 20 percent of MA enrollees from January 2017 to June 2018. Other studies examined national survey data on home health use by MA and FFS beneficiaries (Achola et al. 2023, Videon and Rosati 2025). Videon and Rosati (2025) used the Medicare Current Beneficiary Survey (MCBS) to compare receipt of home-based visits by MA and FFS beneficiaries based on recall. (Although FFS beneficiaries' home visits were validated with FFS claims, the authors could not do the same for MA enrollees.)

The findings across these studies were mixed. Most studies found lower rates of home health care use among MA enrollees than FFS beneficiaries, though not all studies adjusted for characteristics of MA and FFS beneficiaries that could affect utilization. One study found the amount and types of visits to be similar between MA and FFS, though differences in outcomes were mixed. Ma et al. (2024) reviewed 30 studies on MA and FFS home health care from 1997 to 2022 and presented mixed findings on use, intensity of care, and outcomes, though the researchers noted that studies using more recent data tended to find lower use rates among MA enrollees.

These existing studies all have limitations. Studies using OASIS data as the source of home health care information take advantage of the requirement that HHAs submit assessment data directly to CMS for all their Medicare patients. However, our analyses show that about 7 percent of beneficiaries with any home health care records (home health encounter or OASIS) have only MA encounter data—that is, they were not found in the OASIS data (this discrepancy is discussed

further below). Moreover, while OASIS is a rich source of clinical and functional data on the patient, OASIS contains no information on the number, length, or type of home health visits received by the patient during a stay. Claim-level information is needed to obtain such data on visits. Studies mentioned above that use proprietary claims of a provider or plan can report information on visits for a particular sample but do not provide the full, national picture. In addition, several of the studies referenced above focused solely on home health care following an acute inpatient discharge so as to include information from the prior hospitalization. However, this focus excludes the approximately 40 percent of home health stays that do not have a prior institutional stay.²

Notably, none of these studies use MA encounter data to determine home health care utilization among MA enrollees. Since 2012, MA plans have been required to submit to Medicare a record of each encounter that MA enrollees have with a health care provider, though the data were not available to researchers until more recently.³ Complete and accurate encounter data would be the best vehicle for learning about the care provided to MA enrollees. As we reported in our June 2024 report to the Congress, there have been improvements in home health encounter data over time, and combining encounter and OASIS data provides a more complete view of nationwide home health care among MA enrollees than using either source alone (Medicare Payment Advisory Commission 2024a).

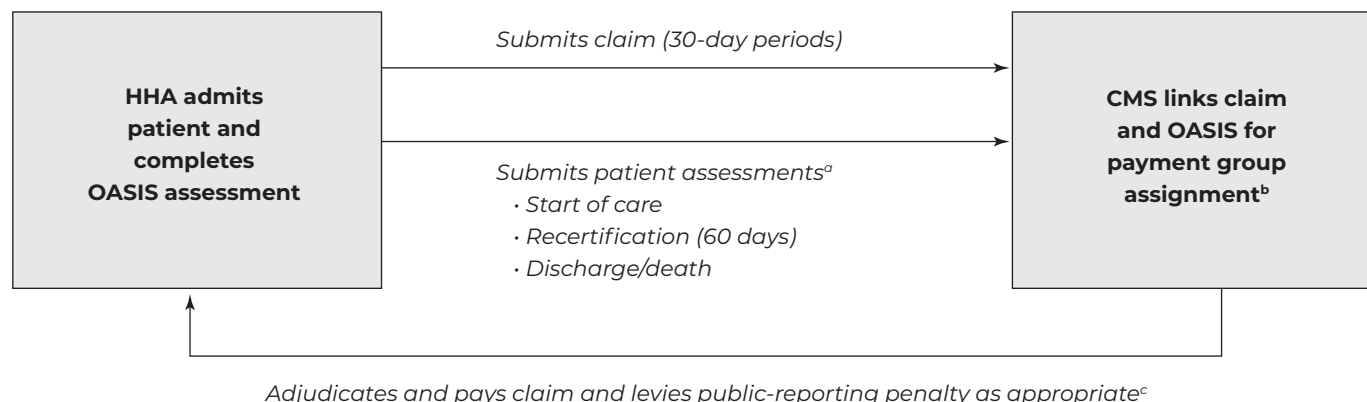
FFS and MA process home health data differently

Differences in how home health care data are processed and flow may affect how complete and standardized the data are between MA and FFS. The three main sources of data to examine home health use among MA and FFS beneficiaries are:

- **Home health claims data** for FFS beneficiaries contain adjudicated claims submitted by HHAs to CMS for payment. The data contain payments made under the home health PPS, the patient's PPS case-mix group, and diagnosis codes, revenue center codes, dates and number of visits, the type of visit (e.g., skilled nursing, physical therapy), and the length of the visit.

**FIGURE
3-1**

**HHAs submit both claims and OASIS data
directly to CMS for FFS Medicare beneficiaries**



Note: HHA (home health agency), FFS (fee-for-service), OASIS (Outcome and Assessment Information Set).

^a OASIS assessments are also required at other time points (such as returning after an inpatient hospitalization).

^b CMS links the claim and the start-of-care assessment in determining payment.

^c CMS levies a 2 percent public-reporting penalty on FFS claims depending on the HHA's percentage of incomplete quality episodes that is calculated based on being able to match start and end assessments for all Medicare patients, including MA enrollees.

Source: CMS claims processing manual (Centers for Medicare & Medicaid Services 2023) and the home health quality reporting requirements. See <https://www.cms.gov/medicare/quality/home-health/home-health-quality-reporting-requirements>.

- **Home health encounter data** for MA enrollees include many of the same fields as the home health claims data, as required by CMS (Centers for Medicare & Medicaid Services 2022). MA plans should include what the patient's case-mix group would be under the home health PPS. Encounter data also contain diagnosis and revenue center codes and dates plus the number, type, and length of visits.
- **OASIS assessments** are required for all Medicare beneficiaries receiving skilled home health care from Medicare-certified HHAs.⁴ The OASIS collects detailed demographic, clinical, and functional information on the patient. Certain items on OASIS are used to case-mix adjust payments in the home health PPS for FFS beneficiaries (and may also be used by some MA plans that set payment rates using the home health PPS). Clinicians need to complete OASIS upon start of care, every 60 days that the beneficiary remains a patient, and upon discharge or death. OASIS data are also required

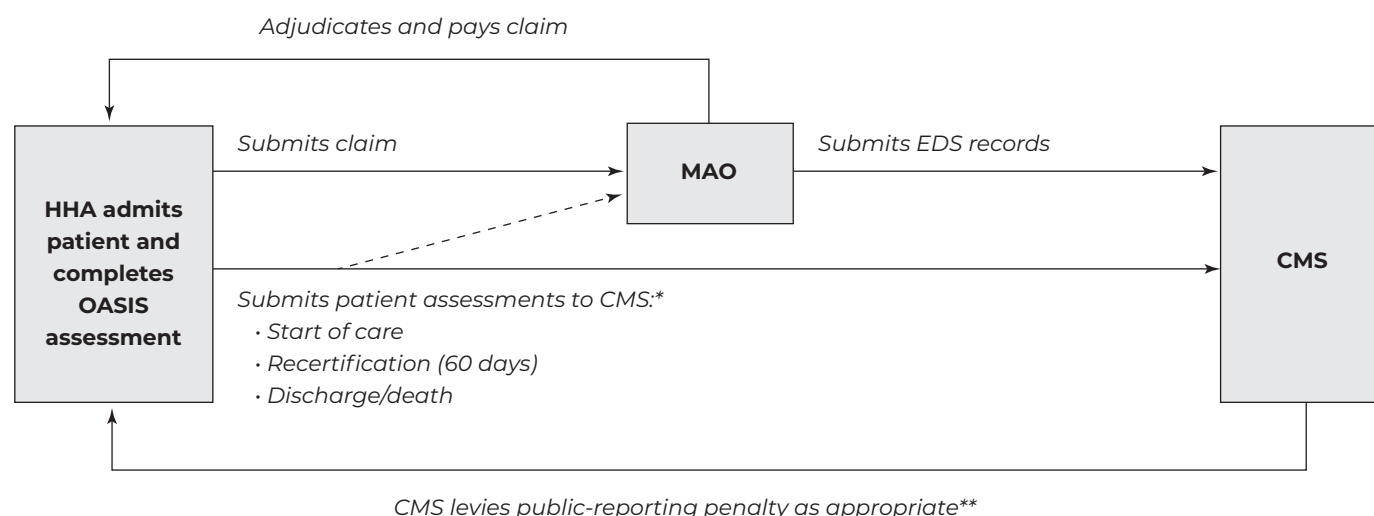
if the patient is transferred to the hospital and returned to the HHA.

As shown in Figure 3-1, under FFS Medicare, the HHA submits both claims and OASIS data directly to CMS, which processes the claim and ensures a corresponding matching OASIS submission (otherwise the claim is denied). Thus, some data auditing and cleaning is conducted during the payment adjudication process.

In contrast, under MA, HHA claim submission, adjudication, and payment occur between the HHA and Medicare Advantage organization (MAO) and do not involve CMS (Figure 3-2, p. 146). The process may differ across plans and by whether the HHA is within the MAO's network. Payment may or may not be based on the home health PPS used by FFS and instead can be made per visit or according to another agreed-upon payment mechanism. MAOs are required to submit home health encounter data to CMS and the

**FIGURE
3-2**

**HHAs submit claims for MA enrollees to plans,
and CMS is not involved in claims adjudication**



Note: HHA (home health agency), MA (Medicare Advantage), OASIS (Outcome and Assessment Information Set), MAO (Medicare Advantage organization), EDS (encounter data set). The dotted line reflects the fact that whether HHAs submit any (and how much) OASIS information to MAOs varies by plan.

* OASIS assessments at other time points (such as returning after an inpatient hospitalization) are also required.

** CMS levies a 2 percent public-reporting penalty on FFS claims depending on the HHA's percentage of incomplete quality episodes (which is based on being able to match start and end assessments for all Medicare patients, including MA enrollees).

Source: CMS encounter data processing manuals (Centers for Medicare & Medicaid Services 2022) and home health quality-reporting requirements. See <https://www.cms.gov/medicare/quality/home-health/home-health-quality-reporting-requirements>.

encounter record; however, unlike in FFS Medicare, the HHA does not directly send any claim information to CMS.

For both FFS and MA patients, CMS requires HHAs to submit OASIS assessments of patients at multiple points throughout their care.⁵ Through the Home Health Quality Reporting Program, CMS checks whether the start and end of care assessments have been submitted for a given home health stay, ensuring that a complete set exists to construct a quality episode for computing performance measures. HHAs that submit 90 percent or more of the required data are considered to have satisfied the requirement, while agencies below this threshold are subject to a 2 percentage point reduction of FFS payments. While this program incentivizes HHAs to

submit complete OASIS data for MA patients, there are two limitations. First, if an HHA does not submit any assessments for an MA patient, CMS would not know that the HHA provided any home health services to the MA enrollee. Second, even under this program, CMS does not require that HHAs submit all of their assessments (the threshold is only 90 percent).

We expect that, because of these different processes, MA enrollees' home health encounter data and OASIS information may be less complete than information available under FFS Medicare. However, we have observed improvements in the data over time, with a higher degree of correspondence in instances of home health use between encounter data and OASIS data in recent years (Medicare Payment Advisory Commission 2024a). Thus, we contend that using these data can

**TABLE
3-1**

Most Medicare beneficiaries with any home health care records appeared in both types of home health data sources, 2021

Home health data source	MA		FFS	
	Number	Percent	Number	Percent
Any (encounter/claim or OASIS)	1,921,640	100%	2,304,700	100%
Matched (home health encounter/claim and OASIS)	1,689,000	87.9	2,265,500	98.3
Had only home health encounter/claim	140,600	7.3	2,800	<1
Had only OASIS	92,100	4.8	36,500	1.6

Note: MA (Medicare Advantage), FFS (fee-for-service), OASIS (Outcome and Assessment Information Set). "Any (encounter/claim or OASIS)" includes beneficiaries present in either the home health encounter data for MA enrollees (or claim for FFS beneficiaries) or OASIS data in the year. "Matched (home health encounter/claim and OASIS)" refers to beneficiaries found in both the encounter data and OASIS for MA enrollees or both the home health FFS claims and OASIS for FFS beneficiaries. "Had only home health encounter/claim" are beneficiaries found only in the home health encounter data for MA enrollees or found only in the home health claims for FFS beneficiaries. "Had only OASIS" are beneficiaries found only in the OASIS data and not in the home health encounter or claims data. The text box on pp. 148–149 provides more detail on matching methods. Counts are rounded to the tens, but percentages are calculated on unrounded numbers.

Source: MedPAC analysis of enrollment, home health encounter, claims, and OASIS data from CMS.

yield important insights on home health care use by MA enrollees, especially when the data sources are combined. To address concerns about data completeness, below, we define an analytic sample that includes counties with indications of higher data completeness.

Methods for estimating home health care use by MA enrollees

For this analysis, we combined home health encounter and OASIS data to identify MA enrollees who used home health care in 2021, the most recent year of encounter data available at the time of this analysis.⁶ We assessed the characteristics of beneficiaries who appear in both data sources, only encounter data, or only OASIS data. We applied the same method to identify FFS beneficiaries who used home health care. We then used multivariable regressions to explore how use of home health care differs by relevant MA-plan characteristics and by MA versus FFS enrollment.

Combining home health encounter and OASIS data sources to identify home health care users

We defined the population of Medicare beneficiaries as those with 12 months of Part A and Part B coverage in 2021. We used the Medicare enrollment file to assign beneficiaries to MA or FFS and applied other cleaning steps described in the text box on pp. 148–149. As shown in Table 3-1, 1.9 million MA enrollees had a home health encounter record or an OASIS assessment. Of these sources, 87.9 percent matched by having both a home health encounter record and OASIS records, 7.3 percent had home health encounter records only, and 4.8 percent had OASIS records only (the text box on pp. 148–149 provides further detail on how these match rates were computed).⁷ In contrast, 98.3 percent of the 2.3 million FFS beneficiaries with any home health record were found in both the FFS claims and OASIS data during the same year (the remaining 1.6 percent of FFS beneficiaries were identified as using home health care through OASIS only, while claims-only beneficiaries made up less than 1 percent). The lower match rate among MA enrollees was not surprising

Data inclusion and cleaning steps

To analyze Medicare Advantage (MA) and fee-for-service (FFS) home health care use, we started with 64 million Medicare beneficiaries enrolled in Medicare as of January 2021 (37 million FFS beneficiaries and 27 million MA enrollees) and made the following restrictions:

- kept only Medicare beneficiaries who had 12 months of Part A and Part B;
- among MA enrollees, kept only those enrolled in HMO or preferred provider organization MA plans (i.e., excluded cost plans, private FFS plans, medical savings account plans, and the Program of All-Inclusive Care for the Elderly plans, for which reporting is not required or would not be as complete) for all 12 months; and
- kept only beneficiaries for whom Medicare is the primary payer in all 12 months.

We excluded beneficiaries who died during the year or joined Medicare in the middle of the year. We also excluded beneficiaries who switched from MA to FFS (or vice versa) during the year (that is, we required beneficiaries in the sample to have 12 months of FFS or 12 months of MA). (Beneficiaries who died in the year or switched payers would be important to examine in future analysis.) After applying these restrictions, we retained 50 million Medicare beneficiaries (27 million FFS beneficiaries and 23 million MA enrollees). We then determined whether the beneficiaries had any records in the FFS home health claims, MA home health encounter records, or OASIS data. We applied the following cleaning steps to each of these data sources:

- **Home health FFS claims data:** We excluded claims for which the Medicare payment amount was zero (this excluded about 5 percent of beneficiaries with home health claims records in the year).⁸

(continued next page)

given differences in the processes for submitting data to CMS described above.

As mentioned above, many studies rely on OASIS data alone to examine utilization among MA home health users. Based on our findings, this method would exclude about 7 percent of MA enrollees with any home health care record. To better understand these beneficiaries, we compared their characteristics (and those of the OASIS-only beneficiaries) with matched MA enrollees with both types of data (Table 3-2, p. 150). Compared with the matched group, MA enrollees who had only home health encounter records were more likely to be Hispanic (20 percent vs. 10 percent), less likely to have a hospitalization in the year (56 percent vs. 61 percent), more likely to be located in an urban area (95 percent vs. 86 percent), and more likely to be

enrolled in an HMO plan (76 percent vs. 59 percent). There were also some differences among the OASIS-only MA enrollees: Compared with the matched group, they were more likely to be dually eligible (41 percent vs. 34 percent) and less likely to have a hospital stay in the year (52 percent vs. 61 percent). Given that the bulk of MA enrollees had both types of home health care records, the matched group was very similar to MA enrollees with any type of home health record.

Table 3-3 (p. 151) shows the number and type of home health care visits received by the matched group and the encounter-only group during the year. Those with home health encounter data only received fewer visits on average (17 vs. 21) and were more likely to have received only one visit in the year (10 percent vs. 3 percent). They also tended to receive a higher share of

Data inclusion and cleaning steps (cont.)

- **Home health MA encounter data:** We removed voided or canceled claims and chart reviews and kept only final action claims (this excluded less than 1 percent of beneficiaries with home health encounter records in the year) (Centers for Medicare & Medicaid Services 2022).
- **Outcomes and Assessment Information Set (OASIS):** We necessarily excluded OASIS assessments missing the beneficiary identifier needed to link to other Medicare data sources. Of the 18 million OASIS records in 2021, about 1.2 million (6 percent) were missing this beneficiary identifier. Based on the OASIS payer source, 970,000 of these records were paid by Medicaid (85 percent of the records missing the beneficiary identifier), but about 180,000 (the remaining 15 percent) indicated MA as the payer. These records represented fewer unique beneficiaries since OASIS data are collected at various time points (about 85,000 of these records were for start or resumption of care). Some of these beneficiaries may have had a home health

encounter record and thus still would be included in our rates of home health use. However, to the extent that some of these approximately 85,000 beneficiaries did not have a home health encounter record, we may be understating MA enrollees' rate of home health use.

We considered MA enrollees identified as having a record in both the home health encounter and OASIS data (or the claims and OASIS data for FFS beneficiaries) as “matched.” To accommodate slight differences in the timing of the encounter or claims records and assessment data submission, we allowed for matches to occur in the month prior to or after 2021. That is, MA enrollees with home health encounter records during 2021 were counted as matches if they had any OASIS record any time between December 1, 2020, and January 31, 2022. Likewise, we counted beneficiaries with OASIS during 2021 as matches if they had a home health encounter record or claim any time between December 1, 2020, and January 31, 2022.⁹ ■

home health aide visits (16 percent) than those in the matched group (6 percent).¹⁰

Match rates varied by the MA parent organization: Across the 185 parent organizations, the match rate ranged from 75 percent to 97 percent at the 10th to 90th percentiles. The rates of encounter data only and OASIS data only also varied across parent organizations. Last, we found that HHAs treating beneficiaries in the encounter data-only group varied in size and geographic location but were not notably different across these dimensions compared with HHAs treating MA enrollees in the matched group.

Taken together, these analyses show that while MA home health care users with only one type of home health data source appear to differ from those with both types of data, there is no reason why they should

not be included in overall counts of home health care use. We will continue to monitor data match rates and the characteristics of MA enrollees found in only one data source.

Data completeness varied by county

Although the encounter-to-OASIS-data match rate of 88 percent among MA enrollees is high, the nontrivial size of the remaining 12 percent means that it is possible that some home health care is occurring that we do not observe in either data source. If home health care does occur that is not picked up in either data source, we would underestimate the home health use rate among MA enrollees. We found that the match rate varies across the country, from 73 percent to 98 percent at the 10th to 90th percentiles (Table 3-4, p. 152). Counties meeting an 85 percent match-rate

**TABLE
3-2****MA home health care users with only encounter or OASIS records differed from those with both types of records, 2021**

	Share of beneficiaries			
	Any home health (EDS or OASIS)	Matched (EDS and OASIS)	Only EDS	Only OASIS
Percent of total	100%	88%	7%	5%
Beneficiary characteristics				
Current eligibility status				
Aged	90	90	92	87
Disabled	10	9	8	13
Sex				
Female	62	62	61	58
Male	38	38	39	42
Age categories				
<45	1	1	1	2
45-64	10	10	8	12
65-79	49	49	48	50
80+	41	41	42	37
Race/ethnicity				
Non-Hispanic White	70	71	58	69
Black	15	15	14	14
Asian/Pacific Islander	2	2	5	2
Hispanic	11	10	20	12
American Indian/Alaska Native	<1	<1	<1	<1
Other or unknown	2	2	2	2
Urban/rural				
Metropolitan	87	86	95	88
Micropolitan	8	9	3	8
Rural	5	5	1	4
Dually eligible or had LIS during year				
No	65	66	64	59
Yes	35	34	36	41
Had hospital stay in year				
No	39	39	44	48
Yes	61	61	56	52
Plan characteristics				
MA plan type				
HMO plan	61	59	76	64
PPO plan	39	41	24	36
Provider-sponsored plan				
No	85	85	80	86
Yes	15	15	20	14
Had home health care cost sharing				
No	82	82	89	85
Yes	18	18	11	15

Note: MA (Medicare Advantage), OASIS (Outcome and Assessment Information Set), EDS (encounter data set), LIS (low-income subsidy), HMO (health maintenance organization), PPO (preferred provider organization). "Any home health (EDS or OASIS)" includes MA enrollees present in either the home health encounter data or OASIS data in the year. "Matched (EDS and OASIS)" are MA enrollees found in both the encounter data and the OASIS data. "Only EDS" are MA enrollees found only in the home health encounter data and not the OASIS data. "Only OASIS" are MA enrollees found only in the OASIS data and not in the home health encounter data. Table 3-1 (p. 147) provides counts of MA enrollees in each of the subgroups.

Source: MedPAC analysis of Medicare enrollment, home health encounter, and OASIS data from CMS.

**TABLE
3-3****MA home health care users with only encounter data received fewer overall visits per beneficiary but more home health aide visits compared with matched users**

	MA enrollees with home health encounter records	
	Matched (EDS and OASIS)	Only EDS
Mean visits per beneficiary	21	17
Median visits per beneficiary (25th to 75th percentile)	13 (7 to 24)	9 (4 to 17)
Share of beneficiaries with one visit	3%	10%
Share of visits per beneficiary by visit type		
Skilled nursing	43%	38%
Therapy	50	45
Home health aide	6	16
Medical social services	1	<1

Note: MA (Medicare Advantage), EDS (encounter data set), OASIS (Outcome and Assessment Information Set). "Matched (EDS and OASIS)" are MA enrollees found in both the home health encounter data and OASIS. "Only EDS" are MA enrollees found only in the home health encounter data and not OASIS data. The table includes 1.6 million matched MA enrollees and 124,000 encounter data-only MA enrollees who were identified as having home health care visits in the year. (The text box on p. 161 describes how home health care visits were defined.)

Source: MedPAC analysis of enrollment, home health encounter, and OASIS data from CMS.

threshold were identified as having higher match rates. Applying this criterion increased the average match rate to 94 percent but decreased the number of counties included in the sample by 17 percent (to 83 percent of counties). The counties meeting the high-match-rate threshold accounted for 72 percent of Medicare beneficiaries in our population. Compared with the full population, the high-match-rate counties had similar shares of MA enrollees and rural Medicare beneficiaries (Table 3-4, p. 152). We did find regional variation in match rates. Counties that were excluded were more likely to be in the West: 22 percent of the Medicare population lived in the West census region, but only 15 percent of all Medicare beneficiaries in the high-match counties lived there (data not shown).

Home health care analytic samples

Our analytic sample was composed of 36 million Medicare beneficiaries who resided in counties

meeting the high-match-rate threshold (Table 3-5, p. 152). Among these beneficiaries, 1.4 million MA enrollees and 1.7 million FFS beneficiaries had at least one home health record in 2021.

The last row of Table 3-5 (p. 152) shows the number of beneficiaries with visit information from the encounter file and assessment information from the OASIS file. This row includes beneficiaries who had at least one home health care visit and who had at least one OASIS assessment for the start or resumption of care in the year. The presence of the assessment for the start or resumption of care was required since we use information on functional and clinical status of beneficiaries from the beginning of their home health stay rather than from interim assessments made for long-term home health care users.¹¹ We excluded any beneficiaries who had visits that occurred before their first OASIS assessment in the year since they likely started care in the prior year. Table 3-5 shows that our

**TABLE
3-4****Most Medicare beneficiaries resided in counties with a high MA home health data match rate, 2021**

	Match rate (EDS and OASIS)	Counties (in percent)	Medicare beneficiary share	MA share of Medicare beneficiaries	Rural Medicare beneficiary share
All counties	88%	100%	100%	38%	7%
10th to 90th percentile	(73% to 98%)				
High-match-rate counties	94	83	72	39	8
10th to 90th percentile	(87% to 98%)				

Note: EDS (encounter data set), OASIS (Outcome and Assessment Information Set), MA (Medicare Advantage). "High-match-rate counties" refers to the subset of counties for which match rates between MA home health encounter data and OASIS data were at least 85 percent. "Match rate (EDS and OASIS)" is the share of MA enrollees with home health encounter records or OASIS records who had both types of records in the year. The 10th to 90th percentile match rates by county are shown in parentheses.

Source: MedPAC analysis of enrollment, home health encounter, and OASIS data from CMS.

analytic sample for assessing home health care visits per beneficiary consisted of 1.0 million MA enrollees and 1.3 million FFS beneficiaries.

Analytic approaches for estimating the probability of home health care use and home health visits per user

We used multivariable regressions to examine the relationships between home health care use and the many characteristics that may influence the

use of home health care. (The text box describes the characteristics we used in our analysis.) We ran separate regressions for the probability of any home health use and, conditional on receiving home health care, the number of visits beneficiaries received. Regressions were run with ordinary least squares and standard errors were clustered at the county level. To mitigate the impact of a small number of very large values, we winsorized visits per beneficiary at the 99th percentile value across MA and FFS

**TABLE
3-5****Home health care analytic samples used in our analysis, 2021**

	Number of Medicare beneficiaries (in millions)	
	MA	FFS
Resided in county with high match rate	16.4	19.5
Had any home health care	1.4	1.7
Had home health care visits and OASIS	1.0	1.3

Note: MA (Medicare Advantage), FFS (fee-for-service), OASIS (Outcome and Assessment Information Set). "Resided in county with high match rate" refers to beneficiaries residing in the subset of counties for which the MA home health encounter data to OASIS data match rate was at least 85 percent. "Had any home health care" included beneficiaries who had a home health encounter or OASIS assessment in the year for MA enrollees and FFS beneficiaries who had a home health FFS claim or OASIS assessment. "Had home health care visits and OASIS" included beneficiaries who had home health visits as reported in the home health encounter or FFS claims and had an OASIS assessment at the start or resumption of care in the year. Beneficiaries with home health visits taking place before their first OASIS start or resumption of care assessment in the year were excluded.

Source: MedPAC analysis of enrollment, MA home health encounter, home health claims, and OASIS data from CMS.

Home health beneficiary, plan, and provider characteristics

We examined a comprehensive set of beneficiary characteristics, including demographic, geographic, and health status information, that likely affect home health care use. These include:

- **Demographics:** We included the current reason for Medicare entitlement, age, sex, geography, and low-income status (measured by indicators for dual eligibility and Part D low-income subsidy status).
- **Hospitalizations:** Many beneficiaries use home health care to recover after an acute care hospitalization. We identified hospitalizations that occurred at any time in the year as well as those that occurred within 14 days of the start of home health care.¹² Home health care may follow skilled nursing facility (SNF) stays or other types

of institutional care, but we did not incorporate those other types of stays into this analysis. We are assessing the completeness of SNF and inpatient rehabilitation facility (IRF) Medicare Advantage (MA) encounter data and plan to incorporate these types of care in future work.

- **Clinical and functional status from OASIS:** Beneficiaries with greater functional impairment or clinical severity may need more home health care visits. We used data from home health care patients' Outcome and Assessment Information Set (OASIS) assessments at the start or resumption of care to categorize them on a set of functional, clinical, and other items (below, we describe how we used OASIS data to obtain beneficiary functional and clinical status).

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home health care users. To control for geographic variation in home health care use, we included county-level fixed effects (which are indicators for the beneficiaries' county of residence) in all regressions. The main results focus on the estimated relationship between MA plan attributes and home health care use among MA enrollees as well as the estimated difference in MA and FFS home health care use among all Medicare beneficiaries. We also ran an alternative specification using HHA-level fixed effects to investigate whether visits per beneficiary differed between MA and FFS beneficiaries within the same HHA.

In descriptive tables provided below showing home health use rates and visits per user by beneficiary and plan characteristics, we geographically standardize both MA and FFS values using the county's share of overall MA enrollment but otherwise do not adjust for other characteristics. Descriptive tables are labeled as "unadjusted" in table headers.

Probability of home health care use among Medicare beneficiaries

We now turn to our results on home health care use rates. Table 3-7 (p. 156) reports the shares of beneficiaries using home health care by beneficiary and plan characteristics and unadjusted (but geographically standardized) rates of home health care use. Overall, among MA enrollees, the home health use rate was 8.4 percent, similar to the 8.6 percent rate among FFS beneficiaries. Not surprisingly, home health use rates were much higher for MA enrollees who had a general acute care hospitalization in the year (41.5 percent). Home health use rates were also higher for those who were female (9.1 percent), were ages 80 and above (15.9 percent), or had low incomes (11.7 percent). The patterns were similar among FFS beneficiaries.

As shown in the bottom part of Table 3-7 (p. 156), among MA enrollees in our study population, 45

Home health beneficiary, plan, and provider characteristics (cont.)

Among MA enrollees, we also assessed how certain plan types and attributes were associated with home health care use. These include:

- **Health maintenance organization (HMO) vs. preferred provider network (PPO):** HMO plans generally require their enrollees to receive care from only in-network providers with whom the plan has negotiated contracts. Under PPOs, MA enrollees can seek care outside of the specified network, though frequently with higher cost sharing.
- **Provider-sponsored plans:** These plans are affiliated with hospitals, physicians, health systems, or other providers. Supporters of these plans tout the closer relationship with and understanding of patients' clinical needs that can improve population health and result in better quality of care. Many but not all of these plans are HMOs. The data to categorize plans as provider sponsored were obtained from the Managed Markets Insight & Technology (MMIT) Directory of Health Plans.
- **Home health care cost sharing:** Some plans require cost sharing on home health care use (through deductibles, copayments, or coinsurance). These requirements may affect the use of home health care (both the probability of any use and the number of visits, depending on how the cost sharing is implemented), particularly in comparison with fee-for-service (FFS) Medicare, which has no home health care cost sharing. We used bid data to determine whether plans required home health cost sharing for their enrollees.¹³

Almost all plans required some sort of prior authorization for home health care use, so there was too little variation to assess its association with home health care use. Additional fields describing the type of prior authorization were not well populated (for example, some plans indicated that prior authorization was required after 60 days or

was required for certain types of therapy or social work services, but most plans did not describe the type of prior authorization required). A recent qualitative study found substantial variation in how prior authorization is implemented across plans (Thomas et al. 2025).

Last, we examined the attributes of the home health agencies (HHAs) in our analytic sample that treated Medicare beneficiaries and how they varied by the share of the HHAs' Medicare beneficiaries who were covered by MA. Attributes included HHAs' size (measured by the number of Medicare beneficiaries treated in a year), ownership (tax status), and type (freestanding vs. hospital based).

Beneficiary information from OASIS

Since its implementation in 1999, HHAs have been required to collect information using the OASIS on Medicare beneficiaries (both FFS and MA) upon admission and at various other points during their home health stay (Centers for Medicare & Medicaid Services 1999).¹⁴ We use information from the start of care (SOC) and resumption of care (ROC) assessments since they indicate the beginning of a home health stay (Abt Associates 2023). In our analytic sample of MA enrollees with home health encounter records (or FFS beneficiaries with home health claims) and OASIS, 90 percent of beneficiaries had only SOC assessments, 9 percent had both SOC and ROC assessments, and less than 1 percent had only ROC assessments.

OASIS items can have multiple responses. For example, responses for activity of daily living (ADL) items range from most independent to most impaired. For other items, responses may indicate the severity of the condition. Table 3-6 shows the items on OASIS we used to describe patients' clinical and functional status in our analyses. We categorized responses into two groups based on the level of severity or impairment, with input from our staff clinician (Table 3-6). That is,

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Home health beneficiary, plan, and provider characteristics (cont.)

responses that indicated greater impairment or severity were assigned into “higher impairment or severity”; otherwise, they were assigned into “lower impairment or severity.”

If beneficiaries had multiple SOC or ROC assessments in the year, we incorporated responses from all the assessments by assigning the beneficiary

a value of “higher impairment or severity” if responses on any SOC or ROC assessment indicated a “higher impairment or severity” grouping. In our analytic sample, most beneficiaries (over 70 percent) had only one assessment, about 20 percent had two assessments, and the remaining 10 percent of beneficiaries had three or more assessments. ■

**TABLE
3–6**

Grouping OASIS item responses, 2021

OASIS item (item code)	Responses grouped into “lower impairment or severity”	Responses grouped into “higher impairment or severity”
Activities of daily living		
Grooming (M1800)	0, 1	2, 3
Dress upper body (M1810)	0, 1	2, 3
Dress lower body (M1820)	0, 1	2, 3
Bathing (M1830)	0, 1, 2	3, 4, 5, 6
Toilet transferring (M1840)	0, 1	2, 3, 4
Toileting hygiene (M1845)	0, 1	2, 3
Transferring (M1850)	0, 1	2, 3, 4, 5
Ambulation/locomotion (M1860)	0, 1, 2	3, 4, 5, 6
Feeding or eating (M1870)	0, 1	2, 3, 4, 5
Clinical and other items		
Therapies (IV, TPN, enteral) (M1030)	4	1, 2, 3
Lives alone with occasional or no assistance (M1100)	1–3, 6–9, 11–14	4, 5, 10, 15
Vision (M1200)	0	1, 2
Unhealed pressure ulcer/injury at stage 2 or higher (M1306)	0	1
Surgical wound (M1340)	0	1, 2
Urinary incontinence or urinary catheter presence (M1610)	0	1, 2
Bowel incontinence frequency (M1620)	0, 1	2, 3, 4, 5, N/A
Cognitive functioning (M1700)	0, 1	2, 3, 4
Depression (M1730)	0, 1	2, 3
Frequency of disruptive behavior symptoms (reported or observed) (M1745)	0, 1, 2	3, 4, 5

Note: OASIS (Outcome and Assessment Information Set), IV (intravenous), TPN (total parenteral nutrition), N/A (not applicable).

Source: OASIS–D All Item Set (https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/homehealthqualityinits/downloads/oasis-d_all-items_final.pdf).

**TABLE
3-7**

Medicare beneficiaries who had a hospitalization, were female, were age 80 or older, or had low incomes were more likely to use home health care (unadjusted), 2021

	Share of all beneficiaries	Beneficiaries using home health care (in percent)	
		MA	FFS
Overall	100%	8.4%	8.6%
Current eligibility status			
Aged	89	8.6	8.9
Disabled	11	7.2	6.9
Sex			
Female	56	9.1	9.5
Male	44	7.4	7.5
Age categories			
<45	3	4.0	4.1
45-64	9	8.1	8.5
65-79	65	6.3	6.1
80+	22	15.9	16.7
Race/ethnicity			
Non-Hispanic White	77	8.4	8.6
Black	10	9.5	9.5
Asian/Pacific Islander	3	5.5	6.1
Hispanic	7	7.9	7.9
American Indian/Alaska Native	<1	9.8	9.7
Other or unknown	3	5.1	4.9
Urban/rural			
Metropolitan	80	8.4	8.7
Micropolitan	12	8.3	8.2
Rural	8	8.4	8.3
Dually eligible or had LIS during year			
No	78	7.3	7.9
Yes	22	11.7	11.5
Had acute care hospitalization in year			
No	88	3.7	4.2
Yes	12	41.5	40.4
MA enrollees only			
MA plan type			
HMO plan	55	8.5	N/A
PPO plan	45	8.1	N/A
Provider-sponsored plan			
No	85	8.4	N/A
Yes	15	7.8	N/A
Had home health care cost sharing			
No	77	8.7	N/A
Yes	23	7.2	N/A

Note: MA (Medicare Advantage), FFS (fee-for-service), LIS (low-income subsidy), HMO (health maintenance organization), PPO (preferred provider organization), N/A (not applicable). Table includes Medicare beneficiaries residing in counties with high match rates for MA home health data (see Table 3-5 on p. 152 for beneficiary counts). "MA beneficiaries using home health care" are defined as those with a home health encounter data set record or Outcome and Assessment Information Set (OASIS) record in the year. FFS home health users are defined as beneficiaries with a home health claim or OASIS record in the year. Rates of home health care use were weighted to reflect the counties where MA enrollees reside to standardize for differences in the geographic composition of the MA and FFS populations. Figures were not adjusted for any other differences in characteristics between MA and FFS populations.

Source: MedPAC analysis of enrollment, MA home health and inpatient encounter, home health claims, OASIS, Medicare Provider Analysis and Review, and plan benefit data from CMS.

percent were enrolled in PPO plans, while 55 percent were in HMO plans. Fifteen percent were enrolled in provider-sponsored plans, and 23 percent were enrolled in a plan with home health care cost sharing. There were some differences in the rates of home health care use by MA plan attributes: Beneficiaries enrolled in HMOs had slightly higher rates than those enrolled in PPO plans (8.5 percent vs. 8.1 percent). Among those enrolled in provider-sponsored plans, 7.8 percent used home health care compared with 8.4 percent of those not enrolled in a provider-sponsored plan. Enrollees in plans with cost sharing for home health care had a lower probability of using home health care (7.2 percent compared with 8.7 percent among those with no cost sharing for home health).

Rates of home health care use varied across MA plans. Among the 4,600 plans in our analysis, the 10th percentile to 90th percentile of home health care use rates was 5 percent to 12 percent. Across the 180 MA plan parent organizations, the home health care use rate ranged from 7 percent to 9 percent (10th percentile to 90th percentile).

Among MA enrollees, rates of home health care use were lower for those enrolled in plans with cost sharing even after adjusting for beneficiary characteristics

To examine the association between plan attributes and home health care use rates, we regressed an indicator for home health care use on the beneficiary characteristics listed in Table 3-7 and included indicators for each of the plan attributes (in separate regressions). As shown in the top section of Table 3-8 (p. 158), rates of home health care use did not differ for PPO enrollees compared with HMO enrollees or enrollees on provider-sponsored plans compared with those not on provider-sponsored plans. However, we found that beneficiaries enrolled in plans with home health cost sharing had, on average, a 6.9 percent lower adjusted rate of home health care use (7.9 percent compared with 8.4 percent for enrollees who were not on plans with home health cost sharing). This difference was statistically significant at the 1 percent level.

As shown in the second section of Table 3-8 (p. 158), only about 4 percent of MA enrollees who did not have a hospitalization in the year used home health

care, and those enrolled in plans with home health care cost sharing had a 12.6 percent lower probability of using home health care, on average. Whether or not the beneficiary was enrolled in a PPO or HMO plan or provider-sponsored plan was not associated with any differences in the rates of home health care use (Table 3-8). The patterns were the same among MA enrollees who had a hospital stay during the year: Only home health care cost sharing was associated with a difference in home health use rates (see the bottom section of Table 3-8).

We note that our indicator for acute hospital stay denotes whether the beneficiary had a hospitalization at any point during the year, regardless of when the home health stay occurred. The hospital stay may or may not have been related to the home health care stay (and could, in fact, occur nearly 12 months apart). It is also possible that a hospital stay occurred following home health care use for some beneficiaries (indeed, potentially preventable hospitalization is an outcome measure used by CMS). Whether a hospitalization occurred during the year is an important beneficiary characteristic that is highly related to home health care use, and future work could specifically examine rates of posthospital or community-admitted home health care use (by linking hospitalizations to subsequent home health care stays). Below, when we examine home health care visits per user, we do define prior hospital stays (using the 14 days prior to the start of home health care).

Rates of MA and FFS home health care use, adjusted for beneficiary characteristics, differ depending on whether hospitalizations occurred in the year

We used the population of MA and FFS beneficiaries to examine differences in the probability of home health care use by payer. We regressed home health care use on the beneficiary characteristics listed in Table 3-7 (excluding MA-plan attributes) and included an indicator for payer. As shown in the top row of Table 3-9 (p. 159), we found that the probability of home health care use (adjusting for beneficiary characteristics) was slightly lower among MA enrollees: 8.3 percent among MA enrollees compared with 8.6 percent among FFS beneficiaries (a difference of 4 percent).

**TABLE
3-8****The probability of home health care use was lower among MA enrollees in plans with home health cost sharing (adjusted), 2021**

	Regression-adjusted probability of home health care use		Difference	
	Yes	No	Percentage points	Percent
Overall				
PPO plan (vs. HMO)	8.3%	8.3%	0.08	1.0%
Provider-sponsored plan	8.3	8.3	0.02	0.3
Plan had home health care cost sharing	7.9	8.4	-0.57*	-6.9
No hospital stay in year				
PPO plan (vs. HMO)	3.7	3.7	0.07	1.9
Provider-sponsored plan	3.7	3.7	-0.004	-0.1
Plan had home health care cost sharing	3.3	3.8	-0.47*	-12.6
Had hospital stay in year				
PPO plan (vs. HMO)	41.7	41.6	0.15	0.4
Provider-sponsored plan	41.7	41.7	0.10	0.2
Plan had home health care cost sharing	40.5	42.0	-1.4*	-3.4

Note: MA (Medicare Advantage), PPO (preferred provider organization), HMO (health maintenance organization). Table includes MA enrollees residing in counties with high match rates for MA home health data (see Table 3-5 on p. 152 for beneficiary counts). Among MA enrollees, we regressed an indicator for whether the beneficiary had any home health care and controlled for the beneficiary characteristics listed in Table 3-7 (p. 156). We included each of the plan attributes separately and county fixed effects. The results in this table show the regression-adjusted probability of home health care use by each plan characteristic using the estimates from the regressions. Differences and percentages were calculated on unrounded numbers.

* Indicates statistical significance at the 1 percent significance level with Bonferroni corrections for multiple comparisons.

Source: MedPAC analysis of enrollment, MA home health and inpatient encounter, home health claims, Outcome and Assessment Information Set, Medicare Provider Analysis and Review, and plan benefit data from CMS.

The differences were in opposite directions when we estimated rates of home health care use by whether the beneficiary had a hospital stay in the year (using separate regression models). Among those without a hospital stay, the rate of home health care use was 13.7 percent lower among MA enrollees than FFS beneficiaries (3.7 percent vs. 4.2 percent, as shown in the second row of Table 3-9). Among those with a hospital stay, the adjusted probability of home health care use was 3.2 percent higher among MA enrollees than among FFS beneficiaries (41.7 percent vs. 40.4 percent).

Several considerations related to plan and provider behavior may drive differences in home health use rates between MA and FFS beneficiaries. Lower rates of home health care use in MA compared with FFS might be explained by MA plans taking actions to manage the home health care use of their enrollees through prior authorization or cost sharing, neither of which are used for home health care in FFS. On the provider side, some HHAs may prefer seeing FFS patients than MA patients. In fact, one large HHA chain we interviewed said that payment for MA home health care patients was frequently below the cost of providing care and, all else equal, they favored

**TABLE
3-9**

The rate of home health care use differed between MA and FFS beneficiaries by whether they had a hospital stay in the year (adjusted), 2021

	Regression-adjusted probability of home health care use		Difference	
	MA	FFS	Percentage points	Percent
All beneficiaries	8.3%	8.6%	-0.34*	-4.0%
No hospital stay in year	3.7	4.2	-0.54*	-13.7
Hospital stay in year	41.7	40.4	1.32*	3.2

Note: MA (Medicare Advantage), FFS (fee-for-service). Table includes MA enrollees residing in counties with high MA home health data match rates (see Table 3-5, p. 152, for beneficiary counts). Among all Medicare beneficiaries, we regressed an indicator for whether the beneficiary had any home health care and controlled for the beneficiary characteristics listed in Table 3-7 (p. 156) (excluding the MA-only plan attributes). We included an indicator for enrollment in MA and included county fixed effects. Regressions were run separately for beneficiaries with and without a hospitalization in the year. The results in this table show the regression-adjusted probability of home health care use by MA and FFS using the estimates from the regressions. Differences and percentages were calculated on unrounded numbers.

* Indicates statistical significance at the 1 percent significance level with Bonferroni corrections for multiple comparisons.

Source: MedPAC analysis of enrollment, MA home health and inpatient encounter, home health claims, Outcome and Assessment Information Set, Medicare Provider Analysis and Review, and plan benefit data from CMS.

admitting FFS patients over MA enrollees. Another consideration for dually eligible beneficiaries is the receipt of Medicaid-covered home- and community-based services (HCBS). One preliminary study found that Medicaid HCBS may be substituting for community-admitted Medicare home health care (that does not follow a hospitalization) and that the substitution occurred more frequently among MA enrollees receiving HCBS (Qi et al. 2024).

The higher use of home health care among MA enrollees with a hospital stay might be explained by plans encouraging substitution of home health care in place of more costly SNF post-acute care following a hospitalization. Leadership of a large HHA chain we interviewed stated that despite lower payments for MA enrollees, they continued to admit posthospital MA patients in order to maintain hospital referral relationships.

We emphasize that, with the information available, it is not possible to draw conclusions on the appropriateness of care based solely on observing these differences.

Visits per beneficiary among Medicare home health care users

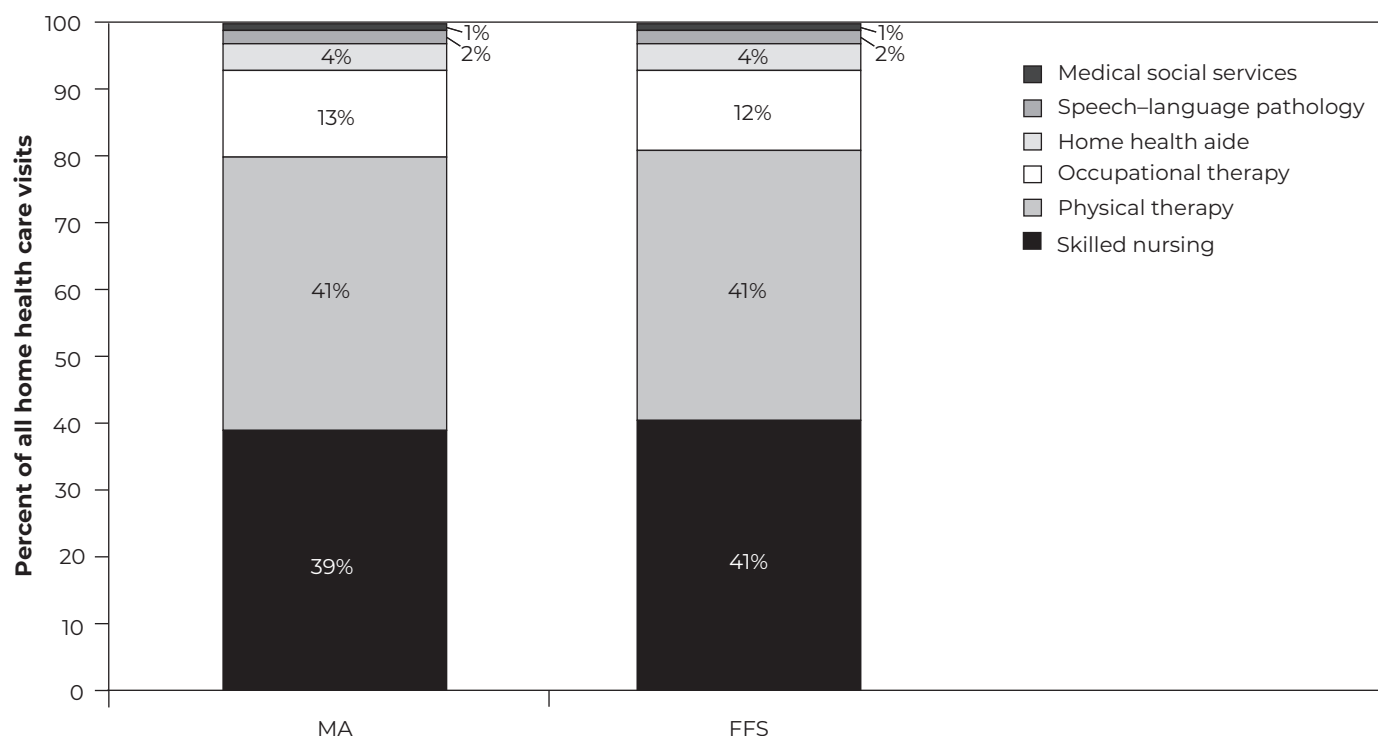
We turn to examining the characteristics of beneficiaries who use home health care and how these characteristics relate to the number of visits received in the year. (The text box on p. 161 describes how visits were identified in the home health encounter and claims data.)

For each home health user, we summed visits across each of the six home health disciplines that occurred in 2021: skilled nursing, therapy (physical, occupational, and speech-language pathology), home health aide, and medical social services. Figure 3-3 (p. 160) shows that skilled nursing, physical therapy, and occupational therapy visits made up more than 90 percent of home health visits among both MA and FFS home health users.

The analysis in the remainder of this chapter analyzes total visits (summed across disciplines) per home health user. An area for future work would be to further assess the association of MA plan types and payer with visits by type.

**FIGURE
3-3**

Skilled nursing and physical therapy were the most common visits among Medicare home health care users (unadjusted), 2021



Note: MA (Medicare Advantage), FFS (fee-for-service). The figure shows the share of visits per home health care user by each of the home health disciplines. (The text box, p. 161, describes how we identified home health visits in the home health encounter and claims data.) Visits were not adjusted for differences in characteristics between MA and FFS populations.

Source: MedPAC analysis of MA home health encounter, claims, and enrollment data from CMS.

As shown in Table 3-11 (p. 162), the most common clinical reason for home health care among beneficiaries in our analytic sample (based on the principal diagnosis cost listed on OASIS) was musculoskeletal rehabilitation (about 30 percent of home health care users). Around 15 percent used home health care for Medication Management, Teaching, and Assessment (MMTA) related to cardiac and circulatory conditions, and 11 percent used home health care for neurological rehabilitation. The distribution of clinical conditions was similar between MA and FFS home health care users.

On average, MA home health users received 17.8 visits during the year (Table 3-11, p. 162). MA enrollees using

home health for wound care received the most visits (25.1 visits per beneficiary, on average). The fewest visits per beneficiary, on average, were among patients using home health care for MMTA surgical aftercare (14.5 visits per beneficiary). On average, FFS home health care users received more visits than MA home health care users across all conditions, though the patterns of visits per user by clinical condition were similar. Overall, the average number of visits per beneficiary among FFS home health users was 20.5 visits.

As shown in Table 3-12 (p. 163), visits per home health user also varied by other beneficiary and plan characteristics. Among MA enrollees, older home health users (ages 80 or more) tended to have more

Methods for counting home health visits

We identified records in the home health encounter data set for Medicare Advantage (MA) enrollees and claims data for fee-for-service (FFS) beneficiaries with revenue center codes and Level II Healthcare Common Procedure Coding System (HCPCS) codes describing home health visits in the six home health disciplines (Table 3-10) (Centers for Medicare & Medicaid Services 2023). In addition to G-codes describing the discipline of the clinician providing the home health visit, we included certain S-codes in the home health encounter data. These are codes used primarily by private insurance and not payable by Medicare, but they were present for about 10 percent of visits for MA enrollees using home health care (Centers for Medicare & Medicaid Services 2022). Since MA organizations (MAOs) may be accustomed to using these S-codes for their commercial populations, we included them when they were present on the record with the corresponding revenue center code. We did not include home health supplies or durable medical equipment, personal care visits not covered under the Medicare home health benefit, or telehealth visits (which were not required to be recorded in the claim until July 2023). MA enrollees using home

health care may also receive supplemental benefits that are not included in these analyses.

Visits reported in the home health MA encounter data set and in FFS claims include the number of “units” for the visit, representing 15-minute increments. Thus, it is possible to calculate the length of visits and overall amount of services received by multiplying the number of units by 15 minutes. However, MAOs vary in how comprehensively they report information on visits and units in the encounter data. Encounter records are supposed to include certain fields that also exist in FFS claims, but since MAOs may pay home health agencies differently from FFS, the data may be less complete. For example, although revenue center code instructions indicate that units represent 15-minute increments (so one visit may be composed of multiple units), MAOs that pay HHAs for a package of visits may incorrectly input the units. Our prior work demonstrated systematic differences in home health visits and units between the encounter record and MA contracts’ bid data, even when the same units were indicated (Medicare Payment Advisory Commission 2024a). In future work, we will explore incorporating units and length of visits in the analysis. ■

**TABLE
3-10**

Codes used to identify home health visits

Discipline	Revenue center codes	Home health HCPCS codes (G-codes)	Additional home health codes (S-codes)
Skilled nursing	055X	G0162, G0493, G0494, G0495, G0496, G0299, G0300	S9123, S9124
Physical therapy	042X	G0151, G0157, G0159, G2168	S9131
Occupational therapy	043X	G0152, G0158, G0160, G2169	S9129
Speech-language pathology	044X	G0153, G0161	S9128
Medical social services	056X	G0155	S9127
Home health aide	057X	G0156	S9122

Note: HCPCS (Healthcare Common Procedure Coding System). “Additional home health codes” were used in addition to the HCPCS G-codes to identify home health visits in the Medicare Advantage encounter data set. These S-codes are used by private payers and not by Medicare.

Source: Medicare claims processing manual (Centers for Medicare & Medicaid Services 2023).

**TABLE
3-11****Home health care visits varied by the clinical reason for using home health care (unadjusted), 2021**

	MA		FFS	
	Share of beneficiaries	Visits per beneficiary (mean)	Share of beneficiaries	Visits per beneficiary (mean)
Overall	100%	17.8	100%	20.5
Neurological rehabilitation	11	20.7	11	23.9
Wounds	8	25.1	8	28.0
Complex nursing interventions	1	18.6	1	20.3
Musculoskeletal rehabilitation	29	15.5	31	17.6
Behavioral health	2	17.0	2	19.9
MMTA: Surgical aftercare	6	14.5	7	16.1
MMTA: Cardiac and circulatory	15	18.3	14	21.6
MMTA: Endocrine	5	19.3	4	23.3
MMTA: Gastrointestinal tract and genitourinary system	5	17.2	5	19.8
MMTA: Infectious disease, neoplasms, and blood-forming disease	4	17.3	4	19.6
MMTA: Respiratory	11	16.9	10	20.1
MMTA: Other	3	16.6	4	19.5

Note: MA (Medicare Advantage), FFS (fee-for-service), MMTA (Medication Management, Teaching, and Assessment). Table includes Medicare beneficiaries residing in counties with high MA home health data match rates (see Table 3-5, p. 152, for beneficiary counts). Visits per beneficiary were geographically standardized to resemble the locations where MA enrollees reside but were otherwise unadjusted. Clinical groups were determined using the principal diagnosis code listed on beneficiaries' Outcome and Assessment Information Set (OASIS).

Source: MedPAC analysis of enrollment, MA home health encounter, home health claims, and OASIS data from CMS.

visits (19.0 visits per year). Home health users with a prior hospitalization (in the 14 days before their start or resumption of care assessment) had more visits, on average, than those without a prior hospitalization (18.9 visits per beneficiary vs. 16.8). FFS home health users had more visits per beneficiary, on average, than MA home health users across all categories we examined.

There was some variation in visits per user by MA plan characteristics. The largest difference was for home health care users enrolled in provider-sponsored plans: They received 15.8 visits compared with 18.1 among home health users not enrolled in these plans.

Table 3-13 (p. 164) shows that beneficiaries with greater impairment or severity on OASIS-based

variables tend to receive more visits than those who are less impaired or severe, on average. For example, among MA home health users categorized as “higher impairment or severity” in dressing of the upper body (item M1810 on OASIS), the average number of visits was 19.5 compared with 12.5 among those categorized as “lower impairment or severity.” Differences by impairment and severity exhibited similar patterns among MA and FFS home health users, though FFS beneficiaries received more visits across all categories, on average. For example, among FFS home health users with “higher impairment or severity” in upper body dressing, the average number of visits received was 22.2 (and 14.0 among those with “lower impairment or severity”) (Table 3-13). In general, across most OASIS

**TABLE
3-12****Prior hospitalizations and certain types of MA plans were associated with a higher number of visits per home health care user (unadjusted), 2021**

	MA		FFS	
	Share of beneficiaries	Visits per beneficiary (mean)	Share of beneficiaries	Visits per beneficiary (mean)
Overall	100%	17.8	100%	20.5
Current eligibility status				
Aged	90	17.8	93	20.5
Disabled	9	17.8	7	20.1
Sex				
Female	62	17.8	61	20.6
Male	38	17.7	39	20.3
Age categories				
<45	1	17.2	1	19.3
45-64	10	17.8	7	20.3
65-79	50	16.8	46	18.9
80+	40	19.0	46	22.2
Race/ethnicity				
Non-Hispanic White	73	17.8	84	20.3
Black	15	18.6	9	21.8
Asian/Pacific Islander	2	16.2	2	19.1
Hispanic	8	17.1	4	20.2
American Indian/Alaska Native	<1	18.1	<1	20.9
Other or unknown	1	16.2	2	18.4
Urban/rural				
Metropolitan	84	17.6	79	20.3
Micropolitan	1	18.4	12	21.1
Rural	6	18.9	8	21.4
Dually eligible or had LIS during year				
No	68	17.5	79	20.1
Yes	32	18.5	21	21.8
Had prior acute care hospitalization (14 days before home health care use)				
No	53	16.8	54	19.7
Yes	47	18.9	46	21.5
MA enrollees only				
MA plan type				
HMO plan	56	17.4	N/A	N/A
PPO plan	44	18.4	N/A	N/A
Provider-sponsored plan				
No	86	18.1	N/A	N/A
Yes	14	15.8	N/A	N/A
Had home health care cost sharing				
No	80	17.9	N/A	N/A
Yes	20	17.4	N/A	N/A

Note: MA (Medicare Advantage), FFS (fee-for-service), LIS (low-income subsidy), HMO (health maintenance organization), PPO (preferred provider organization), N/A (not applicable). Table includes Medicare beneficiaries residing in counties with high MA home health data match rates (see Table 3-5, p. 152, for beneficiary counts). Visits per beneficiary were geographically standardized to resemble the locations where MA enrollees reside but were otherwise unadjusted.

Source: MedPAC analysis of enrollment, MA home health and inpatient encounter, home health claims, Outcome and Assessment Information Set, Medicare Provider Analysis and Review, and plan benefit data from CMS.

**TABLE
3-13****Home health users with greater severity or impairment received more visits (unadjusted), 2021**

Selected OASIS items	Impairment or severity category	MA		FFS	
		Share of beneficiaries	Visits per beneficiary (mean)	Share of beneficiaries	Visits per beneficiary (mean)
Activities of daily living					
Dress upper body (M1810)	Lower	25%	12.5	21%	14.0
	Higher	75	19.5	79	22.2
Bathing (M1830)	Lower	11	11.6	9	13.0
	Higher	89	18.5	91	21.2
Toilet transferring (M1840)	Lower	64	15.1	62	17.3
	Higher	36	22.9	38	25.7
Toileting hygiene (M1845)	Lower	23	12.7	20	14.3
	Higher	77	19.4	80	22.0
Transferring (M1850)	Lower	17	12.5	15	14.2
	Higher	83	18.9	85	21.5
Ambulation/locomotion (M1860)	Lower	11	12.5	9	14.2
	Higher	89	18.5	91	21.1
Feeding or eating (M1870)	Lower	89	16.9	88	19.4
	Higher	11	24.9	12	27.9
Clinical and other items					
Lives alone with occasional or no assistance (M1100)	Lower	83%	17.5	83	20.2
	Higher	17	19.0	17	21.6
Vision (M1200)	Lower	68	16.0	66	18.2
	Higher	32	21.6	34	24.8
Unhealed pressure ulcer/injury at stage 2 or higher (M1306)	Lower	95	17.0	95	19.6
	Higher	5	32.7	5	36.8
Surgical wound (M1340)	Lower	68	18.3	67	21.5
	Higher	32	16.7	33	18.4
Urinary incontinence or urinary catheter presence (M1610)	Lower	45	13.9	43	15.6
	Higher	55	20.9	57	24.1
Bowel incontinence frequency (M1620)	Lower	87	16.6	86	19.1
	Higher	13	25.8	14	29.0
Cognitive functioning (M1700)	Lower	85	16.9	82	19.2
	Higher	15	22.6	18	26.0

Note: MA (Medicare Advantage), FFS (fee-for-service), OASIS (Outcome and Assessment Information Set). Table includes Medicare beneficiaries residing in counties with high MA home health data match rates (see Table 3-5, p. 152, for beneficiary counts). Table 3-6 (p. 155) describes how OASIS responses were coded into lower and higher impairment or severity categories. Visits per beneficiary were geographically standardized to resemble the locations where MA enrollees reside but were otherwise unadjusted.

Source: MedPAC analysis of enrollment, MA home health and inpatient encounter, home health claims, OASIS, MedPAR, and plan benefit data from CMS.

items examined, a greater share of FFS beneficiaries using home health care were categorized in the “higher impairment or severity” group compared with MA home health care users.

Visits per home health user were generally higher among those who had a prior hospitalization compared with those who did not, but the patterns by OASIS item and between MA and FFS were similar when subsetting

**TABLE
3-14**

Among MA enrollees, visits per beneficiary were higher among PPO plans and plans with no home health care cost sharing (adjusted), 2021

	Regression-adjusted average visits per beneficiary		Difference	
	Yes	No	Number	Percent
PPO plan (vs. HMO)	18.4	17.6	0.80*	4.5%
Provider-sponsored plan	16.5	18.2	-1.68*	-9.4
Plan had home health care cost sharing	17.6	18.0	-0.48*	-2.7

Note: MA (Medicare Advantage), PPO (preferred provider organization), HMO (health maintenance organization). Table includes MA enrollees residing in counties with high MA home health data match rates (see Table 3-5, p. 152, for beneficiary counts). Among MA enrollees, we regressed visits per user and controlled for the beneficiary characteristics listed in Table 3-11 (p. 162), Table 3-12 (p. 163), and Table 3-13 (p. 164) and county-level fixed effects. We ran separate regressions with each of the three plan attributes. This table shows the regression-adjusted mean visits per beneficiary by certain plan characteristics using the estimates from the regressions. Differences and percentages were calculated on unrounded numbers. * Indicates statistical significance at the 1 percent significance level with Bonferroni corrections for multiple comparisons.

Source: MedPAC analysis of enrollment, MA home health and inpatient encounter, home health claims, Outcome and Assessment Information Set, Medicare Provider Analysis and Review, and plan benefit data from CMS.

the sample by home health users with and without a prior hospitalization (data not shown).

Home health visits per MA enrollee varied by plan attributes even after adjusting for functional and clinical status

We regressed visits per beneficiary on the characteristics listed in Table 3-11 (p. 162), Table 3-12 (p. 163), and Table 3-13 for MA enrollees who used home health care. We ran separate regressions with each of the three plan attributes. Table 3-14 shows that, after controlling for beneficiary characteristics, home health users enrolled in PPO plans had 4.5 percent more visits than those enrolled in HMO plans (18.4 vs. 17.6 visits per beneficiary). Provider-sponsored plans were associated with 9.4 percent fewer visits per beneficiary, after adjusting for beneficiary characteristics (16.5 visits vs. 18.2 visits). Plans with home health care cost sharing were associated with 2.7 percent fewer visits compared with those without (17.6 visits vs. 18.0 visits). The patterns were similar among MA home health care users with and without a prior hospital stay (data not shown).

Concerning home health care cost sharing, one HHA chain's interviewees noted that MA plans with per visit copays did result in some patients limiting the

number of visits they were willing to receive from the HHA. It is not clear why provider-sponsored plans were associated with fewer visits per beneficiary, even after controlling for functional and clinical status. One possibility is that many provider-sponsored plans are HMOs, and some of them are integrated systems such that the HHAs used by the enrollees may see only patients in that given plan. In such cases, data reporting (such as visits on the encounter record) may be less complete (even after applying our high-match-rate county restrictions). However, we note that the directions of the estimates remained the same even after excluding one readily identifiable integrated plan.

Adjusting for functional and clinical status, MA home health care users had fewer visits per beneficiary compared with FFS home health care users

Next, we used the population of MA and FFS home health users to examine differences in visits per beneficiary by payer. We regressed visits per beneficiary on the characteristics listed in Table 3-11 (p. 162), Table 3-12 (p. 163), and Table 3-13, excluding MA plan attributes and including an indicator for payer. Table 3-15 (p. 166) shows that the average adjusted visits per beneficiary were 18.2 among MA home health

**TABLE
3-15****MA enrollees using home health care received fewer home health visits compared with FFS beneficiaries (adjusted), 2021**

	Regression-adjusted average visits per beneficiary		Difference	
	MA	FFS	Number	Percent
All beneficiaries	18.2	20.4	-2.1*	-11.0%
No prior hospital stay	17.4	19.7	-2.3*	-12.2
Had prior hospital stay	19.2	21.2	-2.0*	-9.7

Note: MA (Medicare Advantage), FFS (fee-for-service). Table includes Medicare beneficiaries residing in counties with high MA home health data match rates (see Table 3-5 on p. 152 for beneficiary counts). Among all Medicare beneficiaries, we regressed visits per user and controlled for the beneficiary characteristics listed in Table 3-11 (p. 162), Table 3-12 (p. 163), and Table 3-13 (p. 164) (excluding the MA-only plan attributes). We included an indicator for enrollment in MA and county-level fixed effects. Separate regressions were run for home health users with and without prior hospitalizations. The results in this table show the regression-adjusted mean visits per beneficiary by MA and FFS using the estimates from the regressions. Differences were calculated on unrounded numbers.

* Indicates statistical significance at the 1 percent significance level with Bonferroni corrections for multiple comparisons.

Source: MedPAC analysis of enrollment, MA home health and inpatient encounter, home health claims, Outcome and Assessment Information Set, and Medicare Provider Analysis and Review data from CMS.

care users and 20.4 among FFS home health care users, a difference of 2.1 visits, or 11.0 percent. The results were similar and in the same direction for beneficiaries with and without a prior hospital stay.

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

Home health agencies treating Medicare beneficiaries

We used the provider number indicated on the home health care users' OASIS assessment to identify which HHA treated the beneficiaries. The same beneficiary

could be assigned to multiple HHAs if the beneficiary was treated by more than one HHA in the year (affecting less than 10 percent of beneficiaries). We found that fewer HHAs treated MA enrollees compared with FFS beneficiaries: 4,600 HHAs treated at least 20 MA enrollees, and 7,000 HHAs treated at least 20 FFS beneficiaries (4,300 HHAs treated both).

To examine the characteristics of HHAs that serve Medicare beneficiaries and understand whether HHAs treating MA enrollees might differ from HHAs that treat FFS beneficiaries, we stratified HHAs by their share of Medicare beneficiaries enrolled in MA and reported the shares of beneficiaries by HHA characteristic (Table 3-16).¹⁵ We excluded HHAs that served fewer than 50 beneficiaries in the year (about 5,900 HHAs remained in the analysis).¹⁶ We found that HHAs serving higher shares of MA patients were more likely to be large agencies compared with HHAs serving lower shares of MA patients. HHAs with MA shares greater than 50 percent were more likely to be treating patients living in urban areas than HHAs with MA shares between 1 percent and 50 percent.

Table 3-16 implies that there were some differences in the HHAs that treat MA and FFS beneficiaries.

**TABLE
3-16****HHAs treating Medicare beneficiaries differed by MA enrollee share (unadjusted), 2021**

	HHAs' shares of MA enrollees				
	0%	1% to 20%	20% to 50%	50% to 99%	100%
Number of HHAs	700	1,200	2,400	1,600	20
Number of beneficiaries (MA and FFS)	28,000	269,000	1.2M	1.0M	4,100
Share of beneficiaries					
HHA type/ownership					
Freestanding for profit	92%	81%	67%	66%	58%
Freestanding nonprofit	5	11	17	23	42
Hospital-based nonprofit	1	6	12	8	<1
All others	3	2	3	3	<1
Geography (beneficiary residence)					
Metropolitan	88	79	78	87	98
Micropolitan	6	13	13	9	2
Other rural	6	8	9	5	1
Size of HHA (based on total Medicare beneficiaries served)					
Small (<120)	37	7	2	2	10
Medium (120–650)	57	41	27	21	19
Large (>650)	6	52	71	77	72

Note: HHA (home health agency), MA (Medicare Advantage), FFS (fee-for-service), M (million). Table includes shares of Medicare beneficiaries who resided in high-match-rate counties who were served by HHAs that treated 50 or more beneficiaries in the year.

Source: MedPAC analysis of enrollment, MA home health encounter, FFS home health claims, Outcome and Assessment Information Set, cost report, and provider of services data from CMS.

To determine whether our estimated differences in visits per beneficiary were driven by MA and FFS beneficiaries using different HHAs or whether the differences persist within the HHA, we re-ran the visits per beneficiary regression using provider fixed effects (indicators for each HHA) instead of county fixed effects.¹⁷ We found that MA enrollees had, on average, 1.8 fewer visits (9.3 percent fewer) than FFS beneficiaries even when controlling for the HHAs in which they received treatment (data not shown). This result was only slightly lower than our findings above (11 percent fewer visits per beneficiary associated with MA enrollment from Table 3-15). This finding means that, on average, MA enrollees received fewer visits than FFS beneficiaries within the same HHA.

Limitations of this analysis

There are some important limitations of our work. We were limited to demographic characteristics from the Medicare enrollment file and an indicator for hospitalization in the year to compare rates of home health use for MA and FFS beneficiaries. Differences in health status across beneficiaries by MA plans and between MA and FFS likely play a role in home health care use rates. When assessing visits per home health care user, we were able to include functional and clinical variables from OASIS data.

Our analysis examines home health visits that are part of the home health benefit, as reported by plans. MA

enrollees may receive other services, depending on their MA plan, that are external to the Medicare home health care benefit but may be similar to aspects of this benefit (such as certain types of in-home health care that some plans offer as supplemental benefits). HHAs may also provide telehealth to their patients, which is not included in our analysis. Starting in July 2023, reporting of telehealth services to home health patients is required on the home health claim for FFS beneficiaries. When the data are available, we will explore the reporting of telehealth provision in MA home health encounters.

Some of the sample restrictions used to conduct this analysis may have affected the representativeness of our findings. We excluded Medicare beneficiaries who did not have a full 12 months of Part A and Part B, including those who were new to Medicare, died, or switched between MA and FFS during the year. These are important groups of beneficiaries who should be analyzed in the future.

We made an effort to base our analysis on complete data by restricting most analyses to beneficiaries in

counties that had higher rates of data completeness; however, this restriction required a trade-off—including a subset of beneficiaries in these counties rather than the entire dataset. Although home health use results changed when we used the full sample, we did find that directions and patterns were generally similar. It is possible that the lack of data completeness, even with our adjustments, affected our results. It is important to continue to monitor reporting of home health care use for completeness and accuracy, as is currently required for MA plans.

With the information available, it is not possible to draw conclusions on the appropriateness of care based on any reported differences. Future, more nuanced work should examine the probability of post-acute or community-admitted home health care use and how that may differ by payer, and the types of home health visits, home health care stays, lengths of stay, and the case-mix groups associated with each home health patient to better understand home health care use under MA. ■

Endnotes

- 1 Between September 2024 and February 2025, we spoke with interviewees at three large nonprofit HHA chains.
- 2 MedPAC analyzed Medicare Provider Analysis and Review and home health claims data from CMS for 2021. Prior institutionalization includes acute care hospitals and SNFs.
- 3 Our June 2019 report to the Congress gives greater detail about the encounter data submission and screening process, feedback provided to plans about submitted data, potential uses of encounter data, and our assessment of encounter data completeness and accuracy (Medicare Payment Advisory Commission 2019).
- 4 If an episode of care consists of only a single home health care visit to the beneficiary, the HHA does not need to submit an OASIS to CMS if it is not billing CMS under the FFS home health PPS (https://qtso.cms.gov/system/files/qtso/OASIS_CAT_2_Static_QA_10-31-2023.pdf). That is, to receive payment for a FFS beneficiary, the HHA would still need to submit an OASIS assessment (so that information on the payment category is provided), but the HHA would not need to submit the OASIS records for MA enrollees since they are not paid under the home health PPS.
- 5 While HHAs are required to submit these assessments at multiple points throughout the patient's care, the home health PPS only uses items from the start of care, resumption of care, and follow-up (recertification) assessments to determine payment for FFS beneficiaries.
- 6 MA plans are typically required to submit encounter data within 13 months of the end of the plan year. The timeline was extended during the COVID-19 public health emergency such that MA plans were allowed to submit 2021 MA encounter data through July 2023 (Medicare Payment Advisory Commission 2023).
- 7 The match rates differ from those previously published due to small refinements made to the methods (Medicare Payment Advisory Commission 2024a). For example, in the current analyses, we allow for matches to occur the month before and the month after calendar year 2021 to account for differences in the timing of submissions between OASIS and encounter and claims data.
- 8 The majority of zero-Medicare-payment claims are for interim claims. Final billing claims include a payment amount.
- 9 For determining whether beneficiaries with OASIS data had home health encounters or claims during the year, we used only start of care, resumption of care, and follow-up OASIS assessments since these indicate ongoing home health care; all OASIS records were used when determining whether a beneficiary with home health claims or encounter data had a matching OASIS record.
- 10 In both the matched and encounter data-only groups, MA enrollees had some type of skilled home health visits (skilled nursing or therapy) during the year in addition to home health aide and medical social services visits (the Medicare home health benefit does not cover beneficiaries needing only nonskilled, personal care visits).
- 11 CMS defines the start of quality episodes using the presence of a start or resumption of care assessment in OASIS (Abt Associates 2023).
- 12 For home health care stays that began early in 2021, we used data from the end of 2020 to determine whether a prior acute care hospitalization occurred.
- 13 Using MA plan bid data, we categorized a plan as requiring cost sharing for home health care if the plan's expected beneficiary home health care cost sharing as a portion of total expected home health care spending was greater than zero. This share was available only for plans' non-dually eligible beneficiaries. We presumed that plans that serve only dually eligible beneficiaries had zero cost sharing (since Medicaid would generally cover any cost-sharing amount). We also assumed that fully dual-eligible beneficiaries had no home health care cost sharing no matter what plan they were enrolled in. PPO plans that expect enrollees to use some out-of-network home health agencies (for which cost sharing is required) would count as plans with home health cost sharing. While home health cost-sharing information was also available in the plan benefit-package data, we found these data fields to be inconsistently completed.
- 14 Patients under the age of 18 and maternity patients are excluded from this OASIS submission requirement. CMS has always required data submission of OASIS data for all Medicare (FFS and MA) and Medicaid patients receiving skilled home health services (with the exception of those under the age of 18 and/or those receiving maternity services). Starting July 1, 2025, CMS is extending the requirement to HHAs' non-Medicare and non-Medicaid patients (see <https://www.cms.gov/files/document/oasisall-payer-transition-fact-sheetdec-2024.pdf>).
- 15 We stratified HHAs based on the share of beneficiaries in our analytic sample that were enrolled in MA (see the

text box on pp. 148–149 describing our inclusion criteria). Thus, HHAs likely treated more Medicare beneficiaries who were not in our analytic sample (e.g., beneficiaries not enrolled in Part A and Part B for 12 months) and would not be counted here. Importantly, this finding means that HHAs categorized as 0 percent MA (and likewise 100 percent) may have treated other MA and FFS beneficiaries that were not in our analytic sample.

- 16 Although over 2,000 HHAs treated fewer than 50 beneficiaries in a year, they composed about 1 percent of beneficiaries in our analytic sample.
- 17 In order to include HHA fixed effects, we had to include only HHAs that treated both MA and FFS beneficiaries. The regression sample included 2.2 million beneficiaries treated by about 6,000 HHAs.

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C H A P T E R

4

**Part D prescription drug plans
for beneficiaries in
fee-for-service Medicare and
Medicare Advantage**

Part D prescription drug plans for beneficiaries in fee-for-service Medicare and Medicare Advantage

Chapter summary

Beneficiaries can choose among Medicare coverage options that include traditional fee-for-service (FFS) Medicare and an array of Medicare Advantage (MA) plans. The Commission supports the availability of these options, which allow beneficiaries to choose between the reduced premiums and cost-sharing liability offered by MA and the broad network of providers and minimal utilization management offered by FFS.

Beneficiaries who opt for FFS Medicare can obtain Part D prescription drug coverage by enrolling in a stand-alone prescription drug plan (PDP). (Many FFS beneficiaries also purchase a Medigap plan to reduce their cost-sharing liability for medical services.) With MA, beneficiaries generally do not separately enroll in a prescription drug plan because their plan is an MA-Prescription Drug plan (MA-PD) that includes prescription drug coverage. Throughout its existence, the Part D program has evolved, and the numerous changes have altered the dynamics in the stand-alone PDP market and the MA-PD market. The different dynamics of the two markets have important implications for plan choice, beneficiary costs, and access to medications.

Consistent with the shift in enrollment from FFS to MA in the broader Medicare program, Part D's enrollment has also shifted from PDPs

In this chapter

- Background
- Plan offerings and enrollment continue to shift away from PDPs
- Concerning trends in the PDP market
- MA and Part D policies that may affect trends in PDP and MA-PD markets
- Factors that may affect relative costs and payments for PDPs and MA-PDs

to MA-PDs. MA-PDs increasingly offer more generous prescription drug coverage (e.g., lower deductibles) to enrollees at lower premiums. At the same time, PDPs continue to play an important role because they provide drug coverage for FFS beneficiaries and, critically, they ensure that premium-free plan options (“benchmark” plans) are available for FFS beneficiaries with low income and limited assets. The average number of PDPs available to FFS beneficiaries has fluctuated over time, with two consecutive years of decline since 2023. The average number of PDPs available in 2025 was the lowest since the program began, but FFS beneficiaries continue to have at least 12 PDPs from which to choose.

Four trends raise concerns about the long-term stability of the PDP market. Those trends reveal differences that may affect the competition both within and between the two sectors and the benefits that PDPs and MA-PDs offer to Medicare beneficiaries. First, the Commission has found that Part D premiums for the basic benefits charged by PDPs have tended to exceed those of MA-PDs. Second, the number of PDPs qualifying as benchmark plans in certain areas of the country has continued to decline. In some regions, beneficiaries receiving the low-income subsidy (LIS) have just one premium-free benchmark plan available. Third, drug costs, on average, have been higher among PDPs compared with MA-PDs, but average risk scores for PDPs have been lower. Risk scores are intended to reflect average drug costs across a group of individuals. PDPs’ higher costs yet lower risk scores suggest that Part D’s payment system may not have adequately adjusted for PDPs’ higher costs before 2025. Finally, PDPs have been more likely to incur losses in Part D’s risk corridors compared with MA-PDs.

With more than half of Part D beneficiaries receiving their drug coverage through MA-PDs, certain MA and Part D policies that were primarily intended to guide plan operations in the MA market may be having unintended effects on PDP and MA-PD offerings and benefits:

- MA-PDs have an additional funding source (“MA rebates”) that can be used to enhance their Part D plan offerings or to reduce their premiums.
- MA-PDs may adjust their premiums after CMS publishes Part D subsidy amounts, allowing them to better target particular premium amounts.
- MA-PDs can offer dual-eligible special-needs plans (D-SNPs) that are open only to individuals who are dually eligible for Medicaid and Medicare, which allows them to restrict enrollment to enrollees who receive Part D’s LIS and to tailor their benefits more effectively to balance enrollees’ needs and plans’ financial goals.

The effects of these policies may be that, over time, the PDP market will become less attractive to insurers. There may be other differences between PDPs and MA-PDs. For example, compared with PDPs, MA-PDs may be able to manage drug costs more effectively through their contractual relationships with clinicians who prescribe medicines to their enrollees; face different incentives for managing drug spending, particularly for medications that affect medical spending; or employ diagnostic coding practices that, on average, increase Medicare's relative payments to MA-PDs. Such differences create a divergence between the relative costs and payments for MA-PDs and PDPs and could compound the effects of MA and Part D policies discussed above.

We conducted further analyses of PDP and MA-PD drug costs and risk scores between 2019 and 2023 to understand why they have diverged. By combining those data, we find that risk-standardized costs—that is, costs divided by risk scores—were lower for MA-PDs than for PDPs in those years. MA-PDs may have had lower risk-standardized costs due to differences in the effectiveness of plans' management of drug spending (which lowers costs), coding intensity (which raises risk scores), or other factors. Our analysis of plans' formularies did not find evidence that MA-PDs achieved lower costs compared with PDPs by having more narrow formularies, higher cost sharing, or greater use of utilization management. Our estimates for 2019 through 2023 show that, relative to the overall Part D population, differences in coding intensity produced higher risk scores for MA-PD enrollees and lower risk scores for PDP enrollees on average. In 2023, MA-PD risk scores were 7.6 percentage points higher than PDP risk scores due to differences in coding intensity, in aggregate. Those differences imply that systematic differences in coding practices by MA-PDs and PDPs affected the ability of Part D's risk-adjustment model to accurately predict costs for either sector in those years. Unlike in MA, differences in coding intensity for MA-PDs relative to PDPs do not increase Medicare's aggregate payments to Part D plans. However, coding differences can cause individual plans with lower relative coding intensity to receive lower Medicare subsidies than other plans with higher relative coding intensity and cause plans with lower coding intensity to charge higher premiums to their enrollees.

While differences in coding intensity explain some of the difference in average risk-standardized costs between MA-PDs and PDPs, a substantial difference remained in all years between 2019 and 2023. The persistence of a large difference in average risk-standardized costs, even after accounting

for differences in coding intensity, suggests that there are other factors that differentially affect spending in the two markets.

Finally, the redesign of the Part D benefit significantly increased plan liability for benefit spending. As more of Medicare's subsidies to Part D plans take the form of risk-adjusted capitated payments rather than cost-based payments, the difference in coding intensity between PDPs and MA-PDs and other factors that affect risk-score trends in the two markets could be amplified. CMS has taken steps that could help to address the divergence in cost and risk-score trends. In 2025, CMS began applying separate normalization factors for MA-PDs and PDPs to adjust for the diverging risk-score trends in these two markets. The use of separate normalization factors is expected to increase risk scores for PDPs (and decrease risk scores for MA-PDs) on average and, consequently, may decrease the difference in risk-standardized costs between the two plan types. However, the use of separate normalization factors alone may still result in inaccuracies in Part D's risk adjustment at the individual plan level. In turn, those inaccuracies could affect enrollee premiums and payments to plans. At the same time, CMS's Part D Premium Stabilization Demonstration, which provides additional subsidies beginning in 2025 to the PDPs to stabilize their enrollee premiums, may help moderate some of the effects of the redesign. The Congressional Budget Office expects that the additional subsidies paid to PDPs under the demonstration will increase federal spending for Part D by roughly \$5 billion in 2025.

For FFS beneficiaries, PDPs are the only options available for obtaining Part D's drug coverage; for FFS beneficiaries who receive the LIS, benchmark PDPs are the only premium-free options for Part D coverage. Because of these critical roles, the Commission plans to continue to assess the drivers of differences in average risk-standardized costs between MA-PDs and PDPs and monitor the availability of PDPs—particularly benchmark PDPs—as plans adjust to the new Part D benefit structure. ■

Beneficiaries can choose among Medicare coverage options that include traditional fee-for-service (FFS) Medicare and an array of Medicare Advantage (MA) plans. The Commission supports the availability of these options since some beneficiaries may prefer to avoid the constraints of provider networks and utilization management by enrolling in FFS Medicare, while others may prefer features of MA, like reduced premiums and cost-sharing liability. Beneficiaries who opt for FFS Medicare can obtain Part D prescription drug coverage by enrolling in a stand-alone prescription drug plan (PDP). With MA, beneficiaries generally do not separately enroll in a prescription drug plan because their plan is an MA-Prescription Drug plan (MA-PD) that includes Part D coverage.

The Part D program is approaching its 20th year, and it now looks quite different than it did at the outset. The policy changes that have been made over time, as well as changes in the business strategies of Part D insurers, have facilitated a growing divergence between the stand-alone PDP market for FFS beneficiaries and the MA-PD market for beneficiaries choosing to enroll in MA. While all plans are subject to the same bidding requirements and payment mechanisms, payments to MA-PDs and the premiums paid by MA-PD enrollees have diverged from payments to PDPs and their enrollees' premiums.

Although beneficiaries, whether enrolled in FFS or MA, could forgo prescription drug coverage, most beneficiaries choose to enroll in Part D. Beneficiaries weigh several factors when choosing between MA and FFS Medicare. Many will compare the total premiums they will owe if they enroll in an MA plan with drug coverage (which includes premium components for Part D benefits and other Medicare and non-Medicare benefits) to the total premiums they will owe if they enroll in the FFS program and purchase a PDP (for drug coverage) and a Medigap plan (for additional cost-sharing coverage). Beneficiaries will also weigh any differences in premiums with differences in benefits, including cost sharing, utilization management, provider networks, drug formularies, and non-Medicare benefits. While prescription drug benefits and premiums are just one piece of that complex choice, the salience of premiums and the importance of drug coverage to beneficiaries suggest that differences between the drug coverage offered by PDPs and MA-PDs could be consequential in driving some beneficiaries' choices between MA and FFS.

Because enrollment in the broader Medicare program has shifted toward MA, the MA-PD market has grown while the PDP market has seen enrollment decline. The number and types of Part D plans offered has shifted to reflect beneficiaries' enrollment choices, with a growing number of MA-PDs and declining number of PDPs.

In this chapter, we describe MA and Part D policies that may be affecting the trends in plan offerings and how other differences in these two markets may compound these effects by creating a divergence between relative costs and payments for MA-PDs and PDPs. In addition to examining the historical trends, we discuss the ways in which the Budget Reconciliation Act of 2022 (commonly referred to as the Inflation Reduction Act (IRA)) may amplify the divergence in relative costs and payments between the two markets. We also discuss CMS's recent efforts to address concerns about the divergence, including changes to the risk-score calculation to use separate normalization factors for PDPs and MA-PDs and the implementation of a demonstration that makes additional payments to PDPs to reduce their enrollees' premiums.

Background

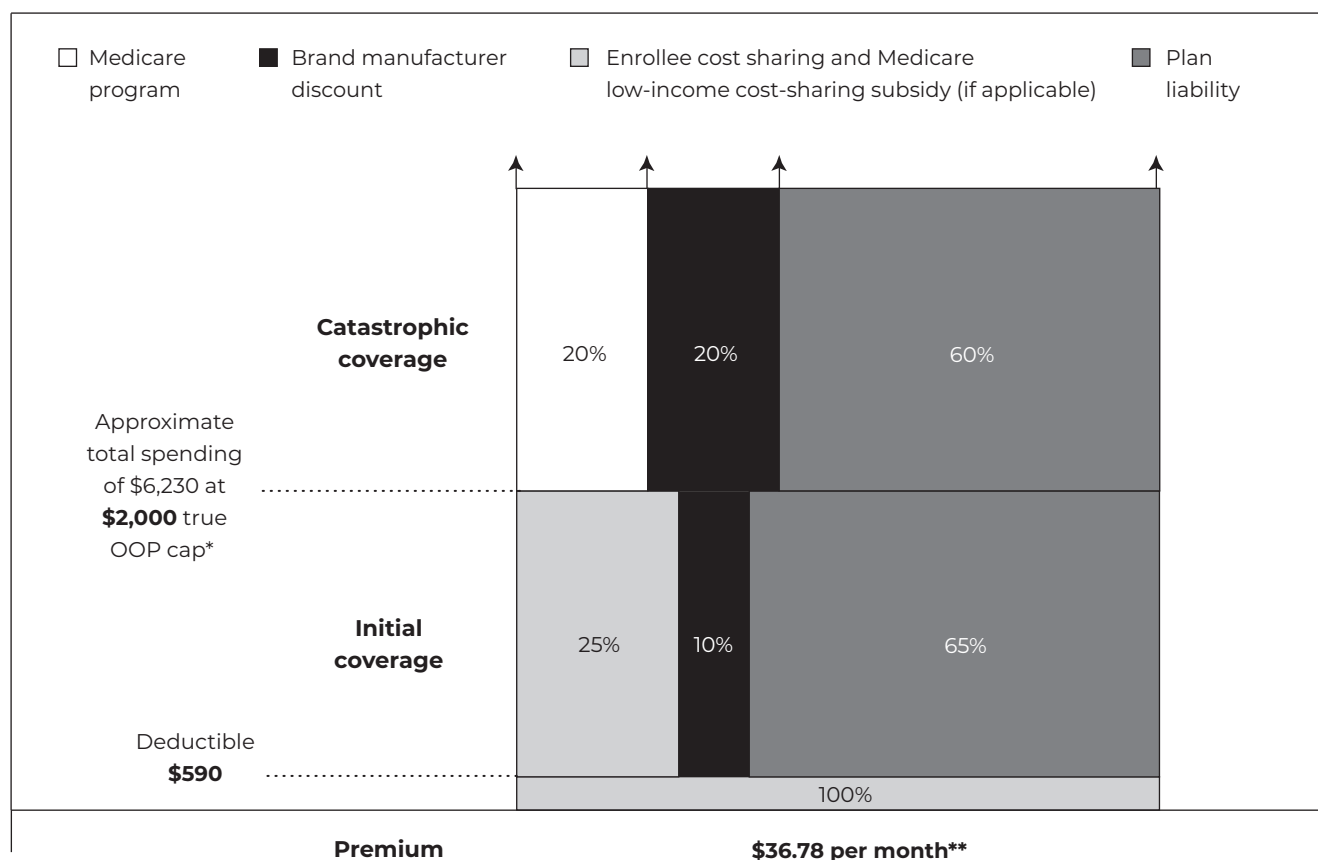
In 2023, Medicare spent over \$112 billion in subsidies for the Part D program. A combination of PDPs and MA-PDs delivers this outpatient drug benefit, competing for enrollees in each of 34 regions (for PDPs) or on a county basis (for MA-PDs). Overall, Medicare subsidizes premiums by about 75 percent and provides additional premium and cost-sharing subsidies for beneficiaries who have low income and limited assets.¹ Medicare's payments to plans are determined through a competitive bidding process, and beneficiaries' premiums are calculated based on plan bids, which reflect plans' estimated costs of providing a basic benefit. Plans bear insurance risk for a portion of their enrollees' drug spending, as shown in Figure 4-1 (p. 180), though Medicare also subsidizes plan spending through a combination of risk-sharing mechanisms.

The Part D bidding process and plan premiums

Each plan submits a bid annually for the upcoming benefit year. The bid reflects a plan's expected costs for providing basic benefits (including drug costs,

**FIGURE
4-1**

Part D standard benefit design, 2025



Note: OOP (out-of-pocket). This benefit structure is applicable to an enrollee who has no supplementary drug coverage and is taking an “applicable drug” (i.e., a brand-name drug, biologic, or biosimilar) for which a manufacturer will owe a discount under the Manufacturer Discount Program. For generic drugs, plan sponsors must cover 75 percent of enrollee spending between the deductible and OOP cap, and Medicare’s reinsurance will pay for 40 percent of spending in the catastrophic phase. For low-income subsidy (LIS) enrollees, Medicare’s LIS pays for all cost sharing except nominal copayments.

* Equivalent to \$2,000 in OOP spending: \$590 (deductible) + \$1,410 (25 percent cost sharing on \$5,640). Total spending at the annual OOP limit would depend on the mix of drugs used and whether the individual received any supplemental benefits.

** There is a base beneficiary premium of \$36.78 (about \$441 per year), which is less than 20 percent of expected Medicare Part D benefits per person, but the actual premiums that beneficiaries pay vary by plan. Federal subsidies pay for the remainder of covered Part D benefits.

Source: MedPAC depiction of Part D benefit structure for 2025.

administrative costs, and profits) minus expected payments from Medicare for individual reinsurance in the catastrophic phase. CMS calculates a single enrollment-weighted nationwide average bid over all MA-PD and PDP plans, using plans’ risk-standardized bid amounts for their basic benefit costs. The base premium for the upcoming year is a share of the nationwide average of the expected basic benefit costs, historically 25.5 percent.² To enroll in a plan, beneficiaries pay the base premium plus any difference between their plan’s bid and the nationwide average

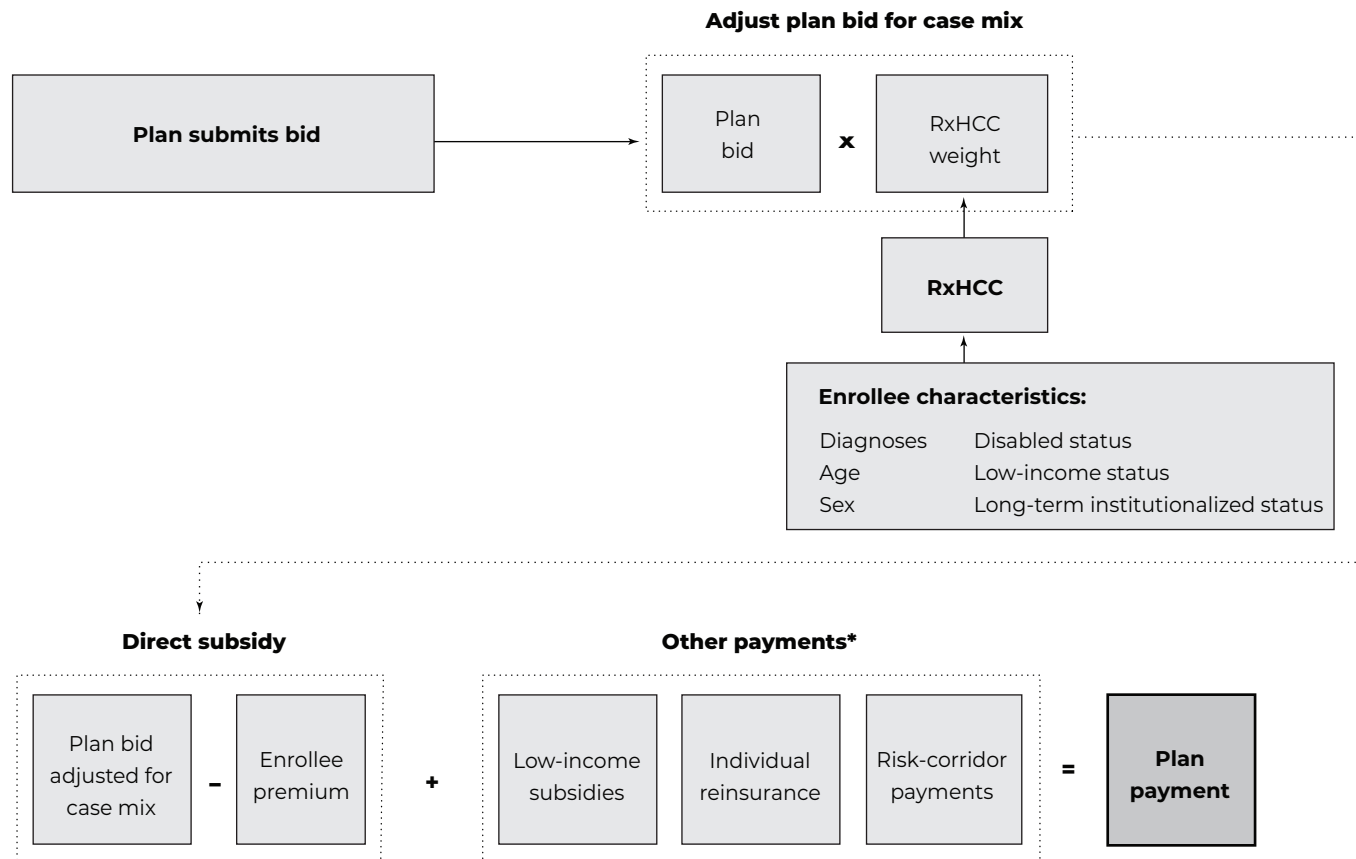
bid; if their plan’s bid is less than the average, their premium will be less than the base premium and could be as low as \$0 if the plan’s bid is less than the average by as much as the base premium amount for that year.

Medicare’s payments to Part D plans

Medicare provides Part D plans with subsidies that aim to average 74.5 percent of expected basic benefit costs.³ Those subsidies take two forms: a direct subsidy and individual reinsurance. Medicare pays a direct subsidy in the form of a capitated payment that is risk

**FIGURE
4-2**

Part D payment system, 2025



Note: RxHCC (prescription drug-hierarchical condition category). The RxHCC is the model that estimates the enrollee risk score. CMS uses five separate sets of model coefficients for long-term institutionalized enrollees, aged low-income enrollees, aged non-low-income enrollees, disabled low-income enrollees, and disabled non-low-income enrollees.

* Plans receive interim prospective payments for individual reinsurance and low-income subsidies that are later reconciled with CMS.

adjusted to account for differences in the expected costliness of a plan's enrollees. (See text box on Part D's risk-adjustment model, pp. 210–211.) Medicare's payments for beneficiaries with a below-average risk score are proportionately reduced, while payments for beneficiaries with an above-average risk score are proportionately increased (Figure 4-2). Medicare also pays individual reinsurance, which is a cost-based payment that covers a given share of expenses in the catastrophic phase of the benefit, serving as an additional form of risk sharing for spending incurred by the highest-cost enrollees. Medicare also pays all or most of the premium for beneficiaries with low income and limited assets who receive the low-income subsidy

(LIS) (up to a regional benchmark), calculated for each PDP region as an enrollment-weighted average premium using LIS enrollees in both PDPs and MA-PDs as weights. Medicare covers most of the cost sharing for such beneficiaries.

Medicare, by law, uses symmetric risk corridors that limit each Part D plan's overall losses (across all of its enrollees) when actual spending for basic benefits is higher than anticipated and limits a plan's unanticipated profits (beyond the amount assumed in its bid) when actual spending for basic benefits is lower than anticipated. In this way, the risk corridors provide a mechanism for Medicare to share insurance risk with

plan sponsors. (For more information on Part D's risk corridors, see the discussion below on how PDPs are more likely to incur losses than MA-PDs are.)

Plan offerings and enrollment continue to shift away from PDPs

To obtain a prescription drug benefit through Part D, FFS beneficiaries must choose among PDPs offered in the state or multistate region in which they live; there are 34 regions across the country. Within each region, there is at least one benchmark PDP available at no premium cost for beneficiaries receiving the LIS since the Medicare program covers the cost up to the benchmark rate for such enrollees. LIS beneficiaries who do not proactively select a plan will be automatically enrolled into a benchmark plan in their region. Thus, benchmark plans serve an important role in ensuring that LIS beneficiaries enrolled in FFS Medicare have available drug coverage at no cost.

Beneficiaries enrolled in MA may obtain prescription drug coverage through conventional MA-PDs that are open to all beneficiaries. MA-PD service areas encompass one or more counties. MA beneficiaries who meet certain eligibility criteria may also enroll in special-needs plans, or SNPs. SNPs are a type of MA-PD designed to provide targeted benefits and are open only to individuals who are dually eligible for Medicaid and Medicare (D-SNPs), who have certain chronic conditions (C-SNPs), or who live in institutions (I-SNPs). Because dual-eligible individuals automatically qualify for the LIS benefit, D-SNPs are able to target their enrollment in ways that a PDP cannot. As we discuss later, D-SNPs have premiums that are below LIS benchmarks, and, as a result, are premium-free to LIS beneficiaries.

Finally, there is a subset of Part D plans known as employer group waiver plans (EGWPs) that are open only to retirees of the organization sponsoring such plans. EGWPs, which may be PDPs or MA-PDs, have become increasingly popular among large employers who offer retiree coverage (Skopec and Zuckerman 2024). Sponsors may contract directly with CMS or on a group basis with an insurer or pharmacy benefit manager to administer the Part D benefit. In 2024, beneficiaries enrolled in EGWPs accounted for about

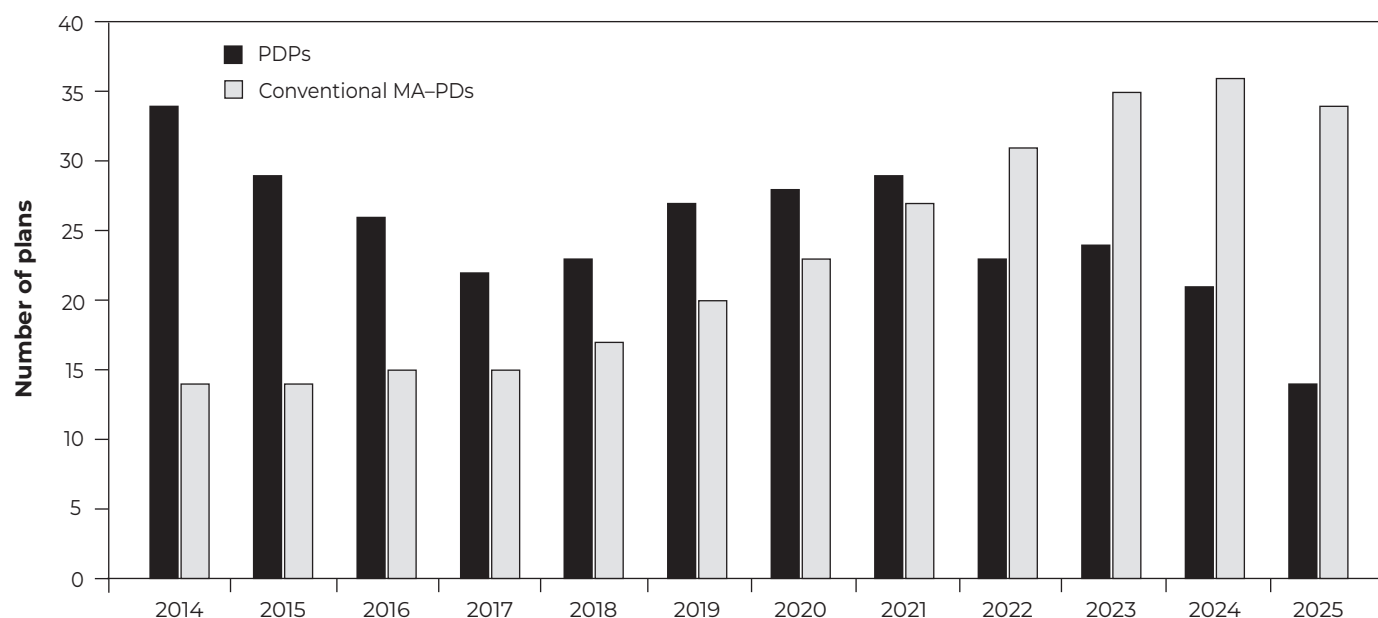
16 percent of all Part D enrollees. The discussion in the remainder of this section focuses on Part D plans that are generally open to all individuals (i.e., non-EGWP plans) and SNPs.

PDP offerings affected by policy change and the shift toward MA

At the start of the Part D program in 2006, CMS did not specify the number or type of PDPs that sponsors could offer, except for the statutory requirement that all PDP sponsors had to offer a basic plan. As a result, between 2006 and 2010, a typical region had more than 50 PDP offerings.⁴ In 2011, CMS implemented a new “meaningful difference” requirement that prohibited sponsors from offering more than one basic plan and allowed sponsors to offer up to two enhanced plans if the actuarial value of the sponsors’ offerings could be shown to be meaningfully different from each other. After the implementation of that requirement, the number of PDPs offered dropped sharply, with a typical region having about 30 PDPs. These meaningful-difference requirements were intended to “ensure that beneficiaries have the tools they need to make informed decisions” and “simplify” the enrollment process (Centers for Medicare & Medicaid Services 2011, Centers for Medicare & Medicaid Services 2009).

The average number of PDPs available to a beneficiary has fluctuated over time (Figure 4-3). In 2025, the average number reached the lowest since the Part D program began, with an average of 14 PDPs available per region. The decrease in offerings since 2023 reflects exits by several insurers, including some large national insurers, as well as consolidation of PDP offerings by the largest firms (CVS Health and UnitedHealth Group). While PDP offerings have declined, FFS beneficiaries continue to have at least 12 PDPs to choose from in every region. Further, the decrease in the number of PDP options, by itself, is not necessarily a cause for concern; a large number of plans can make it more challenging for beneficiaries to make meaningful comparisons across plan options. The average number of conventional MA-PDs available to a beneficiary, on the other hand, has grown steadily, reaching 36 in 2024—the highest since the program’s start (Cubanski and Damico 2023). In 2025, that figure is 34 (Fuglesten Biniek et al. 2024).⁵

Beneficiary enrollment by plan type in Part D has shifted in similar patterns as plan offerings, following

**FIGURE
4-3****Average number of plans available to a beneficiary by plan type, 2014–2025**

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage Prescription Drug [plan]). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs. Conventional MA-PDs are those that are open to all MA-PD enrollees (e.g., they exclude special-needs plans).

Source: MedPAC analysis of the CMS landscape files and *Medicare Advantage 2025 Spotlight: A First Look at Plan Offerings* (Freed et al. 2024).

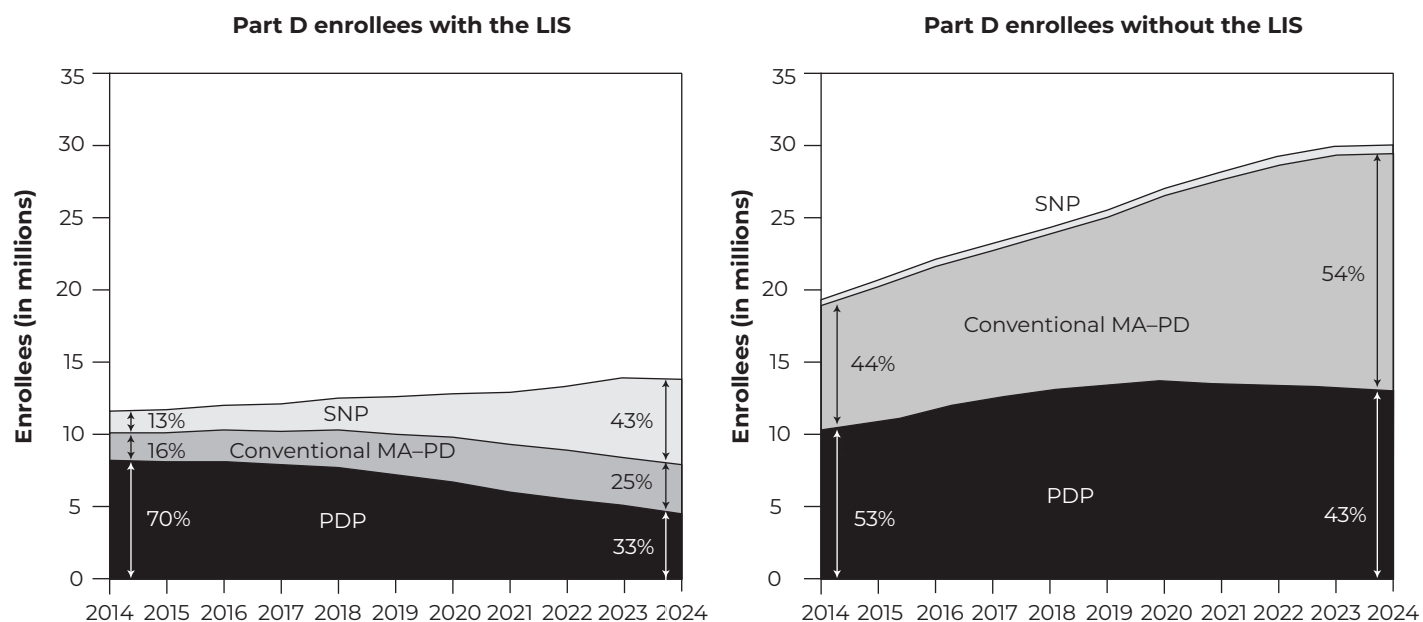
trends seen in the broader Medicare program: away from PDPs and toward MA-PDs. In 2014, 18.6 million, or more than 60 percent of Part D enrollees, were in a PDP compared with 11.5 million in MA-PDs. In 2024, the share of Part D enrollees in MA-PDs rose to nearly 60 percent, driven in part by the rise in beneficiaries enrolling in SNPs. PDP enrollment, on the other hand, had fallen to about 18 million, accounting for just 41 percent of all Part D enrollees. The decrease in the PDPs' share of all Part D enrollment reflects trends observed for the broader Medicare market, where the share of beneficiaries in FFS Medicare dropped from nearly 70 percent in 2014 to less than 50 percent in 2024 (Medicare Payment Advisory Commission 2025).

Among enrollees who do not receive the LIS, PDP market share decreased from 53 percent in 2014 to 43 percent by 2024, while the MA-PD market share saw a corresponding increase during the same period (Figure 4-4, p. 184). Nearly all MA-PD enrollees without the

LIS are enrolled in conventional MA-PDs. During this period, SNPs accounted for less than 3 percent of the Part D market for non-LIS enrollees.

Among enrollees who receive the LIS, PDP market share decreased from 70 percent in 2014 to 33 percent by 2024, while the shares in conventional MA-PDs and SNPs rose to 25 percent and 43 percent, respectively, up from 30 percent for both types of plans combined in 2014 (Figure 4-4, p. 184). D-SNPs account for the vast majority of the LIS enrollment in SNPs, averaging 90 percent of SNP enrollees over the past several years.

This shift has meant a decline in the average share of PDP enrollees receiving the LIS. In 2014, 46 percent of PDP enrollees received the LIS. By 2024, that share had declined to less than 30 percent. In contrast, most of the growth in MA-PD enrollees with the LIS has been in D-SNPs that exclusively serve enrollees who receive the LIS.

**FIGURE
4-4****PDP market share has decreased among enrollees with and without the LIS, 2014–2024**

Note: PDP (prescription drug plan), LIS (low-income subsidy), MA-PD (Medicare Advantage Prescription Drug [plan]), SNP (special-needs plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs, including conventional MA-PDs, which are open to all MA enrollees, and SNPs. Percentages shown reflect enrollees in a given plan type as a share of enrollees with and without the LIS, respectively, in 2014 and 2024. (Components may not sum to 100 percent due to rounding.) SNPs accounted for 2 percent to 3 percent of enrollees without the LIS between 2014 and 2024. Analysis is based on enrollment in July of each year.

Source: MedPAC analysis of the Common Medicare Environment data.

Part D enrollment has become increasingly concentrated in plans offered by the largest organizations

In 2024, over 300 organizations offered about 700 PDPs and over 5,000 MA-PDs (including both conventional plans and SNPs). However, enrollment has become increasingly concentrated at the national level in plans owned by a small number of large insurers that operate in most or nearly all states. Between 2014 and 2024, enrollment in the five largest firms rose from 66 percent to nearly three-quarters of all Part D enrollment (Table 4-1).⁶

At the national level, the PDP market has been more concentrated than the MA-PD market. In 2024, 85 percent of all PDP enrollees were in plans offered by one of the five largest firms (UnitedHealth

Group, Centene, Humana, CVS Health, and Elevance Health), compared with 64 percent and 77 percent, respectively, for conventional MA-PDs and SNPs. The PDP market was less concentrated in 2024 than in 2023, primarily as a result of a substantial loss in PDP enrollment for one of the largest firms (Cigna Group). Market concentration among MA-PDs increased during this period.

Based on enrollment in the five largest organizations, the MA-PD market is more concentrated at the regional level than at the national level, and it has increasingly become so, particularly among SNPs. Between 2014 and 2024, there was an increase in the number of regions where the five largest organizations (based on total national enrollment) accounted for over 80 percent of the region's total MA-PD enrollment.⁷

**TABLE
4-1****Part D market is highly concentrated, both nationally and in each PDP region, 2014–2024**

	Share of enrollment		Percentage point change, 2014–2024
	2014	2024	
In top 5 Part D organizations, national level	66%	74%	8%
PDP	78	85	7
Conventional MA–PD	49	64	15
SNP	39	77	38
In top 5 Part D organizations, PDP regional* level			
PDP	80	87	7
Conventional MA–PD	73	77	4
SNP	58	83	25
In PDP regions with HHI above “highly concentrated” threshold			
PDP	47	100	53
Conventional MA–PD	81	69	–12
SNP	86	84	–2

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]), SNP (special-needs plan), HHI (Herfindahl–Hirschman Index). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs, including conventional MA–PDs, which are open to all MA enrollees, and SNPs. Analysis excludes employer group waiver plans and beneficiaries residing in U.S. territories. The “top 5” Part D firms are identified based on all Part D enrollment. In 2024, the “top 5” firms were UnitedHealth Group, Centene, Humana, CVS Health, and Elevance Health. In 2014, the “top 5” organizations included the three insurers that were among the largest in 2024 (UnitedHealth Group, Humana, and CVS Caremark). The other two were Aetna, which was subsequently acquired by CVS Health in 2018, and WellCare Health Plans, which was acquired by Centene in 2020. The HHI is a measure of market concentration that is used by antitrust enforcement agencies. It is constructed as the sum of squared market shares for all firms in a market. The U.S. Department of Justice generally considers markets in which the HHI is in excess of 1,800 points to be highly concentrated (Department of Justice and Federal Trade Commission 2023).

* There are 34 PDP regions, each consisting of a single or multiple states.

Source: MedPAC analysis of the Common Medicare Environment data.

We also examined market concentration at the PDP region level because competition at this level is most relevant to beneficiaries, who choose among plans in their region. While the top five organizations varied across regions, large national insurers were also dominant at the region level. In 2024, the five largest organizations (at the national level) were also the five largest organizations in five regions. (These five regions accounted for over 20 percent of all Part D enrollees (data not shown).) In another 26 regions (accounting for more than two-thirds of all Part D enrollees), four of the five largest organizations (at the national level) were among the five largest organizations in each region.

However, fewer MA–PD enrollees in 2024 resided in markets that were classified as highly concentrated than in 2014, as measured by the Herfindahl–Hirschman Index (HHI) (a common measure of market concentration used by antitrust enforcement agencies) (Table 4-1, p. 185). Between 2014 and 2024, the share of enrollees in PDP regions with an HHI above the “highly concentrated” threshold decreased by 12 percentage points and 2 percentage points for conventional MA–PDs and SNPs, respectively.⁸ These opposing trends can be explained by the change we have observed in the MA market. For conventional MA plans (most of which are MA–PDs), our previous analysis found that the geographic expansion of large national insurers into

new markets has contributed to an increase in market concentration at the national level and a decrease in concentration in local markets (Medicare Payment Advisory Commission 2025, Medicare Payment Advisory Commission 2024c). By contrast, 100 percent of PDP enrollees were in highly concentrated regions in 2024, up from only 47 percent in 2014.

Just 21 of the roughly 300 organizations that participated in Part D in 2024 offered both PDPs and MA-PDs (in many cases, including SNPs), down from 28 organizations in 2014. However, these 21 organizations accounted for 84 percent of overall Part D enrollment in 2024 (up from 71 percent in 2014) (data not shown). Part D market shares for organizations that offer plans in both PDP and MA-PD markets have increased over time. In 2024, plans offered by these organizations accounted for 98 percent of all PDP enrollment and 75 percent of all MA-PD enrollment, up from 75 percent and 67 percent, respectively, in 2014 (data not shown).

In MA, high enrollment concentration could be a concern if it dampens the competitive pressures that might otherwise drive insurers to maintain or improve quality, make care delivery more efficient, lower premiums, or provide supplemental benefits (Medicare Payment Advisory Commission 2024c). Researchers studying MA market concentration have found evidence that market power affects the generosity of plan offerings such that greater competition was associated with increases in benefit generosity and reductions in premiums (Medicare Payment Advisory Commission 2024c).

In Part D, there may be additional concerns if the high degree of market concentration reduces the number of PDPs that qualify as benchmark plans for FFS beneficiaries with the LIS. When large insurers exit the PDP market, as was the case in both 2024 and 2025, there can be large shifts in which plans qualify as benchmark plans. Because higher market concentration tends to decrease the number of basic plans that may qualify as benchmark plans, such shifts could lead to instability in the LIS market, with a substantial number of beneficiaries needing to be reassigned with each bid cycle.

Further, because of the overlap of the dominant firms in both the PDP and MA-PD markets, the largest firms may benefit from the significant influence their bids

may have on the calculation of the national average bid and the LIS benchmark amounts. That influence, in turn, could give these large firms advantages in preparing their bids, which ultimately determines their enrollees' premiums and whether a plan qualifies as a benchmark plan.

Recent exits by national and regional insurers from PDP markets may also reflect a shift in strategies among firms participating in Part D. In 2025, there are seven firms offering PDPs, down from 11 firms in 2024 (Cubanski and Damico 2024, Cubanski and Damico 2023).⁹ While the largest firms continue to operate in both PDP and MA-PD markets, we are also seeing some sponsors consolidate their PDP offerings. For example, in 2025, CVS Health consolidated its three PDP offerings to just one PDP (Cubanski and Damico 2024). Because many of the large organizations that participate in Part D have a large presence in both the MA-PD and PDP markets, their decisions to exit the PDP market or consolidate their PDP offerings may also be a strategic decision that could be related to the differences between the two markets that affect premiums, payments, and profitability, discussed in the next section.

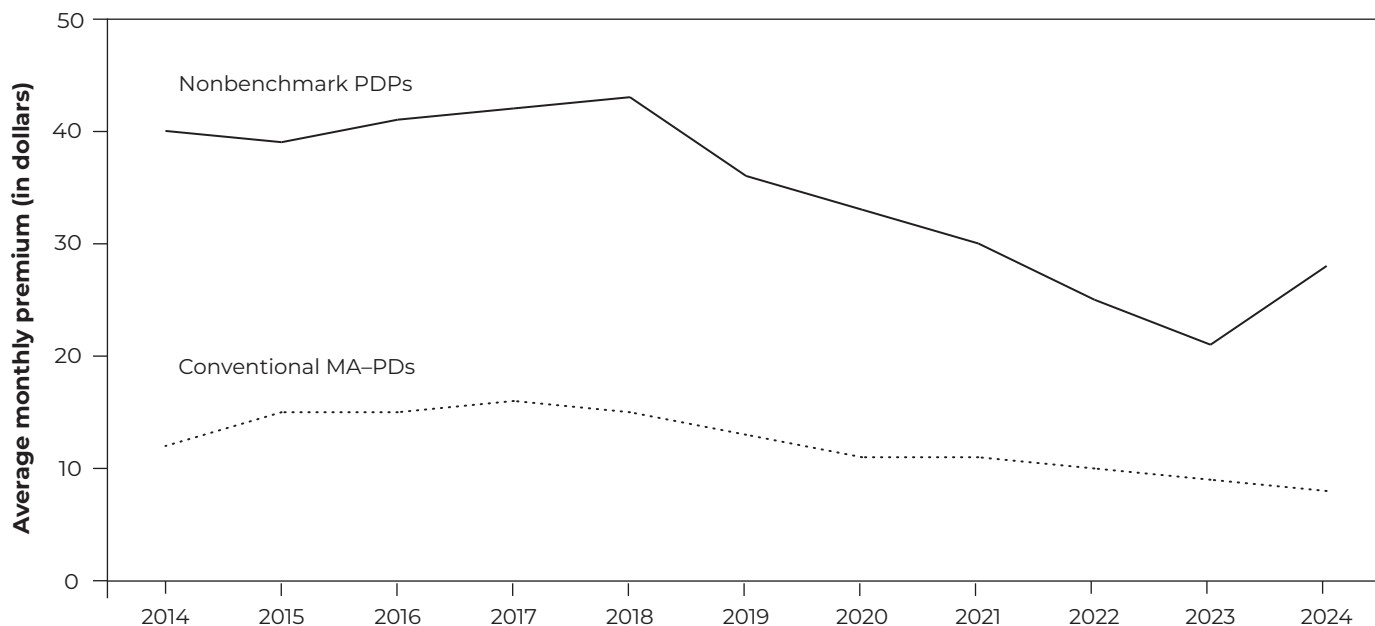
Concerning trends in the PDP market

PDPs play an important role because they provide drug coverage for FFS beneficiaries and, crucially, ensure that premium-free options (benchmark plans) are available for beneficiaries with low income and few assets. However, in an environment in which enrollment is highly concentrated in plans offered by a small number of firms, combined with recent exits by firms offering PDPs, certain trends raise concerns about the continued availability of a sufficient number of PDPs to sustain a level of competition needed to promote lower costs for Part D enrollees and Medicare while ensuring beneficiaries' access to clinically appropriate medicines.

In this section, we describe how the trends in premiums, plan costs, and profitability for PDPs differ from those of MA-PDs. We also examine the trend in the availability of premium-free (benchmark) plans. We discuss how these trends and differences between the two markets may suggest potential issues that affect the long-term stability of the PDP market.

**FIGURE
4-5**

**Average premiums for basic benefits, nonbenchmark PDPs
versus conventional MA-PDs, 2014–2024**



Note: PDP (prescription drug plan), MA-PD (Medicare Advantage Prescription Drug [plan]). Under Part D, basic benefits offered by plans must use the standard benefit defined in law or, if using an alternative benefit structure, must be actuarially equivalent to the standard benefit. Nonbenchmark PDPs are PDPs other than benchmark plans that are premium-free for fee-for-service beneficiaries with low income and limited assets. Conventional MA-PDs exclude special-needs plans. Premiums are weighted by enrollment in the month of July of each year. Average premiums for MA-PDs reflect any Medicare Advantage rebates plans applied to lower their Part D premiums for basic benefits. Note that premiums are based on plans' expected costs. As a result, for any given year, there could be systematic over- or underestimation of benefit costs when there is an unexpected event—for example, an unexpected launch of new drugs, an addition of a new indication for an existing drug that affects the uptake of the drug, or changes in law or Part D policy that were not expected when the bids were prepared more than seven months before the beginning of a benefit year.

Source: Part D premium file and enrollment files from CMS.

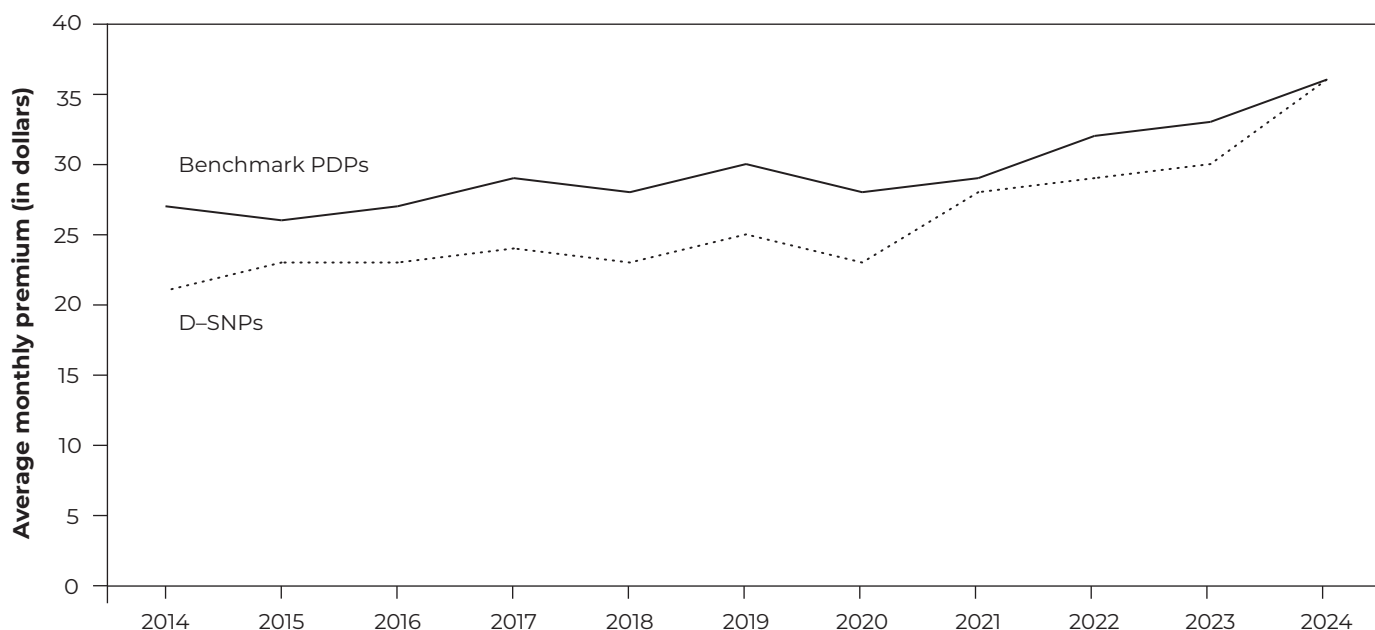
**Premiums charged by PDPs, on average,
exceed premiums for MA-PDs**

Choosing among Part D plan offerings may require complex decisions for some individuals, as these plans differ on multiple dimensions—for instance, formularies, cost-sharing amounts, and the pharmacies in a plan's network. However, for many beneficiaries, particularly those who rely primarily on inexpensive generic medicines or are not on a regular medication regimen, premiums are likely to be the most salient feature when choosing a Part D plan.

Enrollee premiums for basic Part D benefits reflect plan bids (relative to the national average bid amount). This mechanism is intended to provide plan sponsors with incentives to balance the attractiveness of benefit offerings with benefit costs. Premiums are the price

signals that beneficiaries compare when choosing a plan. In general, beneficiaries would be less likely to choose a plan that charges a higher premium without any obvious or perceived difference in benefits (e.g., generosity of drug coverage or breadth of pharmacy network) relative to another plan with a lower premium.¹⁰

Basic premiums charged by PDPs tend to be higher than those of MA-PDs in both the market for beneficiaries without the LIS and for beneficiaries with the LIS. (Basic premiums are for Part D benefits that have the same actuarial value as the defined standard benefit set in law. Plans may charge additional premiums for enhanced, or supplemental, prescription drug benefits.) Figure 4-5 compares “nonbenchmark” PDPs with conventional MA-PDs (i.e., excluding SNPs)

**FIGURE
4-6****Average premium for basic benefits for benchmark PDPs versus D-SNPs, 2014–2024**

Note: PDP (prescription drug plan), SNP (special-needs plan), D-SNP (dual-eligible special-needs plan). Under Part D, basic benefits offered by plans must use the standard benefit defined in law or, if using an alternative benefit structure, must be actuarially equivalent to the standard benefit. Benchmark PDPs are PDPs that are premium-free for fee-for-service beneficiaries with low income and limited assets. SNPs are a type of MA-PDs designed to provide targeted benefits and are open only to individuals who meet certain eligibility requirements. D-SNPs are open only to individuals who are dually eligible for Medicaid and Medicare. Premiums are weighted by enrollment in the month of July of each year. Average premiums for D-SNPs reflect any Medicare Advantage rebates plans applied to lower their Part D premiums for basic benefits. Note that premiums are based on plans' expected costs. As a result, for any given year, there could be systematic over- or underestimation of benefit costs when there is an unexpected event—for example, an unexpected launch of new drugs, an addition of a new indication for an existing drug that affects the uptake of the drug, or changes in law or Part D policy that were not expected when the bids were prepared more than seven months before the beginning of a benefit year.

Source: Part D premium file and enrollment files from CMS.

because these plans primarily compete for enrollees without the LIS. Between 2014 and 2024, the average basic monthly premium for conventional MA-PDs averaged between \$8 and \$16, far below the average charged by nonbenchmark PDPs, which ranged between \$21 and \$43 during the same period. For some beneficiaries, the higher premiums charged by PDPs could be a factor in their decision to choose MA with a Part D benefit (MA-PD) over FFS Medicare with a PDP.

LIS enrollment has increasingly shifted toward D-SNPs and away from PDPs, which has meant that benchmark PDPs are increasingly competing against D-SNPs that serve beneficiaries with the LIS exclusively.

Between 2014 and 2024, average monthly basic premiums among D-SNPs remained below that of

benchmark PDPs, though that difference has generally narrowed over time, reaching less than \$1 by 2024 (Figure 4-6). At the same time, because the premiums for both types of plans are paid entirely by Medicare for beneficiaries who receive the LIS, the difference in the premiums is unlikely to affect beneficiaries' choice of plans. Instead, other factors are likely to influence beneficiaries' choice between a benchmark PDP and a D-SNP, such as the non-drug supplemental benefits offered by D-SNPs (although Medicaid may cover some of those same benefits for dually eligible beneficiaries, which could make the MA supplemental benefits at least partly redundant).

The IRA changed the Part D benefit to shift more of the insurance risk to plans by increasing the share of basic-benefit costs that plans are paid on a capitated basis

(direct subsidy) while reducing the share that is paid on a cost basis (reinsurance). The IRA also made the basic benefit more generous by capping out-of-pocket costs and eliminating the coverage gap. These changes were expected to result in higher bids. (See section discussing the IRA changes on pp. 214–217 for a more detailed discussion of the IRA redesign and 2025 bids.)

In 2025, the national average monthly bid amount rose by nearly 180 percent, with greater variation among PDPs than MA-PDs (Centers for Medicare & Medicaid Services 2024a). Plan sponsors have faced significant uncertainty as many of the IRA policies are implemented for the first time this year. For example, plan sponsors expected the IRA changes to increase the use of specialty drugs and other high-cost medicines, but those expectations differed based on assumptions that varied across plans (Cline and Liner 2024). The different assumptions, in turn, likely drove greater variation in plan bids.

A large variation in bids meant that, for many PDPs, their bids would have resulted in sizable increases in their monthly premiums (Cubanski 2024). (As discussed below, MA-PDs have an additional financing source—MA rebates—to offset increases in enrollee premiums.) In response, CMS implemented a new demonstration that makes additional payments to PDPs (discussed in the section on the IRA redesign and how it may amplify the effects of the differences between PDPs and MA-PDs) to “stabilize year-to-year changes in premiums for participating standalone PDPs” (Centers for Medicare & Medicaid Services 2024b). Even with the demonstration, CMS expects the average total Part D premium (including premiums for both basic and supplemental benefits) charged by PDPs to be substantially higher than those of MA-PDs (\$40 vs. \$13.50) (Centers for Medicare & Medicaid Services 2024a).¹¹ The Congressional Budget Office expects that the additional subsidies paid to PDPs under the demonstration would increase federal spending for Part D by roughly \$5 billion in 2025 (Swagel 2024).

Fewer PDPs qualifying as premium-free to beneficiaries with the LIS

The average number of benchmark plans per region has also generally declined over the past decade, dropping from an average of 10 per region in 2014 to just 3 per region in 2025 (Figure 4-7, p. 190). Benchmark plans, which must be stand-alone PDPs, are important

because they are the only plans into which FFS beneficiaries receiving the LIS may be automatically enrolled if they do not actively select a plan because these plans require no additional premium from the beneficiary.¹² In 2024, there are 5.3 million beneficiaries enrolled in a benchmark plan; nearly 1.4 million LIS beneficiaries are estimated to have been automatically enrolled into such plans.

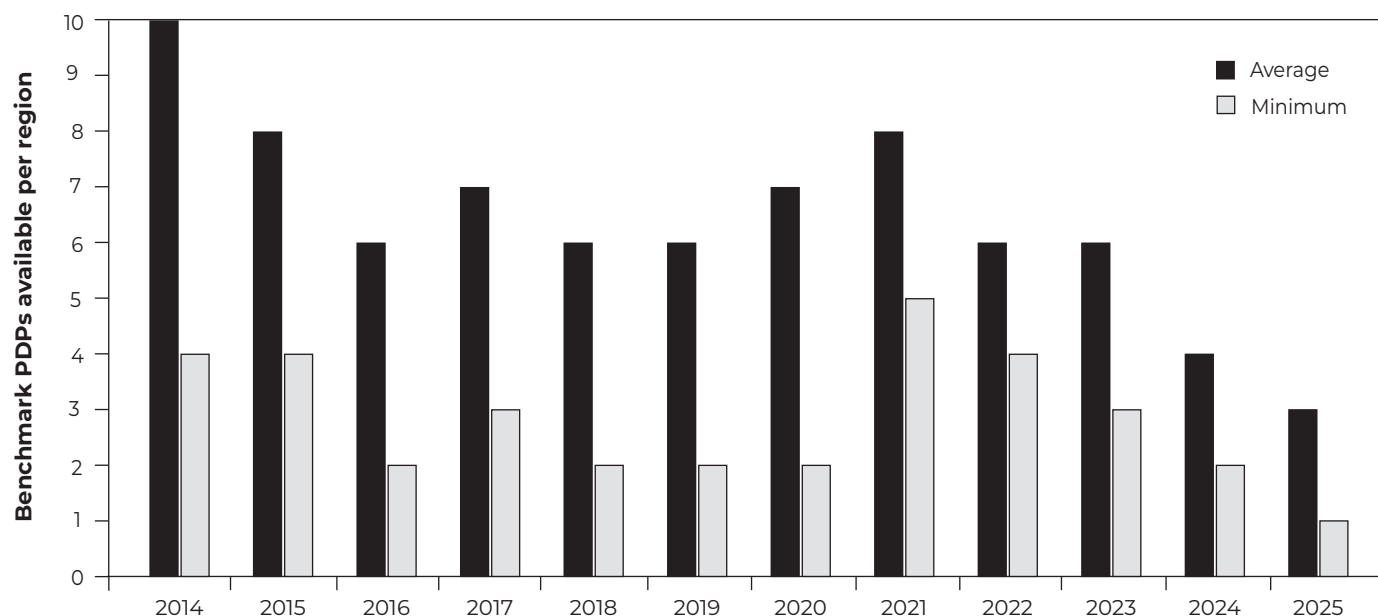
Beneficiaries receiving the LIS can enroll in any plan. However, because the LIS subsidy pays for the basic premium only up to the LIS benchmark amount, a beneficiary would have to pay any basic premium cost above the LIS benchmark amount. In addition, the beneficiary would have to pay the full amount of the supplementary premium if they are in an enhanced-benefit plan.

In some years, the lowest number of benchmark plans available in a region has fallen to two, but in each of those years that minimum was only reached in a single region until 2024, when eight regions had just two plans qualifying as benchmark plans.¹³ In 2025, four regions have just one benchmark plan, and 11 regions have only two, meaning nearly half of the regions across the country have no more than two LIS plans this year. When LIS enrollees have just one or two plans from which to choose (or be assigned to), there is concern about the lack of competitive pressure to keep LIS benchmark premiums low.

Further, in the PDP market, because each sponsor can offer just one basic plan, having fewer plan sponsors will tend to decrease the number of benchmark plans available for LIS beneficiaries. Fewer benchmark plans reduce premium-free plan choices and increase LIS enrollment in the remaining plans. In 2024, the share of enrollees with the LIS averaged 82 percent for benchmark plans, up from 75 percent in 2014. The share of enrollees with the LIS in benchmark plans varies across plans, but the variation has narrowed between 2014 and 2024: In 2014, the share ranged from about 40 percent to 94 percent, compared with a range of between 60 percent and 96 percent in 2024 (data not shown).¹⁴

PDPs, on average, have higher gross drug spending but lower risk scores than MA-PDs

Risk scores assigned to each enrollee aim to reflect the expected costliness of that individual relative to the overall average. Risk-adjustment models are typically

**FIGURE
4-7****Average number of benchmark PDPs has generally declined, 2014–2025**

Note: PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Benchmark PDPs are premium-free options for fee-for-service beneficiaries with low income and limited assets. Excludes terminated plans that are no longer eligible to enroll beneficiaries.

Source: MedPAC analysis of the CMS landscape files.

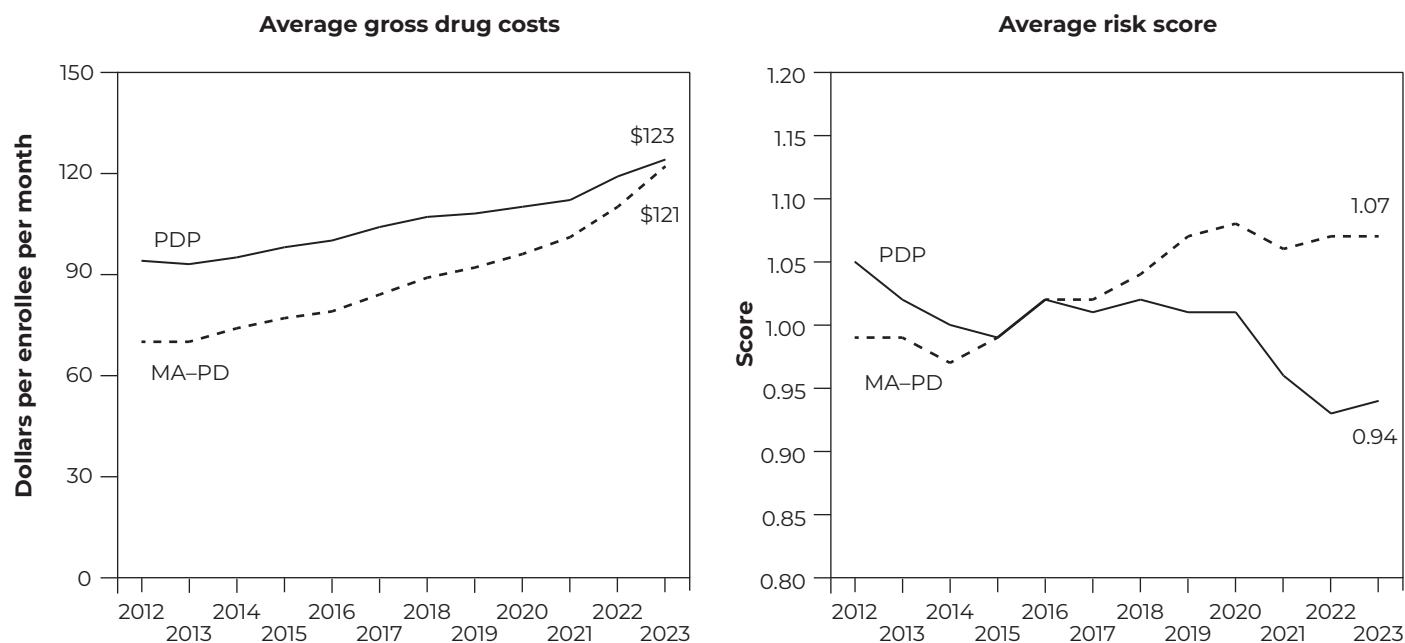
able to predict only a small portion of the variation in spending at the individual level, and inaccuracies in the prediction model could generate incentives for selection if plans are able to predict individual spending more accurately than the model. However, accurate plan-level payment requires only that risk models predict average spending accurately for a group of individuals, such as across all of the plan's enrollees. Part D's risk-adjustment model is based on predicting gross plan costs (for basic benefits) for enrollees in both MA-PDs and PDPs; therefore, we would expect the trends for average risk scores for PDPs and MA-PDs to reflect the trends in average costs of enrollees in the respective markets. On average, PDP enrollees had higher gross costs than MA-PD enrollees from 2012 through 2023 (the most recent year for which we have data) (Figure 4-8). Thus, we would expect the average risk score for PDP enrollees to be higher than that of MA-PD enrollees. However, beginning in 2016,

the average risk score for MA-PD enrollees exceeded that of PDP enrollees (Figure 4-8). The difference in average risk scores for MA-PD enrollees and PDP enrollees has grown over time, reaching nearly 15 percent in 2022 before declining to 13 percent in 2023. In contrast, the average gross costs for MA-PDs and PDPs narrowed from over \$20 in 2012 to just \$2 by 2023. Still, because the average risk score for MA-PDs was substantially above that of PDPs in 2023, there continued to be a divergence in trends between gross costs and risk scores.

Taken together, these two trends imply that over this period, MA-PDs continued to have lower gross drug spending than PDPs despite enrolling a population with risk scores that predicted higher spending than PDPs. This difference could be explained by MA-PDs having relatively effective management of benefit costs compared with PDPs, differences in diagnostic coding, other factors that result in systematic differences in

**FIGURE
4-8**

PDPs, on average, have higher gross drug spending but lower risk scores than MA-PDs, 2012-2023



Note: PDP (prescription drug plan), MA-PD (Medicare Advantage Prescription Drug [plan]). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs. In this figure, “MA-PD” includes both conventional MA-PDs and special-needs plans.

Source: Part D risk-score file and enrollment files from CMS.

spending on medications that are not captured by risk adjustment, or some or all of these factors combined.

When risk scores, on average, are higher for plans with lower average costs, it raises questions about the ability of the risk-adjustment model to accurately predict the relative costliness of enrollees across plans. Under the Part D payment system, higher risk scores translate into higher risk-adjusted direct subsidy payments. Therefore, the ability of risk scores to accurately reflect plan-level costs is critical to ensure appropriate relative payments to plans and the viability of the PDP market.

PDPs are more likely than MA-PDs to incur losses

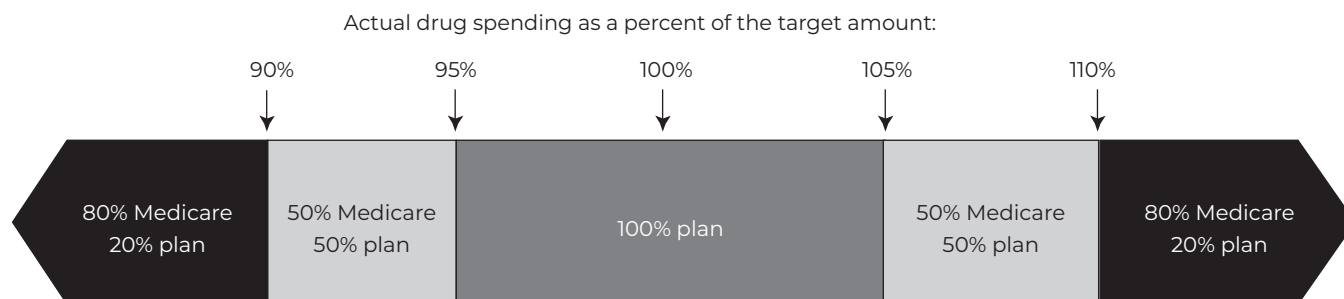
As mentioned above, Part D has symmetric risk corridors that limit each plan’s overall losses or profits (Figure 4-9, p. 192). In addition to projected benefit

costs, plan bids include projections for profit margin and administrative expenses. When actual drug spending (i.e., claims costs excluding profit margin and administrative expenses) for basic benefits in the aggregate (i.e., across all of a plan’s enrollees) is higher than anticipated (as reflected in their bids), risk corridors limit a plan’s overall losses through payments from Medicare to those plans. Similarly, the risk corridors limit a plan’s unanticipated profits when actual spending for basic benefits in the aggregate is lower than anticipated through payments from those plans to Medicare.

Since 2008, the structure of risk corridors has remained unchanged (with the exception of risk corridors used for PDPs participating in the Part D Premium Stabilization Demonstration in 2025, as discussed below). Plans are fully at risk, meaning they

**FIGURE
4-9**

Part D's risk corridors limit a plan's overall losses and profits when actual spending differs from a target amount based on its bid



Note: This figure depicts the risk corridors that have been in place since 2008, but it does not reflect the more generous parameters available to stand-alone prescription drug plans (PDPs) participating in the Part D Premium Stabilization Demonstration that CMS established for 2025. "Target amount" is equal to the plan bid minus administrative costs and profits. Plan bids are based on expected benefit costs net of expected postsale rebates and discounts. Risk-corridor payments are determined after actual levels of drug spending net of rebates and discounts are reconciled with prospective payments.

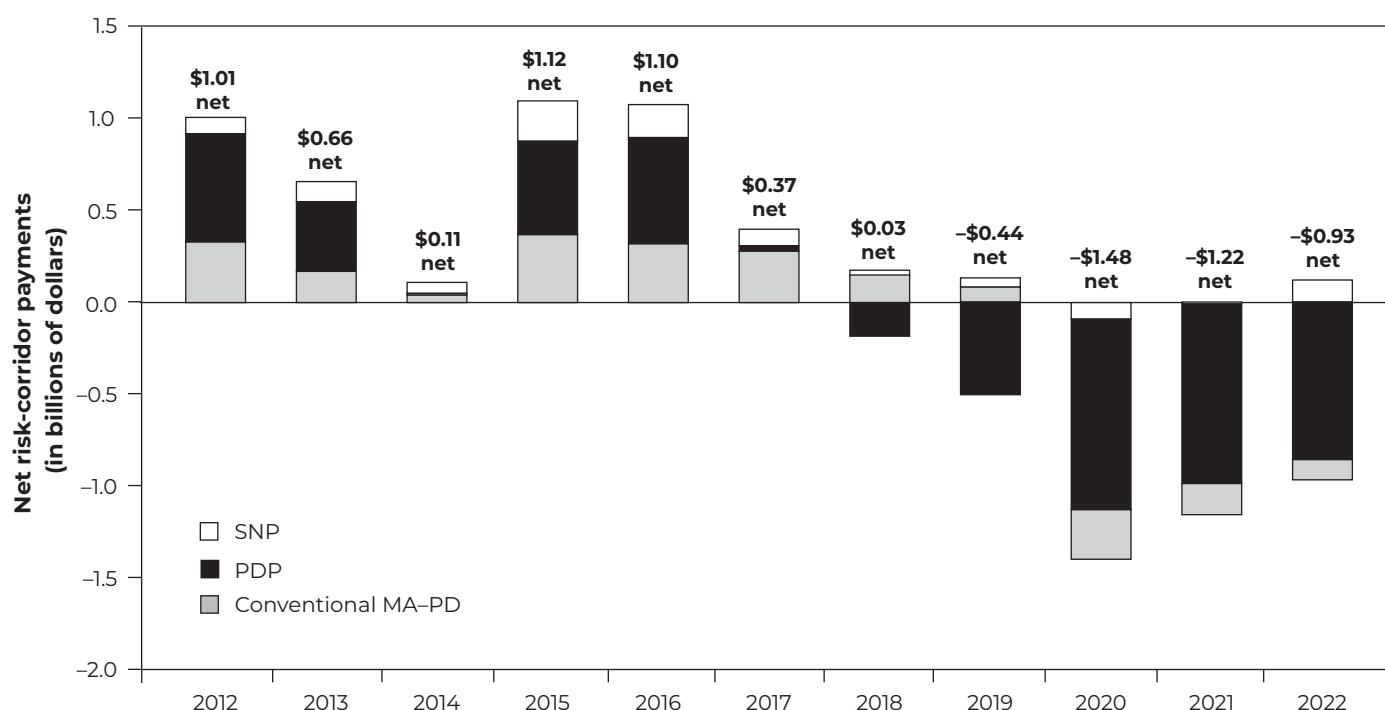
Source: MedPAC depiction of Part D risk corridors as set by law.

do not receive or owe any risk-corridor payments when their actual drug spending falls within the range of 95 percent to 105 percent of a target amount (TA) based on their bid (Figure 4-9).¹⁵ If actual spending is between 105 percent and 110 percent of the TA (or between 90 percent and 95 percent), Medicare splits the losses (or profits) evenly with the plan sponsor. Beyond 110 percent (or below 90 percent), Medicare covers 80 percent of losses (or recoups excess profits).

Aggregate amounts of risk-corridor payments show that plans, on net, incurred losses in the risk corridors after 2018 (Figure 4-10). Between 2018 and 2022 (the most recent year for which data are available), most of those losses were incurred by PDPs. In particular, the magnitude of aggregate net losses for PDPs in the most recent years examined (2020 to 2022) is notable. The period between 2012 and 2022 coincides with years when the average TA had dropped by more than 50 percent, as Medicare's payments to plans increasingly took the form of cost-based reinsurance. The decrease in the average TA was greater for PDPs than for MA-PDs.¹⁶

MA and Part D policies that may affect trends in PDP and MA-PD markets

With MA enrollment accounting for over half of all Medicare beneficiaries, MA payment policies and the distinct incentives in that program may affect how MA insurers operate the drug components of their plans. When the Part D program was created, policymakers may not have anticipated the shift in the Part D market that has taken place over the last decade. Since that time, the program has shifted from relying primarily on PDPs to a program that increasingly uses MA-PDs to provide the drug benefit, particularly for the LIS populations. As a result, certain aspects of Part D's law and regulations may no longer achieve their intended goals. In this section, we highlight MA and Part D policies that may affect plan offerings under Part D.¹⁷ These policies allow MA-PDs to use MA rebates to offer more generous Part D benefits than PDPs and to charge lower (or \$0) premiums without reducing their bids, and provide MA-PDs with an additional opportunity to adjust their MA rebates to meet a target Part D premium. MA-PDs can also more easily

**FIGURE
4-10****Net risk-corridor payments between plans and Medicare, 2012–2022**

Note: SNP (special-needs plan), PDP (prescription drug plan), MA-PD (Medicare Advantage Prescription Drug [plan]). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage (MA) are enrolled in MA-PDs, including conventional MA-PDs, which are open to all MA enrollees, and SNPs. Risk-corridor payments limit each plan's overall losses or profits in excess of the amounts assumed in their bids. Positive amounts reflect the amount by which total risk-corridor payments from plans to Medicare (for a portion of the profits beyond the amounts assumed in plan bids) exceeded total risk-corridor payments from Medicare to plans. Negative amounts reflect the amount by which total risk-corridor payments from Medicare to plans (to cover a portion of their losses in risk corridors) exceeded total risk-corridor payments from plans to Medicare. Excludes employer group waiver plans (EGWPs), Program of All-Inclusive Care for the Elderly (PACE), and demonstration plans. EGWPs do not submit bids and are excluded from the risk-corridor reconciliation process. Between 2012 and 2021, the share of profits or losses accounted for by Medicare-Medicaid Plans and PACE plans ranged from less than 1 percent to nearly 9 percent of the total risk-corridor payments. CMS determines whether any risk-corridor payments are due by comparing plan bids for basic benefits with actual spending. When actual spending exceeds the target amount by more than 5 percent, CMS makes payments to plans to offset a portion of the losses. Similarly, when actual spending is lower than the target amount by more than 5 percent, CMS recoups a portion of the profit (i.e., plans make payments to CMS).

Source: Plan reconciliation data from CMS.

structure plans specifically for enrollees with the LIS by offering D-SNPs (which are open only to LIS beneficiaries).

MA-PDs use MA rebates to make Part D benefits more attractive to enrollees

In addition to the Part D payments that Medicare makes to both PDPs and MA-PD plans, Medicare makes additional payments to MA-PDs (known as MA rebates) that can be used to increase the generosity of drug coverage in those plans. MA-PDs receive rebates when their MA bid for providing the medical benefits covered under Part A and Part B falls below the county-specific

benchmark rates that are used to determine MA payments. Nearly all plans bid below their benchmarks and receive MA rebates. MA-PDs may use rebates to reduce Part D premiums or enhance Part D benefits, usually by lowering cost-sharing requirements for Part D drugs or covering more drugs.¹⁸

MA rebates have grown over time and remain at almost record levels in 2025—about \$211 per enrollee per month across all plan types (Medicare Payment Advisory Commission 2025). The share of rebates that plans allocate to Part D benefits can be substantial. For example, in 2025, conventional MA plans had MA

rebates of about \$188 per enrollee per month, and allocated, on average, about 23 percent of rebates to lower Part D basic premiums (\$15) and to enhance Part D benefits (\$29). These rebate-financed benefits provide financial protection and more generous coverage for MA-PD enrollees, but they could also affect the nature of competition among plans in the Part D market.

PDPs, on the other hand, do not generally receive additional payments to finance their drug benefits or premiums—meaning their bids determine the premiums they can charge to their enrollees. (PDPs did not receive any additional payments from the beginning of the Part D program through 2024. Beginning in 2025, Medicare makes additional payments to PDPs to reduce their premiums through a temporary demonstration.) In addition, if they were to offer supplemental benefits, they would have to charge their enrollees the full cost of those benefits, in addition to the premiums they charge for basic benefits.

MA rebates allow MA-PDs to charge low or \$0 premiums without lowering their bids

The use of the MA rebates to buy down the Part D premiums, while beneficial to individuals who pay the reduced premium, may distort the price signals for beneficiaries by disconnecting premium amounts from the actual drug-benefit costs. Because the enrollee premium is one of the most salient features that beneficiaries focus on as they compare plan options, reductions in premiums by MA-PDs but not by PDPs (which must charge premiums based on their expected benefit costs) may affect beneficiaries' plan choices. Although premiums for the Part D component of MA and PDPs are just one piece of the complex choice between MA and FFS, the salience of premiums to beneficiaries suggests that lower MA-PD premiums could make beneficiaries more likely to enroll in MA plans instead of enrolling in FFS Medicare with a PDP and Medigap plan. For MA plans, using rebate dollars to lower basic Part D premiums could be a particularly effective way to grow their enrollment relative to, for example, using rebates to provide additional supplemental drug or medical benefits.

The disconnect between MA-PD bids for Part D benefits and the premiums paid by their enrollees could also have implications for plan behavior. For

example, MA-PDs may compete less on managing their enrollees' benefit costs or they may not bid as low as they otherwise would have because they are able to reduce their enrollees' premiums using MA rebates. Instead, they may focus more on competing for enrollees using other strategies, such as by offering more enhanced drug benefits. That, in turn, would put upward pressure on Medicare's program spending.

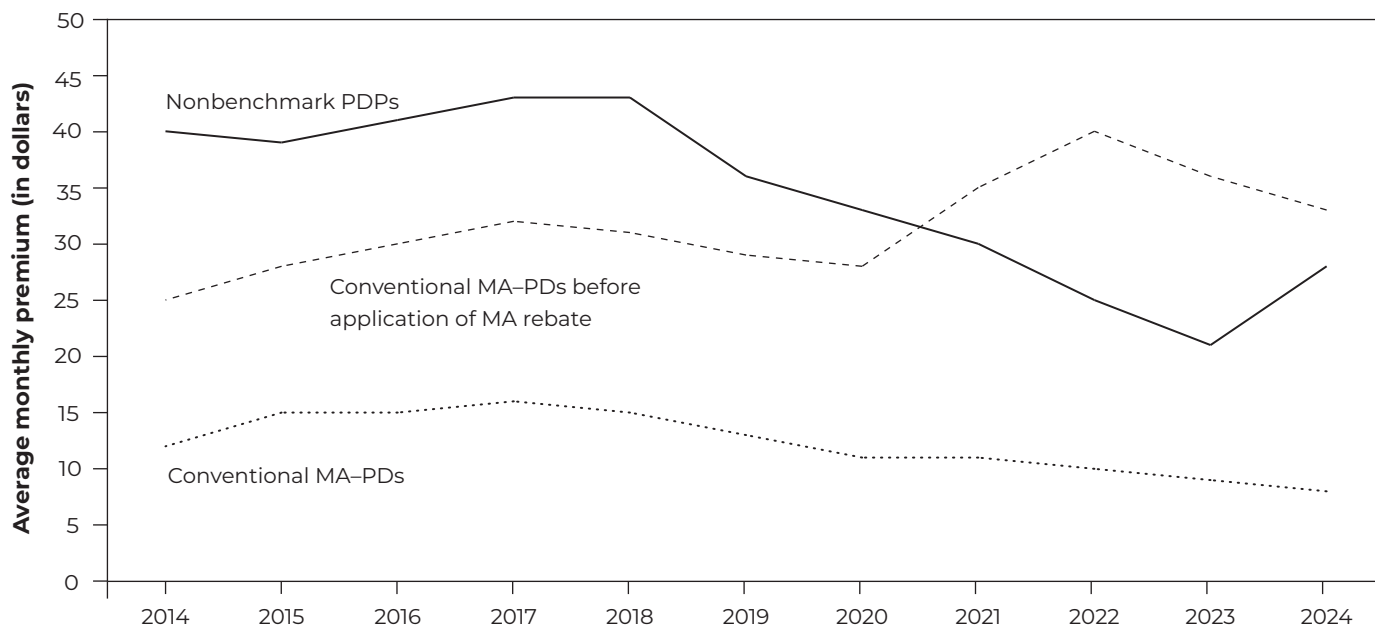
Without MA rebates, average MA-PD premiums would have exceeded those of PDPs in all years from 2021 to 2024

The use of MA rebates to buy down Part D premiums has played an increasingly important role in keeping the basic premiums charged by MA-PDs stable. Since 2022, MA rebates have reduced the basic premiums for conventional MA-PDs by 75 percent, up from just under 50 percent in 2014. Without the use of MA rebates to buy down Part D premiums, the average basic premium charged by conventional MA-PDs would have exceeded that of nonbenchmark PDPs by between \$5 and \$15 in all years from 2021 to 2024 (Figure 4-11). Stated differently, the MA-PD bids since 2021, which set the level of enrollee premiums before the application of MA rebates to reduce them, have, on average, exceeded that of PDPs. Before 2021, on average, conventional MA-PDs would have been able to charge lower basic premiums than nonbenchmark PDPs without the use of MA rebates.

Similarly, MA rebates have been key in keeping the average monthly basic premiums among D-SNPs below that of benchmark PDPs. Average bids submitted by D-SNPs for benefit years 2014 to 2024, reflected by the average basic premiums before the application of MA rebates, were consistently higher than those for PDPs (Figure 4-12, p. 196). During this period, the average MA rebates that D-SNPs used to buy down basic premiums have fluctuated between \$7 and \$16 per enrollee per month (data not shown). That is, without the use of MA rebates, the average monthly basic premium for D-SNPs would have exceeded that of benchmark PDPs by between \$3 and \$11 in every year since 2014.

MA rebates may allow MA-PDs to submit higher Part D bids

Because MA-PDs can buy down Part D premiums, there is a concern that incentives to submit lower bids are weaker for MA-PDs than for PDPs. PDPs have a stronger incentive to submit lower bids because doing

**FIGURE
4-11****Average premiums for basic benefits, nonbenchmark PDPs
versus conventional MA-PDs, 2014–2024**

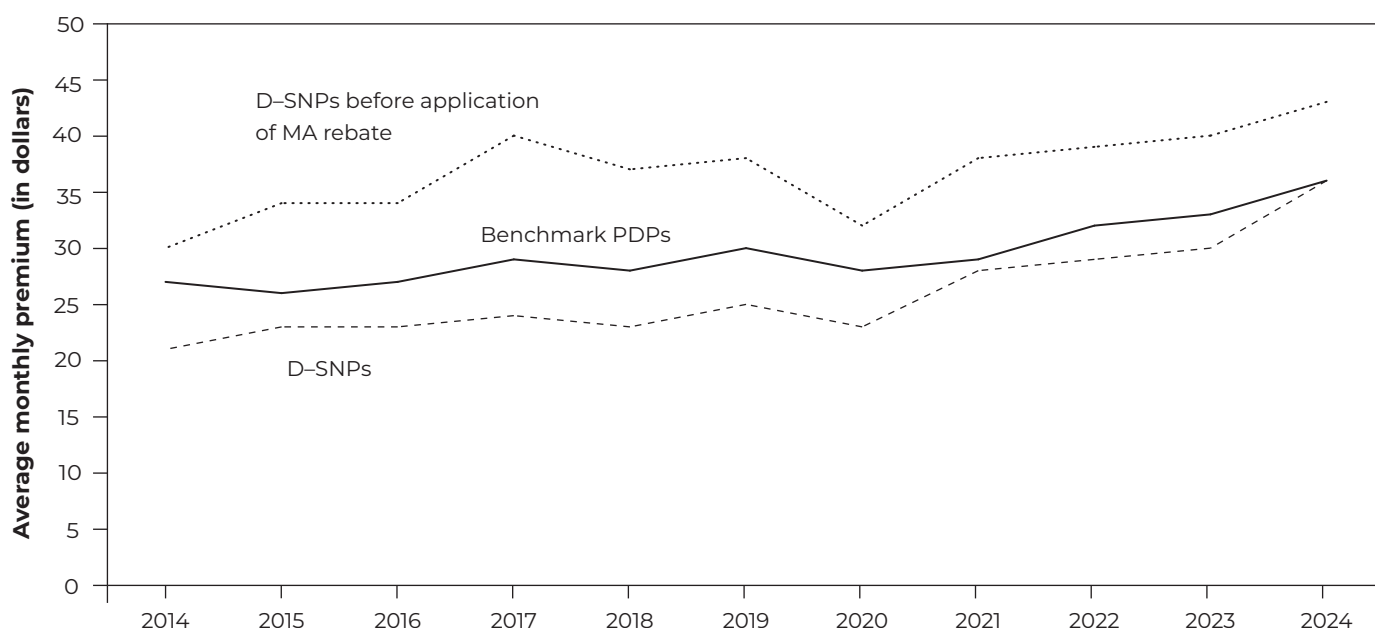
Note: PDP (prescription drug plan), MA-PD (Medicare Advantage Prescription Drug [plan]), MA (Medicare Advantage). Under Part D, basic benefits offered by plans must use the standard benefit defined in law or, if using an alternative benefit structure, must be actuarially equivalent to the standard benefit. PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in MA are enrolled in MA-PDs. Nonbenchmark PDPs are PDPs other than benchmark plans that are premium-free for fee-for-service beneficiaries with low income and limited assets. MA plans that bid below their MA benchmarks receive MA rebates. MA-PDs may use MA rebates to reduce Part D premiums or enhance Part D benefits. “Conventional MA-PDs” excludes special-needs plans. Figures are weighted by enrollment in the month of July of each year. Note that premiums are based on plans’ expected costs. As a result, for any given year, there could be systematic over- or underestimation of benefit costs when there is an unexpected event—for example, an unexpected launch of new drugs, an addition of a new indication for an existing drug that affects the uptake of the drug, or changes in law or Part D policy that were not expected when the bids were prepared more than seven months before the beginning of a benefit year.

Source: Part D premium file and enrollment files from CMS.

so is the only way they can reduce their premiums (or qualify as a benchmark plan), which makes their plans more attractive to enrollees. PDPs must weigh the potentially lower enrollment they will face when submitting a higher bid (and charging the higher premium associated with that bid) to the higher premium and subsidy revenue for each enrollee they will receive when submitting a higher bid. Because MA-PDs can submit higher bids without necessarily increasing their premiums, they may be less concerned that a higher bid will reduce their enrollment. However, submitting higher bids while maintaining lower Part D premiums requires MA-PDs to use more of their MA rebates to buy down those premiums. Using more of their MA rebates requires plans to either reduce their other rebate-funded benefits (such as dental or

vision coverage) or increase their rebates by lowering their MA bids, both of which come at a cost to plans. Therefore, MA-PDs still have some incentives to reduce their Part D bids.

The upward pressure that the use of MA rebates puts on MA-PD bids may also increase total Medicare payments to Part D plans. As described above, the enrollment-weighted average of plan bids is used to calculate the direct subsidy (which is risk adjusted to set payment rates for each plan) and LIS benchmark amounts. Higher average bids lead to higher Medicare payments to plans for the direct subsidy and low-income premium subsidy. As Part D enrollment has shifted toward MA-PDs, these average amounts are increasingly affected by bids submitted by MA-PDs.

**FIGURE
4-12****Average premium for basic benefits for benchmark PDPs versus SNPs, 2014–2024**

Note: PDP (prescription drug plan), SNP (special-needs plan), D-SNP (dual-eligible special-needs plan), MA (Medicare Advantage). Under Part D, basic benefits offered by plans must use the standard benefit defined in law or, if using an alternative benefit structure, must be actuarially equivalent to the standard benefit. PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in MA are enrolled in MA-PDs. Nonbenchmark PDPs are PDPs other than benchmark plans that are premium-free for fee-for-service beneficiaries with low income and limited assets. MA plans that bid below their MA benchmarks receive MA rebates. MA-PDs may use MA rebates to reduce Part D premiums or enhance Part D benefits. Premiums are weighted by enrollment in the month of July of each year. Note that premiums are based on plans' expected costs. As a result, for any given year, there could be systematic over- or under-estimation of benefit costs when there is an unexpected event—for example, an unexpected launch of new drugs, an addition of a new indication for an existing drug that affects the uptake of the drug, or changes in law or Part D policy that were not expected when the bids were prepared more than seven months prior to the beginning of a benefit year.

Source: Part D premium file and enrollment files from CMS.

MA-PDs have an additional opportunity to adjust their MA rebates to meet a target Part D premium

All Part D plans submit their bids to CMS in early June of each year (for the following benefit year). However, MA-PDs have an additional opportunity to reallocate rebate amounts in their bids, after the release of the Part D national average bid, premium, and the low-income premium subsidy ("LIS benchmark") amounts in late July.

During the rebate reallocation period, MA-PD plans are permitted to make limited changes to achieve the target basic Part D premium amount (Centers for Medicare & Medicaid Services 2024b).¹⁹ Specifically, the target amount must be set equal to either (1) the basic Part D premium net of rebates as submitted in the initial bid submission or (2) the low-income premium subsidy amount.

One practical reason for rebate reallocation is to ensure that MA-PD enrollees receive the full value of rebates—for example, when plans initially allocate more rebate than is necessary to achieve their target Part D premium. Rebate reallocations also allow MA-PDs to offer plans with more premium stability from year to year, but they may also give MA-PDs competitive and financial advantages relative to PDPs. The ability of MA-PDs to adjust their premiums after the LIS benchmarks are announced nearly guarantees their ability to qualify as a premium-free plan for LIS enrollees and to receive the maximum LIS premium subsidy amount.

However, PDPs intending to qualify as benchmark plans may need to submit lower bids (and therefore accept lower payments from Medicare) to increase their likelihood of qualifying as benchmark plans. PDPs that qualify as a benchmark plan in one year may

unintentionally miss the LIS benchmark in a subsequent year. If that happens, the plan would not qualify as premium-free and would likely lose some or all of its enrollees who receive the LIS; or if the plan misses the LIS benchmarks by a de minimis amount (less than \$2 per member per month), it would have to waive the “excess” premium to remain premium-free, thereby forgoing payment. In contrast, MA-PDs can offer a premium-free plan without forgoing any payment and without a de minimis limit on the amount of rebate reallocation, as long as the reallocation achieves the low-income premium subsidy amount. Even when PDPs do bid below the benchmark, to the extent that their bids result in basic premiums that are different from the LIS benchmarks, their premium revenue is lower than the revenue based on the maximum LIS premium subsidy amount. In general, because PDPs do not have additional funds or the opportunity to adjust their bids to achieve the intended premiums for their basic plans, they may face greater uncertainty in constructing their bids relative to their MA-PD counterparts.

When structuring benefits specifically for enrollees with the LIS, MA-PDs can offer D-SNPs to restrict enrollment to beneficiaries with the LIS

Managing spending for enrollees with and without the LIS using the same formulary and benefit design can be challenging. Because beneficiaries who receive the LIS face little or no cost sharing, widely used strategies to manage spending and utilization—such as tiered cost sharing—are generally not effective for the LIS population. For beneficiaries without the LIS, on the other hand, tiered cost sharing is generally preferable to a benefit design that applies a uniform coinsurance amount, as is the case with Part D’s defined standard benefit. With tiered cost sharing, plans typically use copays rather than coinsurance for some of the preferred drug tiers, allowing predictability in out-of-pocket (OOP) costs for beneficiaries without the LIS.

PDPs intending to qualify as a benchmark plan must keep their premiums below the LIS benchmark without relying on tiered cost sharing (beyond the statutory copays that set different amounts for brand-name drugs and generic drugs) and therefore must use other strategies to manage benefit spending. For example, we have found that benchmark plans tend to have narrower formularies (Medicare Payment Advisory Commission 2024a). Plans may also rely more

heavily on utilization-management tools, such as prior authorization and quantity limits. However, these strategies may make their benefit less attractive to beneficiaries without the LIS.

Another challenge in serving both LIS and non-LIS populations in the same plan may relate to the trade-off plans face in setting their premiums. Part D’s LIS covers eligible beneficiaries’ basic premium (up to the LIS benchmark amount), so it would be in the plan’s interest to maximize revenue for enrollees with the LIS by setting the basic premium equal to the LIS benchmark amount. However, because premiums are the most salient feature for beneficiaries, particularly for those without the LIS, PDPs must also balance the incentive to maximize per enrollee revenue with the need to keep their premiums competitive (i.e., low).

While the goal of offering D-SNPs may be related to their ability to provide dually eligible (for Medicare and Medicaid) beneficiaries with benefits that are tailored to meet their distinct care needs, such as better coordination with long-term care service providers, with D-SNPs, MA-PDs can also limit enrollment to beneficiaries who receive the LIS (because D-SNPs are open only to dually eligible beneficiaries, all of whom receive the LIS). It is easier to maximize the revenue that plans receive for each enrollee when LIS enrollees are segmented into separate plans from other enrollees (Medicare Payment Advisory Commission 2022). D-SNPs’ ability to limit enrollees to those who receive the LIS is likely to provide them with competitive advantages over PDPs—for example, by allowing them to more effectively tailor their drug benefits. The additional opportunity to adjust their MA rebate allocations after the LIS benchmarks are announced, discussed above, allows D-SNPs to maximize their revenues by setting their premiums at (or very close to) the benchmarks. In turn, their competitive advantages may contribute to the decline in the number of benchmark PDPs.

Separately, MA-PDs can typically offer conventional MA-PDs, nearly all of which are enhanced-benefit plans, with comparatively low premiums (including supplemental premiums that tend to be attractive to beneficiaries without the LIS). By charging a premium for the supplemental benefit, these plans are likely to be able to discourage beneficiaries who receive the LIS from enrolling since Part D’s LIS can only cover the

basic premiums. While qualifying as a benchmark plan may allow PDPs to gain more enrollees with the LIS, PDPs do not have the ability to restrict their enrollees in the way that D-SNPs can. In addition, because ex ante, PDPs do not know whether they will qualify as a benchmark plan, even those that are bidding to qualify as a benchmark plan may still need to offer an attractive benefit to both groups.

This situation could affect how plans design their formularies and structure their benefits to attract enrollees. While PDPs and conventional MA-PDs typically use tiered cost-sharing structures, and conventional MA-PDs largely use a low or no deductible, nearly all D-SNPs offer a defined standard benefit with a standard deductible and coinsurance throughout the benefit phases (Medicare Payment Advisory Commission 2024a). The difference in benefit design is likely driven by the fact that LIS enrollees face, at most, statutorily defined nominal copayments; thus, use of the defined standard benefit is unlikely to affect their decision to enroll in D-SNPs. PDPs serving both beneficiaries with and without the LIS, on the other hand, likely face a greater challenge in balancing the need to offer an attractive formulary and benefit with the need to keep their premiums competitive, while at the same time attempting to maximize revenues for the low-income premium and cost-sharing subsidies. In turn, these formulary and benefit design decisions may affect plans' benefit costs and bids that are the basis for premiums charged to their enrollees.

Factors that may affect relative costs and payments for PDPs and MA-PDs

In this section, we discuss the sizable difference in risk-standardized costs between MA-PDs and PDPs, which in turn may affect the profitability of plans in these two markets. We also discuss factors that may contribute to that difference.

We first show that PDPs had much higher risk-standardized costs than MA-PDs in recent years. We then show results from our analysis of formulary coverage and application of utilization-management tools by MA-PDs and PDPs to assess whether MA-PDs achieved lower risk-standardized costs by applying more restrictions to the drugs used by their enrollees.

We did not find any evidence to support that theory. Next, we examined diagnostic coding practices among MA-PDs and PDPs to see whether there are systematic differences in coding intensity that affect the ability of Part D's risk-adjustment model to accurately predict costs. We found that a portion of the recent differences in risk-standardized costs between MA-PDs and PDPs can be explained by differences in coding intensity.

Average risk-standardized costs for MA-PDs are substantially below those of PDPs

Our analysis of the Part D data found that, on average, enrollees in MA-PDs have lower costs relative to the expected costs based on their risk score. Table 4-2 shows the average gross plan cost standardized to a 1.0 risk score ("risk-standardized cost"). Between 2019 and 2023, the average risk-standardized costs for MA-PDs were consistently below the overall average (across all Part D enrollees) by between 7 percent and 14 percent, while the average risk-standardized costs for PDPs consistently exceeded the overall Part D average by between 9 percent and 13 percent. The double-digit difference in the average risk-standardized costs between the two markets persisted during this period.

In 2023, the difference in the average risk-standardized costs between MA-PDs and PDPs dropped significantly (from over 20 percentage points before 2023 to 16 percentage points in 2023). The decrease in 2023 may have been due, at least in part, to the "unanticipated rapid growth in the use of antidiabetic drugs," which includes a class of drugs called glucagon-like peptide-1 receptor agonists (GLP-1s) (Boards of Trustees 2024). Between 2022 and 2023, Medicare's gross Part D spending for GLP-1 products grew from about \$5.7 billion to \$13.2 billion, or by 130 percent (Office of Inspector General 2025).²⁰

In 2023, the average gross plan liability for MA-PD enrollees, both with and without the LIS, grew faster than for PDP enrollees (Figure 4-13, p. 200). Because MA-PDs had more generous coverage of GLP-1s than PDPs, the uptick in use may have disproportionately affected MA-PDs relative to PDPs (Assistant Secretary for Planning and Evaluation 2024a).²¹ These changes in trends for enrollees with and without the LIS combined caused overall average costs for PDPs and MA-PDs to converge (despite the diverging trends

**TABLE
4-2**

Average risk-standardized gross plan costs for MA-PDs are substantially below those of PDPs, 2019-2023

	2019	2020	2021	2022	2023
Risk-standardized gross plan cost per member per month					
All Part D	\$97	\$99	\$105	\$113	\$120
MA-PD	83	87	92	101	112
PDP	107	110	118	128	131
Percentage difference in the risk-standardized gross plan costs					
MA-PD relative to all Part D	-13.7%	-12.3%	-12.1%	-10.6%	-7.2%
PDP relative to all Part D	10.4	10.8	11.8	13.1	8.8
<i>Absolute percentage point difference between MA-PDs and PDPs</i>	<i>24.1</i>	<i>23.2</i>	<i>23.9</i>	<i>23.7</i>	<i>16.0</i>

Note: MA-PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs. In this table, "MA-PD" includes both conventional MA-PDs and special-needs plans. Figures are calculated on unrounded numbers.

Source: Part D prescription drug event data, Part D risk-score file, and Medicare enrollment files from CMS.

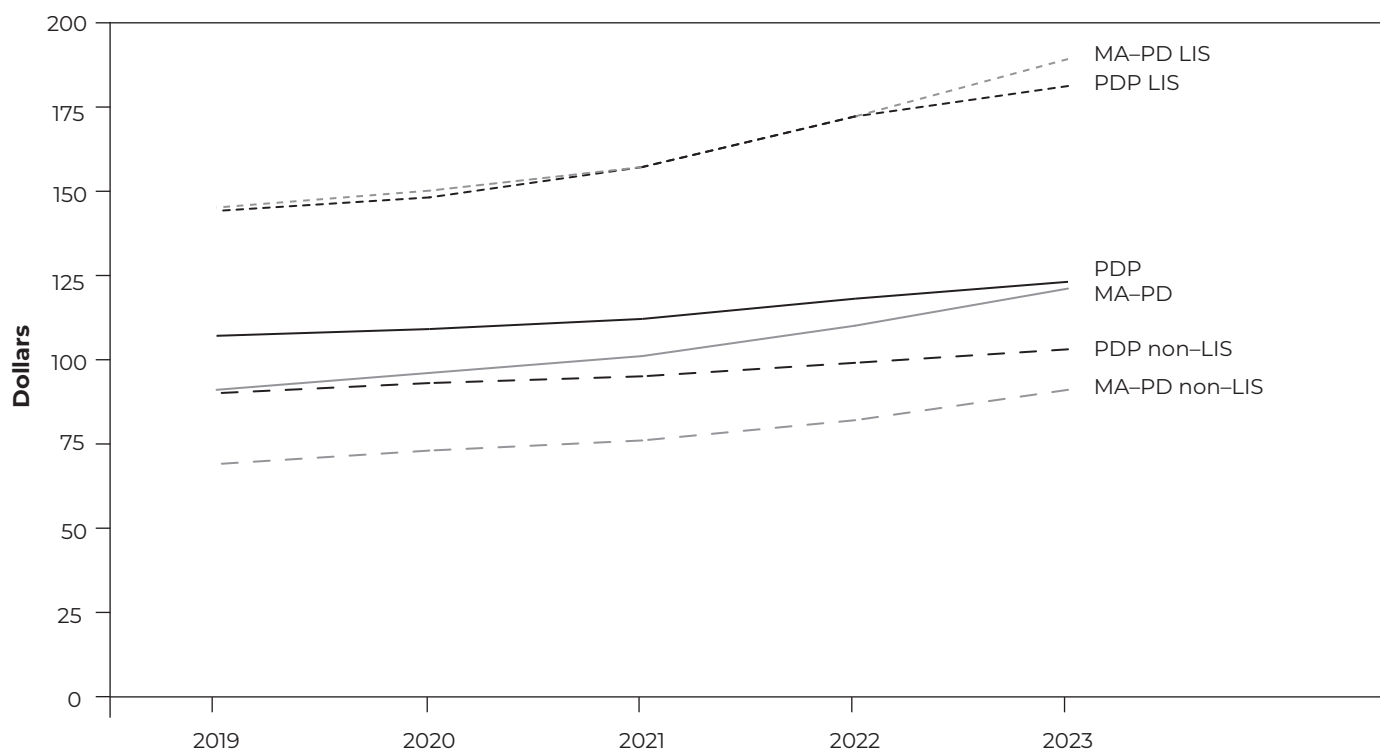
among the LIS enrollees and a modest narrowing of the difference among the enrollees without the LIS).²² In turn, that convergence in the cost trends for PDPs and MA-PDs has decreased the average difference in risk-standardized costs. Still, a 16 percentage point difference in average risk-standardized costs in 2023 is substantial.

Several factors may contribute to the difference between MA-PDs and PDPs in the risk-standardized costs. For example, there could be differences in how effectively plans manage benefit spending, such as through the use of formulary tiering and utilization-management tools. As noted above, the two types of plans might differ in coding intensity. Trends for average risk scores that are not consistent with the trends in actual average costs, as described above, suggest that differential coding intensity between MA-PDs and PDPs may be contributing to the difference in risk-standardized costs in the two markets. Risk-standardized costs could also be affected by other systematic differences in the spending tendencies of MA-PD enrollees relative to PDP enrollees that are not captured by Part D's risk-adjustment model for reasons other than coding intensity.

Differences in MA-PD and PDP formularies suggest more generous coverage among MA-PDs

Differences in formulary design may explain some of the difference in risk-standardized costs between the two plan types. For example, MA-PDs may be achieving lower costs by excluding higher-cost products from their formularies, by placing them on higher copayment tiers, or by applying more utilization-management tools.

We conducted an analysis of Part D plan formularies in 2024 and 2025 to assess differences in formulary generosity between conventional MA-PDs (which exclude SNPs) and PDPs, both immediately before and in the first year of implementation of the IRA's redesigned benefit structure.²³ Based on average coverage rates, tier placement, and the frequency with which utilization-management tools are used for all Part D products, as well as various subsets of products, MA-PDs appear to have more generous formularies, on average, than PDPs. That finding is consistent with nearly all conventional MA-PDs being enhanced plans that must provide a richer benefit than basic plans, which are more common among PDPs. These metrics suggest that beneficiaries enrolled in MA-PDs, on

**FIGURE
4-13****Average gross plan cost per enrollee per month by plan type and LIS status, 2019–2023**

Note: LIS (low-income subsidy), MA-PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs. In this figure, "MA-PD" includes both conventional MA-PDs and special-needs plans.

Source: Part D prescription drug event data and Medicare enrollment files from CMS.

average, have moderately greater and easier access to medications than PDP enrollees, as well as lower OOP costs. Thus, it does not appear that MA-PDs use formularies and utilization-management tools to more aggressively manage their enrollees' spending. In other words, the findings of our formulary analysis do not help explain why MA-PDs have had lower risk-standardized costs than PDPs in recent years. Instead, formulary differences could largely reflect other aspects of the market related to MA plans' ability to use rebates to provide more generous coverage.

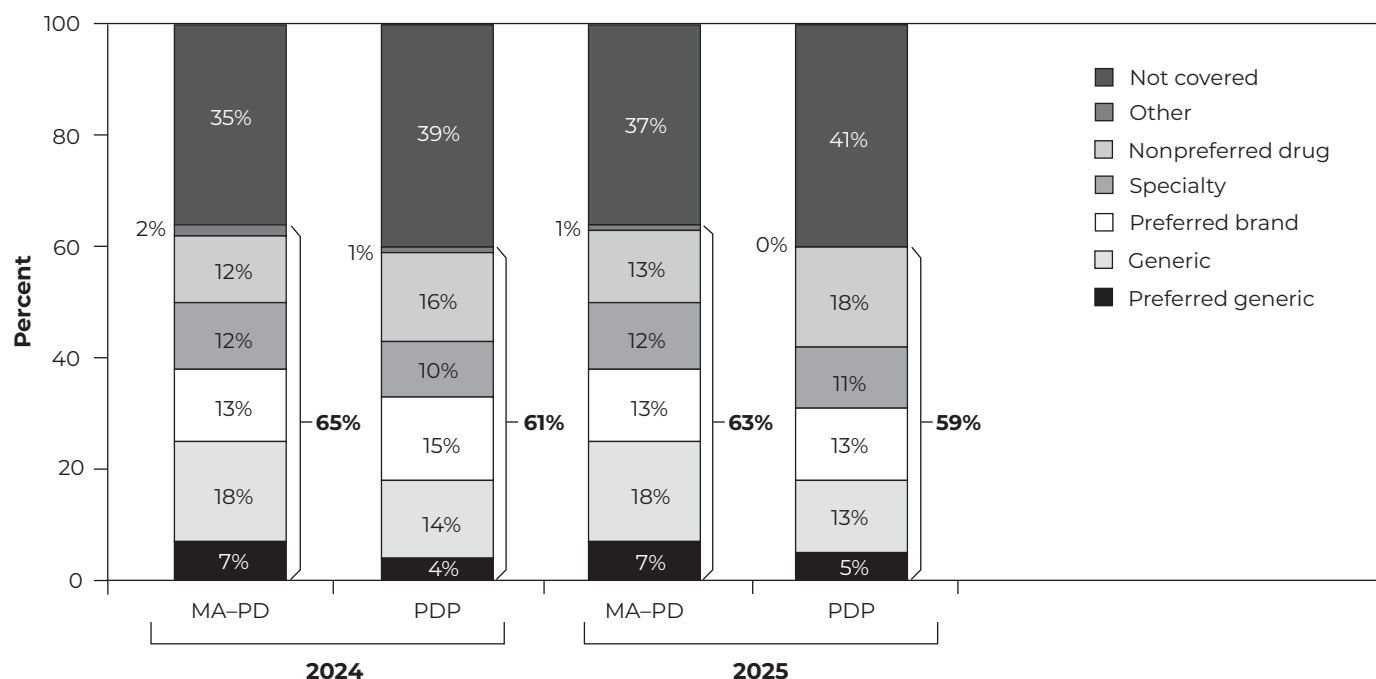
Across all Part D products, MA-PDs cover more products than PDPs, on average, and place covered products on lower tiers

We first compared average coverage rates for all Part D-eligible products for MA-PDs and PDPs in

2024 and 2025. We weighted the coverage rates by plan enrollment in the first half of 2024, meaning that the rates can be interpreted as the percentage of drugs that the average beneficiary has available on their plan's formulary. For this section of the analysis, a drug product is defined at the active-ingredient level, meaning that a drug is considered covered for a beneficiary if at least one formulation of an active ingredient (for example, a particular dose or type of packaging) is included on the formulary, whether brand name or generic. We classified products into tiers using the lowest tier for which any version of the product was included on the plan's formulary.²⁴ Lower tiers indicate more generous coverage of a drug because beneficiaries typically pay less in cost sharing for products on lower tiers (Medicare Payment Advisory Commission 2024a).

**FIGURE
4-14**

Coverage rates and tier distribution, all products, 2024 and 2025



Note: MA-PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs. In this figure, "MA-PD" includes conventional MA-PDs only, not special-needs plans. The total share of drug products covered is equal to the sum of the shares of drugs covered on each formulary tier; the totals are shown by brackets for each plan type and year. A drug product is defined at the active-ingredient level, meaning that a drug is considered covered for a beneficiary if at least one formulation of an active ingredient is covered on the formulary. Components may not sum to total due to rounding.

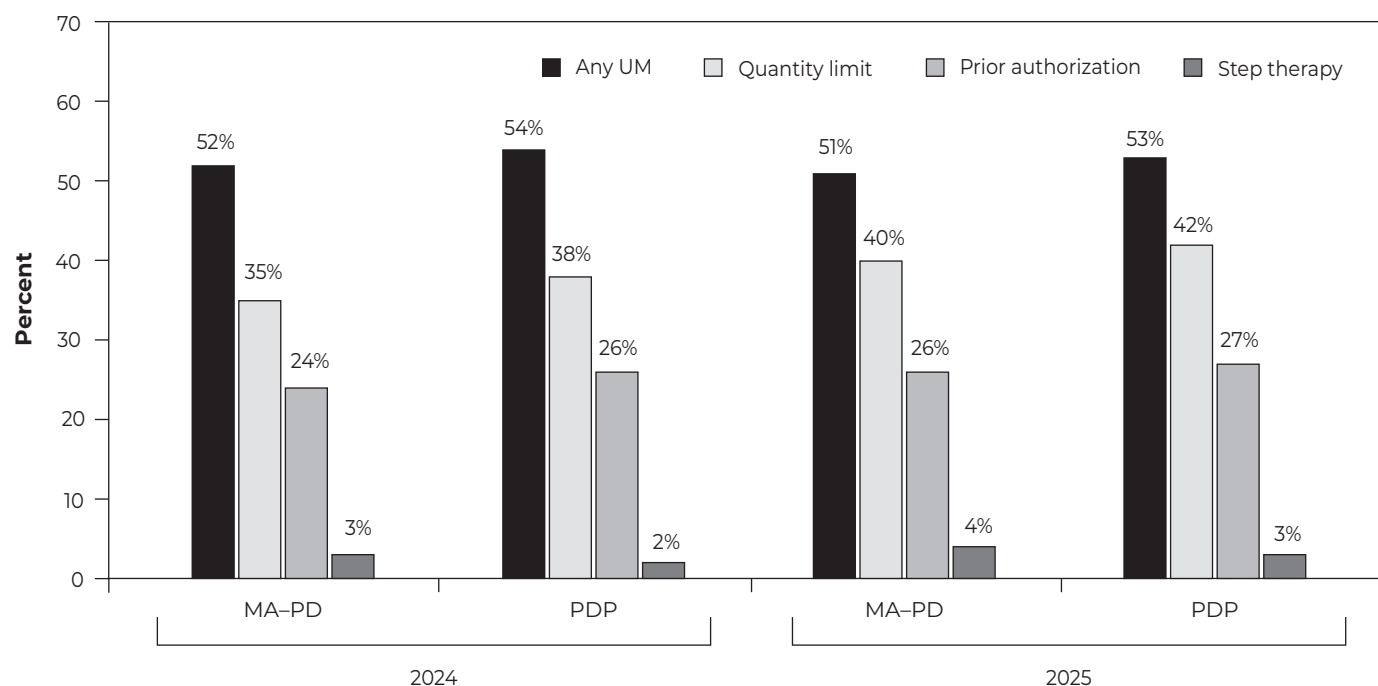
Source: Acumen LLC analysis of Part D formulary files for 2024 and 2025 and 2024 enrollment data for MedPAC.

Our analysis found that the average MA-PD enrollee had a somewhat larger share of drug products available on their plan's formulary and on lower-cost tiers relative to the average PDP enrollee in both 2024 and 2025; both findings indicate more generous coverage for beneficiaries (Figure 4-14). Both MA-PDs and PDPs are covering a smaller share of products in 2025 (63 percent and 59 percent, respectively) compared with 2024 (65 percent and 61 percent, respectively), but MA-PDs again have a larger share of products on formulary and on lower cost-sharing tiers.

Across all Part D-eligible products, MA-PD enrollees on average had access to 25 percent of products on generic tiers, including 18 percent on the preferred generic tier, in both 2024 and 2025, compared with PDP enrollees who had access to just 18 percent of products on either generic tier in both years (Figure 4-14).

MA-PD enrollees will also find fewer products on the nonpreferred tier (12 percent in 2024 and 13 percent in 2025 compared with 16 percent in 2024 and 18 percent in 2025 for PDP enrollees, on average). PDP enrollees have a slightly smaller share of products on the specialty tier in each year compared with MA-PD enrollees, on average. PDPs had more products on the preferred-brand tier in 2024, but in 2025 the shares of products on the preferred-brand tier are equal between MA-PDs and PDPs.

As with our other analyses, we also examined formulary differences between nonbenchmark PDPs with both benchmark PDPs and conventional MA-PDs. Coverage among nonbenchmark PDPs was slightly more generous than benchmark PDPs, in terms of overall coverage rates (60 percent vs. 58 percent in 2025) and tier placement, with 32 percent of covered products

**FIGURE
4-15****Utilization-management rates as a share of on-formulary drugs, all Part D-covered products, 2024-2025**

Note: UM (utilization management), MA-PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs. In this figure, "MA-PD" includes conventional MA-PDs only, not special-needs plans. The shares of products listed as "on formulary" in this chart represent the share of all products at the active ingredient level that are covered on the average beneficiary's formulary. The shares of products with any UM applied, and each type of UM, are calculated as shares among the products covered on plan formularies.

Source: Acumen LLC analysis of Part D formulary files for 2024 and 2025 and 2024 enrollment data for MedPAC.

on the generic tiers, compared with 27 percent among benchmark PDPs and 30 percent of covered products listed as nonpreferred compared with 31 percent among benchmark PDPs. Still, nonbenchmark PDPs are not as generous in terms of coverage or tier placement as conventional MA-PDs.

In addition to having a greater share of products covered, MA-PD enrollees on average were slightly less likely to face access restrictions for their covered products, with an average of 52 percent and 51 percent of products, in 2024 and 2025 respectively, having any form of utilization management (UM) applied, compared with 54 percent and 53 percent of products facing restrictions for PDP enrollees in these years (Figure 4-15).

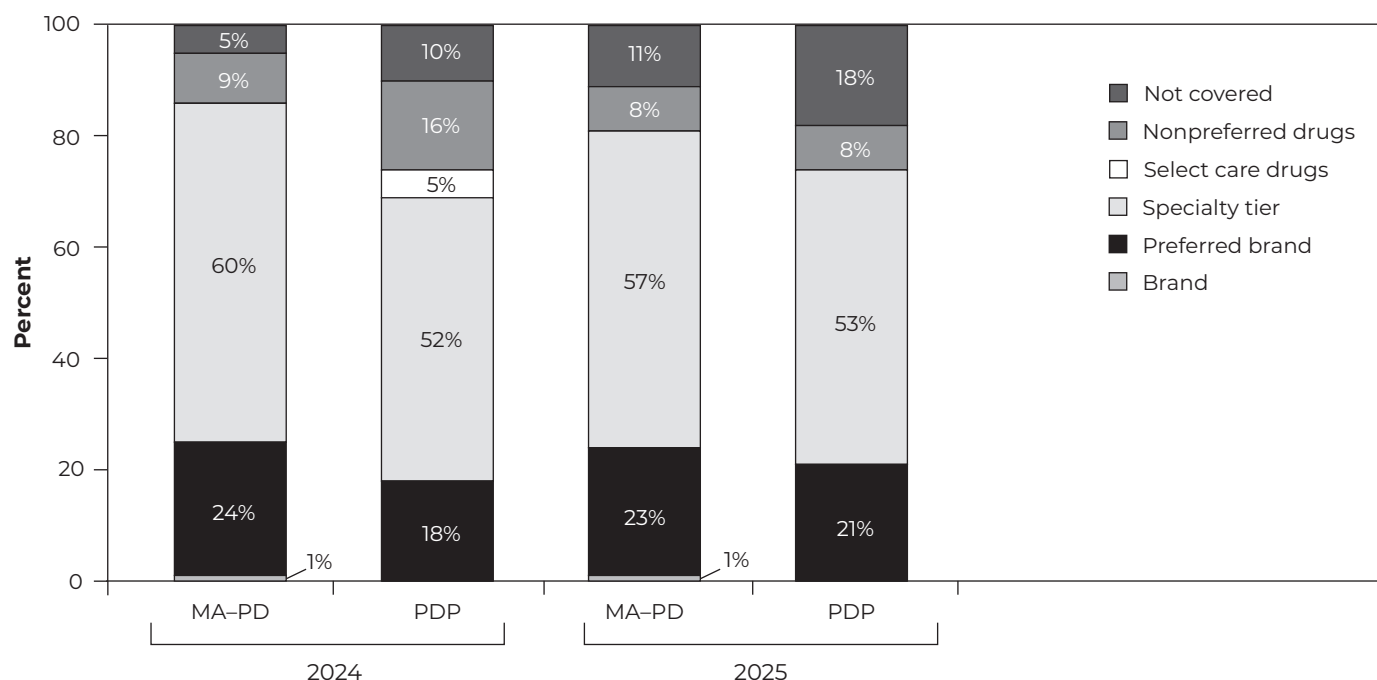
Quantity limits (QLs) are the most used UM tool among both MA-PDs and PDPs, and each plan type increased

their use by about 5 percentage points in 2025 to 40 percent and 42 percent, respectively, among all covered products (Figure 4-15). Prior authorization (PA) is required for roughly one-fourth of covered products, with PDP enrollees having 1 percentage point to 2 percentage points more products subject to PA. On average, across all products, step therapy (ST) is rarely used, though both MA-PDs and PDPs increased its use by 1 percentage point in 2025 to 4 percent and 3 percent, respectively.

Notably, despite each of the three types of UM use increasing in 2025 for both plan types, overall UM use by all types decreased 1 percentage point from 2024 to 2025. This decline could mean that while fewer products have any UM applied, more products are seeing the application of more than one type of UM, such as PA and, even after being authorized, the imposition of QLs.

**FIGURE
4-16**

**Top 20 high-cost, high-utilization products in 2024,
coverage rates, and tier distribution**



Note: MA-PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs. In this figure, “MA-PD” includes conventional MA-PDs only, not special-needs plans. Products were selected based on the highest total gross drug costs among both MA-PDs and PDPs in the first six months of 2024 with an average gross cost per fill of at least \$1,000 and at least 20,000 fills for each plan type. Figures in each column may not sum to 100 percent due to rounding.

Source: Acumen LLC analysis of Part D formulary files for 2024 and 2025 and prescription drug event data and enrollment data for 2024 for MedPAC.

Nonbenchmark PDPs also use UM tools at a slightly higher rate than conventional MA-PDs, applying UM to 53 percent of all covered products.

Products with high total spending were largely placed on specialty tiers and had higher-than-average rates of utilization management

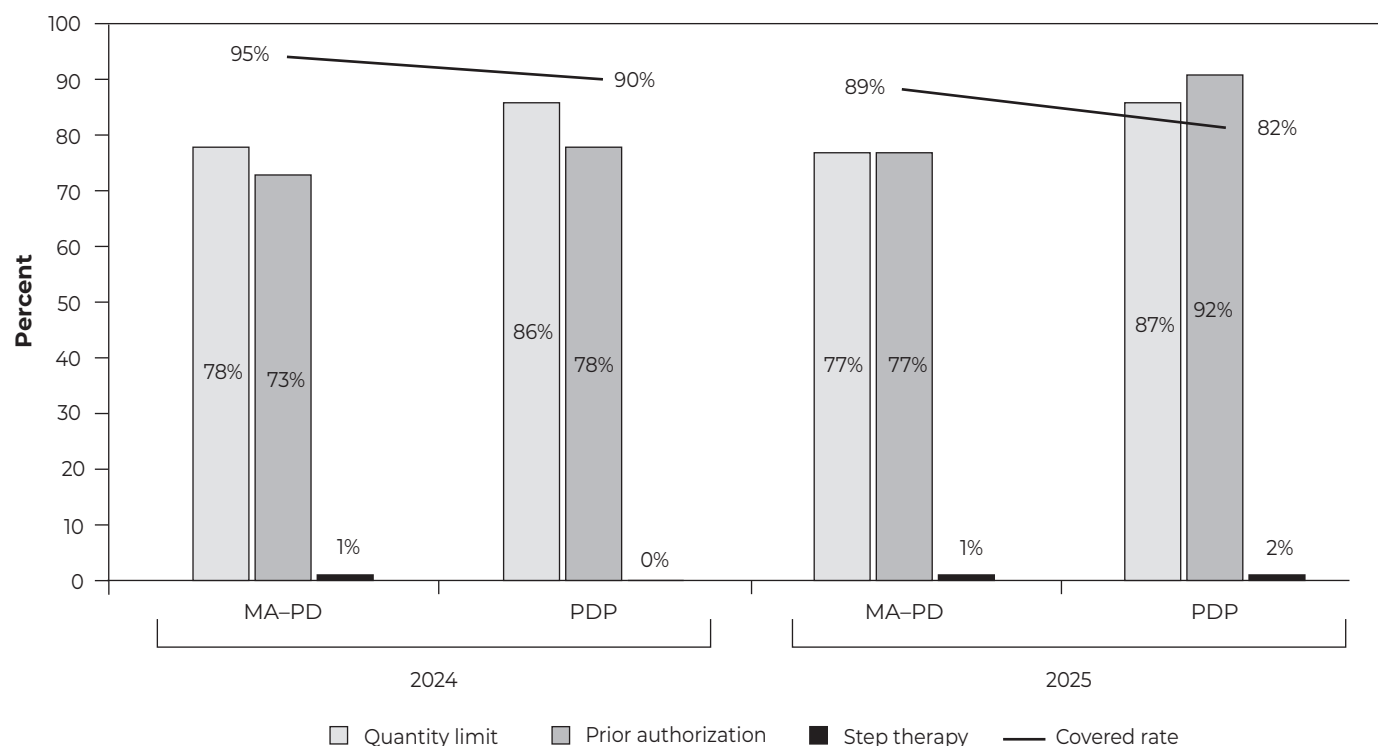
We next considered a subset of products whose coverage is likely to be important to enrollees: products that are both high cost and highly utilized. We identified products that had an average price (as measured by gross cost per fill) of at least \$1,000 and selected the 20 drugs with the highest gross spending and at least 20,000 fills for each plan type in 2024.²⁵ Those 20 products were among the top 24 products, ranked by total gross spending, for MA-PDs and the top 33 for PDPs.

These products, in 2024, accounted for 4.1 million fills and \$8.5 billion in total gross spending for MA-PDs and

4 million fills and \$9.2 billion in total gross spending for PDPs. The average gross spending per fill, weighted by fills in 2024, was \$2,080 for MA-PDs and \$2,302 for PDPs. Seven of these products have been selected for negotiation under the Medicare Drug Price Negotiation Program.²⁶ There are just two generic products among these top 20, both oncology medicines, including lenalidomide (the generic of Revlimid, which is also on the list and accounted for higher gross drug costs) and abiraterone (generic Zytiga).

These products on average had high levels of coverage for both MA-PDs and PDPs, with the average MA-PD enrollee having 95 percent of these products available on their formulary in 2024, compared with 90 percent of products for PDP enrollees (Figure 4-16).

In 2024, MA-PD enrollees were more likely to find these products covered on the preferred-brand tier (24 percent) than PDP enrollees (18 percent),

**FIGURE
4-17****Top 20 high-cost, high-utilization products in 2024,
coverage and utilization-management rates**

Note: MA-PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs. In this figure, "MA-PD" includes conventional MA-PDs only, not special-needs plans. Products were selected based on highest total gross drug costs among both MA-PDs and PDPs in the first six months of 2024, with an average gross cost per fill of at least \$1,000 and at least 20,000 fills for each plan type.

Source: Acumen LLC analysis of Part D formulary files for 2024 and 2025 and prescription drug event data and enrollment data for 2024 for MedPAC.

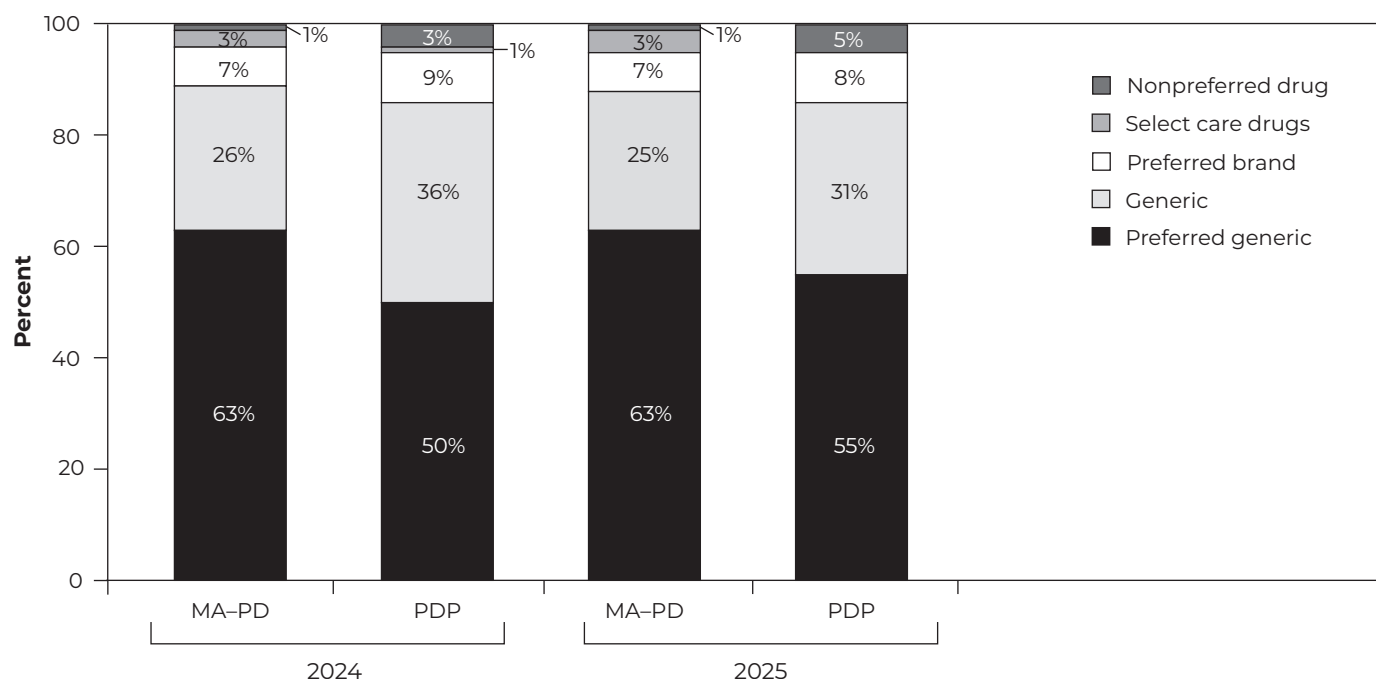
and MA-PD enrollees had just 9 percent of these products placed on the nonpreferred tier on average compared with 16 percent for PDP enrollees. MA-PD enrollees did have a larger share of these products on the specialty tier in 2024 (60 percent on average), compared with 52 percent for PDP enrollees.

In 2024, only two products had coverage rates below 90 percent for MA-PDs; in 2025, this increased to four products, and tier placement for these products changed very little, on average, across MA-PDs between the two years.²⁷ PDPs, on the other hand, were less likely to cover these products in both 2024 and 2025 and had more noticeable changes in tier placement. In 2024, 3 of these 20 products had coverage rates below 90 percent; in 2025, 8 of them are covered on average for fewer than 90 percent of PDP enrollees.²⁸

A handful of these products experienced particularly large drops in coverage rates. Across both MA-PDs and PDPs, Revlimid, Enbrel SureClick, Ingrezza, and Otezla experienced declines in coverage of between 18 percentage points and 35 percentage points. Among PDPs, Trulicity, Humira, and Rybelsus have also seen significant decreases in coverage rates in 2025 among PDPs.

All of these products had some amount of UM applied, except one.²⁹ On average, MA-PDs used UM tools for these products less frequently than PDPs in both 2024 and 2025.

QLs applied to 78 percent of the products for the average MA-PD enrollee and 73 percent of products for the average PDP enrollee, more than twice the rate of QLs applied across all products on average (Figure

**FIGURE
4-18****Tier distribution for the top 50 generic products by fills, 2024**

Note: MA-PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs. In this figure, "MA-PD" includes conventional MA-PDs only, not special-needs plans. These products were the top 50 products that were among each plan type's most filled generics in the first six months of 2024.

Source: Acumen LLC analysis of Part D formulary files for 2024 and 2025 and prescription drug event data and enrollment data for 2024 for MedPAC.

4-17). Similarly, rates of prior authorization (PA) were roughly three times higher for these products than the average rate for all products in 2024 (73 percent to 78 percent compared with 24 percent to 26 percent) and increased even more in 2025. As was true among all products, average rates of ST were very low.

Use of QLs was virtually unchanged from 2024 to 2025 for both plan types, though MA-PDs and PDPs both increased use of PA; PDPs increased PA use by 15 percentage points, so on average PDP enrollees will face PA for 92 percent of these products in 2025.

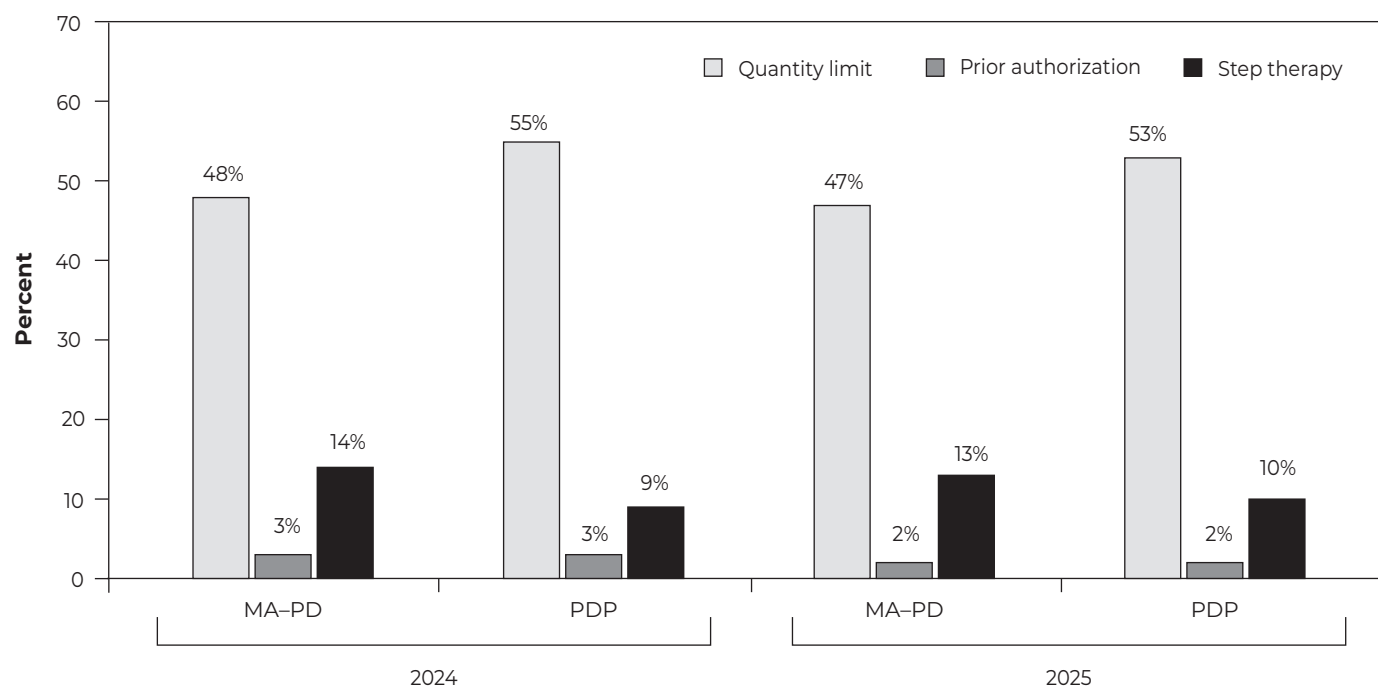
Most commonly filled generic products had near-universal coverage, primarily on generic tiers

Next in our analysis, we considered the most frequently used generics, selecting the top 50 products that were among each plan type's most filled generics: These products were among the top 59 most

utilized for MA-PD enrollees and the top 56 for PDP enrollees.³⁰ These products had an average coverage rate of 100 percent for both plan types in 2024.³¹ The fill-weighted average gross spending for these 50 products per fill in 2024 was \$9.99 for MA-PDs and \$11.04 for PDPs.

While total coverage on generic tiers was roughly equal between MA-PDs and PDPs, MA-PDs currently have a higher share of such products on the preferred-generic tier (63 percent compared with 55 percent for PDPs in 2025) and a smaller share of products on the nonpreferred tier (1 percent compared with 5 percent among PDPs) (Figure 4-18, p. 205).

QLs were applied to roughly half of these products, on average, in 2024, with more products subject to QLs among PDP enrollees (55 percent) than MA-PD enrollees (48 percent) (Figure 4-19). However, unlike

**FIGURE
4-19****Share of products subject to utilization management
among top 50 generic products by fills in 2024**

Note: MA-PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs. In this figure, "MA-PD" includes conventional MA-PDs only, not special-needs plans. These products were the top 50 products that were among each plan type's most filled generics in the first six months of 2024.

Source: Acumen LLC analysis of Part D formulary files for 2024 and 2025 and prescription drug event data and enrollment data for 2024 for MedPAC.

all products overall and the top 20 products with high costs and high utilization, PA rates for these products are quite low (3 percent for both plan types in 2024 and 2 percent in 2025, compared with an average of roughly 25 percent for all products); ST use is more common (roughly 10 percent or more for both plan types in 2024 and 2025, compared with an average of 3 percent for all products among both plan types). PA rates for these products were equal for MA-PDs and PDPs in each year, while MA-PDs had a higher rate of ST use than PDPs in each year (14 percent vs. 9 percent in 2024 and 13 percent vs. 10 percent in 2025). The relatively high rates of ST among these generic products are surprising because ST is usually considered a tool to encourage use of a lower-cost product before trying a more expensive product, yet these products all had an average gross cost per fill of less than \$35. Further, despite the use of step therapy, these products were

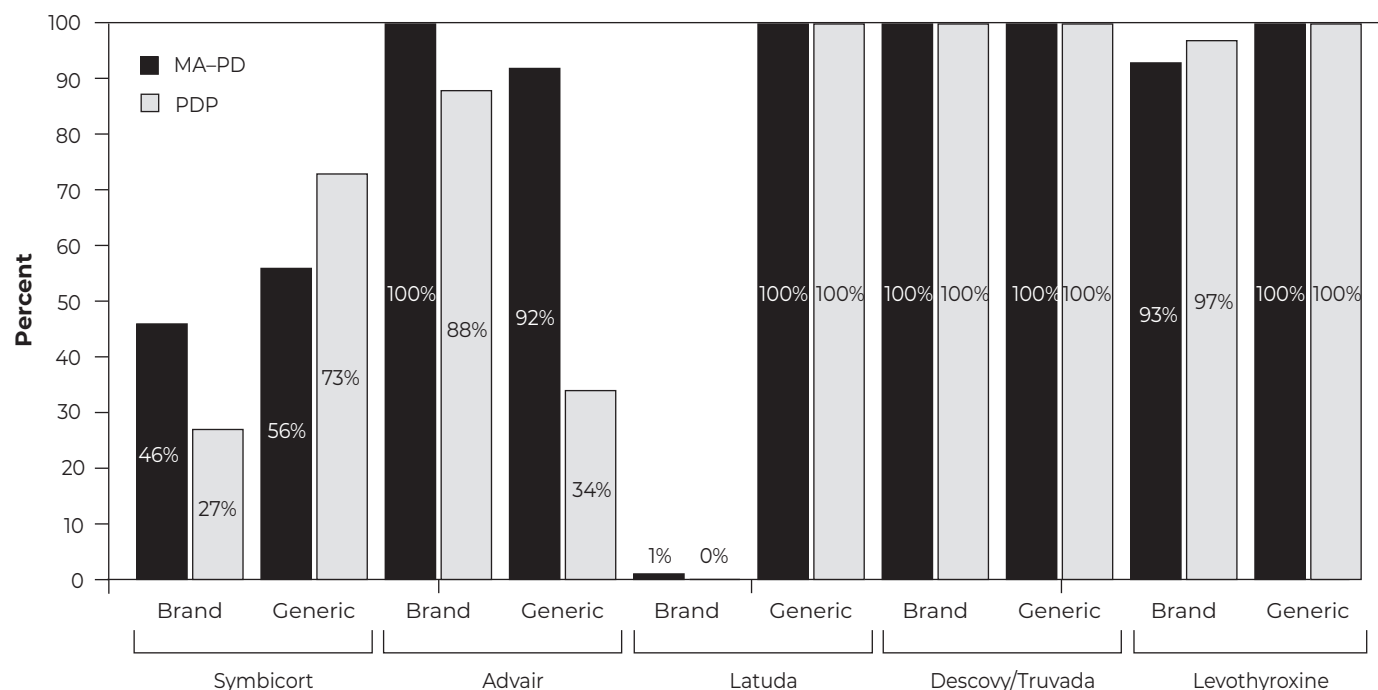
still among the most utilized. We do not have an explanation for the relatively high use of ST at this time.

Formulary preference for some brands remains despite generic availability

One more area of interest in this analysis was frequent plan coverage of brand-name products despite generic availability. For example, in recent years we have discussed the high coverage rates of Symbicort, Advair, Humira, and Descovy/Truvada, despite the availability of less expensive generic or biosimilar products (Medicare Payment Advisory Commission 2025, Medicare Payment Advisory Commission 2023). We found that some preference for these brand-name products still exists in 2025, even for products with authorized generics (AGs), which are generic versions of products that are manufactured by or on behalf of the same manufacturer of the brand-name

**FIGURE
4-20**

Average coverage rates for selected multiple-source drugs, 2025



Note: MA-PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs. In this figure, "MA-PD" includes conventional MA-PDs only, not special-needs plans.

Source: Acumen LLC analysis of Part D formulary data for 2025 and enrollment data for 2024 for MedPAC.

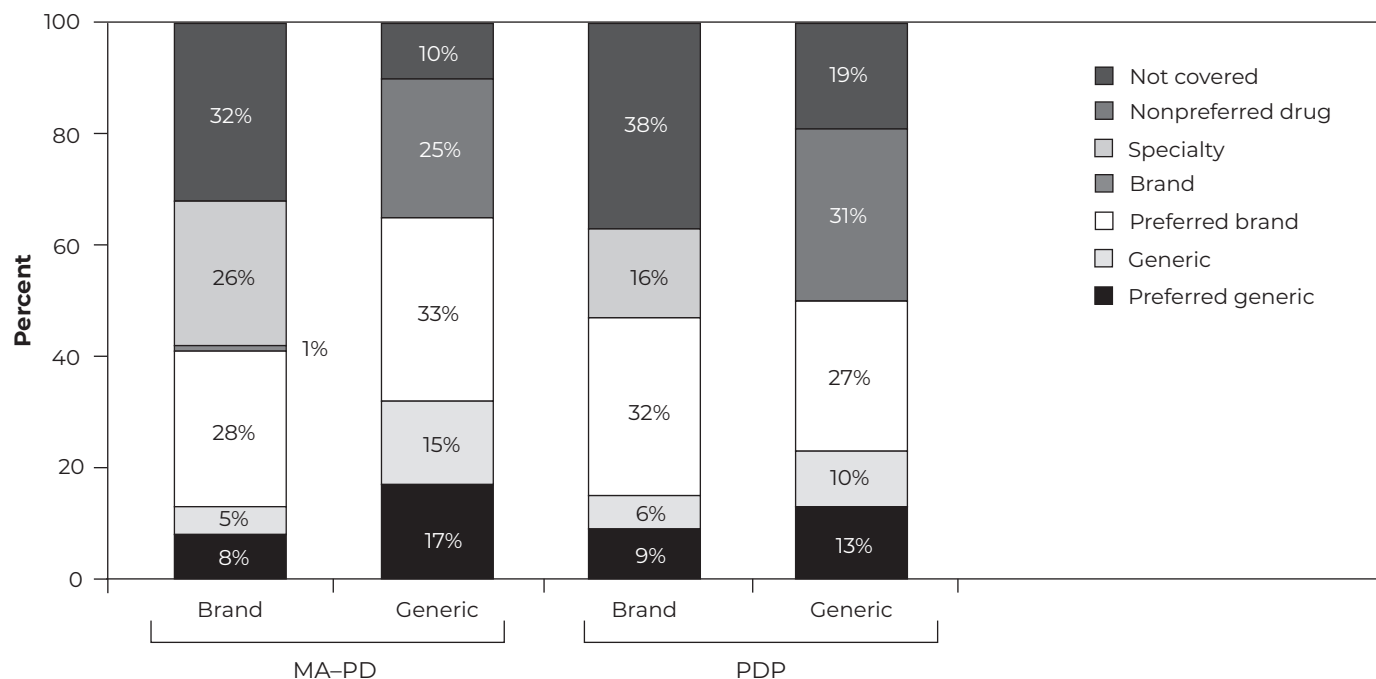
product (Figure 4-20). For example, the AG of Advair HFA, the most commonly used Advair product by number of fills, is covered only for 12 percent of MA-PD enrollees and 14 percent of PDP enrollees, while the branded version is covered for roughly 60 percent of all PDP and MA-PD enrollees (data not shown). The AG of Advair Diskus, by contrast, is covered more favorably than the brand and at a similar rate as the other generic version, among both MA-PDs and PDPs in 2025.

However, if we also consider tier placement and the use of UM, a fuller picture emerges. For many of these products, plans have placed the branded and generic versions on the same tiers, with some branded products on generic tiers and some generics being mostly placed on a brand tier (Figure 4-21, p. 208). In fact, the generic version of Descovy/Truvada is on the nonpreferred tier for 85 percent of MA-PD enrollees and 100 percent of PDP enrollees, while the branded

versions are on the specialty tier for 93 percent of MA-PD enrollees and 100 percent of PDP enrollees. The AG of Advair HFA, when it is covered, is primarily on the nonpreferred tier, while the branded product is almost exclusively on the preferred-brand tier.

The application of UM tools also places generics for several of these products at a disadvantage, particularly among PDPs. PDPs are applying some form of UM to the generic versions of these products for 80 percent of their enrollees, but only 57 percent of enrollees will face UM for the branded version. MA-PD plans apply UM roughly equally across the brand and generic versions of these products.

The findings of our analyses are consistent with the findings of other studies examining Part D coverage rates, tier placement, UM, and OOP costs from recent years. For instance, Joyce and colleagues found that prior to the IRA, PDPs were slightly more likely to

**FIGURE
4-21****Coverage and tier placement for select products, 2025**

Note: MA-PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs. In this figure, “MA-PD” includes conventional MA-PDs only, not special-needs plans.

Source: Acumen LLC analysis of Part D formulary data for 2025 and enrollment data for 2024 for MedPAC.

exclude products from coverage, and the use of UM tools increased for both plan types from 2011 through 2020 (Joyce et al. 2024).

One study found that despite lower expenditures for basic coverage relative to PDPs, in 2019, MA-PDs covered 81 percent of drugs within a class, on average, compared with 74 percent of products covered per class in PDPs. MA-PDs were also found to cover slightly more excluded drugs (such as vitamin supplements and cough and allergy relief products) than PDPs, though the difference is not enough to explain MA-PDs’ higher costs for supplemental coverage (Ippolito and Vabson 2024).

Several studies have found that PDPs were using coinsurance at greater rates than MA-PDs, even before the benefit changes of the IRA began to take effect (Axelsen et al. 2024, Cubanski and Damico 2024, Trish et al. 2025), and greater coinsurance rates are

associated with higher patient OOP costs (Trish et al. 2025). Another study found that MA-PD enrollees, on average, had 24 percent lower OOP costs than PDP enrollees in 2019, largely as a result of MA-PD sponsors’ ability to use MA rebates to provide supplemental coverage to lower enrollees’ cost-sharing liabilities (Ippolito and Vabson 2024).

MA plans’ ability to document additional diagnosis codes may contribute to higher Part D risk scores

Under Part D, Medicare’s subsidy takes the form of two distinct payments: (1) capitated payments called the “direct subsidy” and (2) cost-based reinsurance payments that cover a portion of an individual’s drug spending above the benefit’s OOP limit. As explained above, Medicare’s direct-subsidy payments are risk adjusted to reflect the expected costliness of each enrollee, using the prescription drug hierarchical

condition category (RxHCC) risk-adjustment model. The model uses demographic information and documented medical conditions to predict an enrollee's Part D costs, similar to the way the CMS hierarchical condition category (CMS-HCC) risk-adjustment model adjusts payments to MA plans based on expected costs under Part A and Part B (see text box on Part D's risk-adjustment model, pp. 210–211).

Because the CMS-HCC model uses FFS Medicare claims data to estimate the size of the model coefficients, the model calculates an expected spending amount based on FFS Medicare costs and diagnostic-coding patterns. When MA plans submit more diagnoses for a beneficiary, the payment to the plan increases. This financial incentive to submit more diagnosis codes generally does not exist in FFS Medicare, particularly for physician and outpatient services, which tend to be paid based on procedure codes and account for the majority of diagnoses used in risk adjustment.

MA plans cover the Part A and Part B benefit and have contractual relationships with physicians and hospitals that are the source for diagnostic data used in risk adjustment for MA and Part D payments. Therefore, MA plans can influence diagnostic-coding behavior by offering those providers financial incentives to document more diagnosis codes, such as through pay-for-coding programs, in which plans pay physicians to document more diagnoses, or through subcapitation, in which a portion of higher payments generated by greater coding intensity is retained by subcapitated providers. PDPs do not have such relationships and cannot influence diagnostic-coding behavior in the same way. Furthermore, MA plans have several tools that are unavailable in FFS Medicare to code more diagnoses, including the use of health risk assessments and chart reviews (Medicare Payment Advisory Commission 2025). PDPs do not have a mechanism for using these kinds of tools.

Given the overlap of diagnostic-data sources (physician and hospital claims and encounters) and conditions in the CMS-HCC and RxHCC models, the effects of coding intensity are directly linked between the two risk-adjustment models. Specifically, for the 82 percent of RxHCC model diagnoses that are also included in the CMS-HCC model, higher MA diagnostic-coding intensity relative to FFS transfers directly into higher MA-PD coding intensity relative to PDPs.

Estimating differences in coding intensity between MA-PDs and PDPs

For the past several years, the Commission has evaluated the effects of coding intensity on the CMS-HCC risk scores that are used to pay MA plans for providing services covered under Part A and Part B. To conduct this analysis, we use the demographic estimate of coding intensity (DECI) method that is described in our March 2025 report (see Appendix 11-B). The method compares MA and FFS CMS-HCC risk scores and controls for differences in age, sex, Medicaid eligibility, and institutional status using a separate risk score based on only those demographic factors. The method implicitly assumes that MA enrollees have similar rates of health conditions when compared with FFS Medicare beneficiaries with similar demographic characteristics.

Our analysis of the effects of coding intensity in Part A and Part B shows that MA risk scores relative to FFS have increased over time and were about 17 percent higher than FFS risk scores for similar beneficiaries in 2023 due to coding intensity before accounting for CMS's adjustment for coding intensity (Medicare Payment Advisory Commission 2025). Several studies using a variety of methods and data sources have produced estimates of MA coding intensity relative to FFS that are consistent with our estimates (Congressional Budget Office 2017, Geruso and Layton 2020, Government Accountability Office 2013, Hayford and Burns 2018, Jacobs and Kronick 2018, Kronick and Chua 2021, Kronick and Welch 2014). These results support the assumption that MA enrollees and FFS Medicare beneficiaries with similar demographic characteristics have similar rates of health conditions. Given the overlap in data sources and diagnoses used in the CMS-HCC and RxHCC risk models, we believe that the assumption of similar rates of health conditions is valid for RxHCCs, but we also note that this is the first known study assessing coding intensity in Part D and therefore there are no other studies currently available for comparison.

Evaluating the effects of coding intensity in Part D differs from our analysis of MA coding intensity. Because the RxHCC risk-model coefficients are estimated using all enrollees with Part D coverage (enrollees in both MA-PDs and PDPs), we estimate the effects of coding intensity separately for MA-PDs and PDPs relative to the overall Part D population. Although

Part D's risk-adjustment model

Direct-subsidy payments are calculated based on plan bids that reflect plans' expected basic-benefit costs for an enrollee with average expected costliness. These direct-subsidy payments are adjusted by risk scores—an index of beneficiaries' expected cost—that increase Medicare's payments to plans for beneficiaries who are expected to have higher Part D spending based on their demographics and recorded diagnoses, and vice versa. The goal of risk adjustment is to accurately adjust payments to plans for the expected costs of their enrollees, thereby limiting plan incentives to engage in risk selection (i.e., attracting or avoiding enrollees with certain conditions).

The prescription drug-hierarchical condition category (RxHCC) model uses demographic information (age, sex, disability, institutional status, and eligibility for low-income subsidies) and certain diagnoses to adjust payments to Part D plans. The diagnostic information comes from physician, inpatient hospital, and outpatient hospital records in Medicare Advantage (MA) encounter data or fee-for-service (FFS) claims data in the same manner that codes are used in the CMS hierarchical condition category (CMS-HCC) model that adjusts payments to MA plans.³²

Diagnoses included in the RxHCC model are grouped into condition categories, which are ranked into hierarchies for similar conditions (e.g., diabetes with and without complications). A diagnosis needs to be submitted just once per year for a given RxHCC to count for a beneficiary, and only the highest-ranked RxHCC in a hierarchy counts for beneficiaries with multiple RxHCCs in a hierarchy.

This method of calculating risk scores is similar to the CMS-HCC model used to risk adjust payments to MA plans. Notably, the sources of diagnostic information used in the CMS-HCC and the RxHCC models are the same, and there is substantial overlap in the diagnoses used in the two models. We found that about 82 percent of the diagnoses used in the RxHCC model were also used in the CMS-HCC model in each of the years between 2019 and 2023.³³

Each demographic and RxHCC component in the model has a coefficient that represents the expected gross plan costs (the portion of gross drug spending for which plans bear insurance risk) associated with that component.³⁴ The sum of these dollar-value coefficients is converted to a risk score by dividing by average gross plan costs for the Part D basic benefit. A risk score of 1.0 represents an enrollee with average costliness. Higher risk scores result in

(continued next page)

RxHCC risk scores are based on the overall Part D population, higher MA coding intensity relative to FFS Medicare would still provide MA-PDs with advantages over PDPs if higher coding intensity translates to higher RxHCC risk scores for enrollees in MA-PDs. However, those differences in coding intensity generally do not increase Part D program spending, unlike in MA, where coding intensity that is higher than in FFS increases payments to MA plans.

To apply the DECI method to RxHCC risk scores, for enrollees in MA-PDs, PDPs, and the overall Part D

population, we calculated average RxHCC risk scores and average demographic risk scores separately for enrollees with institutional status, those eligible for the LIS, and those not eligible for the LIS. Then we calculated average RxHCC and demographic risk scores for MA-PDs, PDPs, and Part D overall using the share of all Part D enrollees in each group as weights. Finally, we calculated separate DECI estimates for MA-PD and PDP enrollees using the formula in Figure 4-22 (p. 212).

Up to this point, the calculation of MA-PD and PDP coding intensity includes only “continuing” enrollees

Part D's risk-adjustment model (cont.)

higher direct-subsidy payments. A “normalization factor” is applied to keep the average beneficiary risk score at 1.0 by offsetting year-to-year changes in the average risk score.

The RxHCC model differs from the CMS-HCC model in two important ways. First, the normalization factor for the RxHCC model is calculated across all Part D enrollees, so a 1.0 risk score is maintained across enrollees in both MA-PDs and PDPs. As a result, differential changes in risk scores across enrollees in MA-PDs and PDPs are, by themselves, budget neutral for Medicare (though they could have distributional implications across plans). In 2025, CMS began applying separate normalization factors for MA-PDs and stand-alone prescription drug plans (PDPs) to “more accurately reflect Part D costs in each of these two sectors” (Centers for Medicare & Medicaid Services 2024c). The agency noted that the RxHCC model has historically overpredicted costs for MA-PDs and underpredicted costs for PDPs. That means that, on average, the RxHCC model historically produced risk scores that reflect expected spending that is higher than actual spending for MA-PDs and reflect expected spending that is lower than actual spending for PDPs. The separate normalization factors for 2025 (0.955 for PDPs and 1.073 for MA-PDs) are intended to fix these prediction errors by increasing PDP risk scores and

decreasing MA-PD risk scores while maintaining a 1.0 risk score across all Part D enrollees. In contrast, the normalization factor for the CMS-HCC model is calculated across fee-for-service (FFS) beneficiaries and maintains a 1.0 risk score only among FFS beneficiaries. Because the CMS-HCC normalization factor accounts only for FFS risk-score trends over time, greater increases in MA risk scores relative to FFS result in higher Medicare payments to MA plans (i.e., higher MA coding intensity is not budget neutral for Medicare's Part C payments to plans).

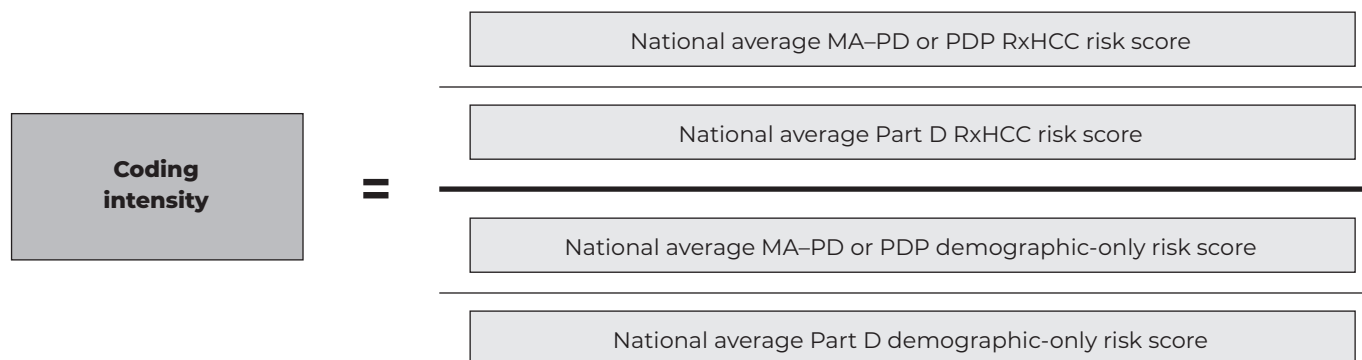
Second, RxHCC model coefficients are estimated using gross plan costs rather than net plan costs, which reflect postsale rebates and fees that can vary by plan and across therapeutic class. As a result, the accuracy of the RxHCC model coefficients reflecting relative plan costs for different demographic and condition components can vary across plans and therapeutic classes (Medicare Payment Advisory Commission 2021). These postsale rebates and fees have grown rapidly, accounting for 31 percent of gross spending in 2022, up from 11 percent in 2010. In contrast to the RxHCC model that uses data for PDPs and MA-PDs, in MA, the CMS-HCC risk-adjustment model coefficients are estimated using FFS claims data and therefore reflect FFS prices for items and services. ■

who have an RxHCC risk score that includes diagnostic information. (“New enrollees” to Medicare have a risk score that is based only on demographic information.) The last step in the calculation is to incorporate the effect of new enrollees, for whom we attribute no coding-intensity effect because their risk scores do not include diagnostic information. The continuing and new-enrollee group weights are based on the share of enrollees and the average risk score for enrollees in each status. Figure 4-23 (p. 213) shows the MA-PD and PDP coding-intensity estimates for 2019 through 2023.

Our estimates show that, relative to the overall Part D population, differences in coding intensity produced higher risk scores for MA-PD enrollees and lower risk scores for PDP enrollees on average. In the aggregate, MA-PD risk scores were about 4.7 percentage points higher than PDP risk scores due to coding intensity in 2019, increasing to about 9.2 percentage points higher in 2022 before falling to 7.6 percentage points higher in 2023. A new RxHCC risk-adjustment model was introduced in 2023, which may contribute to the reduced impact on coding intensity in 2023.

**FIGURE
4-22**

DECI method estimates coding intensity as the ratio of two ratios



Note: DECI (demographic estimate of coding intensity), MA-PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan), RxHCC (prescription drug-hierarchical condition category).

Source: MedPAC adaptation of methods published in Kronick and Chua 2021.

Prior to 2025, higher MA-PD coding intensity resulted in higher payments to MA-PDs and lower payments to PDPs because the RxHCC model was normalized to a 1.0 risk score across the whole Part D population. Starting in 2025, CMS uses separate normalization factors for MA-PDs and PDPs, based on historical MA-PD and PDP risk-score trends that will account for the difference in projected risk scores in the two markets. However, systematic differences between PDPs and MA-PDs in coding would still compromise the ability of the RxHCC model to accurately predict costs because the coefficients from the model are estimated based on the pooled population of MA-PD and PDP data. In turn, those inaccuracies affect enrollee premiums and payments to plans.

Coding differences may affect Part D plan bids and premiums

Increases in a plan's risk scores due to higher coding intensity are offset by a reduction in risk scores for plans with lower coding intensity. Higher or lower risk scores due to relative coding intensity can affect plan payments through their bids and therefore can affect enrollee premiums. Prior to 2025, when a single normalization factor was used for Part D risk scores, differences in coding intensity between MA-PDs and PDPs contributed to payment and premium

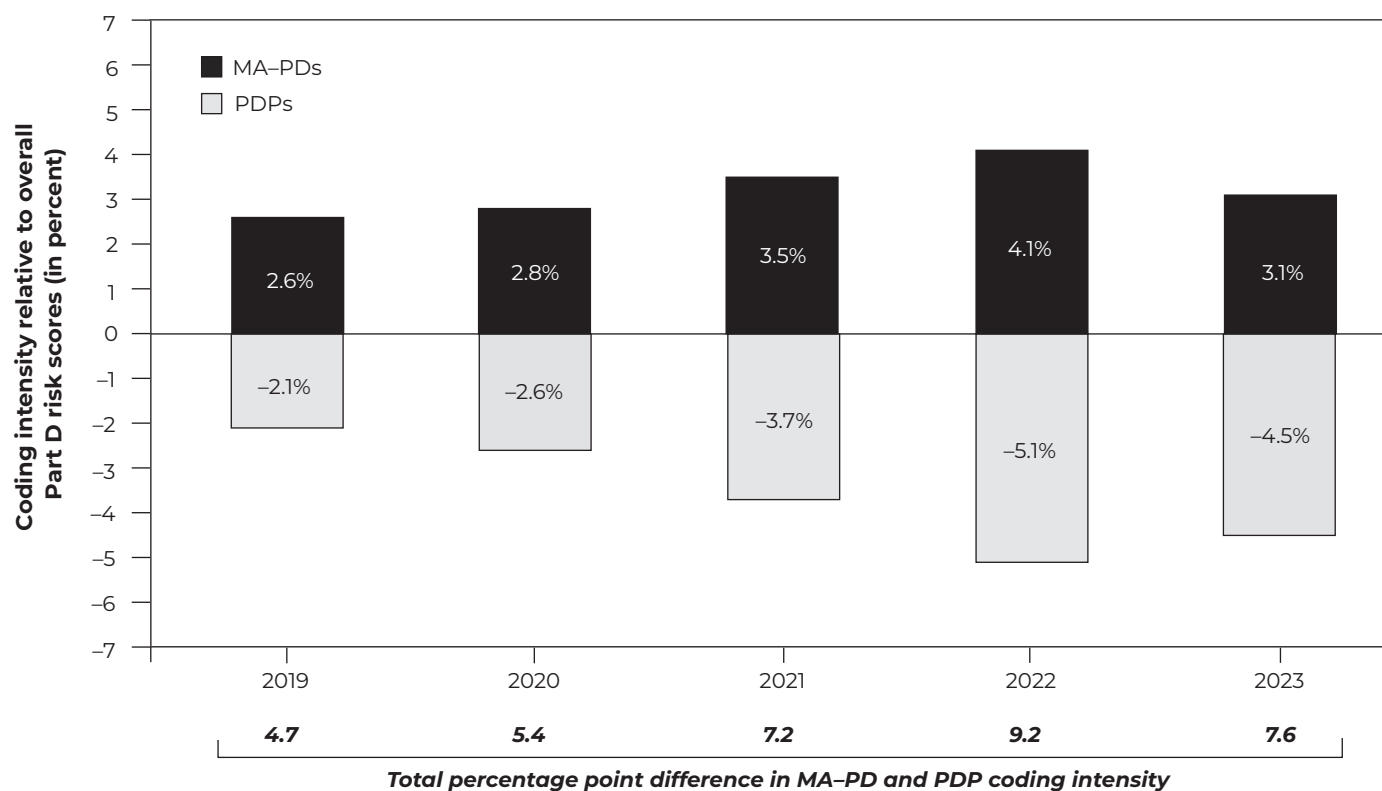
differences in the MA-PD and PDP markets. Starting in 2025, separate MA-PD and PDP normalization factors are intended to eliminate the risk-score differences between MA-PD and PDP markets, but differences in coding intensity across plans within each market will remain and can have similar effects on plan payments and enrollee premiums.

We illustrate how coding differences mechanically affect plan bids and enrollee premiums using a hypothetical example in which we assume that higher coding intensity by Plan A results in an average risk score for that plan that is 10 percent higher (a risk score of 1.10) than the overall average (Table 4-3, p. 214). Because the RxHCC is normalized to 1.0 across both plans, the average risk score for Plan B would necessarily be lower than 1.0 (in this example, 0.90). For simplicity, we also assume that the average expected basic-benefit cost per enrollee is the same (\$50) for both Plan A and Plan B. Risk-standardized plan bids (standardized to a 1.0 risk score) are then equal to the average expected cost divided by the average risk score, or \$45 and \$56 for Plan A and Plan B, respectively.

CMS calculates the national average monthly bid amount (NAMBA) as the enrollment-weighted average

**FIGURE
4-23**

Estimated impact of coding intensity on Part D risk scores was positive for MA-PDs and negative for PDPs, 2019–2023



Note: DECI (demographic estimate of coding intensity), MA-PD (Medicare Advantage prescription drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA-PDs. In this figure, “MA-PD” includes both conventional MA-PDs and special-needs plans. All estimates account for any differences in age, sex, low-income subsidy eligibility, and institutional status between MA-PD and PDP enrollees. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding.

Source: MedPAC analysis of CMS enrollment and risk-score files.

of the standardized bid across all Part D plans. The NAMBA is used to set the base beneficiary premium (BBP), which reflects the enrollees’ share of the total basic-benefit cost, including reinsurance. The risk-standardized plan bid (RSPB) is calculated by dividing the average expected basic benefit cost by the average risk score. In this example, \$50 divided by 1.10, or \$45, would be Plan A’s RSPB and \$50 divided by 0.90, or \$56, would be Plan B’s RSPB.

A plan’s enrollee premium and direct-subsidy amounts are both affected by the plan’s risk score. This is because the RSPB is the basis for calculating both the premium and the direct-subsidy amount:

Enrollee premium

$$\begin{aligned}
 &= \text{BBP} + (\text{RSPB} - \text{NAMBA}) \\
 &= \$30 + (\$45 - \$51), \text{ or } \$25, \text{ for Plan A} \\
 &= \$30 + (\$56 - \$51), \text{ or } \$35, \text{ for Plan B}
 \end{aligned}$$

Direct subsidy per enrollee

$$\begin{aligned}
 &= \text{RSPB} \times \text{average risk score} - \text{premium} \\
 &= \$45 \times 1.10 - \$25, \text{ or } \$25 \text{ for Plan A} \\
 &= \$56 \times 0.90 - \$35, \text{ or } \$15 \text{ for Plan B}
 \end{aligned}$$

**TABLE
4-3**

Hypothetical example of the effects of coding difference on plan payments and profitability

	All Part D			
	Plan A	Plan B	Overall average amounts	
Average expected basic benefit cost per enrollee (plan bid)	\$50	\$50	\$50	
Part D market share	50%	50%	100%	
Average risk score	1.10	0.90	1.00	
Plan bid standardized to a 1.0 risk score (RSPB)	\$45	\$56	NAMBA	\$51
Enrollee premium	25	35	BBP	30
Direct subsidy per enrollee (RSPB × average risk score – premium)	25	15	21	

Note: RSPB (risk-standardized plan bid), NAMBA (national average monthly bid amount), BBP (base beneficiary premium). Under Part D, basic benefits offered by plans must use the standard benefit defined in law or, if using an alternative benefit structure, must be actuarially equivalent to the standard benefit. A plan bid reflects the plan's average expected cost of providing the basic benefit to their enrollees. "Direct subsidy" is a capitated payment made by Medicare to Part D plans, calculated as a share of the national average of plan bids. This example assumes that neither plan faces any reinsurance. Figures are rounded to the nearest whole number.

That is, because of higher coding intensity, the enrollee premium for Plan A is \$25, or \$10 below the premium for Plan B, which is \$35. For the direct-subsidy calculation, higher coding intensity translates to \$10 in higher direct-subsidy amounts for Plan A (\$25) compared with Plan B (\$15).

The IRA redesign may amplify the effects of current policies and other differences between PDPs and MA-PDs

Financing of Part D's prescription drug spending is divided between spending paid in premiums (including the portion subsidized by Medicare) and costs paid either OOP by beneficiaries or by Medicare's LIS at the point of sale when beneficiaries fill their prescriptions.³⁵ The Medicare program subsidizes premiums through the capitated direct subsidy and through cost-based reinsurance for a portion of spending above the annual OOP threshold. Importantly, plans serve as a pass-through for these payments, retaining a portion of them for their administrative costs and profits. The ultimate costs of prescription drug spending are borne by beneficiaries through their monthly premiums and cost sharing when they fill prescriptions and by taxpayers through Medicare's subsidies.

One key change made by the IRA concerns the shift in financing of prescription drug spending from cost sharing paid by beneficiaries when they fill prescriptions to premiums (paid by enrollees and Medicare). That shift was largely achieved by imposing an annual limit on cost sharing paid by beneficiaries. To the extent that the annual OOP cap induces greater utilization of drugs, that would put upward pressure on premiums. (The uncertainty around the magnitude of that utilization effect may account for some of the variation in bids submitted by Part D plans.)

Shift toward premium financing does not, by itself, imply that beneficiaries are paying more in total for prescription drugs. It largely represents a shift from cost sharing paid at the POS to premiums paid by all enrollees (and subsidized by Medicare). This change effectively spreads costs from a small number of beneficiaries with high drug spending to the broader Part D population and to taxpayers who subsidize Part D's benefit costs. In fact, due to the manner in which the IRA and the subsequent demonstration (discussed below) capped enrollees' share of increases in premiums, in 2025, average enrollee premiums were expected to remain stable (Centers for Medicare & Medicaid Services 2024a). At the same time, as a result of changes

**TABLE
4-4****Changes in Part D national average monthly bid amount, base premium, and average subsidies, 2024–2025**

	2024	2025	Change (in percent)
Total expected basic-benefit cost	\$154	\$220	42%
National average monthly bid amount	64	179	179
Medicare's average expected reinsurance	90	40	–55
Base beneficiary premium	35	37	6
Uncapped BBP	39	56	42
Medicare's total subsidy	120	183	53
Medicare's average direct subsidy	30	143	382

Note: BBP (base beneficiary premium). Under Part D, basic benefits offered by plans must use the standard benefit defined in law or, if using an alternative benefit structure, must be actuarially equivalent to the standard benefit. Medicare subsidizes the costs of Part D's basic benefits through direct subsidy (a capitated payment to plans calculated as a share of the adjusted national average of plan bids) and individual reinsurance (a cost-based payment to plans for a portion of drug spending above the annual out-of-pocket limit). Medicare's total subsidy is the amount of total expected basic-benefit costs that are paid by Medicare through these subsidies. Percentage changes were calculated on unrounded figures.

Source: CMS's annual release of Part D national average monthly bid amount and other Part C and Part D bid information.

made by the IRA, in 2025, cost sharing paid at the POS, particularly among those with high drug spending, is expected to decrease (Assistant Secretary for Planning and Evaluation 2024b).

Another key change made by the IRA shifted more of the insurance risk to plans by increasing the share of basic benefit costs that plans are paid on a capitated basis (Medicare's direct subsidy) while reducing the share that is paid based on actual costs (Medicare's reinsurance). This change, combined with the shift toward premium financing described above, heightens the importance of Part D's risk adjustment for determining accurate plan premiums and subsidies.

As we describe below, the increase in bids for 2025 (relative to the 2024 average bid amount) is significantly larger than the amount CMS expected based on changes made by the IRA. In 2023, CMS estimated that the IRA changes will roughly double gross plan liability, and many, including CMS, expected Part D's risk adjustment to take on much greater importance (Centers for Medicare & Medicaid Services 2023, Robb et al. 2024). Some of the increase can largely be explained by higher-than-expected spending growth in 2023 and thus

preceded the planned implementation of the benefit design in 2025 (Congressional Budget Office 2024, Medicare Payment Advisory Commission 2025).

At the same time, the IRA's changes may further amplify the diverging trends between MA-PDs and PDPs that arise from certain aspects of MA and Part D policies and other differences between the two markets. Because MA-PDs have additional tools, including MA rebates and higher coding intensity, available to lower enrollee premiums, the Part D redesign may make MA-PDs relatively more attractive to beneficiaries and contribute to the ongoing shift from FFS to MA.

For 2025, Medicare's average direct subsidy rose by nearly fivefold to \$142.67, up from just under \$30 in 2024 (Centers for Medicare & Medicaid Services 2024b).³⁶ As described above, the NAMBA, which is used to determine the level of Medicare's capitated direct subsidy for the Part D benefit and the premiums enrollees will pay, rose by nearly 180 percent, while expected reinsurance declined by 55 percent (Table 4-4).

The announcement of the national average bid amount was accompanied by the unveiling of a new voluntary

Risk corridors used for participating PDPs under the Part D Premium Stabilization Demonstration

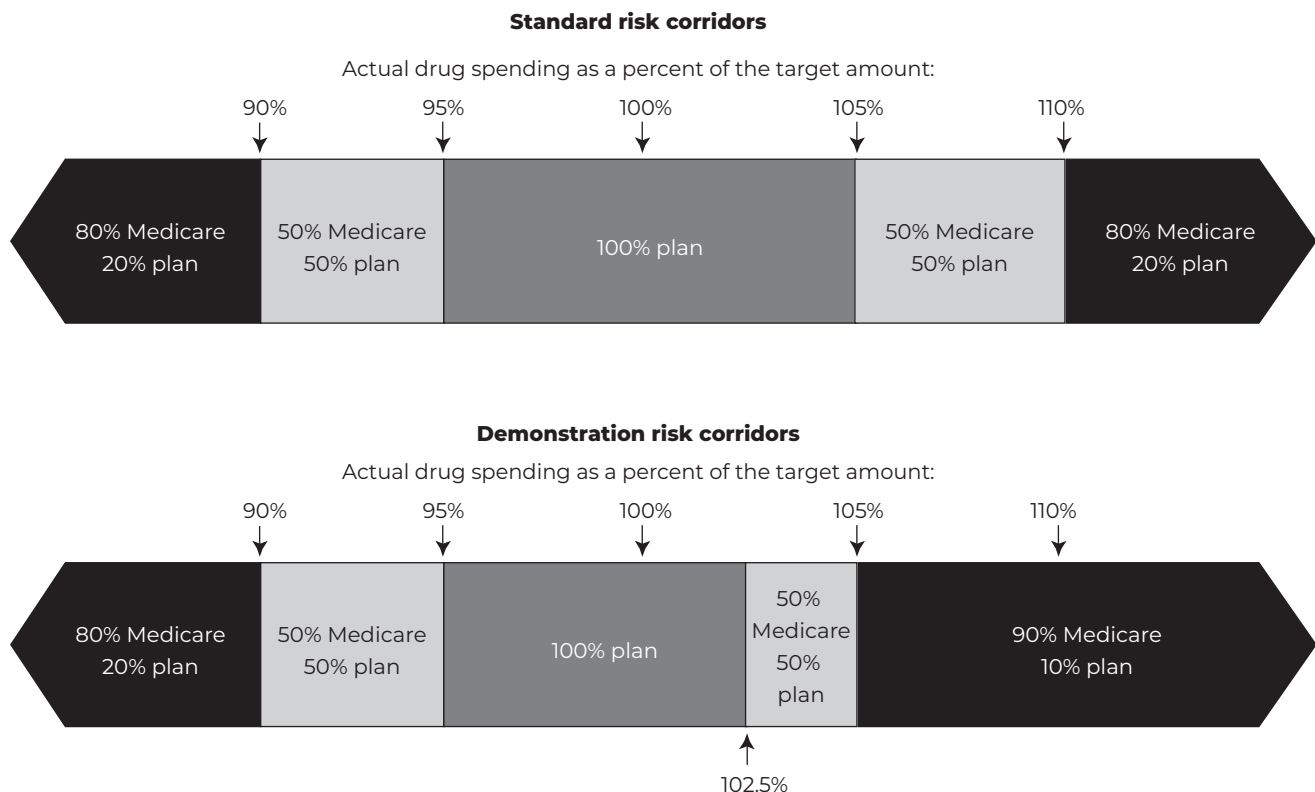
One of the mechanisms Part D uses to share the insurance risk that plans bear is through a protection provided by Part D's risk corridors. Risk corridors limit a plan's overall losses or profits (beyond the amounts assumed in plan bids) by financing some of the higher-than-expected costs (or recouping excessive profits). The "standard" risk corridors are symmetric in that the same thresholds and risk-sharing percentages apply to both losses and profits (Figure 4-24).

For example, if a plan's costs are between 5 percent and 10 percent above the target amount (TA), the losses incurred in the risk corridors are split 50/50 between Medicare and the plan (i.e., Medicare makes payments to the plan for 50 percent of the losses incurred above 105 percent of the TA). Similarly, if costs are between 5 percent and 10 percent below the plan's TA, Medicare recoups 50 percent of the excess profits.

(continued next page)

**FIGURE
4-24**

Risk corridors under the Part D Premium Stabilization Demonstration differ from the standard risk corridors



Note: "Target amount" is equal to the plan bid minus administrative costs and profits. Risk corridors limit a plan's overall losses or profits (beyond the amounts assumed in plan bids) by financing some of the higher-than-expected costs or recouping some of the excessive profits.

Source: MedPAC depiction of Part D's risk corridors.

Risk corridors used for participating PDPs under the Part D Premium Stabilization Demonstration (cont.)

Risk corridors that apply to stand-alone prescription drug plans (PDPs) participating in the Part D Premium Stabilization Demonstration (“the demonstration”) are different from the standard risk corridors in that they provide more generous protection from losses while maintaining the same risk-sharing thresholds and percentages for profit sharing. For losses, plans are at full risk (i.e., 100 percent of the cost) for costs up to 2.5 percent above their TAs, rather than up to 5 percent above their TAs under the standard risk corridors. In addition,

under the demonstration, Medicare will reimburse plans for 90 percent of the losses above 105 percent of their TAs, instead of the 50 percent that applies for losses between 105 percent and 110 percent of the TA and 80 percent above 110 percent of the TA under the standard risk corridors. These changes to the risk corridors are expected to increase Medicare’s costs because Medicare will finance more of the losses while allowing plans to keep a larger share of their profits (relative to the share of losses they assume) in the risk corridors. ■

nationwide demonstration, the Part D Premium Stabilization Demonstration for 2025, which would reduce monthly enrollee premiums for participating PDPs by up to \$15 (Centers for Medicare & Medicaid Services 2024b). The demonstration requires participating PDPs to limit the annual increase in their total monthly premiums (i.e., the sum of the Part D basic and Part D supplemental premiums) to no more than \$35 and provides more generous protection from losses under Part D’s risk corridors (see text box on the risk corridors used under the demonstration). The Congressional Budget Office expects that the additional subsidies paid to PDPs under the demonstration would increase federal spending for Part D by roughly \$5 billion in 2025 (Swagel 2024).

According to CMS, all PDPs (with the exception of 36 EGWPs) are participating in the demonstration, which has kept the average PDP premiums stable (with a slight decrease in the average total monthly premiums of \$1.63 for PDPs) (Centers for Medicare & Medicaid Services 2024a).³⁷ The average total monthly premiums for MA-PDs (after the application of MA rebates) also declined (by \$2.06), which is notable because MA-PDs were not eligible to participate in the premium stabilization demonstration. Even with the demonstration, average monthly premiums for PDPs remained substantially above those of MA-PDs.

Further, some have raised concerns about how increased plan liability under the redesigned benefit will affect plan formularies. In particular, some have argued that because PDPs will be under greater financial pressure (without MA rebates to help finance the increased basic benefit costs), they may respond by changing benefits and formularies to make their plans less generous (Axelsen 2024, Manatt 2024). This consequence, in turn, may affect both plan participation and beneficiary enrollment in the PDP market.

Our analysis of changes in formularies under the first year of the redesigned benefit shows a general tightening of plan formularies for both PDPs and MA-PDs. The magnitude of average changes, however, appears to be generally consistent with the trends over the last several years, in which we have observed a general uptick in the use of coinsurance on brand-name drugs as well as in the use of utilization-management tools. As a result, it is difficult to determine the extent to which the benefit redesign has accelerated the trend toward tighter formularies. ■

Endnotes

- 1 As a result of the changes made by the IRA, beginning in 2024, the annual increase in the base premium is limited to no more than 6 percent. When this provision is binding (as has been the case in 2024 and 2025), the beneficiary's share of Part D benefit costs is less than 25.5 percent; as a result, Medicare's subsidy rate can be higher than the 74.5 percent specified in law.
- 2 See Endnote 1.
- 3 See Endnote 1.
- 4 Between 2006 and 2010, the average number of stand-alone PDPs offered per region ranged from 42 to 55.
- 5 MA-PDs may vary based on either the medical or drug coverage they offer, as well as the supplemental benefits provided under MA. Thus, the figure for the number of MA-PD offerings may not reflect the number of truly unique drug coverage options, but rather the various combinations of different medical and drug benefits that are covered.
- 6 The five largest firms operating in the Part D market in 2024 included UnitedHealth Group, Centene, Humana, CVS Health, and Elevance Health. In 2014, the five largest firms included the three insurers that were among the largest in 2024 (UnitedHealth Group, Humana, and CVS Caremark). The other two were Aetna, which was subsequently acquired by CVS Health, and WellCare Health Plans, which was acquired by Centene in 2020. The analysis excludes employer group waiver plans, which are open only to retirees of the employers that sponsor such plans.
- 7 In 2024, the five largest firms (in each PDP region) accounted for 80 percent of the region's total conventional MA-PD and SNP enrollment in 21 and 25 PDP regions, respectively, up from 19 and 13 PDP regions, respectively, in 2014.
- 8 The HHI approaches zero when a market is occupied by a large number of firms of relatively equal size and reaches its maximum of 10,000 points when a market is controlled by a single firm. The U.S. Department of Justice generally considers markets in which the HHI is between 1,000 and 1,800 points to be moderately concentrated and considers markets in which the HHI is in excess of 1,800 points to be highly concentrated (Department of Justice and Federal Trade Commission 2023).
- 9 The definition of a firm used here (11 firms in 2024 and 7 firms in 2025) differs from the definition used for reporting the number of sponsoring organizations in the market-concentration analysis above, which is based on unique counts of parent organizations that sponsor Part D plans, as reported to CMS in the Part C and Part D data submissions.
- 10 Because of the salience of the premiums in choosing among Part D plan options, beneficiaries may not always choose a Part D plan that is the "best option" for them from the financial perspective when considering out-of-pocket costs, including premiums and cost-sharing liabilities (Abaluck and Gruber 2011).
- 11 The average Part D premium for PDPs reflects the effects of the Part D Premium Stabilization Demonstration, which provided additional subsidies to limit the annual increase in premiums for individual PDPs in 2025. It does not, however, reflect the effects of any enrollment changes for the 2025 benefit year.
- 12 Part D law includes a contingency plan to ensure that FFS beneficiaries have a minimum of two Part D options (which may not be offered by the same plan sponsor) and must include at least one PDP, which would by default qualify as a benchmark plan. When that minimum requirement is not met in any given region, the law allows the Secretary to approve plan(s) that administer Part D's prescription drug benefit without taking insurance risk (or assuming only limited insurance risk).
- 13 At least seven of these regions included among their two benchmark plans a PDP that was terminated effective December 31, 2024, after being under CMS sanction for failing to maintain a Part D summary plan-rating score of at least 3 stars. Plans that are under CMS sanction may not receive auto-enrollment of LIS beneficiaries.
- 14 The range for the share of enrollees with the LIS reflects the 10th and 90th percentiles of the distribution.
- 15 TAs exclude administrative costs and profits that are assumed in bids. The profits that are recouped under Part D's risk corridors are a portion of "excess" profits that plans made above and beyond the amounts assumed in bids.
- 16 The overall average TA dropped from about \$70 per month in 2012 to just under \$30 per month in 2022. On average, plans with lower TAs were more likely to have risk-corridor losses compared with plans that had higher TAs. This pattern was generally true for all plan types.
- 17 For MA plans, the addition of the prescription drug benefit may allow for more targeted selection by "setting generous

cost-sharing rules for drugs taken by beneficiaries that tend to have below-average medical expenses conditional on their diagnosis” (Han and Lavetti 2017). Lavetti and Simon show that MA plans design drug formularies that are significantly different from stand-alone Part D plans in ways that encourage advantageous selection (with respect to HCCs) (Lavetti and Simon 2018).

- 18 MA plans can also use rebates to reduce cost sharing for Part A and Part B services, cover services not covered by Medicare (including dental, vision, and hearing services), or reduce beneficiaries’ Part B premiums.
- 19 The sponsors of MA-PDs may decrease or increase Part D supplemental premiums to adjust for excessive or insufficient rebate allocation to achieve the target amount for their Part D basic premiums. However, sponsors may not make any other modifications to the benefit design, pricing of the Part D basic benefit, the supplemental benefit, administrative costs, or margin that is built into their initial bids. Limited changes may be allowed to the supplemental benefit if the total Part D premium would be negative without such change (according to Appendix E of the Instructions for Completing the MA BPT for Contract Year 2025).
- 20 GLP-1 products included in the analysis by the Department of Health and Human Services’ Office of Inspector General included both self-injectable drugs (Ozempic and Mounjaro) and oral medication (Rybelsus).
- 21 Part C’s star-rating system for Medicare Advantage plans includes a measure of how well blood sugar level is controlled among enrollees with diabetes. Because a plan’s performance on Part C’s star-rating measures directly affects bonus payments that plans receive under the quality-bonus program, MA-PDs may have different incentives for covering GLP-1 medications than PDPs.
- 22 Before 2023, average gross plan cost for LIS enrollees in MA-PDs and PDPs was nearly identical, differing by one dollar or less in most years. In 2023, however, spending grew more rapidly among MA-PD enrollees, resulting in a difference in the average gross plan liability exceeding \$8 per enrollee per month. In contrast, for enrollees without the LIS, because the average gross plan liability among enrollees in MA-PDs had been consistently below that of PDP enrollees before 2023, the faster growth in spending among the MA-PD enrollees in 2023 has resulted in a narrowing of the difference in spending between MA-PD and PDP enrollees (from nearly \$20 in most years to \$12 in 2023).
- 23 SNPs were excluded because they are much more likely to use the defined standard benefit that uses 25 percent coinsurance for all products rather than multiple tiers with varying cost-sharing rates; further, most SNP enrollees receive the LIS and are therefore required to pay only nominal copay amounts set in law, making any cost-sharing differentiations that do exist less likely to influence beneficiary choice of product relative to beneficiaries without the LIS.
- 24 Specifically, a product was assigned to the lowest tier to which at least one national drug code of a product was placed on a plan’s formulary.
- 25 These 20 products, in order of total gross drug costs, include Ozempic, Mounjaro, Trulicity, Revlimid, Humira Pen, Biktarvy, lenalidomide, Jakafi, Xtandi, Ingrezza, Invega Sustenna, Enbrel SureClick, Rybelsus, Creon, Dupixent, Rinvoq, Xifaxan, Vraylar, Otezla, and abiraterone. For this analysis, different strengths of a drug are considered together such that a “product” is defined as all drugs with the same active ingredient, route of administration, dosage form, and brand name.
- 26 Products selected for negotiation among this subset include Enbrel, which was selected for negotiation in 2026, and Ozempic, Rybelsus, Otezla, Vraylar, Xifaxan, and Xtandi, which were selected for negotiation in 2027.
- 27 In 2024, among these 20 products, Revlimid and Ingrezza had average coverage rates below 90 percent among MA-PDs; in 2025, average coverage rates for Enbrel SureClick and Otezla also dropped below 90 percent among MA-PDs.
- 28 In 2024, the three products with average coverage rates below 90 percent for PDPs were Revlimid, Ingezza, and Creon; in 2025, coverage rates among PDPs also fell below 90 percent for Trulicity, Humira Pen, Rybelsus, Enbrel SureClick, and Otezla.
- 29 Creon had no UM among PDPs and a very small share of plans applying ST among MA-PDs (affecting 2 percent to 3 percent of MA-PD enrollees).
- 30 For this analysis, different strengths of a drug are considered together such that a “product” is defined as all drugs with the same active ingredient, route of administration, and dosage form.
- 31 These products accounted for more than 160,000 fills and \$1.6 billion in total gross drug costs among MA-PDs and 156,000 fills and \$1.7 billion in total gross drug costs for PDPs during the first half of 2024.
- 32 Both MA encounter and FFS claims data are used for beneficiaries who switch between MA and FFS enrollment during a calendar year. MA encounter records are submitted

by plans and contain information about Medicare-covered services that an enrollee receives from a health care provider. CMS conducts risk-adjustment data validation audits to ensure that diagnoses recorded in the encounter data are supported by evidence in the patient's medical record, but the scope of the audits has been limited so far.

- 33 The analysis compared the version of the RxHCC model (V05) used between 2017 and 2022 and the new version of the RxHCC model in use since 2023 (V08) to the version(s) of the CMS-HCC models used in each of the corresponding years between 2019 and 2023.
- 34 “Gross plan costs” refers to all gross drug spending covered under Part D’s basic benefit—excluding reinsurance payments—before the application of postsale rebates and discounts. The RxHCC model has five segments for continuing enrollees (community non-low-income beneficiaries ages 65 and over, community non-low-income beneficiaries under age 65, community low-income beneficiaries ages 65 and over, community low-income

beneficiaries under age 65, and beneficiaries who live in institutions) and three segments for new enrollees (low-income beneficiaries, non-low-income beneficiaries, and beneficiaries who live in institutions). CMS estimates a separate set of coefficients for each model segment.

- 35 Pharmaceutical manufacturers also pay for a portion of prescription spending through mandatory discounts (Medicare Payment Advisory Commission 2024b).
- 36 The IRA policy to cap the annual increase in the BBP to no more than 6 percent limited the BBP for 2025 to \$36.78 rather than \$55.98. When the 6 percent cap is binding, as has been the case for 2024 and 2025, the policy automatically increases Medicare’s subsidy rate. (Based on the data released in July 2024, the subsidy rate would be 83 percent in 2025, rather than the 74.5 percent specified in law.)
- 37 CMS calculated the average premium across Medicare beneficiaries who pay full premiums (i.e., the average excludes over 14 million beneficiaries who receive the LIS).

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C H A P T E R

5

Medicare beneficiaries in nursing homes

Medicare beneficiaries in nursing homes

Chapter summary

About 1.2 million beneficiaries live in nursing homes (NHs) due to functional and/or cognitive impairments that prevent them from living in the community. Compared with other beneficiaries, this group is older and has higher medical costs. Medicare's coverage of NH care is largely limited to coverage of short-term skilled care after a hospitalization, although Medicare covers other services received by beneficiaries living in nursing homes, such as physician and ancillary services (e.g., lab tests and physical therapy). More than 80 percent of Medicare beneficiaries in NHs are also covered by Medicaid, the predominant payer for NH care.

In 2023, there were about 15,000 nursing homes nationwide. Nearly all NHs operate as both nursing facilities that provide long-term care and as skilled nursing facilities (SNFs) that provide short-term skilled care. The industry is characterized by independent providers and regional chains. The industry reports an average low profit margin across all payers (0.4 percent in 2023), but that average margin may be understated due to the ways some NHs report their payments. The reported average profit margin on Medicare-covered SNF care is much higher, at 22 percent in 2023.

The quality of care provided to many NH residents is a long-standing problem that has been well documented. The National Academies have

In this chapter

- Overview of nursing home residents and the nursing home industry
- Challenges to improving care for beneficiaries living in nursing homes
- Regulatory requirements for nursing home survey and certification and staffing
- CMS's quality programs for nursing homes
- FFS payment policies aimed at improving quality in nursing homes
- Institutional special-needs plans

described the financing, delivery, and regulation of NH care as “ineffective, inefficient, fragmented, and unsustainable.” Among other problems, NHs have a financial incentive to hospitalize residents so they qualify for Medicare-covered SNF care (for residents who have Medicare coverage), and Medicaid’s base payment rates often do not cover the cost of care.

NHs are subject to regular quality and safety inspections, but evaluations have concluded that these inspections, for a variety of reasons, sometimes fail to identify serious quality problems and may not lead to effective and sustained corrections. To encourage NHs to improve their care, CMS publicly reports a star rating for each NH, which evaluators have found modestly helps consumers select NHs with higher ratings and encourages NHs to improve. However, when a beneficiary needs NH care, a higher-rated facility may not have an available bed or be willing to admit a Medicaid-funded stay (or a stay that is likely to become one).

Medicare has made a variety of efforts to improve care for beneficiaries in NHs. In fee-for-service (FFS) Medicare, the payment system for SNF care includes a value-based purchasing (VBP) program that raises or lowers payment rates to SNFs based on their quality performance. In 2021, the Commission examined the design of this program and recommended that it be replaced. Since then, CMS has made several improvements that address some of the issues raised by the Commission, but the VBP program still has other important design flaws that would require congressional action to correct. We and others have noted that the size of the VBP incentives may be too small to change behavior. Accountable care organizations (ACOs)—groups of providers that agree to bear financial risk for meeting spending and quality targets for their assigned FFS beneficiaries—generally are not designed to focus on beneficiaries in NHs, although one type of ACO, the High Needs ACO, focuses on beneficiaries with complex medical conditions, including those in NHs. However, High Needs ACOs are few, numbering just 13 in 2024. Thus, the Commission has not focused on ACOs as a way to influence care for NH residents.

In the Medicare Advantage program, institutional special needs plans (I-SNPs) are specialized plans that serve beneficiaries who need NH care. I-SNPs now cover about 12 percent of Medicare NH residents. These plans aim to reduce the use of expensive services such as inpatient care (which is often disorienting for residents) by using teams of physicians and nurse practitioners to deliver more preventive and coordinated care within the NH and reimbursing NHs in ways that encourage facilities to deliver more care on-site. The available

evidence suggests that I-SNPs reduce the use of inpatient care and emergency department visits and perform better on some quality measures. However, the evidence base is still somewhat limited and there is little information on important areas such as patient experience. Enrollment in I-SNPs has been growing, but their ultimate reach may be limited because insurers may not want to contract with all NHs, some NHs may not want to participate in an I-SNP (in some cases due to the financial incentives in traditional Medicare to hospitalize residents), and many beneficiaries who have access to I-SNPs do not enroll.

The Commission may consider future work in two areas. First, building on the modest success of the star ratings and the clear relationships between NH staffing and quality, new work could examine alternative designs that would elevate the role of staffing in calculating the overall rating of NHs. Second, given the low enrollment of beneficiaries in I-SNPs despite the evidence of the model's success, new work could examine factors that limit the use of I-SNPs and consider potential policy changes that encourage the broader use of I-SNPs and reduce barriers to expansion, while enabling more rigorous measurement and oversight of I-SNPs. ■

About 1.2 million Medicare beneficiaries live in nursing homes (NHs) due to functional and/or cognitive impairments that prevent them from living in the community. Medicaid finances most NH care, but Medicare does provide limited coverage of skilled care following a hospitalization.

NH residents have significant care needs, but there are long-standing concerns about the quality of care that many of them receive. Numerous studies by the National Academies (and its predecessor, the Institute of Medicine), the Office of Inspector General (OIG), and the Government Accountability Office (GAO) have documented quality problems and the shortcomings of efforts to correct them. The poor quality furnished by many NHs is partly the result of low Medicaid base payment rates that often do not cover the cost of care. In addition, NHs have a financial incentive to send long-stay residents, especially dual-eligible beneficiaries, to the hospital for inpatient care or emergency care (which are both covered by Medicare) instead of treating them in place, thereby shifting the cost of care to other providers. Further, when beneficiaries return to the NH after a hospital stay, the NH can receive higher Medicare rates if the beneficiaries meet coverage rules. While many hospitalizations and emergency department visits are appropriate, some may not be, and all are disorienting for these vulnerable beneficiaries.

In this chapter, we provide an overview of the long-stay NH population, the NH industry, and the major challenges facing this sector. We then review federal nursing home regulations and staffing requirements that establish minimum standards of care. Next, we turn our attention to programs that CMS has implemented to improve NH quality, including the Quality Reporting Program (QRP), NH Compare 5-star ratings, and the Quality Improvement Organization (QIO) Program. We also discuss fee-for-service (FFS) Medicare policies aimed at improving quality, including the skilled nursing facility (SNF) value-based purchasing (VBP) program and accountable care organizations (ACOs). Finally, we consider specialized Medicare Advantage (MA) plans known as institutional special-needs plans (I-SNPs). We find that some of the regulations and quality programs have had modest success at identifying quality problems or improving the care of NH residents, while others have not. Overall, the efforts have fallen short, and the quality of care provided to many beneficiaries living in NHs remains a serious concern.

Overview of nursing home residents and the nursing home industry

Nursing homes provide services such as 24-hour medical and skilled nursing care, rehabilitation services, meals, and assistance with activities of daily living. Nearly all NHs operate as both nursing facilities (NFs), where they provide lower-intensity routine nursing care (often referred to as “custodial care”) for individuals with functional and/or cognitive impairments, and as SNFs, where they provide short-term skilled care following a hospitalization.

For long-stay residents, NH services that are considered long-term care—room and board services, routine nursing care, and assistance with activities of daily living—are largely covered by Medicaid or residents’ out-of-pocket payments. NHs may also provide a variety of medical services, such as physical and respiratory therapies, lab tests, and X-rays, that are covered by Part B.

Medicare does not cover long-stay NH care but does pay for short-term skilled care after a hospitalization. When a NH resident is hospitalized for at least three consecutive days, Medicare covers post-acute care (PAC) for up to 100 days per spell of illness if the beneficiary requires daily skilled nursing or rehabilitation services.¹ (Medicaid may cover skilled care for beneficiaries who do not meet Medicare coverage rules or who have exhausted Medicare’s benefit.) Thus, long-stay residents can shift back and forth between receiving short-term skilled care following a hospital stay, and once discharged from that care, receiving less intensive long-stay care. In addition, Medicare covers hospice care for beneficiaries who have opted to enroll in that benefit. Hospice enrollees are not eligible for any services that treat their terminal condition (such as Part A-covered SNF care), but they can be covered for care that is unrelated to their terminal condition.

The three-day requirement dates back to the beginning of the Medicare program in 1965. It was established to ensure that SNF care was a continuation of acute medical treatment and not long-stay care. While the requirement may distort stays (by, for example, extending some hospital stays unnecessarily to ensure SNF coverage), it helps prevent the current SNF post-acute benefit from

expanding into a long-term care benefit. In 2015, MedPAC recommended that the Congress revise the rule to allow up to two days spent in outpatient observation care to count toward the requirement (Medicare Payment Advisory Commission 2015).

Physicians are also required to visit NH residents on a regular basis. A physician must visit each long-stay resident within 30 days of admission, every 30 days for the first 90 days, and every 60 days thereafter. Other clinicians, such as nurse practitioners, may also visit long-stay residents, but their visits cannot replace the required physician visits. The same visit requirements also apply to residents who are receiving short-term skilled care, but there is more flexibility about the use of other practitioners. In those cases, visits by a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS) can substitute for physician visits on an alternating basis. In 2025, 27 states plus the District of Columbia had granted full practice authority to NPs, allowing them to perform the required physician visits (American Association of Nurse Practitioners 2025). Physician and other clinician services and ancillary services (such as lab tests and physical therapy) are covered by Medicare as long as the services meet coverage rules.²

Long-stay residents differ from other beneficiaries in many respects

Long-stay NH residents (defined as those who have been in a NH for more than 90 days) make up a relatively small share of the Medicare population (Table 5-1).³ In 2023, 1.2 million beneficiaries—about 1.7 percent of the total—were long-stay residents for at least one month of the year. Between 2013 and 2023, the long-stay population dropped in both absolute terms, from 1.4 million to 1.2 million, and as a share of the Medicare population, from 2.6 percent to 1.7 percent (data not shown).⁴ The number of beneficiaries who are long-stay residents at a given point in time is lower because many residents do not live in the NH for the entire year; for example, in July 2023, there were about 840,000 long-stay residents.

As would be expected, in 2023 long-stay residents tended to be older, with a median age of 81 compared with 72 for other beneficiaries, and nearly a quarter of long-stay residents were 90 or older. Consistent with their older age profile, long-stay residents were

more likely than other beneficiaries to be female (62 percent vs. 54 percent). The long-stay population was also more likely to be Black and less likely to be Hispanic or Asian.

Long-stay residents were far more likely than other beneficiaries to have Medicaid coverage (82 percent vs. 14 percent), reflecting that program's role as a major payer for NH care. (We discuss Medicaid's role in more detail below.) Beneficiaries who qualify for both Medicare and Medicaid are commonly referred to as “dually eligible beneficiaries.”

Long-stay residents were also more likely to live in rural areas (24 percent vs. 18 percent), in part because alternatives to NH care, such as home health aides, personal care attendants, and assisted living facilities, were less available in those areas.

The long-stay population has much higher mortality rates: In 2023, 24 percent of long-stay residents died during the year, compared with 3 percent of other beneficiaries. The mortality rate for long-term residents spiked during the coronavirus pandemic, reaching 33 percent in 2020, but it has otherwise ranged between 24 percent and 25 percent over the past decade.

Although long-stay residents must, under our definition, be in a nursing home for at least 90 days, their length of stay can vary considerably. In 2023, the median length of stay was 26 months, or a little more than two years. However, about a quarter of these beneficiaries had been in a NH for less than a year, while a fifth had been in a NH for more than five years. Women tended to have longer stays, on average, than men (3.7 years compared with 2.2 years) (Administration for Community Living 2024). Relatively few long-stay residents are discharged back to the community, so length of stay effectively measures how long these beneficiaries live in a nursing home at the end of their lives. Given how we defined the long-stay population for this analysis, it is worth noting that a beneficiary's stay can include periods in which they receive short-term skilled care, periods in which they receive long-stay care, and periods in which they are in the hospital.

Long-stay residents also tend, on average, to have much higher medical costs. In 2022, among beneficiaries enrolled in FFS Medicare, average

**TABLE
5-1****Medicare beneficiaries who were long-stay nursing home residents differed from other beneficiaries in several respects, 2023**

Characteristic	Long-stay nursing home residents	Other beneficiaries
Number of beneficiaries (millions)	1.2	67.0
Median age (years)	81	72
Age distribution		
Under 65	10%	11%
65–69	8	22
70–74	13	24
75–79	15	19
80–84	16	12
85–89	16	7
90 and older	23	5
Sex		
Female	62	54
Male	38	46
Race		
White, non-Hispanic	74	73
Black	15	11
Hispanic	6	8
Asian	2	4
Other/unknown	2	4
Eligible for full Medicaid benefits	82	14
Residence		
Urban	76	82
Rural	24	18
Died during the year	24	3

Note: We classified beneficiaries as long-stay residents if they had at least one month during the year in which they had been in a nursing home for more than 90 days in total. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare administrative data.

annual program spending on Part A and Part B services was \$31,200 for long-stay residents, compared with about \$11,300 for other beneficiaries. Medicare's per capita spending on long-stay residents was thus almost three times as high as its spending on other beneficiaries in 2022.

Beneficiaries receiving long-stay care differ from those receiving skilled care

Beneficiaries in NHs include those living in the NH who need less intensive nursing care (generally, assistance with activities of daily living such as bathing or dressing) and those recuperating from a hospital

**TABLE
5-2**

Beneficiaries who received only long-stay care were generally more impaired than beneficiaries who received skilled care, October 1, 2023, through March 30, 2024

Characteristic	Long-stay residents		Community-dwelling beneficiaries receiving skilled care
	Receiving only long-stay care	Receiving skilled care	
Number of unique beneficiaries in analysis	1,169,317	571,502	80,226
Share of beneficiaries with:			
Bowel incontinence	62%	53%	42%
Urinary incontinence	62	43	33
Swallowing difficulty	5	22	19
Medically complex conditions	33	41	44
Dementia	53	24	18
Serious mental illness	20	9	6
Cognitive functioning:			
Intact cognition	39%	54%	59%
Moderate impairment	27	27	24
Severe impairment	34	19	17
Median motor score (maximum = 66; higher is better)	30	31	35

Note: Figures were calculated using the most recent assessment for each beneficiary from the Minimum Data Set (MDS) during the analysis period. "Serious mental illness" is defined as having bipolar disorder, a psychotic disorder, or schizophrenia. Cognitive functioning is measured using the Brief Interview for Mental Status (BIMS) test. BIMS scores between 0 and 7 indicate severe cognitive impairment, scores between 8 and 12 indicate moderate cognitive impairment, and scores between 13 and 15 indicate intact cognition. The motor score is a composite of 11 self-care and mobility items recorded in the MDS, including eating, oral hygiene, toileting hygiene, toileting transfer, showering/bathing, lower body dressing, transferring sit to lying, lying to sitting on edge of bed, sitting to stand, chair/bed-to-chair transfer, and walking 10 feet.

Source: MedPAC analysis of MDS data, fourth quarter of 2023 and first quarter of 2024.

stay and requiring daily skilled nursing or rehabilitation services. The majority of long-stay care is paid for by Medicaid and beneficiary out-of-pocket spending, while skilled care is typically covered by Medicare under certain circumstances (such as having a preceding hospital stay of at least three days). However, beneficiaries can shift back and forth between receiving short-term skilled care following a hospital stay and, once discharged from that care, reverting to long-stay care.

In this analysis, we used patient assessment data gathered in the Minimum Data Set (MDS) to compare beneficiaries who received care in NHs between October 1, 2023, and March 30, 2024 (the

first six months that uniform function items were gathered for all assessments). Both Medicare and Medicaid require NHs to use the MDS, which is an instrument that gathers information about patient and service characteristics at set intervals (such as at admission, quarterly, and annually) for both long-stay residents and short-stay patients receiving skilled care. We divided beneficiaries in NHs into three mutually exclusive groups: (1) long-stay residents who received only long-term care, (2) long-stay residents who received short-term skilled care after an acute hospitalization, and (3) community-dwelling beneficiaries who received short-term skilled care after an acute hospital stay.

Table 5-2 compares the shares of beneficiaries with selected impairments and their cognitive and motor scores across the three groups. The left column includes long-stay residents who did not receive any skilled care during the study period. The middle column reports the characteristics of long-stay residents during their posthospital skilled care stay. The right column includes community-dwelling beneficiaries who received short-term skilled care following a hospital stay. In making comparisons across the groups, it is important to keep in mind that some information gathered in the MDS is used to adjust payments and may create incentives for providers to record certain characteristics as worse than they are to boost payments. For example, the Medicare SNF payment system adjusts payments for functional status, depression, difficulty swallowing, and cognitive impairment. Although the case-mix classification systems used by Medicaid vary across states, most systems adjust payments for resident acuity (such as the use of special services, the presence of a limited set of clinical conditions, and functional status).

Long-stay residents who did not receive skilled care were, in most cases, more likely to have impairments compared with either group receiving skilled care. They were more likely to have bowel or urinary incontinence, dementia, and serious mental illness (defined as having bipolar disorder, a psychotic disorder, or schizophrenia). Among the two groups of beneficiaries receiving skilled care, long-stay residents had higher shares of these impairments and conditions compared with community-dwelling beneficiaries, indicating that this latter group was generally less impaired than the institutionalized group.

Interestingly, both groups of beneficiaries receiving skilled care were more likely to have difficulty swallowing compared with residents receiving only long-stay care. This contrast may be partly explained by the greater shares of beneficiaries with medically complex conditions (such as diabetes and chronic kidney disease) as the primary medical condition among the skilled care groups (41 percent and 44 percent vs. 33 percent for the long-stay care-only group). It is also possible that revisions to the case-mix system used to adjust Medicare's payments for skilled care created an incentive to record this impairment. The new case-mix system (which was implemented in October 2019) adjusts speech-language pathology

payments for related comorbidities such as difficulty swallowing. We have found that the share of SNF stays for patients with swallowing disorders increased from about 5 percent in fiscal year 2019 (prior to the new case-mix system) to 20 percent in fiscal year 2022. While most Medicaid case-mix systems for nursing home services adjust payments for resident characteristics, they do not include a separate payment for speech-language pathology services, for which swallowing disorders would be most relevant.

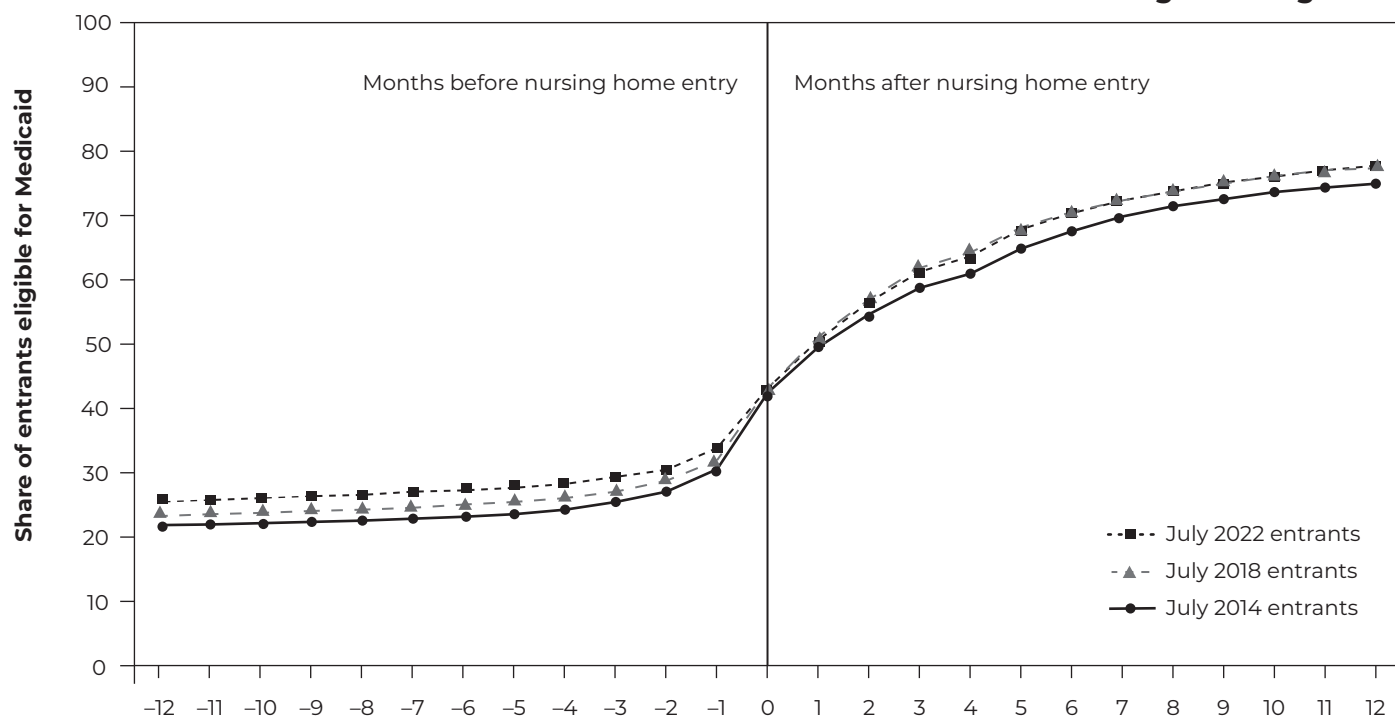
We measured cognitive functioning using the Brief Interview for Mental Status (BIMS) test, which is administered as part of the MDS. Beneficiaries with scores of 7 or lower are considered severely cognitively impaired, those with scores between 8 and 12 are considered moderately cognitively impaired, and those with scores between 13 and 15 are considered cognitively intact (Saliba et al. 2012). We found that a higher share of residents receiving only long-stay care were severely impaired (34 percent) compared with beneficiaries receiving skilled care (19 percent of long-stay residents and 17 percent of community-dwelling beneficiaries). Conversely, a smaller share of the residents receiving only long-stay care were cognitively intact (39 percent) compared with over 50 percent for each of the two groups of beneficiaries receiving skilled care.

The motor score is a composite of the scores on 11 self-care and mobility items collected in the MDS. The median motor score was the lowest (30) for residents receiving only long-stay care, slightly higher (31) for long-stay residents receiving skilled care, and the highest (35) for community-dwelling beneficiaries who received short-term skilled care.

Medicaid plays a key role for long-stay residents

Medicare does not cover long-stay NH care, but the Medicaid program requires states to do so. (Each state Medicaid program also covers other types of long-term services and supports for people who live in the community.) Because of the limited roles played by Medicare and other payers, Medicaid is the predominant payer for NH care: In 2023, the program covered 63 percent of all patient days in nursing homes (Medicare Payment Advisory Commission 2025).

Medicaid's eligibility rules are complex but generally require individuals who live in the community to have

**FIGURE
5-1****Most Medicare beneficiaries become eligible for Medicaid
within a few months of entering a nursing home**

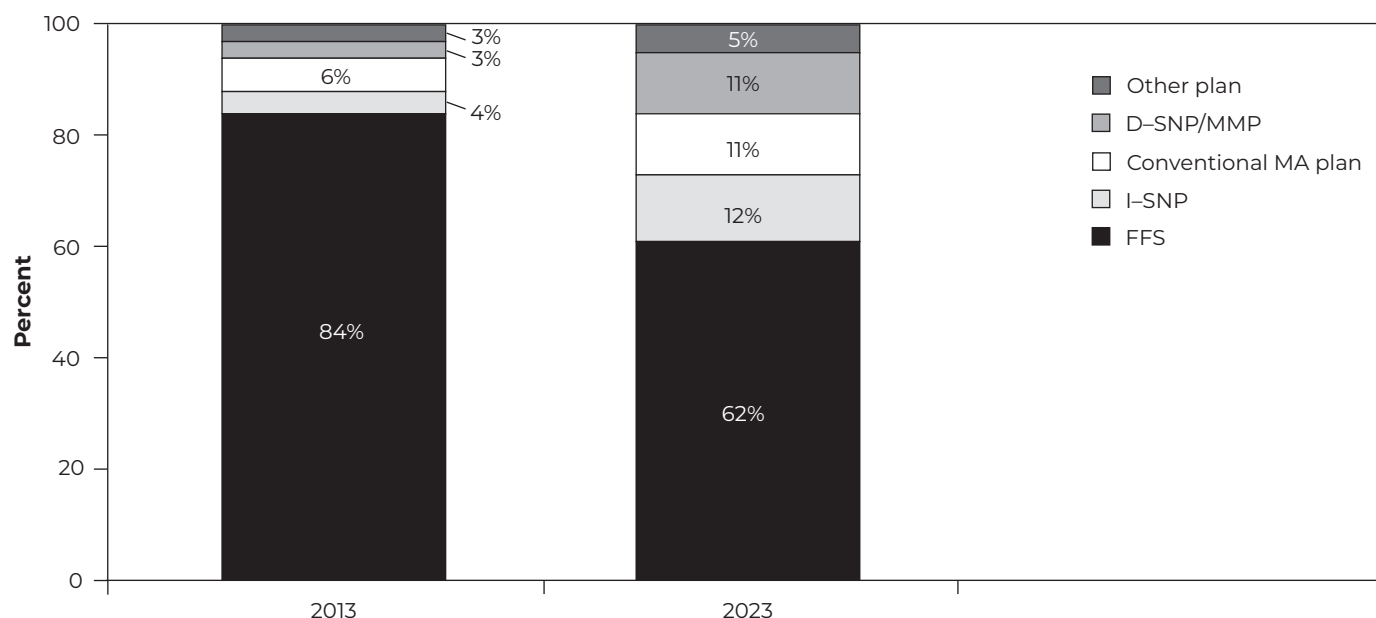
Note: Figure is limited to Medicare beneficiaries who had a nursing home stay that lasted for more than 90 days. "Eligible for Medicaid" means the beneficiary is eligible for full Medicaid benefits, including nursing home care. Figure does not include beneficiaries who had a previous nursing home stay of 90+ days or entered a nursing home less than 12 months after becoming eligible for Medicare.

Source: MedPAC analysis of Medicare enrollment data and Minimum Data Set assessment data.

both limited incomes and limited assets. However, all states have at least one eligibility pathway that allows individuals who have higher incomes and need NH care to qualify for coverage (Medicaid and CHIP Payment and Access Commission 2023). Under these pathways, higher-income individuals must still meet Medicaid's regular asset limits, which are quite low (for an aged individual, roughly \$2,000 in liquid assets). As a result, individuals who have assets that exceed these limits must first deplete them by spending them on NH care before they can qualify, a process often known as "spending down." Once beneficiaries who need NH care qualify for Medicaid, they must contribute nearly all of their income, except for a small allowance for personal needs, toward the cost of their care.⁵ Medicaid then covers the difference between the program's payment rate for NH care and the individual's contribution.

Due to the high cost of NH care, the share of residents with Medicaid coverage rises steadily as the length of stay increases (Figure 5-1). We used MDS assessments to identify cohorts of beneficiaries who entered a nursing home in the same month. We then used monthly enrollment data to track how the share of beneficiaries with Medicaid in each cohort changed over time. In the figure, beneficiaries entered the NH in month zero.

About a third of beneficiaries are already eligible for Medicaid when they enter the NH. After entry, the share with Medicaid rises rapidly, reaching about 60 percent after 3 months and nearly 80 percent after 12 months, indicating that many beneficiaries can pay for only a few months of NH care on their own. The experiences of the 2014, 2018, and 2022 cohorts follow

**FIGURE
5-2****The share of long-stay nursing home residents enrolled in FFS Medicare declined between 2013 and 2023**

Note: FFS (fee-for-service), D-SNP (dual-eligible special-needs plan), MMP (Medicare–Medicaid Plan), MA (Medicare Advantage), I-SNP (institutional special-needs plan). The “other plan” category includes employer-sponsored MA plans, the Program of All-Inclusive Care for the Elderly, cost plans, and MA special-needs plans for beneficiaries with chronic conditions. We counted beneficiaries as long-stay residents if they had been in a nursing home for 90+ days. Figure does not include long-stay residents who do not have both Part A and Part B (about 3 percent of all residents in 2023). Figures are based on July data. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare enrollment data and Minimum Data Set assessment data.

similar trajectories, which suggests that this pattern has been fairly stable over time.

Long-stay residents are more likely to have FFS Medicare than MA

Like other beneficiaries, long-stay residents who have both Part A and Part B can receive their Medicare benefits through the traditional FFS program or a managed care plan offered in their area. In 2023, 62 percent of eligible long-stay residents (about 505,000 beneficiaries) were enrolled in FFS Medicare and 38 percent (about 310,000 beneficiaries) were enrolled in managed care, usually an MA plan (Figure 5-2). The share of long-stay residents with FFS coverage is higher than the corresponding figure for all other Medicare beneficiaries, which was 53 percent (data not shown). However, like other beneficiaries, the share of long-stay residents in FFS Medicare has declined

steadily as managed care enrollment has grown (for example, in 2013, 84 percent of long-stay residents were in FFS Medicare).

Among those in managed care, roughly equal shares were enrolled in three plan types:

- institutional special-needs plans (I-SNPs), which are specialized MA plans that serve beneficiaries who need the level of care provided in a nursing home (12 percent, or about 96,000 beneficiaries);
- conventional MA plans, which are open to all beneficiaries who have both Part A and Part B and live in the plan’s service area (11 percent, or about 89,000 beneficiaries); and
- dual-eligible special needs plans (D-SNPs) and Medicare–Medicaid Plans (MMPs), which are

specialized plans that serve beneficiaries who have both Medicare and Medicaid (11 percent, or about 87,000 beneficiaries).⁶

Since 2013, the shares of long-stay residents enrolled in I-SNPs or D-SNPs/MMPs have each increased by about 8 percentage points, somewhat faster than the share in conventional MA plans, which has increased by 5 percentage points.

Medicare gives all NH residents (not just those who have been in a facility for 90 or more days) more flexibility than other beneficiaries to change their MA or Part D plan. Nursing home residents can change plans—such as switching from FFS Medicare to an MA plan, switching from MA to FFS, or changing their MA or stand-alone Part D plan—on a monthly basis, while other beneficiaries are largely limited to changing plans during the annual enrollment period.⁷

We tracked the cohort of beneficiaries who entered a nursing home in July 2022 and found that their enrollment in FFS Medicare or managed care did shift somewhat in the 12 months after they entered a nursing home. The share of beneficiaries enrolled in conventional MA plans decreased by about 11 percentage points, while the share enrolled in I-SNPs increased by 7 percentage points, and the share in FFS Medicare increased by 4 percentage points. Enrollment in other types of plans changed relatively little, decreasing by 1 percentage point overall. (These are national figures; the figures for individual NHs could easily differ.)

Structure of the nursing home industry

In 2023, there were 15,071 nursing facilities nationwide (Table 5-3). Nearly all facilities (94 percent) participate in both Medicare (as SNFs) and Medicaid (as NFs).⁸ Since 2015, the supply of facilities has steadily declined, by an average of -0.7 percent per year, with larger declines for hospital-based and Medicaid-only facilities (data not shown). The industry is evenly split between large (100 beds or more) and small (under 100 beds) providers, though 12 percent have fewer than 50 beds. The industry is overwhelmingly freestanding (96 percent) and predominantly for profit (72 percent) and urban (73 percent), with 2 percent of facilities located in frontier counties (counties with fewer than six persons per square mile, data not shown).

In October 2024, the median occupancy rate was 84 percent, but rates varied by ownership and star rating. Nonprofit facilities had higher occupancy rates compared with for-profit facilities (88 percent and 73 percent, respectively) and facilities with 5-star ratings had higher occupancy than 1-star facilities (83 percent and 76 percent, respectively) (these figures come from MedPAC analysis of first-quarter 2024 Care Compare data and 2023 Medicare cost-report data).

In terms of payer mix, Medicaid covers 63 percent of days; Medicare's FFS coverage of skilled care makes up 8 percent of facility days but 14 percent of revenues because of Medicare's high payment rates. The share of days covered by Medicare is actually higher than 10 percent because the "other payers" category used in Medicare's cost reports includes days covered by MA plans. All private-sector and other payers make up the other 29 percent of days. That category also includes days covered by private insurance, which plays a relatively small role in financing NH care (see text box on the long-term care insurance market, pp. 240–242). Compared with nonprofit facilities, for-profit NHs receive more of their revenues from Medicaid (Assistant Secretary for Planning and Evaluation 2023).

Payment rates vary considerably by payer. In 2019, the average base payment for Medicaid was \$200 while the average Medicare payment was \$487 (Medicaid and CHIP Payment and Access Commission 2023, Medicare Payment Advisory Commission 2020). However, these rates are not directly comparable because Medicare pays for skilled care whereas Medicaid typically pays for long-stay care. We do not have data on MA payment rates, but we have gathered information from publicly traded SNF companies. In 2019, MedPAC reported that for three SNF companies, FFS Medicare's payment rate averaged 21 percent higher than MA payment rates (Medicare Payment Advisory Commission 2020). We do not know whether the differences in payment rates reflect differences in service intensity, lower payments for the same service, or some combination. We also do not know how these rates compare with rates for other companies. For private-pay residents, one private long-term care insurer, Genworth, reported that the median nursing home cost in 2019 for a semiprivate room was \$250 a day (PR Newswire 2019). The payment differentials could create incentives to rehospitalize NH residents, similar to what has been reported for

**TABLE
5-3****Characteristics of nursing facilities, 2023**

Characteristic	Facility count	Percent
All nursing homes	15,071	100%
Medicare/Medicaid participation		
Both programs	14,202	94
Medicare only	591	4
Medicaid only	278	2
Facility size		
0–49 beds	1,798	12
50–99 beds	5,768	38
100–199 beds	6,651	44
200+ beds	854	6
Ownership		
For profit	10,912	72
Nonprofit	3,198	21
Government	961	6
Facility type		
Freestanding	14,538	96
Hospital based	533	4
Location		
Urban	11,002	73
Rural	4,069	27
Share of days covered by:		
Medicaid		63
Fee-for-service Medicare		8
Other payers (includes MA plans)		29
Total margin (all payers, all lines of business)	12,851	0.4
Non-Medicare margin	12,745	–4.1
Medicare margin	12,844	22.0

Note: MA (Medicare Advantage). Components may not sum to 100 percent due to rounding.

Source: Supply, size, type, and ownership are based on QCOR.CMS.gov/main.jsp for 2023. "Location" is based on data from the CMS Provider of Services file. Share of days and margin data are from 2023 Medicare cost reports and exclude the Medicaid-only facilities.

residents who have both traditional Medicare and Medicaid (Grabowski 2007). We do not know if these incentives are as strong for residents enrolled in MA plans or private-pay residents because we have limited data on their payment rates.

Partly reflecting the differences in payment rates, margins vary considerably by payer. The aggregate Medicare margin in 2023 was 22 percent, compared with a non-Medicare margin of –4.1 percent. The aggregate total margin (including all payers and all lines

The long-term care insurance market

Approximately 7.5 million people (including people under 65 years old) have private long-term care insurance (LTCI) that covers at least some nursing home care (Congressional Research Service 2023). The coverage varies widely across policies. Policies have different daily benefit amounts, levels of inflation protection (which protect policyholders from changes in the cost of care between the initial purchase of the policy and the point when care is needed, which could be many years later), duration (the length of time that the policy provides coverage), and waiting periods (between the point when a policyholder first needs care and when the policy begins paying benefits). Eligibility generally begins when an individual has a documented inability to conduct two activities of daily living.

Early policies covered only institutional care (skilled and residential), but over time coverage expanded to include home- and community-based care (Cohen et al. 2013). Initially, policies were sold as stand-alone policies but have gradually shifted to so-called hybrid policies that combine long-term care (LTC) coverage with life insurance or an annuity (Congressional Research Service 2023).

The sale of private LTCI policies took off when they were promoted as a way to protect an individual's assets without having to spend down to qualify for Medicaid. In 1996, there were 2.5 million stand-alone policies in force, and that number grew to 7.4 million in 2012 (Congressional Research Service 2023). Since

then, the number of policies has steadily declined (to 6.4 million in 2020) as many insurers exited the market because of the poor financial performance of the product (U.S. Department of the Treasury 2020). In 2002, there were 102 companies that sold LTCI policies (Cohen et al. 2013), but by 2020, fewer than a dozen companies sold policies (Rau and Aleccia 2023).

Similarly, since 2022, the federal government has paused applications for its voluntary LTCI program so that it could assess benefit offerings and sustainable premiums (Office of Personnel Management 2024, Office of Personnel Management 2022). This program is not subsidized by the government; it uses private insurers and thus is vulnerable to the same pressures discussed below. Though many companies have “left” the market and no longer issue new policies, they continue to pay out for policies issued in earlier years.

There are many reasons, on both the supply and demand sides, why the market for long-term care insurance is small and relatively few individuals purchase policies. On the supply side, projecting future costs for LTCI policies is challenging because of adverse selection and the long periods of time between when a policy is first issued and when benefits are paid. During the lag time, the risk of the insured pool changes as policyholders age and some low-risk policyholders let their policies lapse as they decide they can no longer afford the policy (or the expected value of the policy is less than the cost). Further, especially once LTCI policies covered

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of business) was 0.4 percent. The margin for any given NH will depend on its payer mix and its costs.

For the approximately 18 percent of NH residents who are not enrolled in Medicaid, the cost of nursing home care are substantial. In 2024, the median cost of a semiprivate room was \$9,277 a month (or \$309 a day), with rates varying more than twofold depending on location (for example, the monthly cost

in Little Rock, AR, was \$7,072 compared with \$15,330 in San Jose, CA) (Genworth 2025).

The NH industry is characterized by independent providers and regional chains. There has been increasing concern about the role of complex ownership arrangements and private equity (PE) investment in nursing homes and their implications for quality.⁹ One study funded by the Department of

The long-term care insurance market (cont.)

home-based care, moral hazard was an issue as policyholders were more inclined to use care than if they did not have LTCI (Konetzka et al. 2019). To manage moral hazard and adverse selection, companies began to stop issuing new policies to individuals with limited function or cognition or with specific diagnoses (Cohen et al. 2013).

Underwriters also made several miscalculations. They assumed that investment returns on LTCI premiums would match historical interest rates, but actual interest rates were much lower (e.g., interest rates in the 1990s ranged from 5 percent to 8 percent, but in the 2000s they were 3 percent to 5 percent), meaning that premiums were too low to cover expected claims (Cohen et al. 2013). Voluntary lapse rates were lower than anticipated, leaving insurers at risk for more policyholders (Congressional Research Service 2023). At the same time, morbidity was somewhat worse than expected (raising the cost of claims), and mortality rates decreased (extending the risks for insurers).

High premiums and large rate increases dampened the demand for LTCI. Between 1990 and 2010, the average annual premium more than doubled from \$1,071 to \$2,283—well above the effects of inflation, which would have increased premiums to \$1,787 (Cohen et al. 2013). Consumer preferences also changed, as people chose comprehensive policies (that cover all LTC expenses, not just institutional care) and better coverage (meaning policies with higher daily benefit amounts), both of which raise

the cost of policies. Coupled with the actuaries' miscalculations, premiums shot up, curtailing demand for new policies and encouraging existing policyholders to drop coverage.

The demand for LTCI may always be somewhat limited: Many wealthy individuals would prefer to self-insure (rather than pay LTCI premiums or spend down to qualify for Medicaid), and middle-income individuals cannot afford the policies. Furthermore, researchers found that the presence of Medicaid discouraged the purchase of LTCI for the lower two-thirds of the wealth distribution (Brown and Finkelstein 2008). Another factor lowering demand is that many individuals are confused about how LTC is financed. A KFF survey conducted in 2022 found that 23 percent of adults thought Medicare covered long-term care; this percentage rose to 48 percent for older adults (65 years and older) (Hamel and Montero 2023). Another survey found that 29 percent of individuals thought they had coverage, yet only 3 percent of individuals actually did (LIMRA 2022).

The use of underwriting by insurers may also discourage the people most likely to need LTC from buying it (Cornell et al. 2016). Insurers limit coverage for older, sicker, and/or cognitively impaired individuals. In 2022, applicant denial rates were 47 percent for 70- to 74-year-olds. Premiums for women are about 60 percent higher than identical policies for men, reflecting women's greater life expectancy and anticipated use of LTC (American Association for Long-Term Care Insurance 2022).

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Health and Human Services Assistant Secretary for Planning and Evaluation found that about 5 percent of all NHs are at least partly owned by PE funds and another 9 percent are at least partly owned by real estate investment trusts (REITs) (Stevenson et al. 2023).¹⁰ This study found that the PE- and REIT-owned facilities are similar to other for-profit facilities in size, resident acuity, and payer mix but have lower overall star quality ratings. Compared with nonprofit

facilities, PE- and REIT-owned facilities are larger and have higher Medicaid shares of revenues, higher acuity mix, and lower star ratings. A recent study found that one-fifth of NHs had changed ownership between 2016 and 2022 and that, after the change, there were small but statistically significant declines in the staffing and health inspection components of the NH star ratings but an increase in the quality component of the ratings

The long-term care insurance market (cont.)

So, although women are more likely to benefit from LTCI given their greater longevity, they may get priced out of the market.

Past policy efforts (at both the state and federal levels) to expand the LTCI market have had little or modest effect. In Medicaid, the Partnership for Long-Term Care Program encourages people to purchase LTCI policies by allowing them to protect more of their assets if they later exhaust their LTCI coverage and need to spend down to qualify for Medicaid.¹¹ One evaluation found that the program had a modest effect on expanding coverage (mostly among wealthy individuals) and was unlikely to have lowered Medicaid spending (Lin and Prince 2013). Policymakers have also tried to expand the LTCI market by offering tax breaks to individuals who purchase policies, thereby effectively lowering their price.¹² Studies found that the tax change increased coverage but the loss in revenue from granting the tax incentives exceeded the savings to Medicaid (Courtemanche and He 2009, Goda 2011). The Community Living Assistance Services and Supports (CLASS) Act was enacted in 2010 as part of the Affordable Care Act of 2010 (ACA) and was intended to establish a voluntary LTCI program funded entirely by enrollee premiums. However, the program was never implemented; in 2011, the Secretary determined that the program was not financially viable, and the Congress repealed it in 2013.

In 2020, a federal task force convened by the Department of the Treasury made recommendations to remove barriers to innovation and increase regulatory efficiency and alignment but did not promote or discourage LTCI (U.S. Department of the Treasury 2020). Its recommendations were aimed at making LTCI more affordable and accessible while letting market forces shape this product. For example, it recommended that state insurance regulators allow for flexibility and experimentation to enable product innovation that best meets consumer needs. It encouraged research on the impact of various product designs (such as newer policies that offer benefits for 12 months) on consumer demand and risk protection. It also recommended that the inflation protection standard (at least a 5 percent compound rate) included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) should be revised due to its costly effects on premiums. It did not recommend any specific alternative financing mechanism, such as products that offer limited coverage for short periods (with no deductions or waiting periods) or catastrophic coverage products. It concluded that additional tax incentives beyond those currently in place would not benefit middle- or lower-income individuals who need financial protection.

Given the factors that limit the supply of LTC insurers and the lack of demand for the product, LTCI may always play a limited role in financing long-term care. ■

(Ryskina et al. 2024). Across all facilities, for-profit NHs have lower levels of staffing and worse quality of care (Assistant Secretary for Planning and Evaluation 2023).

In 2023, rural NHs made up 27 percent of all facilities but much smaller shares of total days and revenues (20 percent and 16 percent, respectively) (Table 5-4). These lower shares are partly explained by the size of rural facilities, which were smaller and had lower occupancy rates compared with urban facilities. In

terms of ownership, a larger share of rural facilities were government owned (such as county owned), and a smaller share of rural facilities were for profit. Compared with urban facilities, rural facilities had lower shares of FFS Medicare days and higher shares of Medicaid days. Rural and urban facilities had similar shares of residents who were eligible for Medicare and Medicaid. Rural facilities had lower average cost per day (\$337 compared with \$479), but their average

**TABLE
5-4****Comparison of nursing homes by location, 2023**

Characteristic	Urban nursing homes	Rural nursing homes
Share of:		
Providers	73%	27%
Total days	80	20
Total revenues	84	16
Average daily census	91	62
Average occupancy rate	78%	72%
Ownership		
For profit	72%	68%
Nonprofit	19	18
Government	8	14
Share of days covered by:		
Medicaid	54%	60%
Fee-for-service Medicare	18	9
Other payers (includes MA plans)	28	31
Share of residents who are dually eligible	46%	46%
Average cost per day	\$479	\$337
Average payment per day	\$478	\$339
Total margin (all payers, all lines of business)	-0.9%	0.2%

Note: MA (Medicare Advantage). The table does not include providers that do not participate in the Medicare program. Components may not sum to 100 percent due to rounding. "Dually eligible" refers to the share of residents who are eligible for Medicare and Medicaid.

Source: MedPAC analysis of 2023 Medicare cost reports.

payments more than covered their costs, so their average total margin (across all payers and sources of revenue) was positive (0.2 percent). In contrast, urban NHs had high payments per day (\$478) that did not cover their costs per day, so their average total margin was slightly negative (-0.9 percent).

As shown in Table 5-4, the profitability of the NH industry appears low based on the information submitted on Medicare cost reports. However, the lack of transparency in the reporting of third-party transactions with related entities makes it difficult to know whether the financing of nursing facilities can be accurately assessed. Nationally, over three-quarters of NHs reported payments to related third parties (including real estate companies, management

companies, pharmacies, and medical supply companies) (Harrington et al. 2024). One study of NHs in Illinois (a state that requires detailed financial reporting) examined costs before and after they entered into a related-party agreement (Gandhi and Olenski 2024). The study found that those facilities' costs increased due to inflated sale-leaseback agreements and costly management fees owed to the related-party entity. After reestimating NH profits based on what costs would have been without the effects of the related-party transactions, the study found that the reported profits were only 37 percent of actual industry profits—that is, 63 percent of the actual profits were "hidden" in inflated costs. The margins reported here would thus be higher if this study's findings held across NHs nationwide.

Challenges to improving care for beneficiaries living in nursing homes

In a 2022 report, the National Academies concluded that “the way in which the United States finances, delivers, and regulates care in nursing home settings is ineffective, inefficient, fragmented, and unsustainable” (National Academies of Sciences, Engineering, and Medicine 2022). For example, differences in payment rates by payer give NHs a financial incentive to hospitalize their long-stay residents to requalify those with Medicare coverage for a higher-payment Medicare-covered stay once they return to the NH, even when the resident has a clinical condition that does not require a hospitalization (Grabowski 2007). These inpatient stays are financially beneficial to the NH, but they are disorienting to residents and unnecessarily expose them to risks associated with hospitalizations.

The quality of care provided to many long-stay residents in NHs is a long-standing problem (Institute of Medicine 2001, Institute of Medicine U.S. Committee on Nursing Home Regulation 1986, National Academies of Sciences, Engineering, and Medicine 2022). The poor quality in many NHs is partly the result of low Medicaid payment rates that on average do not cover the cost of care: The Medicaid and CHIP Payment and Access Commission (MACPAC) reported that, in 2019, 81 percent of NHs had base payment amounts that did not cover their acuity-adjusted costs and that the median Medicaid base payment rate was 86 percent of reported facility costs (Medicaid and CHIP Payment and Access Commission 2023).¹³ However, MACPAC found wide variation across states, with Medicaid base payments ranging from less than 60 percent to over 110 percent of facilities’ acuity-adjusted costs. (This study did not account for the possible effects of NHs using transactions with related parties to obscure some of their profits, discussed above.) The relatively low Medicaid rates for many NHs appear to affect staffing levels that, in turn, affect the quality of care.¹⁴ MACPAC reported that NHs with a high share of Medicaid-covered residents were much more likely to have 1- or 2-star staffing ratings in Nursing Home Compare relative to facilities with lower Medicaid shares (Medicaid and CHIP Payment and Access Commission 2022).

Medicaid’s payment rates mean that many NHs offer low wages for what can be physically and emotionally demanding jobs. NHs compete, often unsuccessfully, with hospitals and the retail sector for aides (Chidambaram et al. 2024). Low wages contribute to low worker-to-patient ratios that create an undesirable work environment, as reflected in high annual turnover rates for nursing staff. As of October 2022, the 12-month turnover rate for nursing staffing (which includes registered nurses, licensed practical nurses, and nurse aides) was 53 percent, and one-quarter of facilities had rates greater than 64 percent—that is, nearly two-thirds of their nursing staff left the facility during the year (Medicare Payment Advisory Commission 2024b). Worker-to-patient ratios and turnover ratios could worsen as the population expected to need NH care grows, lives longer, and has more complex care needs.

Another problem facing institutionalized beneficiaries is the long-standing and extensive racial segregation in NHs that results in worse outcomes for minorities (Bowblis et al. 2021, Konetzka and Werner 2009, Mor et al. 2004, Travers et al. 2021). Racial and ethnic minorities are more likely to reside in communities with NHs that have lower staffing levels and lower quality. From earlier work, we know that beneficiaries’ decisions about where to get their post-acute care is complex, but proximity to family members is important (Medicare Payment Advisory Commission 2024a). Beneficiaries who live in disadvantaged neighborhoods and wish to remain close to home may therefore be choosing among poor-quality homes. Dually eligible beneficiaries are often faced with limited choices among facilities and are more likely to reside in low-quality nursing homes (Sharma et al. 2020). Their choices could be further limited by the NHs willing to take them (due to the relatively low Medicaid payment rates).

One commonly cited measure of NH quality is the rate of transfers of residents to hospitals for inpatient care, emergency department visits, and observation stays. One study of residents with certain common conditions—advanced dementia, congestive heart failure, or chronic obstructive pulmonary disease—found that in 2016 the rates of potentially avoidable hospital transfers were 20 percent, 43 percent, and 41 percent, respectively (McCarthy et al. 2020). Despite the increasing acuity of NH residents between 2015

and 2023, the hours of nursing care per resident day declined by 9 percent. Between 2015 and 2020, the hours per resident day (HPRD) slowly declined until 2020, but then rose in 2021 due to a 17 percent drop in residents during the COVID-19 pandemic. From a low HPRD in 2022, the ratio has slowly increased but in 2024 remained below the 2015 level. Over the same nine-year period (between 2015 and 2023), the share of facilities with serious deficiencies increased from 17 percent to 26 percent (Chidambaram et al. 2024).

CMS uses a mix of data sources and measures to gauge the quality of care in nursing homes. Several measures are based on MDS assessment data, which are gathered on each resident. Other measures are based on claims and have the advantage of being harder to manipulate by providers compared with patient assessment information (see discussion below). On the other hand, the claims-based measures exclude residents not enrolled in Medicare and, among Medicare beneficiaries, exclude those enrolled in MA. For providers with large shares of these residents, the measures may not be good reflections of their care. Staffing measures (HPRD and staffing turnover ratios) are based on payroll data that each nursing home submits to CMS.

The Commission has raised two concerns about quality reporting for NHs. First, many measures are based on patient assessment data that may not be accurate because they are reported by providers and used to establish payments. Providers have long had a financial incentive to record patients' abilities as worse than they are to boost payments (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2019). In 2012, OIG reported that one-quarter of SNF claims had billing errors and that the majority of those were "upcoded" (Office of Inspector General 2012). More recently, CMS reported that the majority of the 14 percent of improper payments to SNFs were due to insufficient documentation to support payment for the service billed (Centers for Medicare & Medicaid Services 2024a). A review of studies of Nursing Home Compare reported evidence of "gaming"—that is, some "improvements" may reflect a more concerted focus on scoring rather than actual improvement (Konetzka et al. 2021b).

Second, there are no measures of resident quality of life, resident satisfaction, and end-of-life and palliative care. Given that nursing home residents

live in the facility and are very unlikely to move back to the community, these measures are key. In 2021, the Commission recommended that CMS finalize development of patient-experience measures and begin to report them (Medicare Payment Advisory Commission 2021).

Regulatory requirements for nursing home survey and certification and staffing

NHs must meet federal regulations aimed at maintaining a safe environment for residents and ensuring a minimum level of quality. To receive Medicare and Medicaid funding, NHs must pass a regularly scheduled survey and correct any deficiencies. NHs must also meet minimum nurse staffing requirements.

Survey and certification

Federal oversight of nursing homes began with the enactment of Medicare and Medicaid in 1965 and the establishment of requirements to participate in the programs.¹⁵ The Nursing Home Reform Act of 1987 laid out federal requirements for quality of care, quality of life, residents' rights, and the safety of the physical environment. Since then, CMS has implemented many changes aimed at improving ownership transparency, staff training, infection control, and quality of care. However, the general structure of the oversight and regulations remains relatively unchanged (National Academies of Sciences, Engineering, and Medicine 2022).

Surveys of NHs are jointly funded by the federal and state governments. States are directed to conduct the on-site inspections at least every 15 months. A team of surveyors (that includes at least one registered nurse) conducts the inspections and documents their findings about the scope and severity of any deficiencies.¹⁶ In an attempt to standardize the surveys, CMS has established national standards for NH inspections in a State Operations Manual. In addition, all surveyors must complete an orientation program, a surveyor course, and annual job-related training courses, in addition to passing a qualifications test (National Academies of Sciences, Engineering, and Medicine 2022).

The on-site survey consists of an unannounced, multiday inspection and interviews with residents.

Each deficiency is rated from “A” to “L” based on its severity and scope. Deficiencies that resulted in no actual harm with the potential for minimal harm are rated from A to C, while widespread deficiencies that pose immediate jeopardy to residents are rated L.

Surveyors prepare a report on the findings of the inspection, detailing the deficiencies, that is shared with the facility. Facilities must draw up and complete a corrective plan to avoid enforcement remedies, and CMS must approve the plan. Depending on the findings, enforcement remedies can include assessing per day or per instance civil monetary penalties (CMPs), denying payments until the deficiencies are corrected, or terminating the nursing home’s participation in Medicare and Medicaid. In fiscal year (FY) 2024, CMPs made up 76 percent of the 8,167 enforcement actions (affecting 4,076 NHs), and denial of payments for new admissions made up another 15 percent.¹⁷ Almost all of the remaining enforcement remedies imposed monitoring, directed plans of action, and directed in-service training (Centers for Medicare & Medicaid Services 2024g). Terminations, which numbered 23 nationwide in FY 2024, are infrequent. Beginning in FY 2025, a facility that is out of compliance can be assessed CMPs per day and per instance (Centers for Medicare & Medicaid Services 2024c).¹⁸ CMS’s funding for mandatory surveys and certifications for all health care providers has remained at \$397 million since FY 2015 with some additional funding in single years from the CARES Act or CMS (Centers for Medicare & Medicaid Services 2025d). In FY 2023, the last year with complete data, states performed 179,766 surveys, of which 83 percent were for NHs (Centers for Medicare & Medicaid Services 2025e).

Although select outcomes for residents have improved after focused attention on specific problems identified in these surveys (such as the use of restraints or antipsychotic drugs), overall quality in many NHs remains a persistent problem (National Academies of Sciences, Engineering, and Medicine 2022). Numerous reports by GAO and OIG over the last two decades have covered topics such as inadequate infection control, concerns about resident safety, elder abuse, underreporting of serious deficiencies, and inadequate staffing on weekends (Government Accountability Office 2020, Government Accountability Office 2019, Government Accountability Office 2009, Government Accountability Office 2008,

Government Accountability Office 2007, Government Accountability Office 2005, Office of Inspector General 2019).

NH inspections should play a key role in ensuring that minimum quality standards are met. But for many reasons, these efforts often fall short. In 2022, OIG assessed CMS’s oversight of state survey agencies from 2015 to 2018 and found that over half of states repeatedly did not meet performance standards, most often because the surveys were not timely. It raised questions about the effectiveness of CMS oversight and the ability of CMS to hold states accountable when problems arise (Office of Inspector General 2022). OIG also noted that its previous reports found that states did not always verify whether nursing homes had corrected deficiencies cited during the surveys or conduct timely surveys following serious complaints. The National Academies recently stated that it was unclear whether the recurring challenges to quality reflect inadequate implementation and enforcement of existing regulations or the inherent limits to what regulation can achieve (National Academies of Sciences, Engineering, and Medicine 2022). The Academies noted that there was a dearth of evidence indicating which regulatory approaches would improve quality.

There are two persistent problems with the state-run inspections. First, as noted by the U.S. Senate Special Committee on Aging, the inspection agencies are “woefully underfunded” such that required inspections are frequently delayed (U.S. Senate Special Committee on Aging 2023). In its FY 2025 budget request, CMS stated that at its 2024 funding level, it would be able to complete only 65 percent of the required inspections (Department of Health and Human Services 2025). The underfunding also results in high vacancy rates for surveyors. In 2022, 31 states plus the District of Columbia had vacancy rates of at least 20 percent for surveyor positions (U.S. Senate Special Committee on Aging 2023). Second, there is large variation across states in whether they achieved survey performance standards (such as the timeliness of surveys and whether survey findings were appropriately documented) (Centers for Medicare & Medicaid Services 2024d). In its assessment of results from state surveys from 2015 to 2018, OIG found large differences across states in how routine inspections are implemented, sanctions are imposed, and complaints

are investigated, and the office raised questions about states' performances in conducting the surveys (Office of Inspector General 2022).

In addition to the variation in state survey performance, there are large differences across states in the citation of serious deficiencies in NHs (defined as causing or likely to cause serious injury, harm, impairment, or death to a resident). KFF reported that, at the state level, the share of NHs with serious deficiencies in 2024 ranged from less than 10 percent to over 40 percent (KFF 2024). It is not possible to know the extent to which the variation in citation of serious deficiencies across states reflects real differences in quality versus differences in surveyors' detection and gradings of deficiencies.

CMS targets the lowest-performing NHs—those with a sustained pattern of numerous and serious survey deficiencies—for more frequent surveys as part of the Special Focus Facility (SFF) Program.¹⁹ These facilities are inspected every six months until they either “graduate” from the program (having improved) or their participation in Medicare and/or Medicaid is terminated. CMS has criteria for graduation but has not established criteria for termination, though SFFs where residents were harmed or the facility's actions caused death (or where residents were likely to experience these serious adverse events) on two surveys are candidates for such action.²⁰

Because of the lack of resources, CMS can include only a fraction of the poorest-performing homes in the SFF Program. In November 2024, there were about 80 SFFs; about 400 more facilities were candidates but not part of the program due to insufficient funding (Centers for Medicare & Medicaid Services 2024h).

The SFF Program has not been studied recently, but older reports indicate that it had mixed results. One 2019 study of the 21 “graduates” of the program found that almost one-third were cited for serious deficiencies (the worst categories of deficiencies, involving harm or immediate jeopardy for residents) in the previous year (Center for Medicare Advocacy 2019). A *New York Times* analysis found that of the nursing homes that had graduated from the SFF Program before 2017, over half were cited for serious harm or jeopardy in the next three years (Rau 2017).

Staffing requirements

Numerous studies have found a relationship between staffing—particularly registered nurse (RN) staffing—turnover, and quality of care. A review of studies published between 2008 and 2014 found that higher RN staffing and a higher ratio of RNs to other nursing staff was associated with fewer pressure ulcers, lower restraint use, decreased probability of hospitalization, fewer inspection deficiencies, decreased mortality, and decreased incidence of urinary tract infections (Dellefield et al. 2015). A systematic review of the relationship between nurse staffing and resident outcomes in nursing homes concluded that RN staffing and higher skill mix (greater share of licensed nurses) was likely associated with fewer pressure ulcers, fewer COVID-19 infections, and lower rates of moderate to severe pain (Jutkowitz et al. 2023). Another systematic review of studies during the pandemic found that, in facilities with known cases, higher staffing was associated with fewer deaths from COVID-19 (Konetzka et al. 2021a). Recent studies that have examined staff turnover using payroll-based data have found that higher nursing staff turnover was associated with lower star ratings (for inspections, quality, and staffing), infection control citations, and quality of care (Gandhi et al. 2021, Loomer et al. 2022, Zheng et al. 2022).

Since 1989, federal staffing standards have required nursing homes certified for Medicare and Medicaid to have (1) a director of nursing who is an RN; (2) an RN on duty 8 consecutive hours per day for 7 days a week; and (3) a licensed nurse—either an RN or a licensed practical nurse (LPN)—on duty for 24 hours per day, 7 days a week. These standards translate to 0.3 hours of nursing time per resident per day for a 100-bed facility (Medicaid and CHIP Payment and Access Commission 2022). The law also requires facilities to have “sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident,” but does not specify a minimum number of nurses per resident to define “sufficient.” Thirty-eight states and the District of Columbia have implemented stricter minimum staffing requirements than the federal requirements (Medicaid and CHIP Payment and Access Commission 2022). The state requirements vary in terms of the staffing affected by them (e.g., RNs or total nursing staff) and their stringency.

In May 2024, CMS issued new requirements that specify the minimum HPRD for total nurse staffing (including RNs, LPNs, and nurse aides (NAs)) (Centers for Medicare & Medicaid Services 2024b). The new rule also required NHs to have an RN on-site 24 hours a day, 7 days a week. The Commission has not taken a position on the new regulations. Industry representatives filed lawsuits against CMS and the Department of Health and Human Services (HHS) to dismiss the staffing rule, arguing that CMS exceeded its statutory authority. On April 7, 2025, a federal judge determined that the new requirements exceeded CMS's authority and dismissed the staffing rule (U.S. District Court for the District of Texas 2025). As this report went to press, CMS had not indicated plans to appeal the decision.

CMS's quality programs for nursing homes

CMS has three programs focused on improving quality: the Quality Reporting Program (QRP), the 5-star quality rating system, and the Quality Improvement Organization (QIO) Program. Many of the measures required by the QRP are included in the rating program. The 5-star system is designed to compare quality across nursing homes. The QIO program is not specific to NHs, but some of its activities have focused on NHs.

SNF Quality Reporting Program

The SNF Quality Reporting Program (SNF-QRP), mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT), requires SNFs to submit quality data to CMS.²¹ There are 15 quality measures in the SNF-QRP. Three-quarters of the measures are based on SNF-reported patient assessment information (such as discharge function score and changes in skin integrity) while the other quarter consists of claims-based outcome measures (e.g., readmission rates) or cost measures that CMS calculates. NH performance on 13 of the QRP measures are publicly posted on the Care Compare website after providers have had a chance to review and correct data (if warranted). (The measures regarding the transfer of health information to the patient and provider post-acute care are not posted.) SNFs that do not submit complete data for at least 80 percent of their patient assessments receive a lower update to their payment rates (the market basket update

percentage minus 2 percentage points). About 2 percent of facilities do not meet the threshold. Starting in FY 2026, facilities must report complete data for 90 percent of their assessments to receive a full update.

In addition to QRP measures, the Care Compare website includes other short- and long-stay measures and resident and staff vaccination rates. In total, 33 measures are reported on the website.

5-star quality rating system for nursing homes

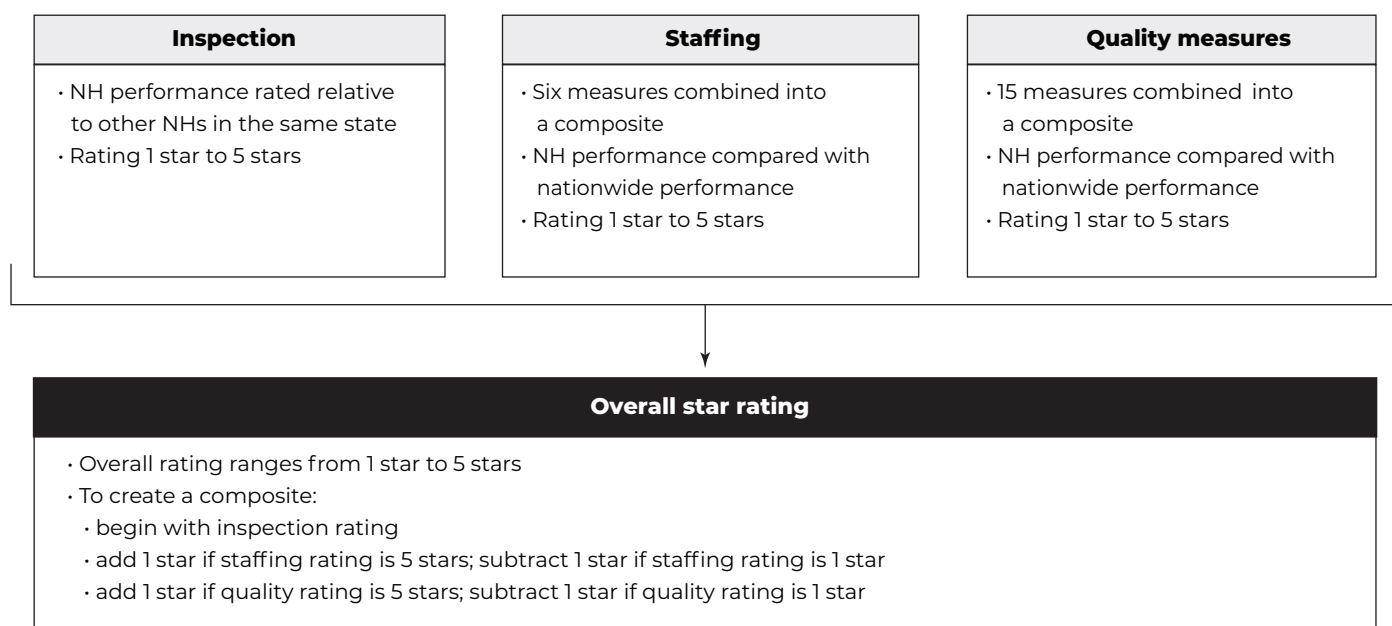
One lever that CMS uses to improve the care furnished in NHs is to publicly report the quality of individual providers. Consumers, their families, and hospital discharge planners can use the information when selecting a facility for post-acute care or long-term care. Managed care organizations, ACOs, and hospital systems can consider the information when determining which providers to include in their network of providers. In 1998, CMS began publicly reporting NH performance on inspections and staffing. In 2009, CMS began publishing star ratings on its website. The idea behind public reporting is that publishing the quality of individual providers would motivate them to improve their care.

To make the publicly reported information easy to understand, NHs receive an overall star rating that is a composite of separate ratings for three domains—the NH inspection, staffing levels, and quality measures (Figure 5-3). For each domain and the overall rating, NHs can receive 1 to 5 stars based on their performance. The overall rating and the three domain ratings are displayed on the Care Compare website. Special Focus Facilities are not rated; instead, a warning icon appears on the Care Compare website.

The inspection rating uses information from the NH's three most recent surveys about safety, quality of life, medication management, resident assessment, NH administration, resident rights, the environment, and kitchen/food services (with the most recent survey's results weighted more heavily than the earlier surveys). Performance is based on the number, scope, and severity of the deficiencies.²² Each deficiency is assigned points; deficiencies that are widespread and put residents at immediate jeopardy count more than other deficiencies. Results from the most recent 36 months of complaint investigations and focused infection-control surveys and the number of repeat visits required to

**FIGURE
5-3**

Nursing home star ratings



Note: NH (nursing home).

Source: CMS Care Compare website, November 2024.

confirm that the deficiencies have been corrected also add points to the total inspection score.

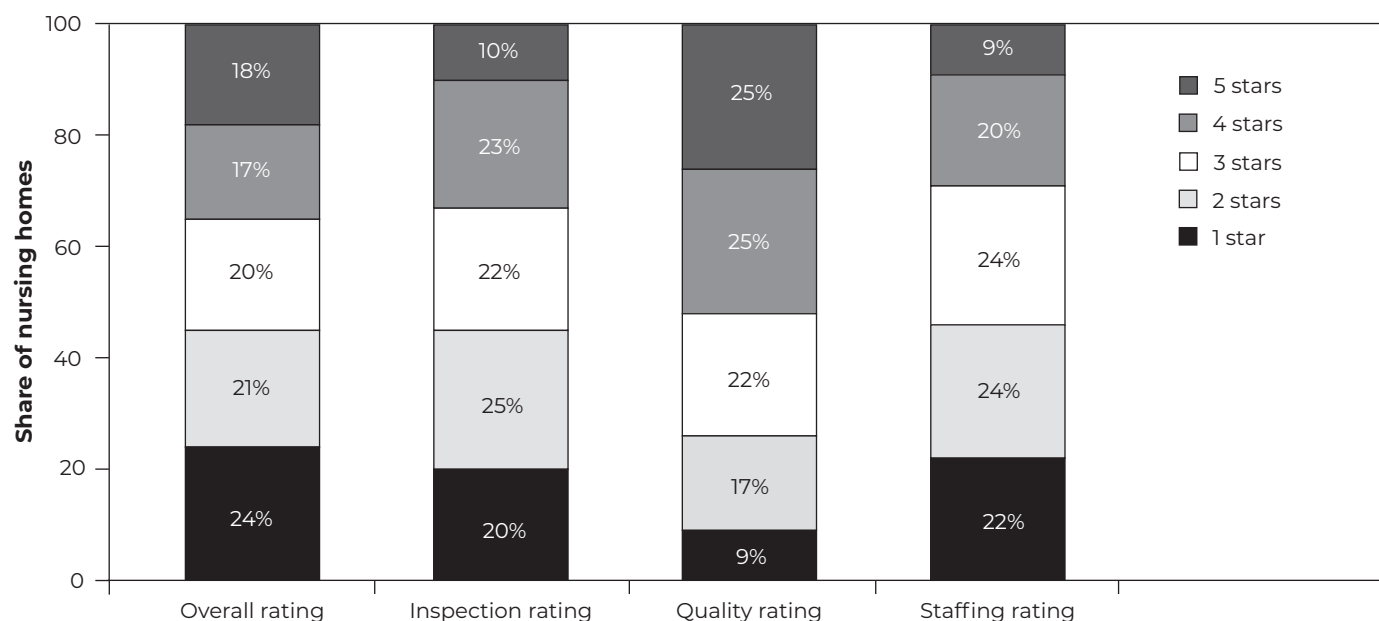
Because state surveyors do the inspections, the inspection rating is based on the relative performance of the NHs in each state. Within each state, the distribution of star ratings is prescribed in advance: The top 10 percent of NHs receive 5 stars (highest performance), the bottom 20 percent receive 1 star, and the middle 70 percent receive between 2 and 4 stars. Because NHs are compared within a state but not across states, the worst (or best) performers in one state could be better (or worse) than the average performers in another state in terms of actual deficiencies.

The staffing rating is a composite of six staffing measures that are calculated from payroll data that NHs must report quarterly. Three are risk-adjusted measures of staffing levels: total nurse staffing (RNs, LPNs, and NAs) across all days, RN staffing across all days, and weekend total nurse staffing. The other three measures relate to turnover for three categories of workers: total nursing staff, RNs, and

administrators. Because the turnover measures look at rates averaged over an entire year, they do not fully capture the day-to-day variation in staffing that has been shown to be related to various health outcomes (Mukamel et al. 2023).

All staffing measure performances are compared nationwide (not by state). Points are assigned based on a NH's performance on each measure and then summed. The measures do not have equal weighting: The maximum number of points a NH can receive is 100 points each for total staffing and RN staffing; 50 points each for total nurse staffing on weekends, total nurse turnover, and RN turnover; and 30 points for administrator turnover. Stars are assigned based on the total points earned across the six measures.

The quality domain is a composite of 15 quality measures: 9 long-stay measures and 6 short-stay measures.²³ The quality-measure performances are compared nationwide. Five of those measures are claims based; 10 are based on patient assessment data. In calculating the composite quality rating, some

**FIGURE
5-4****Nursing home star-rating performance, November 2024**

Source: CMS Care Compare website, November 2024.

measures have more weight than others. Based on expert opinion, measures that NHs have a greater opportunity to improve and measures with higher clinical significance count more than others. In addition to posting the overall quality rating, the Care Compare website reports a facility's performance on some individual quality measures.

The ratings for the inspection, staffing, and quality domains are not averaged to create an overall rating. Rather, the overall rating starts with the inspection rating, and the staffing and quality ratings each can add or subtract one star from it.²⁴ CMS explained that the inspection domain was given the most weight because it reflects an on-site inspection conducted by a trained surveyor. CMS also developed its basic approach for calculating the overall rating before the availability of more accurate and timely staffing data, which may have contributed to its decision to give the rating for the staffing domain less weight. Staffing and quality ratings are updated quarterly, while the

inspection rating is updated when there are new survey results for the facility.

Our analysis of November 2024 star-rating information found that almost one-quarter of NHs had 1-star overall ratings, and 18 percent of facilities had 5-star ratings (Figure 5-4).²⁵ The distributions of ratings for the three domains differed considerably. Smaller shares of NHs had 5-star ratings for inspections and staffing (10 percent and 9 percent, respectively).

For-profit NHs were much more likely to have a 1-star rating than a 5-star rating (28 percent compared with 13 percent) (Table 5-5). In contrast, nonprofit NHs tended to have higher ratings: 11 percent had a 1-star rating and 32 percent had a 5-star rating. Larger facilities were more likely to have a 1-star rating compared with smaller facilities. The average share of residents who were low income was much lower in 5-star facilities (33 percent) compared with 1-star facilities (59 percent).

**TABLE
5-5****Distribution of star ratings by nursing homes' characteristics, 2024**

Characteristic	1 star	2 stars	3 stars	4 stars	5 stars
For profit	28%	23%	19%	16%	13%
Nonprofit	11	15	21	21	32
Urban	24	21	20	16	18
Rural	24	20	19	19	17
0-49 beds	11	14	16	22	36
50-99 beds	20	20	20	18	21
100-199 beds	30	22	20	15	12
200+ beds	30	26	19	11	12
Average low-income share	59	52	46	41	33

Note: Except for the row displaying low-income shares, the values represent the percentage of facilities within each row with the indicated star rating. "Low-income share" is the share of beneficiaries who receive the low-income subsidy in the Part D drug benefit. The shares for the star ratings may not sum to 100 due to rounding.

Source: CMS Care Compare website, November 2024.

The distribution of star ratings varied widely across states. For example, 7 percent of the NHs in one state earned 5-star overall ratings compared with 27 percent of facilities in another state. Because the distribution of inspection ratings within each state is prescribed and uniform (see p. 249), the variation in the overall ratings is due to differences across states in the staffing and quality domains. The differences in the staffing ratings could in part reflect the variation in state staffing requirements. Among the counties with facilities that had star ratings, 37 percent did not have any 4- or 5-star nursing homes (data not shown).

One study surveyed the literature on the Care Compare ratings (71 articles in all) and drew several conclusions (Konetzka et al. 2021b). Overall, consumers use the ratings to select higher-quality facilities, and providers try to improve their ratings. In the first two years of the program, the use of 1-star NHs decreased and the use of 5-star NHs increased (Konetzka et al. 2015). However, the authors noted that the shifts were modest, in part because the use and general awareness of the website was low. An older national survey found that 12 percent of respondents remembered using the website but

often only to gather names and addresses, not to examine quality scores (Castle 2009).

The survey article also noted some important unintended consequences. First, the program may have exacerbated inequities because higher-income beneficiaries were more likely to use the website. Second, providers focus on the measures that are used in the ratings and pay less attention to other aspects of care that may be equally important (like patient experience, discussed below). The study's authors also mentioned that, to improve their scores, some providers use coding and documentation strategies for the self-reported data, such as increased coding of end-stage renal disease, because some quality measures exclude residents with this disease from the rate calculations (Konetzka et al. 2021b). The Commission has raised concerns about the self-reported patient-assessment items, particularly those used for payment, such as a patient's functional status (Medicare Payment Advisory Commission 2019). In an article on NH reporting of major-injury falls, researchers matched patient assessments with inpatient hospital claims and concluded that the NH-reported data could be

highly inaccurate (Sanghavi et al. 2020). In 2027, CMS will begin to validate some of the patient-assessment information (including functional status).²⁶

The NH star ratings do not include measures of patient and family satisfaction. Studies found that resident and family satisfaction were key items that consumers would like added to the Care Compare website (Konetzka and Perrailon 2016, Schapira et al. 2016). In 2021, the Commission recommended that CMS move forward with finalizing the development of and beginning to report patient-experience measures for SNFs (Medicare Payment Advisory Commission 2021). For FY 2024, CMS proposed but did not implement the adoption of a patient-experience measure using the CoreQ survey for short-stay residents, which includes four items that ask beneficiaries if they would recommend the facility, how they rate the staff and the care they received, and whether their discharge-planning needs were met. In 2025, CMS requested information on patient-experience measures and said it would consider those comments in future measure development.

One potential area of future work is to consider alternative designs of the overall rating of a NH. Given the clear relationship between staffing and quality and the availability of good staffing data, the staffing domain could play a larger role in determining a NH's overall rating.

Quality Improvement Organization Program

In 1992, CMS began the QIO Program to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries and to make sure that those services are reasonable and necessary.²⁷ The program is not specific to nursing homes, and its focus on this setting has been inconsistent over time. More recently, the program has offered quality improvement tools, training, and other resources to help nursing homes improve their star quality rating (Centers for Medicare & Medicaid Services 2024e). In FY 2023, spending on the QIO Program (across all providers and topics) totaled about \$814 million (Centers for Medicare & Medicaid Services 2024f).

In its 12th multiyear scope of work (covering the period from November 2019 to November 2024), the program had 12 partners who worked directly with NHs to

reduce adverse drug events and health care-associated infections. Partners also helped train NH staff regarding infection prevention and control in NHs serving small, rural, vulnerable, and disparate populations (Centers for Medicare & Medicaid Services 2024e). Results from this cycle of work have not been evaluated.

A consensus report conducted for the National Academies concluded that there is a lack of evidence showing that the QIO Program is effective (National Academies of Sciences, Engineering, and Medicine 2022). Earlier reports completed by the Institute of Medicine and the Assistant Secretary for Planning and Evaluation drew similar conclusions (Assistant Secretary for Planning and Evaluation 2007, Institute of Medicine 2006). Studies have had serious methodological problems, such as selection bias and the lack of controls for confounding factors. A review of 25 years of external evaluations found that the effects of the program have been small or difficult to interpret and that the program lacked consistent data collection and reporting to compare results across individual projects it has supported (Shaw-Taylor 2014).

FFS payment policies aimed at improving quality in nursing homes

FFS Medicare has payment policies that aim to give NHs and other providers financial incentives to improve the care furnished to NH residents. The SNF value-based purchasing (VBP) program and ACOs increase and decrease payments based on the care they provide to beneficiaries. Because the policies apply only to Medicare-covered services, they have limited ability to improve quality. In addition, between 2012 and 2020, there was a demonstration to reduce avoidable hospitalizations among NH residents.

SNF Value-Based Purchasing Program

Quality payment programs—also known as VBP programs—can create incentives for providers to furnish high-quality care. These programs adjust payment rates or make separate payments based on a provider's performance on one or more quality measures. Providers with relatively good quality receive higher payments than those with poorer quality. Medicare has had a VBP program in place for SNFs since October 1, 2018.

Key design features of the VBP program were established in the Protecting Access to Medicare Act of 2014 (PAMA). The law mandated the use of a single measure (all-cause readmissions to hospitals within 30 days of discharge from the hospital) to gauge the quality of care; required the Secretary to develop a methodology to ensure that the measure results are reliable and valid; and specified the performance scoring (40 percent of SNFs must have their payments lowered by the VBP), the funding for the incentive payments (a 2 percent reduction to the payment rate), and the distribution of those payments to SNFs (between 50 percent and 70 percent must be paid out to providers). CMS opted to return 60 percent of the withhold (or 1.2 percent, before factoring in performance).

In a mandated report to the Congress, the Commission compared the design features of the SNF-VBP program with a general set of principles regarding the design of quality-incentive programs (Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2018). The Commission concluded that the SNF-VBP program design was sufficiently flawed that it should be eliminated and replaced with a new program that (1) scores a small set of performance measures, (2) incorporates strategies to ensure reliable measure results to avoid rewarding random variation rather than actual performance, (3) establishes a system to distribute rewards that minimizes cliff effects (so that providers with similar measure results do not receive very different payments), (4) accounts for differences in patient social risk factors using a peer-grouping mechanism, and (5) completely distributes a provider-funded pool of dollars. MedPAC modeled an illustrative VBP design with these features, including peer groups to address differences in shares of low-income beneficiaries, and found that such a design was feasible and would result in more-equitable payments across SNFs.

Since then, CMS has made important changes to the VBP program that, to varying degrees, address the Commission's concerns. In 2020, the Secretary of HHS was granted the authority to add up to eight measures. Over the next two years, CMS plans to add seven measures: infections requiring hospitalization, total nurse staffing per resident day, staff turnover rates,

discharge to community, percentage of residents with a fall with major injury for long-stay residents, discharge function score for SNF patients, and hospitalizations per 1,000 long-stay residents (Centers for Medicare & Medicaid Services 2024c). In addition, CMS will replace the 30-day all-cause readmission rate with a potentially preventable readmission rate for SNF patients in FY 2028. This change is consistent with comments that the Commission made in 2017, encouraging CMS to rethink its readmission measure so that SNFs were held accountable for hospitalizations during the entire stay, not just the first 30 days (Medicare Payment Advisory Commission 2017).

CMS also revised the reliability standards, though improvements could still be made. For some measures, the measure must have “moderate” reliability but does not meet a commonly used standard of “good” reliability, whereby 70 percent of the variation is explained by differences in performance and 30 percent is explained by random variation. In addition, providers do not have to meet the minimum case counts for all measures. In FY 2028, when there will be eight measures in the program, providers will be required to meet the minimum counts for four of them.

Beginning in FY 2027, the VBP will consider social risk factors in scoring a SNF's performance. An adjustment will increase VBP payments for SNFs that provide high-quality care and care for high proportions of low-income beneficiaries. The size of the adjustment will vary based on how many top performances the SNF has and its share of dually eligible beneficiaries. In April 2025, CMS proposed eliminating this adjustment, but when this report went to press, the adjustment remained in place (Centers for Medicare & Medicaid Services 2025c).

Two other features of the VBP program do not meet the Commission's principles and would require congressional action to change. First, the design may not encourage all providers to improve because, by statute, the program must lower payments for 40 percent of SNFs. As a result, not every improvement may be rewarded. Second, the program does not pay out the entire provider-funded incentive pool of dollars. Even in FY 2027, when the payback percentage will increase from 60 percent to 66 percent of the pool, the VBP program will be used to achieve Medicare savings.

Since the VBP program began in 2019, average SNF performance has worsened. The average risk-standardized 30-day readmission rate increased slightly (from 19.4 percent in FY 2019 to 20.4 percent in FY 2023). Over the same period, the penalties and rewards have been relatively small, ranging from increases or decreases of about 2 percent.²⁸ In 2024, CMS estimated that the VBP program would result in \$185 million in Medicare savings (Centers for Medicare & Medicaid Services 2024c). Although the statute requires that payments be lowered for providers in the bottom 40 percent of readmission rates, about 70 percent of providers typically have their payment lowered. The modest impact on readmissions and payments likely reflects that the withhold is small (2 percent of Medicare's payments, or about 0.3 percent of aggregate NH revenues). SNFs may have concluded that the small increment to the payment rates would not fund the investment required to substantially improve their readmission rates.

Our evaluation of the first three years of the SNF-VBP program (covering FY 2019 through FY 2021) found that facilities were more likely to have larger payment reductions if they were smaller, treated more complex patients, had higher shares of dually eligible beneficiaries, were freestanding, or were for profit (Medicare Payment Advisory Commission 2021).²⁹ These results were consistent with research done by others (Daras et al. 2021, Hefelet al. 2019). Two studies found that SNFs with the lowest margins were more likely to be penalized by the VBP program, which might make it harder for them to invest resources to improve their quality (Qi et al. 2020, Sharma et al. 2021). SNFs with lower RN staffing levels were less likely to receive VBP rewards, though we did not find consistent relationships between payment adjustments and staffing (Daras et al. 2021, Medicare Payment Advisory Commission 2021). After examining rates of preventable critical incidents, GAO concluded that the payment incentives were insufficient to get SNFs to increase their RN staffing levels (Government Accountability Office 2021).

Demonstration to reduce avoidable hospitalizations

From 2012 to 2020, the CMS Innovation Center conducted a demonstration, known as the Initiative to Reduce Avoidable Hospitalizations Among Nursing

Facility Residents, aimed at lowering hospitalizations for long-stay NH residents.

The demonstration had two phases. The first phase (2012 to 2016) funded seven entities to implement a variety of clinical and education-based initiatives in 143 NHs. Grants to entities funded the hiring of RNs or advanced practice RNs to provide direct care and/or education and to manage medications. Some used funds to enable the adoption of technology that would enhance the coordination among the home, physicians, pharmacies, and hospital.

CMS's evaluation of the first phase found that the demonstration lowered the probability of avoidable hospitalizations and emergency department visits but, after accounting for the grants provided to participants, this phase raised program spending by \$28 million (RTI International 2017). There was no impact on resident mortality. The demonstration had no effect on MDS-based quality measures.³⁰ Of the varying approaches taken by the seven participating entities, models that included consistent, hands-on daily care showed larger changes compared with models that did not include direct care or included intermittent care or a rotating set of staff across the participating NHs.

The second phase (2016 to 2020) provided financial incentives to counter the FFS incentives to send residents to the hospital for six potentially avoidable conditions and to increase physician presence in NHs.³¹ Participants included some NHs from Phase 1 that opted to continue (this group had the clinical and educational funding of Phase 1 plus the financial incentives of Phase 2) and a new group of NHs that had only financial incentives. In total, there were six entities with 263 NHs, including 115 from Phase 1. There were three financial incentives. First, NHs received an additional per diem payment (\$218 per day) for a period of in-house treatment for residents. Second, physicians, NPs, and physician assistants (PAs) received a higher (hospital-level) payment when they treated residents (\$206 for an initial visit compared with \$138). These two incentives aimed to encourage facilities and clinicians to treat in place rather than send residents to the hospital for potentially avoidable conditions. The third incentive allowed practitioners to bill once a year for an evaluation to coordinate care (\$80 for the visit), which may have enhanced early detection of changes in residents' clinical conditions.

The evaluation of the second phase found no clear evidence that the financial incentives lowered hospitalizations, ED visits, or spending (RTI International 2017). Hospital and ED use and spending did not decrease further than what was achieved by entities in the clinical and educational phase. Hospitalizations, ED visits, and Medicare spending increased, relative to a national comparison group, among NHs that received the combination of clinical and educational activities and financial incentives. Among NHs with only financial incentives, there was no consistent evidence that utilization and spending were lowered. Participants reported that they did not change their practices in response to the financial incentives because reducing hospitalizations by treating in place was already a goal. High staff and administrator turnover at some NHs undermined the program's success because the frequent training of staff meant that the initiative did not move beyond a start-up phase. The evaluators concluded that there was value in providing on-site clinical care but that any financial incentive needs to be sufficient and appropriately structured to change behavior.

A separate study also found that the financial incentives alone or in combination with the clinical and educational incentives did not lower hospitalizations or spending (Tyler et al. 2022). Based on interviews with participants, the authors concluded that three components are needed for successful implementation: low turnover in staff and leadership; leadership and staff support; and provider engagement and support. Financial incentives alone were insufficient to reduce hospitalizations of long-stay NH residents.

Accountable care organizations

An ACO is a collection of providers that voluntarily enter into arrangements that hold the providers accountable for the quality and cost of care for a defined group of beneficiaries. ACOs are largely comprised of physician groups, health systems, or hospitals, but they may also partner with other providers, including NHs/SNFs, to help meet spending and quality benchmarks. If an ACO is successful at both, the ACO earns savings; if it is not, it is potentially at risk for losses.³² Common ACO strategies for managing spending include reducing hospitalizations, avoiding or reducing the use of post-acute care, and managing the use of ancillary services. ACOs have curbed the use

of SNFs by shortening SNF stays and by avoiding the setting altogether (Barnett et al. 2019).

Beneficiaries are eligible for assignment to an ACO if they had Part A and Part B coverage for at least one month and had no MA enrollment or Part B-only months during the prior two-year assignment window. Beneficiaries are assigned to an ACO based on where they receive the plurality of their primary care.³³ During a payment year, participating providers generally continue to receive FFS payments, but at the end of the year, total spending is compared with the ACO's financial benchmark.³⁴ If spending for the assigned beneficiaries is below the benchmark, the ACO earns a share of the savings; if spending is above it, the ACO may be at risk for a share of the difference (the "loss"). An ACO selects a level of risk it will accept (subject to CMS approval).

There are two types of Medicare ACOs—the Medicare Shared Savings Program (MSSP) and ACO Realizing Equity, Access, and Community Health (REACH). MSSP ACOs must have at least 5,000 beneficiaries assigned to them and focus on the over-65 population without specific care needs.³⁵ In 2025, there are 476 MSSP ACOs providing care to 11.2 million assigned beneficiaries (Centers for Medicare & Medicaid Services 2025b). REACH ACOs are part of a CMS Innovation Center demonstration that began in 2021 and will run through 2026 and tests different risk-sharing options. In 2025, there are 103 REACH ACOs with 2.5 million assigned beneficiaries, down from 122 REACH ACOs with 2.6 million beneficiaries in 2024 (Centers for Medicare & Medicaid Services 2025b).

ACOs generally are not designed to focus on managing the care of NH residents, so it is difficult to draw conclusions about their impact on nursing home care.³⁶ However, one part of the ACO REACH initiative is testing the use of High Needs ACOs, which are smaller (a minimum of 1,200 assigned beneficiaries in 2025) and focus on beneficiaries with complex medical conditions. To be eligible for assignment to a High Needs ACO, a beneficiary must have at least one chronic condition or a high risk score, have frailty or impaired mobility, or have received a substantial amount of SNF or home health care in the past year. High Needs ACOs must have a model of care that is designed to address the complex care needs of their assigned beneficiaries and their health disparities within their beneficiary populations. In 2025, there are

**TABLE
5-6**

Share of long-stay residents assigned to ACOs, 2023

Type of ACO	Number of ACOs	Total enrollment	Long-stay residents as a share of ACO-assigned beneficiaries
MSSP	453	10,019,782	1%
REACH	132	1,967,836	1
Standard and new	118	1,948,983	1
High Needs	14	18,853	28

Note: ACO (accountable care organization), MSSP (Medicare Shared Savings Program), REACH (Realizing Equity, Access, and Community Health).
High Needs ACOs are small ACOs (maximum assignment of 3,000 beneficiaries) that focus on beneficiaries with complex medical conditions.

Source: MedPAC analysis of ACO assignment data and nursing home assessment data.

13 High Needs ACOs, down from 14 in 2024 (Centers for Medicare & Medicaid Services 2025a).

Nursing home participation in ACOs

To gain insight into NH participation in ACOs, we conducted 15 interviews with a variety of stakeholders, including ACO representatives, trade associations, beneficiary advocates, and consultants. We asked interviewees about a NH's decision to participate in an ACO, the types of NHs that ACOs seek to partner with, how ACO care models work in NHs, and how ACO care models compare with I-SNP care models. Some interviewees (representing companies that offered both models in NHs) said they saw ACOs and I-SNPs as complementary businesses. I-SNPs were for beneficiaries who preferred MA, and ACOs were for beneficiaries who prioritized retaining their existing relationships with clinicians through the FFS program. NHs that want to participate in some form of an alternative payment model might choose between an I-SNP and an ACO, depending on the amount of risk they were willing to assume. NHs that wanted to gain some experience with risk sharing might start with an ACO affiliation, while those ready for more risk might partner with an I-SNP.

Other interviewees spoke about competition between the two models. Some reported that when a NH has both an ACO and an I-SNP, they compete for residents, especially among those who are likely to be low cost. Although physicians are not precluded

from participating in both an I-SNP and an ACO, one interviewee told us that some ACOs try to switch physicians from being part of an I-SNP to an ACO, contending that the physicians and their patients would face fewer hassles with the ACO.

Most ACOs do not have much experience with long-stay NH residents. (When ACOs focus on NHs, they mostly try to manage the SNF services of their assigned beneficiaries, who will largely be admitted from the community.) The lack of experience reflects the composition of most ACOs' assigned beneficiaries. On average, long-stay residents make up about 1 percent of the beneficiaries assigned to ACOs (Table 5-6). In contrast, about 28 percent of High Needs ACOs' assigned beneficiaries were long-stay residents.

However, there is some variation across individual ACOs in the shares of beneficiaries who are long-stay residents (Table 5-7). While two-thirds of ACOs had less than a 1 percent share, 15 ACOs had 10 percent or more (including three MSSP and three REACH ACOs that had greater than 50 percent shares, data not shown). In one MSSP ACO, 86 percent of its assigned beneficiaries were residents of NHs. All REACH ACOs with greater than 10 percent shares were High Needs ACOs. The low shares for the majority of ACOs are not surprising since most physician practices do not focus on the long-stay population or furnish care in NHs.

The ACOs with high shares of long-stay residents are smaller than other ACOs. MSSP ACOs with 10 percent

**TABLE
5-7**

On average, ACOs with a high share of long-stay residents were smaller compared with other ACOs, 2023

ACO model	Long-stay beneficiaries as share of total enrollment	Number of ACOs	Mean ACO size
MSSP	10+%	6	8,434
	1% to 9.9%	138	20,094
	Less than 1%	309	23,169
REACH	10+%	9	1,314
	1% to 9.9%	37	15,070
	Less than 1%	86	16,261

Note: ACO (accountable care organization), MSSP (Medicare Shared Savings Program), REACH (Realizing Equity, Access, and Community Health). "Size" is measured by the mean number of all assigned beneficiaries.

Source: MedPAC analysis of ACO assignment data and nursing home assessment data.

or more long-stay residents averaged about 8,400 assigned beneficiaries compared with over 20,000 for ACOs with lower shares of long-stay beneficiaries. The size differences are larger for the REACH ACOs: Those with the highest shares of long-stay beneficiaries (10 percent or more) were less than one-tenth the size of ACOs with higher shares (about 1,300 compared with about 15,000).

Interviewees told us that ACOs seek partnerships with NHs/SNFs that have low spending and hospitalization rates. Many MSSP ACOs may affiliate with SNFs/NHs so they can apply for a waiver from the three-day prior hospital stay requirement for Medicare coverage of SNF care.³⁷ In addition to seeking efficient NHs (those with low spending and high quality), we heard about the importance of the "fit" between the ACO and the NH's leadership and culture, especially for ACOs focused on NH residents because care coordination is key to the ACO's success. We were told that the physicians working in a NH determine whether a NH participates in an ACO and whether the partnership is successful. When an ACO includes physicians treating residents without the NH's support (or even knowledge), the NH has no incentive to make the ACO successful.

A SNF may be an "affiliate" of or a "participant" in an ACO. An affiliate has a formal agreement with the ACO that allows the ACO to apply for a waiver from the three-day hospital stay requirement for Medicare

coverage.³⁸ A participant is part of the ACO's network and will receive referrals for care but is not on the affiliate list for stays to be waived from the three-day hospital stay requirement.

ACOs often do not have SNF participants or affiliates, which could be optimal. In 2023, 68 percent of ACOs had no SNF participants, 74 percent had no SNF affiliates, and 49 percent had neither participant nor affiliated SNFs (based on MedPAC analysis of 2023 CMS ACO participation data). A survey of 366 ACOs conducted between October 2015 and January 2016 found that over half of them did not have a formal relationship with SNFs, though most had preferred SNF networks (Kennedy et al. 2020). The respondents reported that factors considered in establishing a partnership with a SNF included the NH's star rating, the average length of its SNF stays, its hospital readmission rate, its capacity to manage high-acuity patients and administer intravenous medications, its ability to admit patients within a short window, and a 24/7 referral line.

Just as ACOs are largely not focused on NHs, many NHs do not track whether their residents are assigned to an ACO, which may be appropriate given that the majority of their residents are not in an ACO. Across all NH residents in 2023, 55 percent met the ACO eligibility criteria, but only 16 percent were actually assigned to one (Table 5-8, p. 258). Of the NH residents who were

**TABLE
5-8**

Most nursing home residents were not assigned to an ACO, 2023

Nursing home residents	All long-stay residents	Share of all NH residents	Nursing home residents as a share of ACOs' eligible beneficiaries
All	838,561	100%	
ACO eligible	458,314	55	100%
ACO assigned	131,060	16	29
MSSP	108,862	13	24
REACH	22,198	3	5

Note: ACO (accountable care organization), NH (nursing home), MSSP (Medicare Shared Savings Program), REACH (Realizing Equity, Access, and Community Health). Beneficiaries are eligible for assignment if they had Part A and Part B coverage for at least one month and no Medicare Advantage enrollment or Part B-only months during the prior two-year assignment window. Figures are based on July data.

Source: MedPAC analysis of ACO assignment data and nursing home assessment data.

ACO eligible, less than one-third (29 percent) of them were assigned to one. An interviewee said that while a NH might partner with a High Needs ACO, not all of their residents met the eligibility requirements.

We were told that physicians are key in deciding whether a NH works with an ACO. If the ACO's physician groups work in NHs, they are more likely to get the NH to affiliate with the ACO. One interviewee told us that some ACOs try to entice physicians to participate in the ACO by offering night and weekend coverage by nurse practitioners. We also heard of ACOs that partnered with physician practices that worked in the NH, but the NH was unaware of their ACO participation, making it harder for the ACO to be successful.

NHs are generally not participating entities that share risk with CMS. Therefore, a NH relies on the agreement it reaches with an ACO about whether the NH will receive a portion of any earned savings. Having an affiliation or partnership with an ACO or being in a preferred network does not mean that the ACO shares its earned savings (these data are not collected by CMS). In a survey of 138 ACOs in the program from July 2019 through 2020, over half had a preferred network of SNFs, and of those almost all (91 percent) did not offer financial incentives to the preferred SNFs (Secordel et al. 2024).³⁹ Affiliations also do not

guarantee referrals since ACOs cannot recommend SNFs or NHs to their assigned beneficiaries, who retain their freedom to choose another SNF/NH. (From earlier work, we know that beneficiaries' decision about where to get their post-acute care is complex, but proximity to family members is important in making their selection (Medicare Payment Advisory Commission 2024a).) We were told that NHs do not always know that some of their residents are in an ACO, and their residents may not know that they have been assigned to one.

Interviewees said that when NHs decide whether to affiliate with an ACO, they weigh the lost revenue from fewer high-payment SNF days and other services against the opportunity to receive some share of the ACO's earned savings. One interviewee told us that a NH needs to have between 30 percent and 40 percent of its revenues in risk-bearing arrangements (either an ACO, an I-SNP, or both) before it shifts away from a FFS mentality. In ACOs where the NHs and the physician group practices share in the earned savings, all caregivers have a financial incentive for the ACO to succeed. One ACO company told us that their NHs received about 20 percent of the ACO's share of earned savings. However, since NHs often do not receive any of the earned savings, the benefit of partnering with an ACO is the referral volume and perhaps the preference for ACO volume over managed care volume.

Partnerships are also a function of the relative negotiating positions of the ACO and SNF. A highly rated SNF in a market with few other SNFs would have little incentive to affiliate with an ACO just to get referral volume, and it could have the leverage needed to negotiate a share of earned savings. In a market saturated with SNFs, a higher-quality home might be able to get a partnership that helps with only referral volume but not a portion of any earned savings.

ACO model of care in nursing homes

The ACO and NH representatives we spoke with reported that ACOs use a less intensive model of care compared with I-SNPs. (See below for a full discussion of the I-SNP model of care.) They told us that ACOs generally do not provide on-site care and instead rely on the NH staff combined with patient monitoring and, for those with the capital and trained staff, telemedicine visits. The evaluation of the Next Generation ACOs described activities to improve the quality and management of SNF care (which is provided to both short-stay and some long-stay NH residents), including embedded staff (such as care managers or NPs), to better manage patient care and transitions (NORC at the University of Chicago 2024b). High Needs ACOs with high shares of NH residents are more likely to provide hands-on care, but even then, the ACO is likely to provide fewer visits per week than it would in the typical I-SNP model. One ACO with a high share of long-stay residents told us they provided “wellness visits” to detect clinical conditions that warrant attention and a variety of services that enabled physicians to treat residents in place, such as monitoring changes in patients’ conditions, managing medications, and reporting lab results. In addition, when the ACO’s beneficiaries went to the ED or hospital, the ACO managed their transition to the ED and their return to the NH after discharge from the hospital. One NH representative who participated in both an I-SNP and an ACO said that its NH’s clinical staff used the same model of care for all residents (even those not in either program) to simplify care decision-making.

We found no studies that examined the care models that ACOs used for long-stay residents, but there were studies of ACOs’ management of SNF services. One study found that, compared with ACOs without formal relationships, ACOs with formal relationships with PAC providers (including SNFs) were more likely

to have advanced care-transition management, end-of-life planning, readmission preventions, and care management (Colla et al. 2016). A study of 138 ACOs’ preferred SNF networks found that ACOs expected the SNFs to share quality and cost data, notify the ACO about patient transfers to the hospital, and meet length-of-stay targets for their SNF stays (Secordel et al. 2024). This study’s respondents reported little use of virtual visits for care on the weekends or for consultations. Another study of 366 respondents to the National Survey of ACOs reported that the primary mechanism ACOs used to manage care in their preferred SNF networks was to have clinical staff visit ACOs’ beneficiaries across multiple SNFs and provide on-call advice. The ACOs said they established performance measures for lengths of stay and readmission rates and had clinical protocols for ambulation, pressure-ulcer prevention, pain management, and other condition-specific guidelines (Abt Associates 2020, Kennedy et al. 2020).

Service use and quality results

Previous evaluations conducted for CMS of an earlier ACO model called the ACO Investment Model (AIM) and the Next Generation ACOs found that reductions in SNF use (fewer admissions and shorter stays) were a contributing factor to lowering ACO costs, but they did not examine the impacts of ACOs on long-stay residents (Abt Associates 2020, NORC at the University of Chicago 2024b).⁴⁰ However, one study examined spending and use among NH residents in ACO-affiliated NHs (Chang et al. 2021). It found that NH residents assigned to ACOs had statistically significant lower hospitalization rates, fewer ambulatory care-sensitive conditions, and fewer ED visits, but there was no difference in Medicare spending per resident.

It is hard to draw any conclusions about the quality of care furnished to NH residents because the quality results are reported for the entire attributed population for an ACO, not for their NH residents separately. In addition, the measures are not tailored to the NH population, and, in fact, NH residents are excluded from some of the measures (such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures).

In contrast, the evaluation of the Global and Professional Direct Contracting Model separately examined High Needs ACOs. Compared with other

**TABLE
5-9**

I-SNP participation, 2015-2025

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Insurers	17	21	24	28	31	37	39	39	36	31	32
Contracts	44	37	41	49	57	72	82	87	85	82	80
Plans	57	79	83	97	125	150	172	184	190	175	163
Enrollment (in thousands)	51	60	66	77	91	94	90	102	112	125	122

Note: I-SNP (institutional special-needs plan). Enrollment figures for 2015-2024 are based on July data; figures for 2025 are based on March data. The 2023 figure for total I-SNP enrollment differs somewhat from the corresponding figure in Table 5-10 because the two tables use different data sources.

Source: MedPAC analysis of Medicare enrollment data.

ACOs, High Needs ACOs generally have larger shares of their assigned beneficiaries living in NHs and thus are more likely to reflect ACOs' effects on NH residents.

The most recent evaluation of the High Needs ACOs included eight ACOs (NORC at the University of Chicago 2024a). It found that of their almost 8,000 assigned beneficiaries, two-thirds were dually eligible and about half had a NH stay of more than 100 days in the prior year. On average, each beneficiary had 12 conditions.

Compared with a group of beneficiaries with similar characteristics, the model lowered hospitalizations (-6.1 percent), ED visits and observation stays (-5.0 percent), SNF days (-12.3 percent), home health episodes (-5.1 percent), and specialty care (-8.9 percent), and all but the declines in home health use were statistically significant. We note, however, that declines in utilization are not necessarily indicative of higher quality. Spending on hospice care increased, which is consistent with improved end-of-life care.

Relative to a comparison group, High Needs ACOs had small improvements in certain quality measures, but those changes were not statistically significant. Reductions in hospitalizations for ambulatory care-sensitive conditions (-0.8 percent), unplanned hospitalizations for beneficiaries with multiple chronic conditions (-1.4 percent), and all-condition readmissions (-5.0 percent) were consistent with improved quality but were not statistically significant.

Institutional special-needs plans

At a conceptual level, private health plans could potentially be more effective than traditional Medicare at delivering care to long-stay NH residents because plans have stronger incentives to coordinate care and manage overall spending. In the MA program, insurers can offer several types of special-needs plans that are only available to certain types of beneficiaries with distinct care needs. One type of special-needs plan, the I-SNP, is of particular interest because it targets beneficiaries who have lived (or are expected to live) in a NH for at least 90 days or live in the community but need the level of care provided in a NH.⁴¹ I-SNPs provide Medicare-covered services only; they do not provide any Medicaid-covered benefits such as nursing home care.

Although this section focuses on the experience with I-SNPs, Medicare has three other plan types that, to varying degrees, target beneficiaries who either live in NHs or live in the community but need a NH level of care (see text box (pp. 262-263) on Medicare plans that target beneficiaries who live in NHs or who need a NH level of care).

Insurers have been able to offer I-SNPs since 2006, but the concept of using capitated health plans to care for long-stay NH residents dates back even further, to a demonstration from 1994 to 2005 known as Evercare. Making Evercare and certain other demonstrations a

**TABLE
5-10****Distribution of I-SNP enrollment, by plan type and share of enrollees living in nursing homes versus the community, July 2023**

I-SNP type	Plans	Enrollees	Nursing home share	Community share
Facility based	76	80,945	99.1%	0.9%
Hybrid	71	25,188	66.3	33.7
Institutional equivalent	43	7,041	0.9	99.1
Total	190	113,174	85.7	14.3

Note: I-SNP (institutional special-needs plan). We considered enrollees to be living in a nursing home if they had a nursing home assessment from the Minimum Data Set that covered the first day of the month. The figure for total I-SNP enrollment differs somewhat from the corresponding figure in Table 5-9 because the two tables use different data sources.

Source: MedPAC analysis of Medicare enrollment data and nursing home assessment data.

permanent part of Medicare was one motivation for the creation of special-needs plans (Schmitz et al. 2008).

MedPAC last examined I-SNPs in depth in 2013, when the authority for insurers to offer special-needs plans was still temporary. At the time, the Commission found that I-SNPs performed better than other MA plans on some quality measures and recommended that the Congress permanently authorize them (Medicare Payment Advisory Commission 2013). In 2018, the Congress permanently authorized all types of special-needs plans, including I-SNPs.

Aside from the limits on the types of beneficiaries who can enroll, I-SNPs are generally subject to the same rules and requirements as other MA plans. For example, they are paid using the same payment system, are largely required to ensure that their provider networks meet the same adequacy standards, and can require enrollees to obtain prior authorization before using particular services.⁴² However, like all special-needs plans, I-SNPs must also follow an evidence-based model of care, complete annual health assessments for their enrollees, and report some additional quality data.

The I-SNP market has always been relatively small (Table 5-9). In 2025, a total of 32 insurers offer I-SNPs, and they collectively have about 122,000 enrollees. (For comparison, the MA program as a whole has 168 participating insurers and 34.5 million enrollees.) The

share of long-stay NH residents who are enrolled in I-SNPs is also low, about 12 percent in 2023 (data not shown). However, over the past decade, the number of insurers that offer I-SNPs has grown, and total enrollment has more than doubled.

CMS allows insurers to offer three types of I-SNPs:

- Facility-based institutional SNPs (FI-SNPs) cover only beneficiaries who live in NHs that are part of the plan's provider network;
- Hybrid institutional SNPs (HI-SNPs) cover beneficiaries who either live in NHs that are part of the plan's provider network or live in the community; and
- Institutional-equivalent SNPs (IE-SNPs) cover only beneficiaries who live in the community.

The vast majority of I-SNP enrollees are in facility-based or hybrid plans (Table 5-10). We compared I-SNP enrollment data with NH assessment data to determine which enrollees lived in NHs and found that about two-thirds of the enrollees in hybrid plans lived in NHs and about one-third lived in the community. (That ratio rarely held for an individual hybrid plan—35 of the 41 hybrid plans with more than 100 enrollees had more than 90 percent of their enrollment in one setting or the other.) Across all I-SNPs, we found that about 85 percent of enrollees lived in NHs.

Experience with other Medicare plans that target beneficiaries who live in nursing homes or need a nursing home level of care

In addition to institutional special-needs plans (I-SNPs), Medicare offers three plans for beneficiaries who live in nursing homes (NHs) or need a nursing home level of care: dual-eligible special-needs plans (D-SNPs), Medicare–Medicaid Plans (MMPs), and the Program of All-Inclusive Care for the Elderly (PACE).

D-SNPs are specialized MA plans that serve people who have both Medicare and Medicaid. The level of integration between these plans and Medicaid varies, but some D-SNPs that are more highly integrated cover Medicaid long-term services and supports (LTSS), including NH care. In 2023, D-SNPs had 5.2 million enrollees, but only 63,000 (about 1 percent) were long-stay residents. However, long-stay residents are a much higher share of the enrollment in some individual plans; for example, they represent more than 10 percent of the enrollment in most D-SNPs in Minnesota.

MMPs are part of a demonstration testing the use of highly integrated plans for dually eligible beneficiaries. Ten states have tested MMPs, and they are still in operation in eight states. CMS will end the demonstration at the end of 2025; when that happens, we expect most MMPs to convert into D-SNPs. In 2023, MMPs had 306,000 enrollees, and 23,000 (about 8 percent) were long-stay residents. As with D-SNPs, the share of enrollees who are long-stay residents varies considerably across plans.

PACE plans serve beneficiaries who are 55 or older and need the level of care provided in a NH. The program aims to keep people living in the community instead of going into NHs, and it uses a distinctive model of care based on adult day-care centers that are staffed by interdisciplinary teams that provide therapy and medical services. PACE plans provide all Medicare- and Medicaid-covered services. In 2023, PACE plans had about 58,000 enrollees, and 3,000 (about 5 percent) were long-stay residents (who lived in the community when they first enrolled).

These plans have the potential to improve care in several ways for beneficiaries who need a NH level of care. Since they cover both medical services and Medicaid LTSS (this is true for all MMPs and PACE plans but only some D-SNPs), they can better coordinate care for beneficiaries who need both types of services. Since Medicaid pays these plans for LTSS on a capitated basis, they have incentives to encourage the use of community-based forms of LTSS, which are usually less expensive than NH care on a per capita basis and often more in line with beneficiaries' preferences. For example, the use of community-based LTSS could potentially avoid or delay some NH placements or enable some NH residents to return to the community. Finally, for long-stay NH residents, these plans (like I-SNPs) have incentives to avoid costly inpatient stays and emergency department visits by providing more care in the NH setting.

I-SNPs differ from these three plan types because they provide Medicare benefits only and do not include any Medicaid LTSS coverage. Some observers have criticized this lack of integration, arguing that I-SNPs (particularly facility-based I-SNPs) have incentives to keep enrollees in NHs instead of trying to return them to a community setting. However, it is unclear how many residents can plausibly return to the community after being in a NH for 90 days (a requirement for enrolling in an I-SNP). One interviewee said that efforts to return NH residents to the community are more likely to succeed if they target residents shortly after they have been admitted and become progressively harder when residents have been in a NH for longer periods of time. If the number of long-stay residents who could be returned to the community is relatively small, requiring I-SNPs to be more closely integrated with Medicaid may have little effect.

For D-SNPs, relatively little research has looked specifically at their effects on long-stay NH residents or on NH admissions. One study of dually

(continued next page)

Experience with other Medicare plans that target beneficiaries who live in nursing homes or need a nursing home level of care (cont.)

eligible beneficiaries in Minnesota compared those enrolled in highly integrated D-SNPs with those enrolled in a combination of FFS Medicare and Medicaid managed care; the study found that D-SNP enrollees were more likely to receive community-based LTSS but did not have a lower likelihood of NH admission (Anderson et al. 2016). Another study of highly integrated D-SNPs in Massachusetts found that enrollees, relative to a comparison group of dually eligible beneficiaries, had lower rates of NH use and lower mortality rates (JEN Associates Inc 2013).

For MMPs, CMS has contracted with RTI to evaluate the effects of each demonstration on areas such as program costs and service use. The evaluations that have been released so far typically cover the first four to five years of a demonstration (Feng and Greene 2023a, Feng and Greene 2023b, Feng and Greene 2023c, Feng and Greene 2023d, Feng and Greene 2023e, Feng and Greene 2023f, Feng and Greene 2023g, Feng and Greene 2022a, Feng and Greene 2022b, Feng and Greene 2021a, Feng and Greene 2021b).

One key question about the demonstrations had been whether MMPs could achieve more desirable patterns of service use—for example, reducing the use of NHs and expanding the use of community-based forms of LTSS. As a result, one metric that RTI has tried to calculate for each demonstration has been the change in the likelihood that enrollees will have a long NH stay. RTI produced estimates for 7 of the 10 states with demonstrations. The results have been mixed: RTI found that the likelihood of having a long NH stay increased in two states, decreased in four states, and did not change by a statistically significant amount in one state.

The findings from the evaluations are somewhat challenging to interpret given the analytic approach that was used. RTI measured the effects of the demonstration by comparing dually eligible beneficiaries who are eligible for the demonstration

(whether or not they actually participated) with similar groups of dually eligible beneficiaries in other states. The participation rates for many demonstrations have been lower than expected, often between 20 percent and 40 percent overall, with even lower rates for long-stay residents as many either opted out when states tried to passively enroll them in MMPs or disenrolled from MMPs after a short period of time.⁴³ The low participation rates make it less clear that any differences between the demonstration-eligible and comparison populations are due to the demonstration rather than other factors.⁴⁴

For PACE, the research literature is somewhat dated, with many studies now more than 10 years old. In 2014, the Assistant Secretary for Planning and Evaluation (ASPE) reviewed the literature on PACE and found that the quality of the existing studies varied and that identifying a good control group to compare with PACE enrollees was a particular challenge (Ghosh et al. 2014). The review found “strong evidence” that PACE reduces inpatient hospitalizations and “some evidence” that PACE enrollees have a lower mortality rate. The review also found that PACE enrollees had higher rates of NH admissions but noted that existing studies did not distinguish between short-term (post-acute) and long-term NH stays.

Following the literature review, ASPE commissioned a study to look at the effects of PACE on short-term versus long-term NH use (Ghosh et al. 2015). The study found that, relative to beneficiaries enrolled in Medicaid home- and community-based services (HCBS) waiver programs, PACE enrollees were more likely to have short-term NH admissions but they “tended to be limited in duration.” The study also found that PACE appears to “delay, but not ultimately prevent, long-term NH stays.” A separate study found that PACE enrollees were less likely to have a long NH stay than HCBS enrollees (Segelman et al. 2017). ■

Unless indicated otherwise, this section focuses on the experience with I-SNPs in nursing homes.⁴⁵ The survey is organized into six sections:

- key features of the I-SNP model,
- the insurers that offer I-SNPs,
- nursing home participation in I-SNPs,
- beneficiary enrollment in I-SNPs,
- the impact of I-SNPs on quality and outcomes, and
- I-SNP payment rates, rebates, and extra benefits.

For this work, we used several types of administrative data, including enrollment data, nursing home assessment data, MA quality data, and MA bid data. We also interviewed a variety of stakeholders who are knowledgeable about I-SNPs, such as NH operators, insurers that offer I-SNPs, consultants, and academic researchers.

Key features of the I-SNP model

The I-SNP model is based on the premise that plans can improve the quality of care for long-stay residents by delivering more care within the NH and reducing the use of expensive services such as inpatient care and emergency room visits. While there can be some variation across plans, our interviews suggest that I-SNPs largely appear to use the same basic approach to try to meet this goal. That approach has several features that distinguish I-SNPs from both FFS Medicare and conventional MA plans:

- *Use nurse practitioners (NPs) to deliver more care within the nursing home.* The NPs make regular visits to the NHs in the plan's provider network. (Our interviewees said NPs typically visit the NH two to three times each week.) The NP monitors the health of the plan's enrollees, coordinates their care with their physicians, communicates with family members, and works with the NH clinical staff to deliver on-site care. For example, the NP could direct the NH clinical staff to provide skilled care to an enrollee without a prior hospital stay, a practice known as "skilling in place."⁴⁶ The NPs for insurer-sponsored plans are typically employed by the plan; the NPs for provider-sponsored plans could be employed by either the plan or the NH or serve on a contracted basis.

- *Generate sufficient enrollment within the nursing home.* Scale plays an important role in the I-SNP care model. From the plan's perspective, the NPs are more cost-effective when they can see a large number of enrollees in the same NH instead of seeing a similar number spread across multiple facilities. According to our interviewees, I-SNPs aim to enroll somewhere between 40 percent and 70 percent of the long-stay residents in a NH, which for a medium-sized NH translates to roughly 20 to 40 enrollees.
- *Modify financial incentives for the nursing home.* In FFS Medicare, NHs have an incentive to send long-stay residents to the hospital so they can qualify for Medicare-covered, higher-payment skilled care. Once residents qualify for skilled care, NHs also have an incentive to continue providing them with skilled care because Medicare pays for that care using daily rates.⁴⁷ In MA, NHs can have similar incentives because many plans also appear to use daily rates for SNF care, although the incentives may be weaker than in FFS Medicare because plans often pay lower rates and may approve fewer days of care. In contrast, I-SNPs reimburse NHs using a variety of approaches (discussed in more detail later) that aim to reduce or eliminate these marginal incentives.
- *Minimize revenue losses for the nursing home.* If an I-SNP is successful at reducing hospitalizations for its enrollees, the NH might receive less revenue if fewer residents receive Medicare-covered skilled care. This potential loss of revenue could make NHs less willing to contract with I-SNPs. As a result, I-SNPs need to ensure that their payment arrangements with NHs, in aggregate, minimize or avoid these losses and make it attractive for NHs to contract with them.

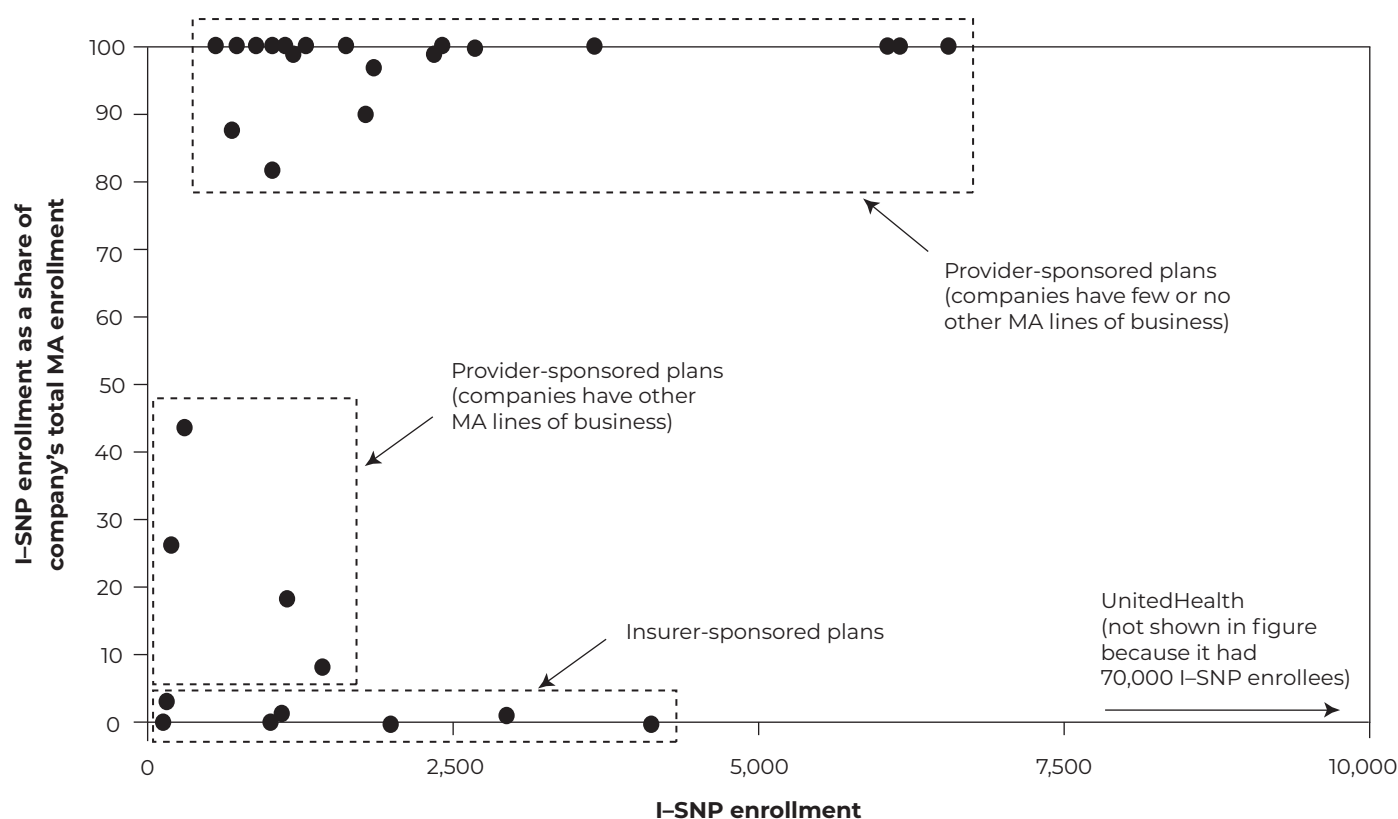
The insurers that offer I-SNPs

Figure 5-5 shows the insurers that offered I-SNPs in 2024. Each dot in the scatterplot is a different company. The horizontal axis shows the number of beneficiaries enrolled in the company's I-SNPs while the vertical axis shows its I-SNP enrollment as a share of its overall MA enrollment (across all types of MA plans, not just I-SNPs).

Most of these insurers have relatively few I-SNP enrollees—nearly all have fewer than 5,000 enrollees

FIGURE 5-5

An overview of the companies that offered I-SNPs in 2024



Note: I-SNP (institutional special-needs plan), MA (Medicare Advantage). Figures are based on July data.

Source: MedPAC analysis of Medicare plan enrollment data.

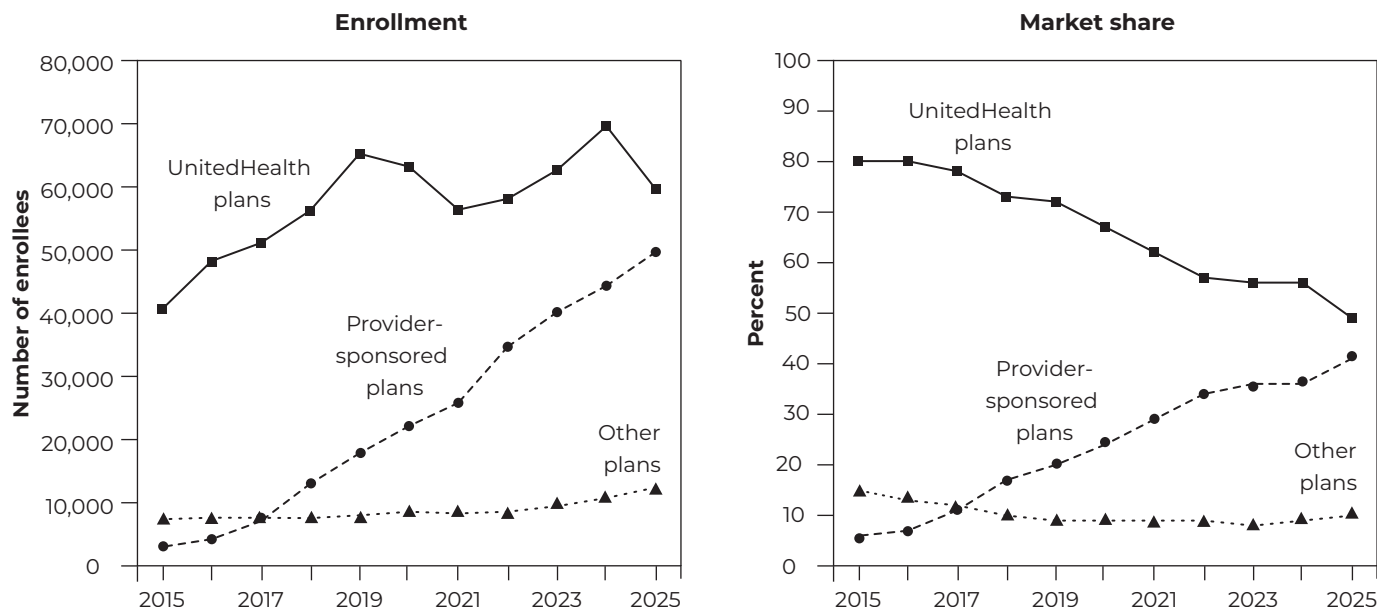
and most have fewer than 2,500. At the same time, there is wide variation in the importance of I-SNPs to their overall MA business. These insurers can be divided into three major groups:

- **UnitedHealth.** This company was the only insurer that participated in the original Evercare demonstration, the predecessor for I-SNPs. Those Evercare plans were converted into I-SNPs in 2006 and UnitedHealth has been a major presence in the I-SNP market ever since. It has been the largest I-SNP insurer since 2012.⁴⁸

UnitedHealth's I-SNP enrollment—about 70,000 in 2024—is so much larger than other insurers' that the company does not appear in Figure 5-5 due to the scale we used. However, UnitedHealth is also

the largest insurer in the MA program, and its I-SNP enrollment accounts for less than 1 percent of its overall MA enrollment.

- **Provider-sponsored plans.** Most of the companies (23 out of 31) that offered I-SNPs are “provider-sponsored” or “provider-led” plans, where the NHs in the plan's provider network have an equity or ownership stake in the insurer that sponsors the I-SNP. These insurers are largely clustered at the top of Figure 5-5; most have relatively few enrollees, and the I-SNP is often their only MA line of business. A few of these insurers, located in the middle box in Figure 5-5, are somewhat less reliant on I-SNPs (for example, they may also offer a conventional MA plan or D-SNP) but the I-SNP

**FIGURE
5-6****Changes in I-SNP enrollment and market share, 2015–2025**

Note: I-SNP (institutional special-needs plan). Figures for 2015–2024 are based on July data; figures for 2025 are based on March data.

Source: MedPAC analysis of Medicare plan enrollment data.

still accounts for between roughly 10 percent and 45 percent of their overall MA enrollment.

- *Insurer-sponsored plans.* The remaining insurers, located in the box running just above the horizontal axis in Figure 5-5, p. 265, are traditional health insurers that offer I-SNPs that both have relatively low enrollment and represent a very small share of their overall MA enrollment. This group includes companies such as Humana, Elevance Health, and CVS Health (Aetna).

The number of companies that offer I-SNPs more than doubled between 2015 and 2021, rising from 17 to 39 (Table 5-9, p. 260). This growth was largely driven by provider-sponsored plans, which accounted for 25 of the 35 companies that entered the market during this period; the overall change in the number of I-SNP insurers was smaller because 13 companies either left the market or were acquired by other insurers (data not shown). As a result, the enrollment

and market share for provider-sponsored I-SNPs climbed rapidly (Figure 5-6). Between 2015 and 2021, their enrollment grew from about 3,000 to about 26,000, while enrollment in UnitedHealth's I-SNPs grew from 41,000 to 56,000. (During the pandemic, enrollment in provider-sponsored plans continued to grow because the entry of new plans more than offset the additional deaths due to COVID-19. The footprint for UnitedHealth's I-SNPs was more stable, so the effects of the pandemic on their enrollment are more apparent.) In terms of market share, provider-sponsored plans jumped from 6 percent to 29 percent, while UnitedHealth declined from 80 percent to 62 percent.

After peaking at 39 insurers in 2021 and 2022, the number of companies that offer I-SNPs has declined somewhat, falling to 32 in 2025 (Table 5-9, p. 260). The number of new entrants has fallen sharply: Only 4 companies have entered the market since 2021, while 11 companies have either closed their I-SNPs or

sold them to other insurers. However, enrollment in provider-sponsored plans has continued to grow, and the market shares for I-SNPs are currently around 50 percent for UnitedHealth, 40 percent for provider-sponsored plans, and 10 percent for other insurer-sponsored plans.⁴⁹

Several interviewees said the decline in the launch of new provider-sponsored plans was at least partly due to the pandemic, which forced NHs to focus on more immediate, day-to-day challenges. Since the end of the pandemic, they have seen renewed interest in the concept and expected more provider-sponsored plans to enter the I-SNP market in the next few years.

Provider-sponsored plans can be structured in a variety of ways. In some cases, the I-SNP is a fully owned subsidiary of a NH chain, and the chain bears full financial risk for any losses that the plan might experience. This approach appears to be more common when the NH chain is relatively large; for example, Pruitt Health Premier is owned by a single chain that has over 100 NHs (ATI Advisory 2020). In these cases, the NH chain may contract with an outside company to perform some of the plan's insurance functions. In other cases, the I-SNP is a joint venture between one or more NH chains and an outside company that both handles some or all of the plan's insurance functions and has an ownership stake in the plan. Several interviewees said this approach is appealing to NHs that either do not want to bear full financial risk for an I-SNP or do not have enough capital to finance one on their own. For example, Perennial Advantage was formed by three NH chains, and Simpra Advantage is backed by 28 chains, many of them small chains with 10 or fewer NHs (ATI Advisory 2020, Flynn 2021, Silverstein 2019). Some provider-sponsored plans also allow NHs to participate in their provider network without taking an ownership stake (the traditional approach for insurer-sponsored plans), while one traditional insurer has formed a partnership in which a company that normally offers provider-sponsored plans operates some of the insurer's I-SNPs on a subcapitated basis (Grebbin 2023, McKnight's Long-Term Care News 2024).⁵⁰

Several interviewees said that provider-sponsored plans need a minimum level of enrollment to be profitable. They noted that offering a plan entails a variety of relatively fixed costs (such as obtaining an

insurance license, capital reserves, and regulatory compliance) that make a plan unprofitable unless the costs can be spread across a sufficiently large base of enrollees. When we asked how many enrollees these plans needed, their answers varied but had similar orders of magnitude: one interviewee said 1,000 enrollees by the end of the second or third year; a second interviewee said 500 enrollees in plans that are part of a joint venture and 2,000 to 3,000 enrollees in plans owned entirely by a NH chain; while a third interviewee said "in the thousands."

Nursing home participation in I-SNPs

Long-stay residents cannot enroll in an I-SNP unless their NH participates in the plan's provider network. As a result, NHs play a key role in determining how much of the long-stay population has access to an I-SNP. CMS requires that all I-SNPs that serve people in nursing homes (that is, the facility-based and hybrid plans) have at least one NH in their provider network in each county in their service area.

No publicly available data indicate which NHs participate in I-SNPs. To better understand these relationships, we used monthly enrollment data to identify the beneficiaries enrolled in I-SNPs and NH assessment data (from the MDS) for 2018 through 2023 to identify long-stay residents and the specific facilities in which they lived. We then calculated the number of long-stay residents in each NH as of July 1 of each year. We considered NHs to be participants in an I-SNP if two or more long-stay residents were enrolled in an I-SNP offered by the same insurer.⁵¹

In 2023, about a quarter of all NHs—more than 3,700 facilities—participated in I-SNPs (top panel of Table 5-11 (p. 268)). Between 2018 and 2023, the share of NHs that participated grew steadily, increasing by 12 percentage points, or almost 1,700 facilities. In our annual status report on the MA program, we measure access to I-SNPs by calculating the share of beneficiaries who live in counties where an I-SNP is offered, and we found that access grew from 46 percent in 2013 to 77 percent in 2023 (Figure 5-7, p. 269). However, for long-stay residents, access is better measured by the share of residents who live in NHs that participate in I-SNPs. Using this approach, the share of long-stay residents who have access to an I-SNP is much lower (about 33 percent in 2023) but has also been increasing over time (Figure 5-7 and the middle panel of Table 5-11).

**TABLE
5-11**

Between 2018 and 2023, nursing home participation in I-SNPs grew, but the share of eligible residents who enrolled declined somewhat

	2018	2019	2020	2021	2022	2023
Total nursing homes	15,186	15,121	15,018	14,905	14,806	14,643
NHs participating in I-SNPs	2,054	2,401	2,747	3,015	3,390	3,746
NHs not participating in I-SNPs	13,132	12,720	12,271	11,890	11,416	10,897
Share of NHs participating in I-SNPs	13.5%	15.9%	18.3%	20.2%	22.9%	25.6%
Total long-stay residents (in thousands)	915	908	857	762	793	815
Long-stay residents of NHs participating in I-SNPs	180	204	211	207	239	268
Long-stay residents of NHs not participating in I-SNPs	735	704	646	554	554	548
Share of long-stay residents eligible to enroll in I-SNPs	19.7%	22.5%	24.6%	27.2%	30.1%	32.8%
Total I-SNP enrollees in NHs (in thousands)	69	81	83	79	87	96
Share of eligible long-stay residents enrolled in I-SNPs	38.2%	39.7%	39.3%	38.3%	36.6%	35.7%

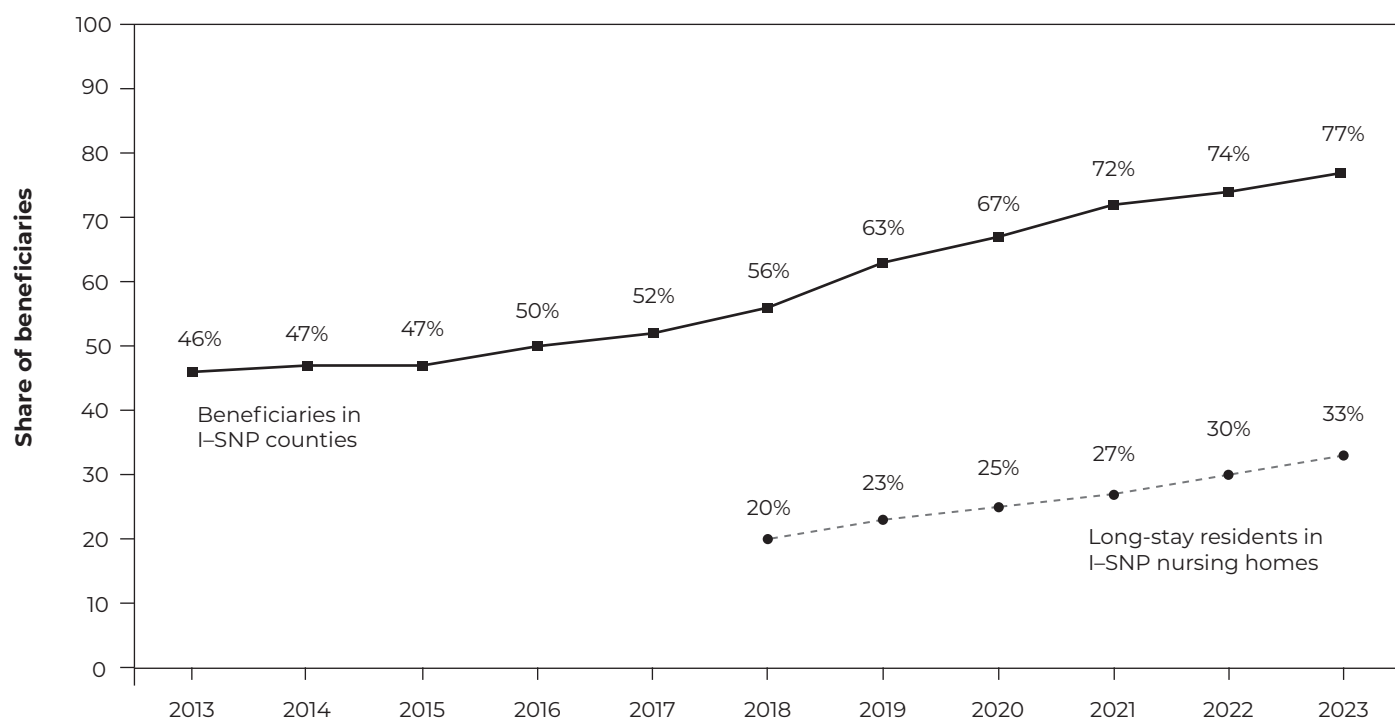
Note: I-SNP (institutional special-needs plan), NH (nursing home). We counted beneficiaries as long-stay residents if they had been in a nursing home for 90+ days. The total number of NHs is based on facilities with at least one long-stay resident. We counted NHs as participating in I-SNPs if they had two or more long-stay residents enrolled in I-SNPs offered by the same insurer. The figures for long-stay residents exclude residents who cannot enroll in an I-SNP because they do not have both Part A and Part B (about 3 percent of all residents). Figures are based on July data for each year. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare enrollment data and nursing home assessment data.

We also calculated the share of long-stay residents in the participating NHs that were enrolled in an I-SNP. As part of this calculation, we excluded beneficiaries that had Part A only or Part B only because they cannot enroll in an MA plan. Some interviewees also noted that, as a practical matter, some long-stay residents will not enroll in an I-SNP because they have retiree health coverage that requires them to enroll in FFS Medicare or an employer-sponsored MA plan, but we cannot identify these people with administrative data. Among long-stay residents with access to an I-SNP, we found that the share who actually enrolled in an I-SNP declined somewhat, from 38 percent in 2018 to 36 percent in 2023 (bottom panel of Table 5-11). In sum, Table 5-11 indicates that the growth in I-SNP enrollment between 2018 and 2023 was driven entirely by growth in the number of participating NHs rather than growth in the share of eligible beneficiaries who enroll.

Nearly all NHs (between 98 percent and 99 percent) that participated in I-SNPs worked with a single insurer. This arrangement means that when long-stay residents have access to an I-SNP, they typically have one plan available and are not choosing among I-SNPs offered by different insurers.⁵² Our interviewees indicated that both insurers and NHs have strong incentives to prefer these one-to-one relationships. For insurers, having exclusive access to the NHs in its network makes it more likely that I-SNPs can generate the “critical mass” of enrollment needed to operate in a cost-effective manner. For NHs, working with a single insurer is preferable because their clinical staff need to become familiar with only one insurer’s care model.

The NHs that participate in I-SNPs tend to keep working with the same insurer over time. On an annual basis, 93 percent of the NHs that participated in I-SNPs between 2018 and 2022 worked with the

**FIGURE
5-7****The share of beneficiaries with access to an I-SNP increased from 2013 to 2023**

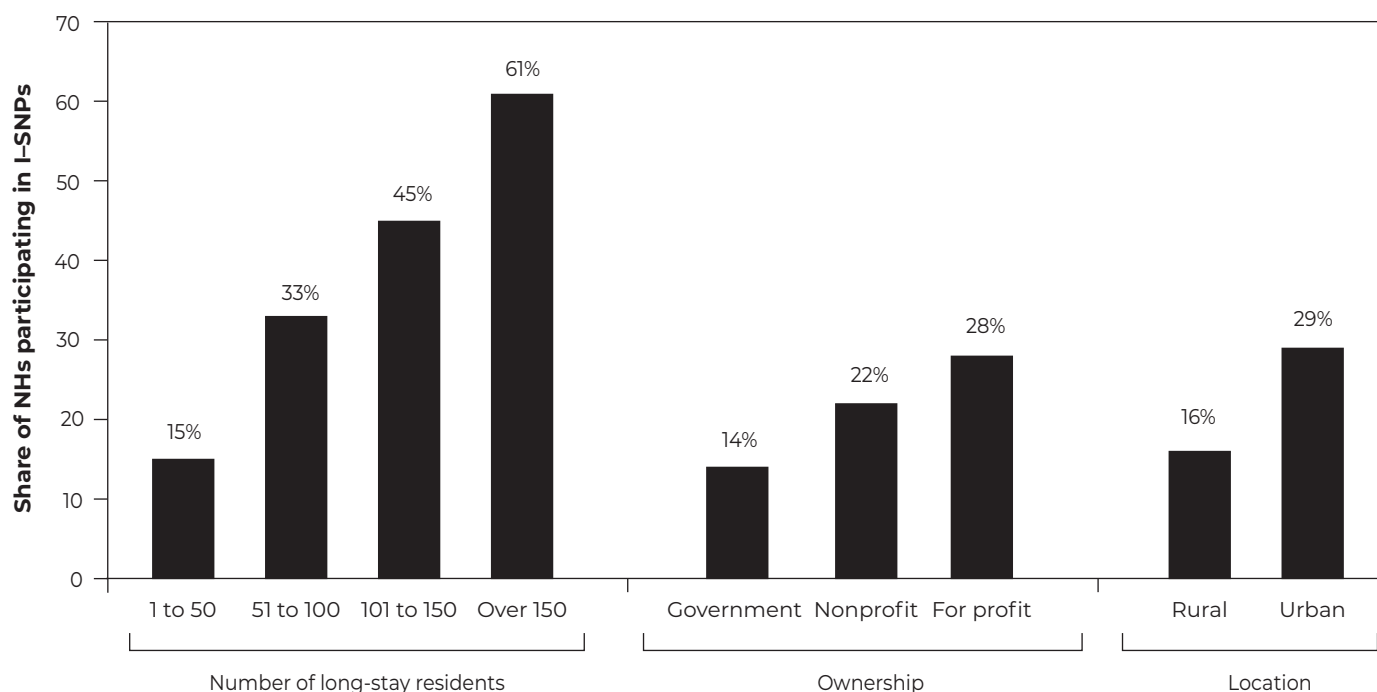
Note: I-SNP (institutional special-needs plan). Figure is based on beneficiaries who have both Part A and Part B. Figures for the share of long-stay residents who live in I-SNP nursing homes are based on July data for each year.

Source: MedPAC analysis of MA plan bids, Medicare enrollment data, and MDS assessments.

same insurer in the following year, 2 percent switched to another insurer, between 4 percent and 5 percent stopped participating in I-SNPs, and less than 1 percent closed. While these annual changes were relatively small, the cumulative effects were larger. We took the NHs that participated in an I-SNP in 2018 and looked at their status in 2023, five years later. We found that 73 percent of those NHs still worked with the same insurer, 9 percent had switched to another insurer, 15 percent did not participate in an I-SNP, and 3 percent had closed. The NHs that stopped participating tended to have fewer I-SNP enrollees than the NHs that continued to participate, underscoring the importance of adequate enrollment in the I-SNP model. (For example, the NHs that stopped participating between 2022 and 2023 had an average of 13 enrollees, while the NHs that continued participating had an average of 26 enrollees.)

Some types of NHs are more likely to participate in an I-SNP than others. Figure 5-8 (p. 270) shows how participation varies based on the number of long-stay residents, ownership type, and whether the NH is located in a rural or urban area. I-SNP participation was strongly associated with NH size: In 2023, about 15 percent of facilities with 50 or fewer residents participated, compared with about 60 percent of facilities with more than 150 residents. Given the importance of scale for I-SNPs, insurers may be less interested in smaller NHs because it is harder to generate enough enrollment to operate in a cost-effective manner.

In terms of ownership, for-profit NHs are more likely to participate than nonprofit NHs, but the difference in their participation rates is relatively small, about 5 percentage points in 2023. Government-owned

**FIGURE
5-8****Variation in nursing home participation in I-SNPs,
by selected facility characteristics, 2023**

Note: I-SNP (institutional special-needs plan). We counted beneficiaries as long-stay residents if they had been in a nursing home for 90+ days. Figures are based on July data for each year.

Source: MedPAC analysis of Medicare enrollment data, nursing home assessment data, and provider of services file.

facilities have the lowest participation rates but account for less than 6 percent of all facilities. In terms of location, NHs in urban areas are almost twice as likely to participate as those in rural areas (in 2023, 29 percent vs. 16 percent). NHs in urban areas may be more attractive to insurers because they tend to be larger and the distances between them tend to be shorter, which may make the use of NPs more cost-effective.

The NHs that participate in I-SNPs differ from nonparticipating NHs in other respects as well (Table 5-12). Participating NHs have a larger share of patient days covered by Medicaid (60 percent vs. 54 percent) and lower total margins across all payers and sources of revenue (less than 0.1 percent vs. 0.7 percent). The participating NHs also tend to have lower staffing levels and lower overall quality ratings on the Care Compare website.

Our interviewees said that NHs participate in I-SNPs for a variety of reasons; many were tied to concerns about broader developments in Medicare that they considered unfavorable for the NH industry. For example, some NHs want to get ahead of the ongoing shift from traditional FFS payment to value-based payment but do not think the existing value-based models provide opportunities for NHs to receive shared-savings payments. Similarly, interviewees said the steady growth in MA enrollment puts financial pressure on NHs because plans tend to pay less for skilled care and approve fewer days of care. As a result, some NHs see I-SNPs as a way to generate additional revenue and gain more control over their reimbursement. One NH representative simply thought that an I-SNP would be a beneficial option for the facility's residents; they said their subsequent experience had been positive. Another interviewee said

**TABLE
5-12**

Additional differences between nursing homes, by participation in I-SNPs, 2023

Characteristic	Nursing homes participating in I-SNPs	Nursing homes not participating in I-SNPs
Share of days covered by:		
Medicaid	60%	54%
Fee-for-service Medicare	9	11
Other payers (includes MA plans)	31	35
Total margin (all payers, all lines of business)	<0.1	0.7
Median total nurse staffing (hours per resident day)	3.60	3.79
Average overall quality rating (low = 1 star, high = 5 stars)	2.68	2.86

Note: I-SNP (institutional special-needs plan), MA (Medicare Advantage). Figures for share of days covered by different payers and total margins are based on freestanding facilities.

Source: MedPAC analysis of Medicare enrollment, nursing home assessment, cost report, Bureau of Labor Statistics, U.S. Census, and Nursing Home Compare data.

NHs are more likely to participate when state Medicaid programs raise payment rates for long-stay care; the higher reimbursement makes NHs more willing to accept some uncertainty about the revenues they would receive from an I-SNP.

Several interviewees also mentioned reasons why NHs may not participate in I-SNPs:

- Two interviewees said that a subset of NHs think their most profitable strategy is to maximize the number of residents in FFS Medicare and limit their interactions with MA plans. One interviewee estimated that this group represents about 20 percent of all NHs.
- Some interviewees said that NHs in states that use case-mix systems to adjust their Medicaid payment rates for long-stay care are less likely to participate due to concerns that I-SNPs will lower their case mix and reduce their Medicaid revenues. However, they did not explain exactly how participation in an I-SNP might affect a facility's Medicaid case mix.
- One NH interviewee said that NHs need significant administrative capabilities (such as data analytics and ongoing staff training) to participate

successfully in an I-SNP, and that many smaller NHs may be unsure about their ability to develop those capabilities.

How NHs are reimbursed by I-SNPs

We asked interviewees to describe how I-SNPs reimburse participating NHs for care. Their responses indicate that, while the methods used to reimburse NHs vary to some degree, the most common approach is a combination of capitated payments and incentive payments.

The capitated payment typically covers Part A skilled care and Part B therapy services (the primary types of services that NHs provide on-site) and is paid on a per member per month basis. The payment appears to rarely cover services provided outside the NH. The capitation rate is based on historical utilization rates for skilled care but also includes an allowance for the additional “skilling in place” that NHs are expected to provide to the plan's enrollees. Two interviewees said that some I-SNPs also use FFS payment amounts when developing their capitation rates, which can make participation in the I-SNP attractive since many MA plans use lower rates to pay for skilled care.

Two interviewees said I-SNPs may still pay NHs on a FFS basis in some situations. One NH representative said it was paid on a FFS basis during the first year that it participated in an I-SNP before switching to capitated payments in later years. One plan representative said it preferred to use capitation for its participating NHs but would also allow NHs to be paid using a FFS-based approach combined with larger incentive payments.

The use of capitated payments removes the financial incentive that NHs have in FFS Medicare to send long-stay residents to the hospital so they can receive higher-paid skilled care when they return. One representative of a NH chain said the use of capitation had also changed how its facilities deliver therapy services; the chain now tries to provide more therapy at an earlier stage while also providing less therapy overall.

The incentive payments can take a variety of forms, but interviewees said they are often tied to NH performance on certain quality metrics and/or the overall spending for plan enrollees. One representative of a NH chain said its quality-based incentive payments were tied to performance on three measures: the occurrence of falls resulting in major injury, the use of multiple medications (polypharmacy), and hospitalizations. Another interviewee said incentive payments are often tied to hospitalizations. The spending-based incentive payments are often structured as “shared savings” arrangements where NHs receive a portion of the savings that occur when total spending for enrollees is lower than a target amount. Both types of incentive payments for NHs are typically “upside only,” meaning that the facility receives additional payments if it performs well but is not penalized if it performs poorly. (In provider-sponsored I-SNPs, the corporate owner of the NH may experience financial losses even if individual facilities are not penalized.) The incentive payments may be quite large compared with the incentives used in FFS payment systems: One NH interviewee said that incentive payments accounted for about half of the chain’s I-SNP revenue, with capitated payments accounting for the other half. (For comparison, the value-based purchasing program for SNF care adjusts payment rates by between –2.0 and +1.8 percent.)

Like the capitated payments, these incentive payments aim to change the financial incentives that NHs face

in FFS Medicare. The capitated payments help ensure that, at the margin, NHs do not receive additional revenue if they send an I-SNP enrollee to the hospital; the spending-based incentive payments go a step further by making it possible for NHs to receive lower incentive payments when their residents are hospitalized. At the same time, the quality-based incentives aim to ensure that NHs still provide adequate care. Plan representatives said that their payment methods, in combination, help ensure that the plan and its participating NHs have aligned incentives.

One interviewee said NHs need to evaluate the overall impact of an I-SNP’s payment structure on their revenues before contracting with a plan. Another interviewee said this evaluation was challenging given the uncertainty about the amounts the NH would receive in incentive payments. Some interviewees said NHs can receive more revenue when residents are enrolled in an I-SNP than they would if those residents were enrolled in either FFS Medicare or another type of MA plan.

Beneficiary enrollment in I-SNPs

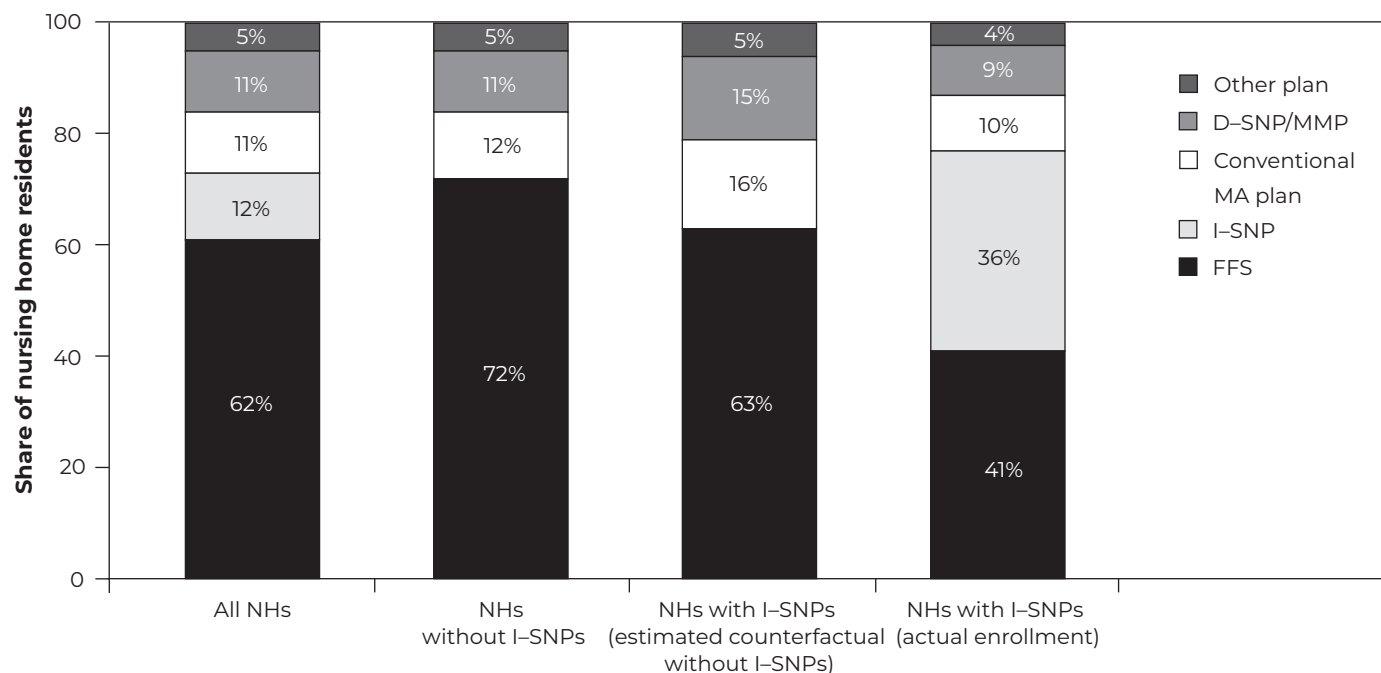
The limited availability of I-SNPs means that enrollment patterns for long-stay residents differ noticeably depending on whether their NH participates in an I-SNP (Figure 5-9). The first column in Figure 5-9 shows the overall enrollment pattern for all long-stay residents, with 62 percent enrolled in FFS Medicare and the other 38 percent enrolled in a private health plan, including 12 percent in I-SNPs. As a group, long-stay residents are more likely to be enrolled in FFS than other beneficiaries (in 2023, about 48 percent of all beneficiaries were in FFS).

The second column shows long-stay residents of NHs that do not participate in I-SNPs; a sizable majority (72 percent) of these beneficiaries were enrolled in FFS, and only 28 percent were in a health plan.

The third and fourth columns show long-stay residents of NHs with I-SNPs, presented in two ways. The third column estimates what the enrollment pattern for these NHs would look like if they did not participate in I-SNPs by assigning I-SNP enrollees to the coverage they had before joining the I-SNP. Without I-SNPs, we estimate that 37 percent of the residents in these NHs would be in MA plans, which is higher than the corresponding figure for NHs without I-SNPs (28

**FIGURE
5-9**

Share of long-stay nursing home residents enrolled in FFS Medicare versus private health plans, by type of nursing home, 2023



Note: FFS (fee-for-service), D-SNP (dual-eligible special-needs plan), MMP (Medicare–Medicaid Plan), MA (Medicare Advantage), I-SNP (institutional special-needs plan), NH (nursing home). The “other plan” category includes employer-sponsored MA plans, the Program of All-Inclusive Care for the Elderly, cost plans, and MA special-needs plans for beneficiaries with chronic conditions. The “counterfactual” column estimates what the enrollment pattern for NHs with I-SNPs would look like if I-SNPs were not available, based on the type of coverage that beneficiaries had before they enrolled in an I-SNP. We counted beneficiaries as long-stay residents if they had been in a nursing home for 90+ days. Figure does not include long-stay residents who cannot enroll in an MA plan because they do not have both Part A and Part B (about 3 percent of all residents). Figures are based on July data. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare enrollment data and Minimum Data Set assessment data.

percent). The NHs that participate in I-SNPs thus face higher MA penetration than nonparticipating NHs. As noted earlier, our interviewees said that concerns about rising MA enrollment are one factor that leads NHs to participate in I-SNPs.

The fourth column shows the actual enrollment pattern in NHs with I-SNPs. Only 41 percent of residents were in FFS, followed by 36 percent in an I-SNP and 23 percent in another type of health plan. The figures in this column suggest that I-SNPs attract enrollment from both FFS and other MA plans. Our interviewees indicated that, from a financial standpoint, most NHs find enrollment in FFS or an I-SNP preferable to other types of health plans. (The Commission has long

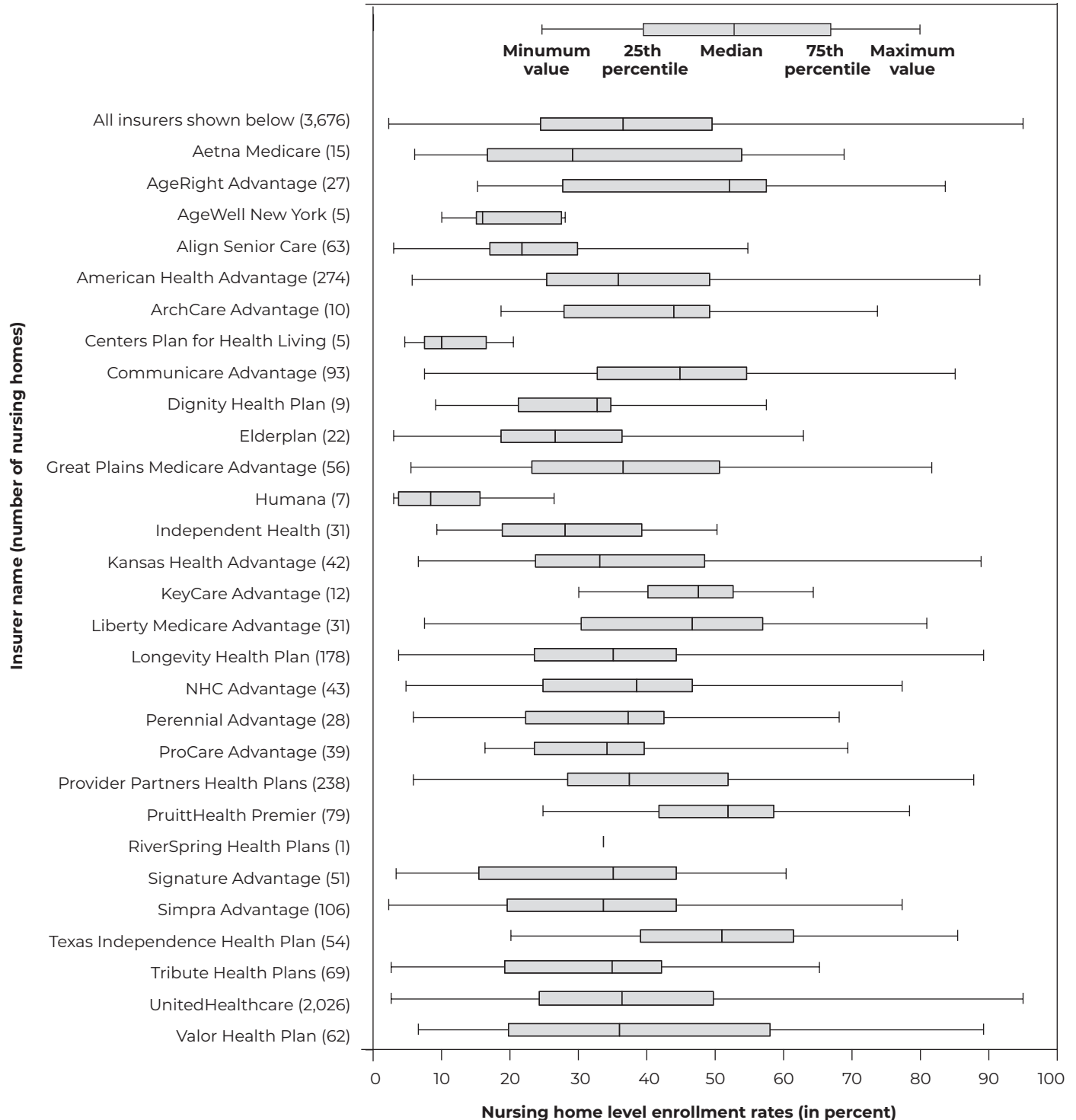
found that, in FFS, providers’ average profit margins for skilled care have exceeded 10 percent; in I-SNPs, NHs can use their decision to participate in a plan’s provider network to negotiate more favorable payment arrangements.) As a result, in aggregate, the share of residents with one of those forms of coverage is relatively similar across the two types of NHs: 72 percent and 77 percent, respectively.

The share of long-stay residents who enroll in I-SNPs varies across NHs

Among the NHs that participate in I-SNPs, the share of long-stay residents who enroll in I-SNPs varies widely (Figure 5-10, p. 274). Each row in the figure is an individual insurer, and the total number of NHs in

**FIGURE
5-10**

The share of long-stay residents who enroll in I-SNPs varies across both nursing homes and insurers



Note: I-SNP (institutional special-needs plan). We calculated enrollment rates for each nursing home based on long-stay residents (those who have been in the nursing home for 90+ days) who have both Part A and Part B. Enrollment rates are based on July 2023 data. This figure does not include five I-SNP insurers (Bright Health, Elevance Health, Florida Complete Care, SCAN Group, and UCare) that primarily enroll beneficiaries who live in the community. This figure uses the marketing name for each insurer; if an insurer used more than one marketing name for its I-SNPs, we used the most common marketing name.

Source: MedPAC analysis of Medicare enrollment data and nursing home assessment data.

its network is shown in parentheses after the insurer's name. The box plot for each insurer shows how enrollment rates vary at the NH level across its provider network, using the minimum value, 25th percentile, median, 75th percentile, and maximum value.

For example, the box plot for AgeRight Advantage summarizes the distribution of the enrollment rates for the 27 NHs in its network; the NH with the lowest enrollment rate had 15 percent of its long-stay residents enrolled in the I-SNP, while the NH with the highest enrollment rate had 83 percent enrolled.

Figure 5-10 shows that NH-level enrollment rates vary both within and across insurers. For many insurers, enrollment rates in the middle half of their distribution (between the 25th percentile and 75th percentile) ranged from roughly 20 percent to roughly 50 percent. At the same time, many insurers also had some NHs with relatively low rates (fewer than 20 percent of eligible residents enrolled) and some NHs with relatively high rates (more than 80 percent of eligible residents enrolled). Looking across insurers, among the 20 companies that had more than 25 NHs in their network, the median NH-level enrollment rate ranged from 21 percent to 52 percent.

Some interviewees specified the share of eligible long-stay residents that I-SNPs aimed to enroll in each NH, either among the facilities in their plan or across the market generally. Their estimates ranged from 40 percent to 70 percent. However, actual enrollment rates are often lower than this range, which suggests that I-SNPs may still be viable even if fewer residents enroll. (In absolute terms, in 2023, the median participating NH had only 21 I-SNP enrollees, and half of all participating NHs had between 13 and 33 enrollees.)

The length of time that NHs participate in I-SNPs appears to have relatively little effect, at least in aggregate, on the share of long-stay residents who enroll. For example, we identified 278 NHs that began participating in an I-SNP in 2019 and continued working with the same insurer through 2023. During this period, the overall share of long-stay residents in these NHs who were enrolled in an I-SNP ranged between 37 percent and 40 percent. The cohorts of NHs that began participating in 2020 and 2021 followed a similar pattern.

Demographic differences between I-SNP enrollees and other long-stay NH residents

The residents of NHs that participate in I-SNPs differ in some respects from the residents of NHs that do not participate (first two columns of Table 5-13 (p. 276)). Residents of participating NHs are more likely to be Black (19 percent vs. 13 percent), have Medicaid (86 percent vs. 80 percent), and live in an urban area (84 percent vs. 72 percent). However, the two groups were similar in terms of their median age, the share who were female versus male, median length of stay, and annual mortality rates.

The third and fourth columns of Table 5-13 (p. 276) compare long-stay residents who enrolled in I-SNPs with residents who had access to an I-SNP but did not enroll. The I-SNP enrollees had much longer lengths of stay (median of 42 months vs. 20 months) and much lower mortality rates (20 percent vs. 25 percent). They were also much more likely to have Medicaid (97 percent vs. 80 percent), but that difference is likely due to their longer length of stay. (Because of the high cost of NH care, the share of residents with Medicaid rises rapidly as length of stay increases.) The I-SNP enrollees were also younger and more likely to be female, Black, and live in a rural area, but these differences were small.

The longer lengths of stay and lower mortality rates suggest that some types of long-stay residents are more likely than others to enroll in I-SNPs. Although these differences could also indicate that I-SNPs reduce the mortality of their enrollees, the fact that lengths of stay and mortality rates look quite similar for participating and nonparticipating NHs suggests that the differences are more likely due to selection among the residents who have access to an I-SNP. It is unclear whether this selection is favorable or unfavorable for I-SNPs in the sense that we use “favorable selection” in our broader analyses of MA payments to describe how MA enrollees tend to have lower spending than their risk scores predict. More research would be needed to understand the relationship between differences in length of stay, beneficiary risk scores, and MA payments for long-stay residents.

This research would need to address several challenges. For example, our methodology for measuring favorable selection partly relies on a comparison of FFS beneficiaries who later switch

**TABLE
5-13****Selected characteristics of long-stay nursing home residents, based on whether their nursing home participated in an I-SNP and whether they enrolled in an I-SNP, 2023**

Characteristic	Nursing home participated in an I-SNP		Among nursing homes that participated in an I-SNP	
	Yes	No	I-SNP enrollees	Non-I-SNP enrollees
Beneficiaries (in thousands)	391	781	129	262
Median age (years)	80	81	79	80
Median length of stay (months)	26	26	42	20
Sex				
Female	63%	62%	64%	62%
Male	37	38	36	38
Race/ethnicity				
White, non-Hispanic	70	77	70	70
Black	19	13	21	19
Hispanic	7	6	7	7
Asian	2	2	1	2
Other/unknown	2	2	1	2
Eligible for full Medicaid benefits	86	80	97	80
Residence				
Urban area	84	72	83	85
Rural area	16	28	17	15
Died during the year	24	24	20	25

Note: I-SNP (institutional special-needs plan). We classified beneficiaries as long-stay residents if they had at least one month during the year in which they had been in a nursing home for more than 90 days.

Source: MedPAC analysis of Medicare administrative data and nursing home assessment data.

to MA with FFS beneficiaries who remain in FFS Medicare. That approach also adjusts for differences in the geographic distribution of the two groups. The number of beneficiaries who could be used in such an analysis would be limited. The number of long-stay NH residents with FFS coverage is relatively small and declining, and the share of these residents who switch directly to an I-SNP is even smaller. In addition, many residents live in NHs for a relatively short period of time, so partial-year spending may

be a greater factor relative to the general Medicare population. Thus, any comparison of risk scores and spending might need to use monthly spending data to account for seasonality, instead of the annual data that are typically used. Finally, such an analysis would need to account for the coronavirus pandemic, most likely by using either prepandemic data (which would be older) or postpandemic data (which will still be relatively limited).

Some MA enrollment and marketing rules are particularly relevant for long-stay NH residents and I-SNPs

The MA program has rules that specify (1) when beneficiaries can enroll in or change their plan and (2) how insurers can market plans to beneficiaries. Three provisions are particularly relevant to I-SNPs because they apply specifically to nursing homes or are more likely to affect long-stay NH residents.

First, Medicare gives beneficiaries in NHs more flexibility to change their MA or Part D plan. Nursing home residents can change plans—such as switching from FFS Medicare to an MA plan, switching from MA to FFS, or changing their MA or stand-alone Part D plan—on a monthly basis, while other beneficiaries are largely limited to changing plans during the annual enrollment period. This provision recognizes that NH residents often have complex health needs and may need to change their enrollment in the middle of a plan year.

There have been concerns that some NHs may abuse this flexibility by disenrolling residents from various types of private Medicare health plans and switching them into FFS Medicare without their consent in order to avoid the lower payment rates for skilled care and utilization management that many plans employ. In 2015 and 2021, CMS sent memos to long-term care facilities that warned them about engaging in this “unacceptable practice” and reiterated the procedures that facilities need to follow to obtain a resident’s consent to disenroll from a health plan (Centers for Medicare & Medicaid Services 2021, Centers for Medicare & Medicaid Services 2015).

Second, although Medicare generally requires that any decision to enroll or disenroll in a plan must be made by the beneficiary, another individual can make those decisions on a beneficiary’s behalf if they are authorized to do so under state law (Centers for Medicare & Medicaid Services 2014). Our NH interviewees indicated that more than half of their long-stay residents had authorized representatives and that residents who still made their own decisions nonetheless consulted closely with family members.

Finally, MA’s marketing rules prohibit agents and brokers from conducting door-to-door marketing. Since the NH is the residence for its long-stay beneficiaries, the agents and brokers for an I-SNP

cannot enter the facility unless they have scheduled a sales meeting with a resident. In a provider-sponsored I-SNP, NH staff can provide information about the I-SNP to the facility’s residents but cannot provide enrollment forms or have sales meetings with residents. If a resident expresses interest in enrolling in the I-SNP, the NH staff will pass their information on to an agent or broker for the plan, who will then schedule a sales meeting with the resident (or their authorized representative). One of our interviewees indicated that word of mouth plays an important role in marketing I-SNPs and that many residents in a NH will become interested in the plan if they hear that other residents have had a positive experience.

The impact of I-SNPs on quality and outcomes

In 2013, the Commission’s recommendation to make I-SNPs a permanent part of the MA program was based on an assessment that “I-SNPs perform better than other SNPs and other MA plans on the majority of available quality measures” (Medicare Payment Advisory Commission 2013). In this section, we present an updated analysis of I-SNP performance that uses more recent data, includes more utilization measures, and draws on research literature that largely did not exist in 2013. We find once again that I-SNPs tend to perform somewhat better than other types of MA plans in caring for long-stay NH residents.

CMS requires MA plans to annually collect and report several types of quality data, including:

- the Healthcare Effectiveness and Data Information Set (HEDIS), a set of clinical quality measures developed by the National Committee for Quality Assurance (NCQA) to evaluate health plans;
- the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a beneficiary survey developed by the Agency for Healthcare Research and Quality to assess patient experience; and
- the Health Outcomes Survey (HOS), a beneficiary survey developed by CMS to assess changes in beneficiaries’ physical and mental functioning.

However, I-SNPs are exempt from the requirements to conduct the CAHPS and HOS surveys. Similarly, long-stay NH residents in other plans are also excluded from the surveys. As a result, our ability

to assess I-SNP performance using MA quality data is limited to HEDIS measures and does not address important aspects of quality, such as patient experience. (Other researchers, discussed below, have tried to evaluate I-SNP performance using quality measures based on MDS assessment data.) CMS also does not calculate HEDIS measures for beneficiaries in FFS Medicare, so we can only use the data to compare I-SNPs to other types of health plans. We analyzed two types of HEDIS measures: risk-adjusted utilization measures and clinical quality measures.

Risk-adjusted utilization measures

I-SNPs aim to reduce avoidable or unnecessary inpatient stays and ED visits by improving care coordination and providing more primary care within the NH setting. One way to assess the effectiveness of this approach is by using three measures of service use related to hospitals: acute hospital discharges, all-cause readmissions, and ED visits. When plans report these measures, they report both actual service use and an estimate of expected service use for enrollees who meet the measure's HEDIS specifications. Plans calculate the expected service use by applying a set of risk-adjustment models that are developed by NCQA and predict an enrollee's service use based on such factors as age, sex, and the presence of various clinical comorbidities. By itself, lower utilization is not necessarily indicative of better quality, but, as noted earlier, research suggests that a significant share of the hospital-related service use by NH residents is potentially avoidable. MA plans report a measure of hospitalizations for potentially preventable complications, but we could not use it in our analysis because its specifications exclude I-SNP enrollees and NH residents.

We calculated scores for these measures using person-level data for measurement year 2023, the most recent year available. We limited our analysis to long-stay NH residents, defined as beneficiaries who had at least one long-stay month during the year. Ideally, we would calculate separate scores for different plan types to compare their relative performance. However, we were concerned that the risk-adjustment models would not adequately account for underlying differences between I-SNP enrollees and nonenrollees, as discussed in the previous section. We therefore decided to calculate scores at a more aggregated level by dividing long-

stay residents into two groups based on whether they lived in NHs that participated in an I-SNP. These more aggregated scores are less likely to be affected by limitations in the risk-adjustment models.

Table 5-14 shows the observed and risk-adjusted expected amounts for each measure plus the ratio of the two amounts, stratified by whether the NH participated in an I-SNP. An observed-to-expected ratio lower than 1 means NHs had lower utilization than expected given the demographics and clinical conditions of their long-stay residents, while a ratio greater than 1 means NHs had higher utilization than expected. The NHs that participated in I-SNPs performed better than the nonparticipating NHs on all three measures: They had fewer hospital discharges, all-cause readmissions, and ED visits.

These results should be treated with some caution for several reasons. First, NHs are not randomly assigned to participate in I-SNPs, and there could be unmeasured differences between the MA enrollees in the two groups of NHs that influence the differences we observe. Second, the risk-adjustment models are calibrated on a broad sample of MA enrollees—meaning that the observed-to-expected ratio across the entire sample should equal 1.0—and may not be as accurate for a small subset of MA enrollees like long-stay NH residents. For example, the overall ratio of 0.79 for ED visits across all long-stay residents in MA plans suggests that the expected utilization amounts for that service are overestimated for those beneficiaries. Third, the specifications for these measures may also exclude a significant amount of service use; for example, the Commission has found that, across all MA enrollees, the specifications for the all-cause readmission measure exclude 45 percent of index hospitalizations and 71 percent of readmissions (Medicare Payment Advisory Commission 2024a).⁵³ The specifications for all three measures also exclude beneficiaries with any hospice use during the year, a group that is more likely to live in NHs.

Clinical quality measures

In addition to the utilization measures, MA plans reported data for 33 other HEDIS measures for the 2023 measurement year. As with the utilization measures, we used data for long-stay NH residents to calculate scores for these measures. However,

**TABLE
5-14****Nursing homes that participated in I-SNPs performed better on three
HEDIS measures of service use related to hospitals, measurement year 2023**

Type of service use	Observed amount	Risk-adjusted expected amount	Ratio of observed to expected amount
Acute hospital discharges			
NH participated in an I-SNP	35,483	39,786	0.89
NH did not participate in an I-SNP	58,501	52,381	1.12
Total	93,984	92,168	1.02
All-cause readmissions			
NH participated in an I-SNP	3,210	3,494	0.92
NH did not participate in an I-SNP	4,615	4,788	0.96
Total	7,825	8,282	0.94
Emergency department visits			
NH participated in an I-SNP	24,044	40,190	0.60
NH did not participate in an I-SNP	48,859	52,102	0.94
Total	72,903	92,293	0.79

Note: I-SNP (institutional special-needs plan), HEDIS (Healthcare Effectiveness Data and Information Set), NH (nursing home). Figures are based on beneficiaries who were long-stay nursing home residents (90+ days) for at least one month during the year. The specifications for these measures exclude beneficiaries who are considered outliers because of their high levels of service use (for example, having four or more hospital discharges during the year). Figures for acute hospital discharges and hospital readmission rates include observation stays. Table does not include beneficiaries in Puerto Rico. All differences between the observed-to-expected ratios for the two groups of NHs were statistically significant ($p < 0.05$).

Source: MedPAC analysis of HEDIS person-level data for measurement year 2023, enrollment data, and Minimum Data Set assessment data.

since these are largely process measures rather than outcomes measures, their scores are not risk adjusted and we do not have the same concerns about the effects of selection on the scores for different plan types. As a result, we stratified these results by plan type instead of NH participation in an I-SNP. We compared I-SNPs with the two other plan types that cover a significant number of long-stay NH residents: (1) conventional MA plans and (2) D-SNPs or MMPs (which are specialized plans for beneficiaries who have both Medicare and Medicaid).

We excluded 20 measures from our analysis because we determined that they could not be used to assess I-SNP performance. The specifications for 15 measures exclude elderly beneficiaries (usually age 66 or older) who were either long-stay NH residents or I-SNP enrollees at any time during the year. The

rationale for the exclusion is that these measures may not be well suited for an institutionalized population. This exclusion applies to about 90 percent of I-SNP enrollees. We also excluded five measures because the scores for at least one plan type were based on fewer than 200 cases and thus apply to a relatively small number of enrollees.

Table 5-15 (p. 280) shows the scores for the remaining 13 measures. In most cases (which are noted with asterisks), the differences between the scores for conventional MA plans and D-SNPs/MMPs and the scores for I-SNPs were statistically significant. However, the differences between the scores on some measures are relatively small and may not be very meaningful to beneficiaries, even if they are statistically significant. CMS has addressed this challenge in some analyses of HEDIS scores by requiring that scores

**TABLE
5-15****HEDIS scores for long-stay nursing home residents on
selected measures, by plan type, measurement year 2023**

Measure	Conventional MA plans	D-SNPs & MMPs	I-SNPs
Higher scores indicate better performance:			
Adults' access to preventive/ambulatory health services	99.2%*	99.6%*	>99.9%
Adult immunization status			
Influenza	34.6*	33.6*	37.8(+)
Herpes zoster	12.6*	11.4*	3.6(-)
Pneumococcal	53.4*	49.5*	30.0(-)
Tetanus, diphtheria, and acellular pertussis	28.0*	26.7*	9.6(-)
Antidepressant medication management			
Effective acute-phase treatment	83.8	82.6*	84.7
Effective continuation-phase treatment	76.0*	76.0*	78.3
Depression screening	3.9*	6.5*	15.9(+)
Follow-up after ED visit for people with multiple high-risk chronic conditions	39.3*	41.7*	44.6
Follow-up after hospitalization for mental illness			
7-day follow-up	8.1*	12.7*	3.6(-)
30-day follow-up	16.0*	24.9*	8.1(-)
Pharmacotherapy management of COPD exacerbation			
Bronchodilator	80.3*	85.1	86.8
Systemic corticosteroid	61.1	61.0	63.2
Use of spirometry testing in the assessment and diagnosis of COPD	8.9*	9.2*	3.0(-)
Lower scores indicate better performance:			
Nonrecommended PSA-based screening in older men	7.8	8.7*	7.6
Potentially harmful drug-disease interactions in older adults			
Chronic kidney disease	7.8	9.5*	6.8
Dementia	43.7*	43.9*	34.4(+)
History of falls	51.7	52.8*	49.4
Use of high-risk medications in older adults	30.6*	32.2*	25.0(+)
Use of opioids at high dosage	1.8*	3.1*	2.6
Use of opioids from multiple providers			
Multiple pharmacies	1.2*	2.0*	0.1
Multiple prescribers	19.7*	23.4*	21.8
Multiple prescribers and pharmacies	1.0*	1.7*	0.1

Note: HEDIS (Healthcare Effectiveness Data and Information Set), MA (Medicare Advantage), D-SNP (dual-eligible special-needs plan), MMP (Medicare-Medicaid Plan), I-SNP (institutional special-needs plan), ED (emergency department), COPD (chronic obstructive pulmonary disease), PSA (prostate-specific antigen). Figures are based on beneficiaries who were long-stay nursing home residents (90+ days) for at least one month during the year. This table does not include beneficiaries who were enrolled in other plan types, such as employer-sponsored MA plans or chronic condition special-needs plans. These other plan types collectively accounted for about 15 percent of the long-stay residents enrolled in health plans. Table does not include beneficiaries in Puerto Rico.

* The difference between this score and the I-SNP score is statistically significant ($p < 0.05$).

(+) I-SNPs performed better; the differences between their score and the scores for the other two plan types were both statistically significant (at the 5 percent level) and practically significant (a difference of at least 3 percentage points).

(-) I-SNPs performed worse; the differences between their score and the scores for the other two plan types were both statistically significant (at the 5 percent level) and practically significant (a difference of at least 3 percentage points).

Source: MedPAC analysis of HEDIS person-level data for measurement year 2023.

differ by at least 3 percentage points to have “practical significance” (Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2023b). Using this standard, the right column notes where I-SNPs performed better or worse than the other plan types and the differences were both statistically and practically significant. I-SNPs had mixed performance on adult immunization status, with a better score on influenza and lower scores for three other conditions. I-SNPs performed better on depression screening, limiting harmful drug-disease interactions in people with dementia, and limiting the use of high-risk medications. However, they performed worse on follow-up care after a hospitalization for mental illness and the use of spirometry testing.

Our finding that I-SNPs performed better on limiting harmful drug-disease interactions and limiting the use of high-risk medications differs from our 2013 analysis, which found that I-SNPs performed worse than other plans on those measures. However, it is unclear whether this change in findings reflects improvements in I-SNP performance or underlying differences in the methodologies we used for the two analyses. In particular, our previous analysis compared I-SNPs to all enrollees in other MA plans, regardless of whether they were NH residents, while our updated analysis is limited to NH residents.

The research literature on I-SNPs is limited but suggests they reduce the use of inpatient care

Relatively few studies have examined how I-SNPs affect service use and quality of care. Aside from the Commission’s 2013 analysis, we are aware of only five studies that have looked specifically at this topic.

In 2002, researchers evaluated the Evercare demonstration, the predecessor for I-SNPs (Kane et al. 2002). The study compared Evercare enrollees with two groups of FFS beneficiaries: (1) those who lived in participating NHs but did not enroll and (2) those who lived in NHs that did not participate. The authors found that the hospitalization rate for Evercare enrollees was about 50 percent lower than the rates for both control groups. However, when “intensive service days” (instances when plans provided higher levels of care at the NH in lieu of inpatient care) were counted, admissions for the three groups were similar, suggesting that Evercare shifted some care to NHs but did not reduce the overall “incidence of events that

traditionally required hospitalization.” The authors also found that Evercare had mixed effects on various other quality metrics, like functioning levels and mortality.

In 2019, a study used data from 2014 to 2015 to compare enrollees in UnitedHealth’s I-SNPs to long-stay NH residents with FFS Medicare (McGarry and Grabowski 2019). The study was limited to enrollees in NHs with “mature” I-SNPs, which were defined as having at least 12 months of experience, at least 30 enrollees, and at least 30 percent of long-stay residents enrolled. The study found that utilization rates for inpatient stays, 30-day readmissions, and emergency visits were about 50 percent lower for I-SNP enrollees than the FFS comparison group, while utilization rates for SNF stays were about two times higher, again suggesting that I-SNPs shift some care from hospitals to NHs.

Also in 2019, a different study used 2011 and 2013 data to examine whether NH participation in I-SNPs leads to lower use of hospice care (Dhingra et al. 2019). The study found that I-SNP participation was associated with lower hospice use in smaller NHs (50 beds or less) and higher hospice use in larger NHs (more than 100 beds), but the magnitude of the changes in hospice use was relatively small.

In 2024, another study examined the impact of I-SNPs on hospitalization rates and a set of MDS-based quality measures (Chen and Grabowski 2024). The study compared NHs with “mature” I-SNPs (in this case, defined as having 33.75 percent or more of long-stay residents enrolled) with NHs without I-SNPs. Within these two groups of NHs, the study’s primary analysis focused on long-stay residents in MA plans and used a difference-in-differences methodology to estimate changes in hospitalization rates and quality measures once NHs with I-SNPs reached the maturity threshold. The study found that NHs with I-SNPs had hospitalization rates that were 4 percentage points lower than the rates for NHs without I-SNPs and that those reductions occurred in the three years after the I-SNP reached maturity. However, this finding was sensitive to the method used to define the start of a NH’s participation in an I-SNP. The impact of I-SNPs on other quality measures was mixed, with decreases in urinary tract infections and pressure ulcers, increases in the number of residents who needed help with activities of daily living, and no effect on mortality rates.

In 2025, an industry-funded study used 2022 data to examine the association between I-SNP enrollment and a set of eight outcome measures (ATI Advisory 2025). The study focused on long-stay NH residents and compared I-SNP enrollees with FFS enrollees and enrollees in other types of MA plans. The study found that, relative to the other two groups, I-SNP enrollees had lower levels of functional impairment but higher levels of cognitive impairment. Compared with enrollees in other MA plans, I-SNP enrollment was associated with fewer ED visits, hospitalizations, and all-cause readmissions. The study also found that I-SNP enrollment was associated with better performance on two of four quality measures (occurrence of pressure ulcers and of falls resulting in a major injury) and higher spending on outpatient prescription drugs.

Overall, the research literature suggests that I-SNPs (1) reduce the use of inpatient care by their enrollees, although estimates of the size of the reduction vary, and (2) do not have a clearly positive or negative impact on various other quality measures. However, these studies likely overstate the impact of using I-SNPs on a broader scale because they focus on either a relatively small demonstration project or a subset of participating NHs with “mature” I-SNPs. (Evercare operated in five cities and, at its peak, had about 270 participating NHs and 10,000 enrollees. We estimate that, in 2023, only about a quarter of the NHs that participated in an I-SNP met the “mature” criteria from the McGarry study of at least 30 enrollees and at least 30 percent of long-stay residents enrolled; those facilities accounted for about half of I-SNP enrollment in NHs.) If I-SNPs were used on a broader scale, the additional insurers and NHs that participated may be less successful with the I-SNP model.

I-SNP payment rates, rebates, and extra benefits

Under the MA payment system, plans submit bids that reflect their estimate of the cost of providing the Part A and Part B benefit package. Each bid is compared with a benchmark that is based on local FFS costs in the plan’s service area; the benchmarks are calculated at the county level and range from 95 percent to 115 percent of local FFS costs. Plans that have a quality rating of 4 stars or better (out of 5) qualify for more generous benchmarks (usually 5 percent higher). Plans

that bid below their benchmark—which nearly all plans do—receive a portion of the difference between the two amounts as a “rebate” that is used to provide supplemental benefits to their enrollees; plans that bid above the benchmark must charge their enrollees a premium equal to the difference.

Table 5-16 shows the average benchmark, bid, rebate, and payment amount in 2025 for the three main types of MA plans that cover long-stay NH residents: conventional plans, D-SNPs, and I-SNPs. (Unlike Table 5-15 (p. 280), this table does not include MMPs because they have a different payment system.) In dollar terms, the figures for I-SNPs are much higher because these plans are available only to beneficiaries who need NH care, a group with very high average medical costs. In contrast, beneficiaries who need NH care represent a small share of enrollment in conventional plans and D-SNPs, so the figures for those two plan types largely reflect costs for beneficiaries in community settings, which are lower on average. However, the payment amount for a long-stay NH resident in a conventional plan or D-SNP will be much closer to the I-SNP average because the MA risk-adjustment system increases payments for beneficiaries who are expected to have high costs.

Relative to their benchmarks, I-SNPs have much higher bids, on average, than both conventional plans and D-SNPs (91 percent vs. 77 percent and 79 percent, respectively). The higher bids may indicate that I-SNPs have higher costs relative to their benchmarks or that I-SNPs face less competitive pressure than the other plan types, perhaps due to such factors as the practice of NHs contracting with a single insurer and the year-to-year continuity in insurer–NH relationships. The higher bids also mean that I-SNPs receive lower rebates (6 percent of their benchmarks vs. 15 percent for conventional plans and 14 percent for D-SNPs). Overall, the payment amounts for I-SNPs equal 97 percent of their benchmark, on average. None of our interviewees expressed concern about the adequacy of MA payments for I-SNPs.

When evaluating MA payment rates, the Commission has emphasized the importance of accounting for two key factors besides plan benchmarks and bids: coding intensity (MA’s risk-adjustment system partly uses diagnosis codes to adjust payments to account for differences in enrollees’ health status, which

**TABLE
5-16****Differences in bids, rebates, and payment rates between
I-SNPs and other types of MA plans, 2025**

	Conventional MA plans	D-SNPs	I-SNPs
Average amount (per member per month):			
Benchmarks	\$1,206	\$1,819	\$3,035
Bids	924	1,427	2,749
Rebates	187	258	190
Total payments	1,111	1,685	2,938
As a share of benchmarks:			
Bids	77%	79%	91%
Rebates	15	14	6
Total payments*	92	93	97
Average allocation of rebates			
Reduced Part A/Part B cost sharing	42%	4%	14%
Supplemental benefits	29	90	53
Enhanced drug coverage	15	<1	4
Reduction in Part D premium	8	4	26
Reduction in Part B premium	7	2	3

Note: I-SNP (institutional special-needs plan), MA (Medicare Advantage), D-SNP (dual-eligible special-needs plan). All dollar figures are risk adjusted. Benchmarks include quality bonuses. Estimates do not include beneficiaries with end-stage renal disease. Components may not sum to totals due to rounding.

* Figures for total payments do not account for the effects of coding intensity or selection.

Source: MedPAC analysis of MA bid data from CMS.

gives plans a financial incentive to submit more diagnosis codes) and favorable selection (beneficiaries who enroll in MA tend to have lower spending than their risk scores predict). Both factors increase MA spending and make plan enrollees appear more costly than they really are.

With respect to coding intensity, the Commission projects that, in 2025, the risk scores for MA enrollees are about 16 percent higher than they would have been if those beneficiaries were in FFS Medicare (Medicare Payment Advisory Commission 2025). CMS reduces MA risk scores to account for the higher coding intensity, but its adjustment eliminates only about 40 percent of the overall effect, and as a result MA risk scores (and payments) are still about 10 percent too high.

Although MA plans have an incentive to submit more diagnosis codes for all enrollees, the Commission has found that coding intensity varies across insurers, geographic regions, and types of enrollees. For long-stay NH residents, we estimated that the amount of coding intensity in 2023 was 12.7 percent, somewhat lower than the overall figure of 17.3 percent (Medicare Payment Advisory Commission 2025). After accounting for the CMS reduction in MA risk scores, the amount of coding intensity for long-stay NH residents was roughly 6 percent. The lower coding intensity for these enrollees could be at least partly due to their high mortality rates (when plans submit more diagnosis codes for an enrollee, they do not lead to higher payments for the enrollee until the following year). We did not estimate the amount of coding intensity for I-SNPs specifically, but they account for

about 30 percent of the long-stay residents in MA plans.

With respect to favorable selection, the Commission estimated that, in 2025, its effects will increase MA payments by about 11 percent (Medicare Payment Advisory Commission 2025). Favorable selection can occur due to unmeasured differences in health status but can also result from other factors such as differences in beneficiaries' propensity to seek care for reasons that are unrelated to their health. The Commission's methodology for measuring favorable selection is designed to produce a comprehensive estimate of its effects on MA spending, and we have not produced separate estimates for long-stay NH residents—who account for less than 1 percent of MA enrollment—or for I-SNP enrollees. Table 5-13 (p. 276) suggests that there is selection among I-SNP enrollees, but we do not have enough information to determine whether this selection affects MA payments for them.

As part of their bids, MA plans indicate how they plan to use their rebates to provide five types of extra benefits: reduced beneficiary cost sharing for Part A and Part B services, supplemental benefits that Medicare does not cover, enhanced Part D drug coverage, lower Part D premiums, and lower Part B premiums (bottom half of Table 5-16 (p. 283)). The three types of plans use their rebates in different ways. Conventional plans focus on reducing Part A and Part B cost sharing and providing supplemental benefits, while D-SNPs use almost all of their rebates to provide supplemental benefits. Most D-SNP enrollees already have their Part A, Part B, and Part D premiums and cost sharing covered by Medicaid and the Part D low-income subsidy (LIS).

By comparison, I-SNPs use about half of their rebates to provide supplemental benefits and use a relatively large share (26 percent) to lower their Part D premiums. These rebates lower the Part D premiums for I-SNPs to the point where the remainder is fully covered by the LIS, which more than 90 percent of I-SNP enrollees receive. (In 2025, only three I-SNPs, with a combined total of fewer than 200 enrollees, charge Part D premiums to LIS beneficiaries.) The fact that I-SNPs use a relatively large share of their rebates to lower their Part D premiums in this manner indicates that they have relatively high costs for

prescription drugs, which is consistent with a recent study of I-SNPs (ATI Advisory 2025). As with D-SNPs, most I-SNP enrollees pay little or no cost sharing for Part D drugs because they are covered by the LIS.

In 2024, the actuarial firm Milliman examined the supplemental benefits that I-SNPs offered (Yeh and Yen 2024). The study found that all I-SNPs offered by national carriers (which, in this case, largely meant UnitedHealth plans) offered benefits such as dental, vision, and hearing benefits; podiatry services; over-the-counter items and services; and transportation. These benefits are also widely covered by conventional MA plans, although the extent of the coverage varies across plans. The I-SNPs offered by regional carriers (largely provider-sponsored plans) were less likely to offer those benefits (for example, only about half of the plans offered dental benefits) and were more likely to offer certain other benefits such as social-needs benefits, food and produce, and nonmedical transportation. The study also noted that I-SNPs faced growing competitive pressure from D-SNPs, which were increasingly offering so-called flex cards that enrollees can use for expenses such as food and utilities. Some of our interviewees expressed similar concerns about the extra benefits offered by D-SNPs.⁵⁴

The MA star ratings provide limited insight into I-SNP performance

Under the MA quality-bonus program, plans receive star ratings that determine whether they qualify for an increase in their benchmark. Plans that receive a rating of 4 stars or more (out of 5) typically qualify for an increase of 5 percent.⁵⁵ However, plans that do not have enough data to calculate a star rating (because they are new or have low enrollment) receive an increase of 3.5 percent.

This year, a large majority of I-SNP enrollees (88 percent) are in plans that received some type of quality bonus—65 percent in plans that received the standard 5 percent bonus and 22 percent in plans that received the smaller 3.5 percent bonus (largely because they have low enrollment, not because they are new to the market).

The star ratings are based on 44 measures of clinical quality, patient experience, and plan performance. CMS calculates a rating for each MA contract rather

than each individual plan. (In MA, an insurer must sign a contract with CMS to participate in the program. An insurer can have multiple MA contracts and can offer multiple plans under each contract.) Some contracts may not have enough data to calculate scores for every measure. When they lack enough data, CMS does not calculate a star rating unless the contract can report scores for at least half of the measures related to MA and, if the contract includes plans that have drug coverage, half of the measures related to Part D. For contracts that have both SNP and non-SNP products, the threshold for getting a star rating is 15 of 29 MA measures and 6 of 11 Part D measures.

However, different requirements apply to contracts composed solely of I-SNPs. These contracts report fewer measures because I-SNPs do not administer the CAHPS and HOS beneficiary surveys (the sources for the patient-experience measures) and do not report some clinical quality measures. Their threshold for calculating a star rating is therefore lower: 9 of 17 MA measures and 5 of 9 Part D measures. In 2024, about three-quarters of all I-SNP enrollees were in these I-SNP-only contracts.

Regardless of the type of contract used, the star rating provides very limited insight into the performance of I-SNPs. When a contract includes both I-SNPs and non-I-SNP plans, the I-SNPs may account for a small share of the contract's total enrollment, and its star rating will largely reflect the performance of the non-I-SNP plans. When a contract has only I-SNPs, its star rating does not incorporate any patient-experience measures, and some of the clinical quality measures that are used may have limited value. (For example, the star ratings for these contracts are based on 11 HEDIS measures and 6 measures of plan administrative performance, but the specifications for 5 of those HEDIS measures exclude I-SNP enrollees over the age of 65, who account for about 90 percent of all I-SNP enrollees, because the measures are not considered clinically appropriate for those beneficiaries.) The star ratings also do not measure other important dimensions of care for NH residents such as quality of life.

Calculating star ratings for I-SNP-only contracts is also challenging because many have relatively low enrollment. Only about 20 percent of the I-SNP-only contracts with less than 1,000 enrollees have a star

rating compared with about 70 percent of contracts with 1,000 to 2,000 enrollees and 100 percent of contracts with more than 2,000 enrollees. Nearly all of the I-SNPs that do not have a star rating due to low enrollment are provider-sponsored plans. Although some provider-sponsored plans do have star ratings, the ones without star ratings account for 63 percent of the overall enrollment in provider-sponsored plans.

Some provider-sponsored plans are structured in ways that make it unlikely they will receive a star rating for many years. In these cases, the I-SNP is part of a contract that also has at least one non-I-SNP plan, but the non-I-SNP plan has minimal enrollment (often fewer than 100 people), suggesting that the company may not actively market the product. The presence of the non-I-SNP plan ensures that the contract's star rating is not determined using the rules that apply to I-SNP-only contracts and effectively raises the threshold for calculating a star rating from 9 of 17 measures to 15 of 29 measures.

However, since the contract is almost entirely comprised of I-SNP enrollees, there will not be enough data to produce scores for many of the measures that are part of the higher threshold, such as the patient-experience measures. As a result, the star rating for the contract is still effectively based on the 17 measures used for I-SNP-only contracts, but the contract will not receive a star rating until it has enough I-SNP enrollees to produce scores for 15 of those measures. The number of I-SNP enrollees needed to produce scores for 15 measures appears to be much higher than the current enrollment in provider-sponsored plans. (As of the writing of this report, only two I-SNP-only contracts have scores for 15 or more measures. Both contracts belong to UnitedHealth, and the smaller of the two has about 9,000 enrollees. The next-largest contract, which is part of a provider-sponsored plan, has about 2,000 enrollees and reported scores for only 11 measures.) The presence of a small non-I-SNP plan thus extends the period of time in which a plan receives a guaranteed quality bonus of 3.5 percent and may appeal to plans that are concerned about receiving a low star rating. In 2024, as many as 10 provider-sponsored plans may have used this strategy in at least one of their contracts. Another possibility is that some provider-sponsored plans are interested in expanding their MA business beyond the NH setting (for example, by targeting beneficiaries in the non-NH

parts of a continuing-care retirement community) but have generated relatively little enrollment to date.

Potential future work

Private health plans have the potential to improve care for long-stay nursing home residents by providing more care in NHs and changing the financial incentives

that NHs have in FFS Medicare to send long-stay residents to the hospital. However, the share of long-stay residents enrolled in I-SNPs is low. Future work could examine factors that limit the use of this model and could consider potential policy changes to reduce barriers to expansion. ■

Endnotes

- 1 A spell of illness ends when a beneficiary has not been an inpatient in a hospital or SNF for 60 days. At that point, a subsequent hospitalization starts a new spell of illness, and a beneficiary can receive another 100 days of SNF benefits following a 3-day hospital stay. Observation days and emergency room visits do not count toward the three-day hospital stay requirement. Copayments (\$209.50 per day in 2025) begin on the 21st day of the stay.
- 2 For example, therapy services must be ordered by a physician, require the skills of technical or professional personnel, and be furnished directly by or under the supervision of such personnel. Coverage ends when a skilled service is no longer needed (such as maintenance services performed by the patient with assistance from an unskilled caregiver).
- 3 We identified beneficiaries who had been in a NH for more than 90 days using the risk scores that CMS calculates for all beneficiaries to adjust payments to MA plans to account for differences in health status. These scores differ depending on whether a beneficiary lives in the community or a NH, and they include a monthly indicator that shows when a beneficiary has been in a NH for more than 90 days. CMS develops this indicator using information from the Minimum Data Set (MDS), a standardized assessment that NHs complete for every resident when they are admitted and at least quarterly after that. Since NHs are financed by a variety of payers, the MDS is especially useful because it can identify all long-stay residents, regardless of payer. Beneficiaries who reach the 90-day threshold are counted as long-stay residents until they die or have been discharged to the community for more than 14 days.
- 4 The long-stay population had been declining even before the coronavirus pandemic, from 1.4 million in 2012 to 1.3 million in 2019. During the pandemic, the long-stay population dropped sharply, to 1.1 million in 2021, but it has partially rebounded since then.
- 5 If the individual seeking NH care has a spouse who still lives in the community, Medicaid has provisions that reserve some of the couple's income and assets for the use of the community-dwelling spouse.
- 6 D-SNPs are part of the MA program, while MMPs are part of a separate demonstration project aimed at developing new models of care for dually eligible beneficiaries. MMPs have a high level of integration with Medicaid, while the level of integration for D-SNPs varies. We combine the two plan types here because (1) both plans serve dual-eligible beneficiaries and (2) we expect that most MMPs will be converted into D-SNPs when the MMP demonstration concludes at the end of 2025.
- 7 Beneficiaries who switch from MA to FFS Medicare may have difficulty purchasing a supplemental Medigap policy because they will typically be subject to insurance underwriting in most states. The availability of Medigap coverage will not be a concern for most NH residents who are dually eligible beneficiaries because Medicaid covers their Part A and Part B cost sharing.
- 8 Some nursing homes might not participate in either Medicaid or Medicare. We do not have information about them, though there are likely to be only a few.
- 9 PE firms invest in NHs because they are a steady source of income given the aging population, reliable government payers, and favorable tax treatment of earnings. PE firms acquire undervalued or underperforming NHs and then try to make them more valuable by increasing their volume, shifting to a more profitable payer mix, lowering their operating costs, and increasing the use of related third parties from which to buy services (such as staffing and therapy services). When purchasing a NH, a PE firm may separate the NH's operations from its real estate. The NH then becomes a tenant and assumes responsibility for the facility's operations. PE firms often require NHs to pay management and rental fees that also increase the PE firm's revenues (Medicare Payment Advisory Commission 2021).
- 10 Another study that made different assumptions in its estimates found higher shares of nursing homes with at least some REIT or PE ownership (13 percent and 16 percent, respectively) (Williams Jr. et al. 2024). Notably, these estimates may overstate the level of REIT and PE activity because they do not consider any subsequent divestments.
- 11 The Partnership for Long-Term Care Program began in the 1990s as a demonstration in California, Connecticut, Indiana, and New York. In 2005, the Congress gave all states the option of participating.
- 12 For example, the Health Insurance Portability and Accountability Act of 1996 allowed premiums to be considered a medical expense on federal tax returns.
- 13 Base payment amounts do not include supplemental payments that 23 states make to NHs and collectively account for 5 percent of Medicaid payments. Supplemental-payment data at the provider level are not reliable for nearly all states.

- 14 The relationship between staffing and the quality of NH care has been extensively studied. In general, studies find that higher levels of registered-nurse staffing are related to better outcomes but that total nurse staffing and staffing mix have mixed results (Clemens et al. 2021, Jutkowitz et al. 2023). Konetzka and colleagues found that, in facilities with known COVID-19 cases, higher staffing was associated with fewer deaths (Konetzka et al. 2021a).
- 15 Nursing homes must also meet state licensure requirements that are generally similar to the federal standards but may differ. For example, some states have minimum staffing requirements.
- 16 Nursing homes are separately inspected to follow up on resident or family complaints. Complaint investigation teams are not required to have a registered nurse. The timing of complaint-related surveys depends on the severity of the complaint. In addition, states must separately inspect 20 percent of homes each year for compliance with infection-control requirements, targeting homes with new COVID-19 cases or low staff vaccination rates.
- 17 Although nursing homes can be denied payment for all residents, in 2024 there were no such enforcement actions.
- 18 Until FY 2025, providers that did not comply with participation requirements were assessed either a per day or a per instance penalty based on the severity and scope of harm (or potential harm) to residents, and providers could not be assessed multiple instances (e.g., noncompliance on different days of the survey) for the same deficiency. Beginning in FY 2025, a facility that is out of compliance can be assessed both types of penalties and for multiple instances for the same deficiency (Centers for Medicare & Medicaid Services 2024c).
- 19 CMS identifies low-performing facilities using the results from the three most recent inspections. Facilities with the most deficiency points are eligible for the SFF Program.
- 20 An SFF graduates from the program when it has had two consecutive surveys that have 12 or fewer deficiencies with a rating of “E” or lower.
- 21 The measures included in the Quality Reporting Program include changes in skin integrity, share of residents experiencing falls with major injury (long-stay), discharge mobility score, discharge self-care score, drug regimen review, transfer of health information to the provider post-acute care, transfer of health information to the patient post-acute care, discharge function score, percentage of patients/residents who are up to date on their COVID-19 vaccine, Medicare spending per beneficiary, discharge to the community, potentially preventable 30-day postdischarge readmissions, SNF-care-associated infections requiring hospitalization, COVID-19 vaccination coverage among health care personnel, and influenza vaccination coverage among health care personnel.
- 22 The “scope” of a deficiency refers to whether it was isolated (a single instance) or widespread. The severity indicates whether the deficiency put residents at jeopardy of being harmed or were harmed (the highest severity) or there was no harm or the potential for only minimal harm (the lowest severity).
- 23 The nine long-stay measures include the percentage of long-stay residents whose need for help with activities of daily living increased; whose ability to move independently worsened; who have or had a catheter inserted and left in their bladder; who had a urinary tract infection; who experienced one or more falls with major injury; who got an antipsychotic medication; the percentage of high-risk residents with pressure ulcers; the number of hospitalizations per 1,000 long-stay residents; and the number of outpatient emergency department visits per 1,000 long-stay resident days. There are six short-stay measures: the percentage of short-stay residents whose ability to move independently improved; who had new or worsened pressure ulcers; who got antipsychotic medication for the first time; who were rehospitalized; who had an emergency department visit; and the rate of successful discharge home. All of the claims-based measures and four of the Minimum Data Set-based measures (moving independently for long-stay residents, improvement in short-stay residents’ ability to move around on their own, presence of a catheter, and pressure ulcers in short-stay residents) are risk adjusted.
- 24 For example, the overall rating of a facility is raised by 1 star if it achieves 5 stars for its staffing rating; conversely, its rating is lowered by 1 star if the facility has 1 star for its staffing rating. A facility with 1 star on its inspection rating cannot have its overall rating increased by more than 1 star based on staffing and quality ratings.
- 25 One- and 2-star facilities treated 45 percent of residents, while 4- and 5-star facilities treated 35 percent of residents.
- 26 CMS will validate patient assessment information used in the Value-Based Purchasing Program (see p. 252).
- 27 Precursors to the QIO Program included the Professional Standards Review Organizations and the Peer Review Organization.
- 28 To account for the effects of COVID-19 on staffing and SNF admissions, the VBP suppressed performance results during the public health emergency. For FY 2022 and FY 2023, all

- providers received 60 percent of the 2 percent withhold for a net reduction of 1.2 percent.
- 29 Because the performance period is lagged by two years and the baseline period is two years before that, results reported for FY 2019 through FY 2021 predate the COVID-19 public health emergency.
 - 30 The MDS-based quality measures included catheter inserted and left in the bladder, antipsychotic medication use, one or more falls with major injury, self-reported moderate to severe pain, Stage II or higher pressure ulcers, decline in activities of daily living, urinary tract infections, and depressive symptoms.
 - 31 The six conditions accounted for a large share of potentially avoidable hospitalizations and included pneumonia, congestive heart failure, chronic obstructive pulmonary disease/asthma, skin infection, fluid/electrolyte disorder or dehydration, and urinary tract infections.
 - 32 The terms “earned savings” and “shared savings” are equivalent. In this section, we use the term “earned savings.”
 - 33 In some cases, visits furnished by certain specialties, such as cardiology and hematology, are included in the assignment. Primary care visits furnished in NHs are counted, but any SNF visits are excluded.
 - 34 In some ACO models, providers can be paid a per member per month amount for primary care or all services. An ACO’s benchmark is based on the historical spending on beneficiaries who would have been assigned to the ACO (based on the ACO’s participating physicians) and the spending on assignable beneficiaries in the ACO’s region. The benchmark is trended forward and adjusted to reflect the mix of beneficiaries assigned to the ACO.
 - 35 In MSSP ACOs, at least one primary care visit has to be with a physician (i.e., visits by only nurse practitioners do not trigger assignment).
 - 36 There is one NH-led ACO, Genesis, but we are not aware of any independent research on its performance.
 - 37 A list of SNF affiliates must accompany a MSSP ACO’s application to CMS. The SNF affiliates must have at least a 3-star rating from the CMS 5-star quality-rating system. In 2023, 45 percent of ACOs had a SNF waiver from CMS. A study of ACOs that had obtained SNF waivers between 2014 and 2019 found that the waivers were infrequently used. Less than 5 percent of ACO SNF stays were waiver stays, and the majority were for beneficiaries admitted from the community without a prior hospital stay (Centers for Medicare & Medicaid Services 2023c).
 - 38 In the Medicare Shared Savings Program, the three-day waiver option is not available to long-stay residents.
 - 39 Studies suggest that ACOs generally distribute earned savings to practices based on the number of beneficiaries assigned to their clinicians (Khullar et al. 2024, Schulz et al. 2015). As noted above, beneficiaries are assigned to the clinician who provides the plurality of primary care services.
 - 40 There were initially 47 AIM ACOs, but by 2020 the participation had dwindled to 14. ACO administrators said they exited because they were not ready for the increased risk bearing that would accompany continued participation.
 - 41 Insurers can also offer I-SNPs that target beneficiaries who live in certain other institutional settings—such as intermediate care facilities for individuals with intellectual disabilities, psychiatric hospitals, rehabilitation hospitals, or long-term care hospitals—but have never done so.
 - 42 Starting in 2025, CMS allows certain I-SNPs to request an exception from the network-adequacy standards if they are unable to contract with some types of providers or provide sufficient access to Medicare benefits through additional telehealth coverage. However, we estimate that only about 15 percent of I-SNP enrollees are in plans that are eligible to apply for an exception.
 - 43 The disenrollment of many long-stay residents from MMPs was one reason why CMS issued its 2015 memo to long-term care facilities warning them against trying to disenroll residents from health plans without their consent.
 - 44 The evaluation of Ohio’s demonstration, which has had much higher participation rates than other states, found that MMPs reduced the likelihood of a long NH stay.
 - 45 The I-SNPs that serve people living in the community often appear to focus on assisted living facilities (ALFs), which provide a range of services—such as 24-hour supervision, medication management, meals, housekeeping, and transportation—but are not health care facilities like NHs. Some interviewees said ALFs have been a challenging setting for I-SNPs because they do not have the same clinical staff as NHs and because their residents tend to have higher incomes and are more interested in maintaining FFS coverage so that they have broad access to providers.
 - 46 In FFS Medicare, beneficiaries cannot receive skilled care unless they have a prior inpatient stay that lasts three days or more. MA plans can waive this requirement, and nearly all plans (not just I-SNPs) do so. Skilled care services must be ordered by a physician, require the skills of technical or professional personnel (such as registered nurses, licensed

practical nurses, physical or occupational therapists, or speech-language pathologists), and be furnished directly by or under the supervision of skilled personnel.

- 47 Medicare's coverage of skilled care is limited to 100 days of care per spell of illness.
- 48 Prior to 2012, SCAN was the largest I-SNP insurer. At the time, special-needs plans simply had to ensure that enrollees who met the "special needs" requirement were a disproportionate share of their overall enrollment, which meant that they could also enroll beneficiaries who did not meet the special-needs requirement. SCAN's I-SNPs had their roots in another demonstration, the social HMO (S/HMO) demonstration, in which health plans provided some forms of long-term services and supports in addition to Medicare benefits. Beneficiaries could enroll in S/HMO plans if they simply had a high risk of needing NH care (Medicare Payment Advisory Commission 2003). Starting in 2012, special-needs plans had to limit their enrollment to beneficiaries who meet the special-needs requirement. Most enrollees in SCAN's I-SNPs did not meet this requirement and switched to other MA plans or traditional Medicare.
- 49 The 2025 decline in enrollment in UnitedHealth's plans is largely due to the company's decision to close 28 I-SNPs (out of a total of 67) at the end of 2024. The plans that were closed had relatively low enrollment. Most of the plans that were closed (23 of 28) were institutional-equivalent plans.
- 50 In a subcapitated arrangement, a health plan makes capitated payments to another company to provide certain services or care for certain enrollees.
- 51 There were a significant number of NHs (about 750 in 2023) that had a single I-SNP enrollee. For years in which we had data available, we looked at I-SNP enrollment in these NHs in both the prior year and the following year—for example, taking NHs that had a single enrollee in July 2022 and looking at their enrollment in July 2021 and July 2023. We found that the vast majority of these NHs had either zero or one I-SNP enrollee in both the prior year and the following year and concluded that they did not participate in an I-SNP in any meaningful fashion. For example, some of the one-enrollee cases involved beneficiaries who lived in a participating NH; had an inpatient stay; were discharged to a second, nonparticipating NH (where they were the only I-SNP enrollee); and then disenrolled from the I-SNP shortly thereafter.
- 52 In some cases, insurers offer multiple I-SNPs in the same county, including more than one I-SNP of the same type (for example, two facility-based plans). In these situations, the plans may differ in various respects, such as their coverage of supplemental benefits and premiums, and the beneficiaries who live in NHs that contract with these insurers do have some degree of choice among I-SNPs.
- 53 The underlying rationale for these exclusions is that the readmission measure should focus on instances in which service use is more likely to reflect the impact of a plan's care-management strategies. For example, the specifications exclude beneficiaries who had four or more inpatient stays during the year and require beneficiaries to be continuously enrolled in the plan for 12 months prior to an index hospitalization and the 30 days after an index hospitalization.
- 54 D-SNPs have offered the flex cards as part of a demonstration project (the Value-Based Insurance Design Model) that gives MA plans more flexibility to target their extra benefits to enrollees based on their health or socioeconomic status. CMS plans to end this demonstration at the end of 2025, and it is unclear whether D-SNPs will still be able to offer these cards in the future.
- 55 In certain counties, plans that earn a quality bonus receive a benchmark increase of 10 percent.

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C H A P T E R

6

Medicare's measurement of rural provider quality

Medicare's measurement of rural provider quality

Chapter summary

The Commission supports Medicare's measurement of the quality of care furnished by providers to monitor performance, inform patients and payers, and encourage the provision of high-quality care. The Commission has published principles for measuring quality in Medicare; for instance, quality programs should focus on measures tied to clinical outcomes, patient experience, and value, and quality measurement should not be unduly burdensome for providers.

Because of low patient volumes in many rural health care settings, there are practical challenges in measuring some individual rural providers' quality of care and in holding these providers accountable in quality reporting programs. For example, low patient volume means that it is difficult to produce reliable and valid estimates on quality measures for some rural providers. In addition, low-volume providers may have limited staff and funds available for quality-improvement activities (including unduly burdensome data collection and reporting).

The Commission acknowledged these difficulties when it established specific principles to guide expectations about quality in rural areas. These principles were developed with hospitals in mind but could be applied to other providers. First, expectations for quality of care in rural

In this chapter

- MedPAC's principles for and prior work on quality measurement
- Medicare's current quality reporting programs and rural providers
- Initiatives to improve measurement of rural providers' quality of care
- Appendix: Quality measures included in Medicare fee-for-service quality reporting programs

and urban areas should be equal for the nonemergency services that rural providers choose to deliver. Second, all providers should be evaluated on the services they provide—emergency and nonemergency alike—and the quality of the services should be collected and reported publicly.

Because of the Commission's continued interest in rural provider quality, we expanded our reporting of provider quality to include comparisons of rural and urban areas, where relevant and available, in our March 2025 report on the adequacy of payments in the fee-for-service (FFS) payment systems. In general, the comparisons of provider quality in rural and urban areas were mixed across and within settings. For some quality measures, rural quality was better than urban; for others, urban quality was better; and for others, the quality results were similar.

The Congress has enacted pay-for-reporting quality programs for FFS provider types that account for a large majority of services furnished to Medicare beneficiaries. In these programs, providers that successfully report designated quality-measure data are financially rewarded (or not penalized). CMS uses the quality data to publicly report provider performance on the Care Compare website to hold providers accountable to consumers and encourage improvement. Some rural providers are not required to participate in the Medicare quality payment programs; however, the majority of rural providers do have at least some Medicare quality results publicly reported.

We reviewed FFS Medicare's requirements for the quality reporting programs and participation by rural providers. To determine participation by rural and urban providers, we used Care Compare data files. Hospitals, clinicians, and inpatient rehabilitation facilities had comparable shares of rural and urban providers with publicly reported quality results. Rural skilled nursing facilities and dialysis facilities had lower shares of providers with publicly reported quality results compared with their urban counterparts; in contrast, rural home health agencies and hospices had higher shares of providers with publicly reported quality results compared with their urban counterparts. Policymakers could consider future work to understand these differences and reduce them, if feasible.

Medicare Advantage (MA) plans, Part D plans, and accountable care organizations (ACOs) are also required to report quality-measure data to CMS. Many of the quality measures are calculated based on the experience of a sample of patients across participating providers. Beneficiaries residing in rural areas who are assigned to ACOs or are enrolled in MA plans may or may not be

included in the quality-measure results that CMS currently collects for those entities because of sampling methodologies.

There are several federal and stakeholder initiatives to drive improved quality measurement of rural providers, including identifying and developing metrics that are most relevant for rural providers and making technical assistance available to rural providers for quality measurement and improvement. For example, the federal Medicare Beneficiary Quality Improvement Project helps critical access hospitals report measures for CMS quality reporting programs and use that data to guide quality improvement efforts. The Commission will continue to monitor the implementation and effectiveness of these initiatives. ■

Rural communities across the U.S. are diverse in terms of income and demographics. For example, though residents of rural areas have lower average incomes relative to the national average, the range of rural incomes across the country is wide, and some rural areas have average incomes that exceed national averages.¹ What most rural areas have in common is low population density, resulting in low patient volumes for local health care providers and longer travel times for services. Population density is often too low to support certain specialized services, meaning that rural beneficiaries must travel farther for some types of care, especially for some specialized services. Beneficiaries in our annual focus groups who live in rural areas largely seem to accept that residing in a rural area often means forgoing easy local access to a wide range of health services (NORC at the University of Chicago 2024).

About 17 percent of Medicare beneficiaries reside in rural areas (Medicare Payment Advisory Commission 2024a). These beneficiaries may accept limitations on the types of services to which they have easy access, but they should not have to compromise on the quality of care they receive. The Commission has maintained that expectations for quality of care in rural and urban areas should be equal for the nonemergency services that rural providers choose to deliver, and we have continuously supported appropriate and effective measurement of the quality of care that both rural and urban beneficiaries receive. The goal of quality measurement is to improve the quality of care delivered to patients—and, ultimately, to improve the health of individuals and communities—using tools that help providers quantify and track processes, outcomes, and other factors related to providing high-quality care.

The Medicare program, like many other health care purchasers, uses provider-level quality measures to monitor provider performance, publicly report information to patients and payers, and incentivize high-quality care. The Congress has established pay-for-reporting quality programs for fee-for-service (FFS) provider types that account for a large majority of services furnished to Medicare beneficiaries and pay-for-performance (i.e., value-based purchasing) programs for some FFS provider types. In addition, Medicare requires Medicare Advantage (MA) plans, Part D plans, and accountable care organizations (ACOs) to submit quality results to CMS and applies

financial incentives based on their quality performance. However, some rural providers are not currently required to participate in Medicare's quality programs, which may impact the availability of quality information to monitor provider performance.²

In this chapter, we review the Commission's prior work on quality measurement, including the Commission's principles for rural quality of care, and present information on the inclusion of rural providers in current Medicare FFS and MA quality programs.

MedPAC's principles for and prior work on quality measurement

The Commission has developed a general set of principles for measuring quality in the Medicare program and has made several recommendations based on these principles to improve Medicare's quality programs. These include recommendations that the Congress eliminate the Merit-based Incentive Payment System (MIPS) for clinicians and replace Medicare's current quality programs for inpatient hospitals, skilled nursing facilities (SNFs), and MA plans with programs that focus on measures of outcomes, patient experience, and value. The Commission also established a set of principles in 2012 to guide expectations for the quality of care in rural areas. First, expectations for quality of care in rural and urban areas should be equal for nonemergency services that rural providers choose to deliver. Second, all providers should be evaluated on the full range of services they provide (emergency and nonemergency alike), and the quality measures for the services should be collected and reported publicly. In our March 2025 report on the adequacy of FFS payments, we compared measures of provider quality by geographic area. In general, the comparisons of rural and urban quality results were mixed across and within settings: For some quality measures, rural quality was better than urban; for others, urban quality was better; and for others, there was little or no difference between rural and urban quality.

MedPAC principles for quality measurement

The Commission has recommended that Medicare link payment to quality of care to reward accountable entities and providers for offering high-quality care

to beneficiaries. However, the Commission has also expressed concern that Medicare's quality-measurement programs are "overbuilt," relying on too many measures (Medicare Payment Advisory Commission 2018a). For example, CMS's current measure inventory includes 517 measures (Centers for Medicare & Medicaid Services 2025d). Also, many of these measures focus on processes that are not associated with meaningful outcomes.

The proliferation of measures has resulted in an increase in providers' burden to collect the data, confusion among consumers and purchasers who see conflicting measure results, and operational difficulties among payers. One study of the volume and cost of quality reporting at an academic medical center identified 162 unique quality metrics, which required an estimated \$5 million in personnel costs to prepare and report (Saraswathula et al. 2023). Another study estimated that physicians and their staff spend, on average, 785 hours per physician per year dealing with various payers' quality-measure reporting programs and that physicians could care for an additional nine patients per week if they did not have these obligations (Casalino et al. 2016).

The overabundance of measures led the Commission to formalize, in our June 2018 report to the Congress, a general set of principles for measuring quality in the Medicare program (Medicare Payment Advisory Commission 2018a). We apply these principles in (1) modeling the redesign of quality payment (or value-based purchasing (VBP)) programs; (2) assessing the adequacy of Medicare payments (taking into consideration quality of care and identifying efficient providers); and (3) commenting on CMS's proposals for quality measurement. Among the principles:

- Quality measurement should be patient oriented, encourage coordination across providers and time, and promote relevant change in the delivery system.
- Quality measurement should not be unduly burdensome for providers; for instance, Medicare quality programs could remove "topped out" measures.³
- Medicare quality programs should include population-based measures tied to clinical and functional outcomes, patient experience, and

value (e.g., Medicare spending per beneficiary, measures of services that have little or no clinical benefit). Providers may choose to use more granular measures to manage their own quality improvement.

- Medicare should target technical assistance resources to low-performing providers.

MedPAC recommendations to redesign some of Medicare's quality payment programs

Elements of Medicare's current quality programs are inconsistent with the Commission's principles for measuring quality. As a result, we have made several recommendations for improvement. First, in 2018, the Commission recommended that the Congress eliminate the Merit-based Incentive Payment System (MIPS) for clinicians because it impedes progress toward high-value care (Medicare Payment Advisory Commission 2018b). In our March 2019 report to the Congress, we recommended replacing four of Medicare's current hospital quality programs with a single, outcome-based hospital value-incentive program (VIP) (Medicare Payment Advisory Commission 2019). The Commission recommended in the June 2020 report that the Congress replace the MA quality-bonus program (QBP) with an MA-VIP that is consistent with our principles (Medicare Payment Advisory Commission 2020). In our June 2021 report to the Congress, we recommended that the Congress eliminate the current SNF-VBP program and design a new SNF-VIP that aligns with the Commission's principles for quality measurement (Medicare Payment Advisory Commission 2021). These value-incentive programs would be an improvement over the current programs because they focus on measures of outcomes, patient experience, and value.

MedPAC's support for efforts to align quality measures across programs

In recent years, the Commission has supported several of CMS's efforts to improve its quality programs. CMS has constructed various frameworks of quality measurement to drive care improvement for patients covered across federal programs. The goal of these frameworks is to guide CMS as it develops new quality measures, designs public reporting of quality payment programs, and provides technical assistance for quality improvement. These frameworks consistently focus

on (1) alignment of measures across programs and (2) prioritization of outcome measures. For example, the agency has worked with the Core Quality Measures Collaborative, a broad-based coalition of health care workers, to develop core sets of measures that align quality assessment across payers (Jacobs et al. 2023, Partnership for Quality Measurement 2024). These efforts to streamline quality measures across payers, which decreases provider burden, aligns with the Commission's principles for quality measurement.

In addition, although CMS has been shifting focus from process measures to outcome measures in some of the Medicare quality programs, the Commission has called for more work to develop measures tied to clinical outcomes and patient experience. For example, we recommended that the Secretary finalize the development of and begin to report patient-experience measures for SNFs (Medicare Payment Advisory Commission 2021). The Commission has also discussed developing new outcome measures for ambulatory surgical centers (ASCs), including surgical-site infections occurring at ASCs, specialty-specific clinical guidelines to assess whether services provided in ASCs are appropriate, and a claims-based outcome measure for cardiology services (Medicare Payment Advisory Commission 2025).

MedPAC principles for rural quality of care

In 2012, the Commission established a set of principles to guide expectations for the quality of care in rural areas (Medicare Payment Advisory Commission 2012). These principles generally focused on hospital quality but could serve as the basis for evaluating the quality of other providers. First, expectations for quality of care in rural and urban areas should be equal for nonemergency services that rural providers choose to deliver. That is, if a provider has made a discretionary decision to provide a service, that provider should be held to a common standard of quality for that service, whether the service is provided in an urban or a rural location. Note, however, that emergency services in urban and rural areas may be subject to different quality standards to account for different levels of staff, patient volume, and technology. For example, a patient may present with a heart attack with a significant blockage, in which case the standard of care is angioplasty and a stent in a catheterization lab. Such care is readily available in catheterization labs in urban

areas. However, small rural hospitals, which may be too far from the nearest catheterization lab to safely transport heart attack patients (even by helicopter), may be forced to use a thrombolytic to treat the blockage. We would not expect equal outcomes in this emergency situation, and the relevant quality benchmark for emergency care should be that of either other small hospitals or the expected outcomes given additional transportation time if the small rural hospital no longer offered emergency care.

Second, all providers should be evaluated on the full range of services they provide (emergency and nonemergency alike), and the quality measures for the services should be collected and reported publicly. The Commission specifically applies this principle to hospitals—that all hospitals should be subject to public disclosure of their performance scores in order to give rural and urban patients equal access to information. This information includes measures common among rural and urban providers as well as measures that are specific to rural providers' scope of practice, such as timely communication of patient information after a transfer.

MedPAC reporting on the quality of rural providers

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional FFS payment systems. To determine an update recommendation, we estimate the adequacy of FFS Medicare payments to providers in the current year by considering (1) beneficiaries' access to care, (2) the quality of care, (3) providers' access to capital, and (4) how Medicare payments compare with providers' costs. Beyond questions of payment updates, we consider how payment rates may affect providers' ability to serve Medicare beneficiaries based on geographic, demographic, and other characteristics.

The Commission has a long history of monitoring rural beneficiaries' access to care and developing recommendations designed to preserve or improve that access (Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2018a, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2001). Because of the Commission's continued interest in rural-provider quality, where relevant and available,

**TABLE
6-1**

**Comparing rural quality-measure results with those in urban areas:
Findings from MedPAC's 2025 fee-for-service payment-adequacy analyses**

Provider type	Quality measures	Rural quality compared with urban
Hospitals	Risk-adjusted mortality rate	Higher (worse)
	Risk-adjusted readmission rate	Lower (better)
	Patient experience	Higher (better)
Physician and other health professionals	Risk-adjusted rate of ambulatory care-sensitive hospitalizations	Similar
	Risk-adjusted rate of ambulatory care-sensitive ED visits	Higher (worse)
	Patient experience	Similar
	Annual flu vaccination	Lower (worse)
Outpatient dialysis facilities	Share of beneficiaries on hemodialysis and peritoneal dialysis receiving adequate dialysis	Similar
	Hemoglobin status of dialysis beneficiaries	Similar
	Patient experience	Similar
Skilled nursing facilities	Risk-adjusted rate of discharge to the community	Lower (worse)
	Risk-adjusted potentially preventable readmission	Similar
	Case-mix-adjusted registered nurse staffing	Higher (better)
	12-month nursing staff turnover	Lower (worse)
Home health agencies	Risk-adjusted rate of discharge to the community	Similar
	Risk-adjusted potentially preventable readmission	Similar
	Patient experience	Higher (better)
Inpatient rehabilitation facilities	Risk-adjusted rate of discharge to the community	Similar
	Risk-adjusted potentially preventable readmission	Similar
Hospice providers	Patient experience	Higher (better)

Note: ED (emergency department). "Similar" rural and urban measure results are those that are within a 3 percent difference. CMS has used a difference of 3 percent as a threshold for "practical significance" in quality-measure comparisons (Centers for Medicare & Medicaid Services 2024m). Because these analyses were conducted as part of MedPAC's assessment of the payment adequacy of Medicare's fee-for-service prospective payment systems (PPSs), only providers that participate in the relevant PPSs are included. As a result, critical access hospitals, which provide care mainly in rural areas and are not paid under the inpatient PPS, are excluded. Results from skilled nursing stays provided in hospitals in rural areas, which are not paid under the skilled nursing facility PPS, are also excluded. Rural home health and hospice providers are defined by the share of beneficiaries treated who reside in rural areas, not the location of the provider.

Source: Medicare Payment Advisory Commission 2025.

we added reporting of provider quality by geography to our March 2025 report on the adequacy of FFS payments. Table 6-1 summarizes the findings from these analyses. In general, the comparisons of rural and urban quality results were mixed across and within settings: For some quality measures, rural quality was better than urban; for others, urban quality was better; and for others, there was little or no difference between rural and urban quality.

Medicare's current quality reporting programs and rural providers

Quality payment programs are intended to create incentives for providers to furnish efficient, high-quality care. There are broadly two types of quality payment programs. The first are pay-for-reporting programs in which providers (or the accountable

entity) that successfully report designated quality measures are financially rewarded (or not penalized). The second type are pay-for-performance programs (e.g., VBP programs). Typically, these programs adjust payments to a provider upward or downward based on its performance on quality measures. A provider's performance during an assessment period is compared either with that of other providers or with some performance scale and then converted to a provider-specific payment adjustment. This payment adjustment is applied to all payments for that provider in a later fiscal year. The quality data from both types of programs can be used for public reporting of provider performance to hold providers accountable to consumers and encourage improvement.

Medicare has generally taken a phased approach by implementing provider-based pay-for-reporting (or penalty for nonreporting) programs before pay-for-performance programs. The Congress has enacted quality reporting programs for FFS provider types that account for a large majority of services furnished to Medicare beneficiaries. The Congress has also implemented several pay-for-performance programs that tie FFS payment to a provider's performance on quality standards. As required by law, CMS reports data from those quality programs on the Care Compare websites as summary star ratings and as detailed measure results. In addition, CMS requires ACOs to report quality-measure results and uses those results in determining participating providers' shared savings and losses. Finally, as mandated by Congress, CMS collects quality-measure results from MA and Part D plans and has implemented a quality-bonus program for MA plans. All these quality payment programs have generally focused on process measures in their early stages, but programs have begun to include more measures of outcomes and patient experience over time (Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2018). (See text box on types of quality measures and their data sources, p. 310.)

Some rural providers are currently not required to participate in the Medicare quality reporting programs. Rural providers may be excluded from quality programs in legislation because they are paid outside of traditional payment systems (e.g., providers that

are paid on a cost basis) or because of program rules defined by CMS (e.g., minimum case counts).⁴

Most rural areas have low population density, resulting in low patient volumes for local health care providers. As a result, some rural providers do not have enough patients to produce reliable and valid measurement results. In addition, quality measurement may create a heavier burden for rural health care providers than for their urban counterparts. Many rural providers are small and may have limited time, staff, and finances available for quality-improvement activities, including data collection, management, analysis, and reporting. People who work in small hospitals and practices often have multiple, disparate responsibilities (e.g., direct patient care, business and operational responsibilities) that compete with quality-improvement activities (National Quality Forum 2015, Rural Health Information Hub 2024). Even with these challenges, the majority of rural providers do have at least some Medicare quality results publicly reported.

The Commission recognizes that there are practical challenges in measuring some individual rural providers' quality of care and holding these providers accountable in quality reporting programs. But we also maintain that it is important to evaluate providers on the quality of services they offer and to hold all providers accountable, through public reporting, for the care they provide to Medicare beneficiaries. Many of the challenges are broader limitations in measuring the quality of smaller providers and are not unique to rural providers.

In this section, we review the requirements of quality reporting programs and participation by rural and urban providers, including hospitals, clinicians, SNFs, home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), dialysis facilities, and hospices. To determine participation by rural and urban providers, we used Care Compare data files, which CMS makes publicly available.⁵ We also focused on reporting outcome measures, such as readmission rates and patient-experience measures, consistent with the Commission's principles for quality measurement.

Table 6-2 (p. 311) summarizes the comparisons of rural and urban providers with publicly reported Medicare quality results. Hospitals, clinicians, and IRFs had comparable shares of rural and urban providers

Types of quality measures and their data sources

Measures used to assess and compare the quality of health care organizations broadly apply to the categories described below (Centers for Medicare & Medicaid Services 2025a, Centers for Medicare & Medicaid Services 2024g).

Structure measures assess features of a health care organization or clinician relevant to their capacity to provide good health care. Examples include use of electronic health record technology that meets health information technology criteria and implementation of quality-improvement activities. Data sources can include attestations from the health care organization.

Process measures focus on steps that should be followed to provide good care. These steps can assist in maintaining, monitoring, or improving patients' health status. Examples include breast cancer screening and medication review. These measures are based on patient information that can be found in administrative data (e.g., claims and encounter data) but generally also require clinical information from medical records.

Intermediate outcome measures assess the change produced by a health care intervention that leads to a long-term outcome. "Diabetes care: Blood sugar controlled" is an example of an intermediate outcome measure in which the related outcome of interest would be "better health status for beneficiaries with diabetes." Like process measures, these measures are based on patient information found in administrative data but generally also require clinical information from medical records.

Outcome measures focus on the health status of a patient (or change in health status) resulting from health care—desirable or adverse. Examples

include hospital readmission rates (lower rates represent better outcomes) and patient reporting of maintained or improved health status. These measures are based on patient information found in administrative data but generally also require clinical information from medical records or patient surveys.

Patient-experience measures reflect patients' perspectives on the care they received (for example, the ease of getting needed care and seeing specialists). The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a set of patient-experience surveys administered to Medicare beneficiaries and other patients to gather information on respondents' personal experiences of interacting with their health plan and health care providers. CAHPS results are used to measure quality from the patient's perspective across several measures, including getting appointments and care quickly and the patient's overall rating of their health plan.

Access measures reflect processes and issues that could create barriers to receiving needed care. "Plan makes timely decisions about appeals" is an example of an access measure. These measures are based on information collected by the Medicare program or providers.

Cost/resource use measures count health services (in terms of units or dollars) applied to a population or event (including diagnoses, procedures, or encounters). A resource-use measure counts the frequency of use of defined health system resources. Some may further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource use. An example of a cost/resource use measure is Medicare spending per beneficiary. These measures are based on administrative data. ■

with publicly reported quality results. Rural SNFs and dialysis facilities had lower shares of providers with publicly reported quality results compared with their urban counterparts, whereas rural HHAs and

hospices had higher shares of providers with publicly reported quality results compared with their urban counterparts. Policymakers could consider future work to understand these differences.

**TABLE
6-2**

Comparing the shares of rural and urban providers with publicly reported Medicare quality results, by provider type

Provider type	Finding
Hospital	Comparable shares of rural and urban PPS hospitals had publicly reported quality results.
Clinician	Comparable shares of eligible rural and urban clinicians reported data for MIPS, which CMS uses for public reporting of quality results.
Skilled nursing facility	Lower share of rural SNFs had publicly reported quality results compared with urban SNFs.
Home health agency	Higher share of rural HHAs had publicly reported quality results compared with urban agencies.
Inpatient rehabilitation facility	Comparable shares of rural and urban IRFs had publicly reported quality results.
Hospice	Higher share of rural hospices had publicly reported quality results compared with urban agencies.
Dialysis facility	Lower share of urban dialysis facilities had publicly reported quality results compared with rural dialysis facilities.

Note: PPS (prospective payment system), MIPS (Merit-based Incentive Payment System), SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehabilitation facility). “Comparable shares” are within 10 percentage points of each other.

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024 (Centers for Medicare & Medicaid Services 2024a).

In this section, we also discuss quality reporting and rural providers for ACOs, MA plans, and Part D plans.

Measuring the quality of rural hospitals (inpatient, outpatient, and rural emergency)

Medicare has two quality reporting programs for acute care hospitals: the Hospital Inpatient Quality Reporting Program (IQRP) and the Outpatient Quality Reporting Program (OQRP).⁶ Under these programs, hospitals receive a 2 percentage point reduction in payment for failing to successfully report quality-measure data. By law, the hospital QRPs exclude facilities that are not paid through inpatient or outpatient prospective payment systems (PPSs), such as the roughly 1,370 critical access hospitals (CAHs) that primarily operate in rural areas (see Chapter 7 of this report for more information about CAH payments).⁷ About 700 PPS hospitals (slightly less than a quarter of all PPS hospitals) are located in rural areas and included in the quality programs.

There are 36 quality measures in the IQRP and 15 in the OQRP for fiscal year (FY) 2025; these 51 measures across

the two programs are mainly based on coverage year 2023 performance (Table 6-3, p. 312) (see Table 6-A1 (pp. 324–325) and Table 6-A2 (p. 326) in the appendix for the full list of measures and data sources).⁸ Hospitals report about half of those measures to CMS (e.g., patient-experience surveys, health care–associated infections, medical record–abstracted measures), while the other half are claims-based outcomes (e.g., rates of readmissions and mortality) or cost measures that CMS calculates. CMS determines a minimum number of eligible cases that a provider must have for a given measure result to be publicly reported on the Care Compare website. If a provider’s number of cases is too low for a measure, then the result may be too unreliable to use to assess performance. In these instances, CMS does not display the provider’s measure result on Care Compare but adds a footnote on the website that the “number of cases/patients is too few to report” (Centers for Medicare & Medicaid Services 2025g). CMS uses other footnotes on Care Compare when a provider’s measure results are not included on the website (e.g., “results are not available for this reporting period”).⁹

**TABLE
6-3**

Public reporting of rural and urban hospital quality in FFS Medicare, 2024

Medicare quality reporting program	Quality measures	Public reporting of rural hospital quality	Public reporting of urban hospital quality
Inpatient QRP	36 measures, including readmission, mortality, and patient experience	97% of PPS hospitals in rural areas had publicly reported readmission rates; 80% had patient-experience results publicly reported. 82% of CAHs had readmission measure results publicly reported; 23% had patient-experience results publicly reported.	97% of PPS hospitals in urban areas had publicly reported readmission rates; 89% had patient-experience results publicly reported.
Outpatient QRP	15 measures, including patient experience and whether patient left before being seen in ED	79% of PPS hospitals in rural areas had the ED throughput measure publicly reported. 49% of CAHs had the ED throughput measure publicly reported.	73% of PPS hospitals in urban areas had the ED throughput measure publicly reported.
Rural emergency hospital QRP	4 measures that are part of Outpatient QRP, including time spent in ED	Data collection began in 2024, and results have not yet been publicly reported.	N/A

Note: FFS (fee-for-service), QRP (Quality Reporting Program), PPS (prospective payment system), CAH (critical access hospital), IPPS (inpatient prospective payment systems), ED (emergency department), N/A (not applicable). The QRPs require hospitals to submit quality data, which CMS uses to publicly report hospital quality performance on the Care Compare website. The shares of providers that meet the requirements for public reporting include those that reported the required data and met CMS's minimum case requirement (i.e., reliability standard) for the measure. Where feasible, we highlighted outcomes and patient-experience results consistent with the Commission's principles for quality measurement. (See appendix for more details of measures included in some of the programs.) Close to a quarter (or about 700) of IPPS hospitals are located in rural areas. There are about 1,350 CAHs included in this analysis.

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024.

Although CAH payments are not impacted by whether the CAH reports IQRP or OQRP data, CAHs are encouraged to voluntarily submit measure data for public reporting on Care Compare (Centers for Medicare & Medicaid Services 2024f). During interviews with leadership of several CAHs that were voluntarily reporting IQRP and OQRP measures, they cited the value of voluntarily reporting in order to gain experience with quality measurement.

In our review of the Care Compare data CMS publicly reported as of December 2024, we found that no PPS hospital or CAH had publicly reported data for all 51

IQRP or OQRP measures. This finding likely results from a combination of factors, including not having minimum case counts, exceptions for measures that are not applicable to the services the hospital provides, and hospitals' electing to suppress a measure from being publicly reported. Thus, for the analysis of shares of hospitals with publicly reported data, we focus on public reporting of specific measures as opposed to reporting the complete measure set.

Most CAHs voluntarily opted to participate in the IQRP or OQRP, meaning they reported at least some of the 51 measures to CMS for public reporting. This finding is

consistent with results reported by the Medicare Rural Hospital Flexibility (Flex) Program (Lahr et al. 2023).¹⁰ Also, comparable shares of rural and urban IPPS hospitals had publicly reported results.

In December 2024, 82 percent of CAHs had their claims-based readmission rate publicly reported on Care Compare, compared to 97 percent of urban and rural IPPS hospitals (Table 6-3). These hospitals participated in the IQRP and met the minimum case requirement of 25 eligible cases for the measurement year for public reporting. For the patient-experience measures, many CAHs did not report the measures to CMS or did not meet the minimum case requirements for public reporting (which is a minimum of 25 completed surveys for a four-quarter period). Only about a quarter (23 percent) of CAHs had patient-experience results publicly reported. (The Flex Program collects patient-experience results directly from CAHs and reports that 95 percent of CAHs are collecting patient-experience surveys.) By contrast, 89 percent of urban IPPS hospitals and 80 percent of rural IPPS hospitals met the minimum survey requirements and had results publicly reported on Care Compare. Leadership at one CAH we visited in the summer of 2024 recounted receiving only one completed patient-experience survey in a months-long period. Although the CAH leadership said the information was helpful for their own quality-improvement activities, the CAH did not meet the CMS minimum for public reporting.

For the OQRP measure of median time from emergency department (ED) arrival to departure, almost half (49 percent) of CAHs had a result reported on Care Compare, meaning they chose to participate in the program and met minimum case requirements for public reporting (Table 6-3). This share is less than the 73 percent of urban IPPS hospitals and 79 percent of rural IPPS hospitals that had the median time for ED arrival and departure publicly reported.

The rural emergency hospital (REH) is a new Medicare provider type, effective January 1, 2023 (Medicare Payment Advisory Commission 2024b). The Congress established REHs to respond to concerns about rural hospital closures and give rural communities a new provider type to support access to emergency care. When an eligible facility converts to an REH, it must provide ED services and observation care and is allowed to provide additional outpatient medical

and health services if elected by the REH and if these services do not exceed an annual per patient average length of stay of 24 hours.

Beginning in 2024, REHs must report data for the REH Quality Reporting Program, which includes four measures from the OQRP (Table 6-3) (see Table 6-A3, p. 327, in the appendix for the full list of measures and data sources). CMS intends to publicly report these results after completion of a data-collection period, provided that sufficient case volumes are achieved.

Measuring the quality of rural clinicians

In its annual assessment of payment adequacy for clinician services, the Commission has noted that it is difficult to assess the quality of clinician care for several reasons (Medicare Payment Advisory Commission 2025). The difficulty extends to the quality of clinician care in both urban and rural areas. First, Medicare does not collect beneficiaries' clinical information (e.g., blood pressure, lab results) or patient-reported outcomes (e.g., improving or maintaining physical and mental health) at the FFS-beneficiary level. Second, CMS measures the performance of clinicians using the MIPS, which, in March 2018, the Commission recommended eliminating because it is fundamentally flawed (Medicare Payment Advisory Commission 2018b). For example, MIPS allows clinicians to choose which measures of quality and improvement activities they will report from a catalog of hundreds of measures, which makes it harder to compare clinicians because they are not being evaluated on the same measure set; for some measures, only a few clinicians may report. Third, for claims-based measures, Medicare's "incident to" policies obscure who actually performed a service because a substantial portion of services performed by advanced practice registered nurses (APRNs) and physician assistants (PAs) appear in claims data to have been performed by physicians. As noted above, in June 2019, the Commission recommended requiring APRNs and PAs to bill the Medicare program directly. Finally, there is the matter of small numbers of cases for measuring individual clinicians, a perennial issue in quality measurement for clinician services because it can make the results at the individual clinician level unreliable. Acknowledging all these challenges in measuring the quality of clinician care and our standing recommendation to eliminate MIPS, we present information on the program here

**TABLE
6-4**

Participation of rural and urban clinicians in the Merit-based Incentive Payment System, 2022

MIPS measures	Rural clinician participation	All clinician participation
100s of measures across four categories: quality, improvement activities, promoting interoperability, and cost; clinicians select a small set of quality and improvement-activity measures to report	94% of MIPS-eligible clinicians in rural areas submitted MIPS data.*	94% of MIPS-eligible clinicians in rural areas submitted MIPS data.*

Note: MIPS (Merit-based Incentive Payment System). MIPS is a program that adjusts Medicare Part B payments for eligible clinicians based on their performance in four categories: quality, cost, promoting interoperability, and improvement activities. Federally qualified health centers (FQHCs) and rural health clinics (RHCs) do not have Medicare-specific quality reporting programs, but FQHCs are required to report quality data to other federal agencies. We compare rural clinician and all clinician participation in MIPS because that is the method CMS uses in the Quality Payment Program Experience report.

* Clinicians who bill exclusively through FQHC and RHC payment models may voluntarily report on measures and activities under MIPS but are not subject to a payment adjustment.

Source: Centers for Medicare & Medicaid Services 2025e, Centers for Medicare & Medicaid Services 2024a.

because it is the basis for data CMS publicly reports on Care Compare on clinician quality.

In 2017, CMS launched the Quality Payment Program (QPP) to provide clinicians with incentives to perform well on quality measures (MIPS) or to participate in advanced alternative payment models (A-APMs). (Examples of A-APMs include accountable care organization (ACO) models that require providers to take on a specified minimum level of financial risk.) Under current law, starting in 2026, payment rates will increase by 0.75 percent per year for qualifying clinicians in A-APMs and by 0.25 percent per year for all other clinicians (Medicare Payment Advisory Commission 2025).

Under the QPP, clinicians remaining in traditional FFS Medicare (i.e., not joining an A-APM) are subject to additional reporting and payment requirements through MIPS. (MIPS is a pay-for-performance program, but we include it in this chapter because the program's quality measures are used for public reporting by CMS.) MIPS is a system that calculates individual-clinician-level or group-level payment adjustments based on performance across four performance categories—quality, improvement activities, interoperability improvement, and cost.

Clinicians select a small set of measures of quality and improvement activity to report, from a list of hundreds of measures that apply to different specialties or clinical conditions (Table 6-4). MIPS-eligible clinicians receive a MIPS payment adjustment—positive, negative, or neutral—based on their performance across the categories in a prior year.

To account for the issue of few cases with which to measure clinician quality, MIPS excludes clinicians who do not meet low-volume thresholds of Part B-covered services. In 2022, clinicians were required to participate in MIPS if they billed more than \$90,000 for Part B-covered professional services, saw more than 200 Part B patients, and provided more than 200 covered professional services to Part B patients. Also, clinicians who bill for Medicare Part B services exclusively through federally qualified health center (FQHC) or rural health clinic (RHC) payment methods (i.e., all-inclusive payment) may voluntarily report on measures and activities under MIPS but are not subject to a payment adjustment.¹¹ However, if a clinician practices in an RHC or FQHC and also provides services that are billed under the fee schedule for physician and other health professional services, then payment for those services could be eligible for MIPS payment adjustments.

In 2022, the rate of reporting for MIPS-eligible clinicians was high, including clinicians in rural areas. Ninety-four percent of all MIPS-eligible clinicians (who are therefore required to participate), as well as MIPS-eligible clinicians in rural areas, actively submitted data (Table 6-4) (Centers for Medicare & Medicaid Services 2024l). The roughly 6 percent of MIPS-eligible clinicians who did not report may still have been scored on administrative claims measures that are automatically calculated by CMS for the quality and cost-performance categories. Rural clinicians engaged (i.e., reported data) in MIPS in 2022 received a mean payment adjustment of 2.04 percent, which was slightly lower than the mean for all engaged MIPS-eligible clinicians, 2.40 percent. (Both groups had a minimum payment adjustment of -9 percent and maximum of 8.26 percent.) The share of MIPS-eligible clinicians in rural practices receiving an exceptional payment adjustment (38 percent) was consistent with MIPS-eligible clinicians overall (42 percent).¹² Nonreporting rural clinicians received a mean MIPS payment adjustment of -3.8 percent, which was slightly lower than the mean payment adjustment of -3.4 percent for all nonreporting MIPS-eligible clinicians. (Both groups had a minimum payment adjustment of -9 percent and maximum of 0 percent.)

Measuring the quality of rural skilled nursing facilities

The SNF Quality Reporting Program (SNF-QRP) requires SNFs to submit quality data, which CMS uses to publicly report SNF quality performance on the Care Compare website. Freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed hospitals (e.g., PPS hospitals, including those in rural areas, that furnish post-acute care in swing beds) that do not report complete SNF-QRP data receive reduced payment updates. By law, the QRP excludes facilities such as CAHs that are not paid through the SNF-PPS.¹³

In FY 2025, there are 15 quality measures in the SNF-QRP. SNFs report about three-fourths of the measures to CMS (e.g., measures based on the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument and personnel vaccination rates), while the other quarter consists of claims-based outcome measures (e.g., readmission rates) or cost measures that CMS calculates (Table 6-5, p. 316) (see Table 6-A4, p. 328, in the appendix for the full list of measures and data sources). CMS determines a minimum number

of eligible cases that a provider must have for the measure result to be publicly reported. If a provider has too few cases, then the measure result may be too variable to reliably assess performance and is not reported on Care Compare. Also, if a provider does not report a measure result to CMS, then the provider does not have a publicly reported result for that measure.

Close to a third of freestanding, hospital-based, and non-CAH swing-bed facilities (about 4,700) are located in rural areas. Based on our analysis of the CMS Care Compare data reported as of December 2024, we found that SNFs in rural areas had fewer quality data publicly reported than SNFs in urban areas. Forty-five percent of freestanding SNFs, hospital-based SNFs, and non-CAH swing-bed facilities in rural areas reported and met the minimum case count for all 15 SNF-QRP measures (Table 6-5, p. 316). This share is lower than the 65 percent of freestanding SNFs, hospital-based SNFs, and non-CAH swing-bed facilities in urban areas that had all 15 SNF-QRP measures publicly reported. For the claims-based outcome measure of potentially preventable postdischarge readmissions, CMS established 25 index admissions as the minimum number of eligible patients. Seventy-four percent of freestanding SNFs, hospital-based SNFs, and non-CAH swing-bed facilities in rural areas had the minimum case count for publicly reporting the readmission measure. By comparison, 87 percent of freestanding SNFs, hospital-based SNFs, and non-CAH swing-bed facilities in urban areas had the minimum case count for publicly reporting the readmission measure.

Almost all of the roughly 1,370 CAHs have swing beds, in which beneficiaries can receive acute or post-acute care. SNF swing beds in CAHs do not have to report data for the QRP, so none have reported all of the measures and/or met the minimum case count for all 15 SNF-QRP measures. However, 17 percent of CAHs with SNF swing beds in rural areas met the minimum case requirement for some measures and had readmission results publicly reported.

Measuring the quality of rural home health agencies

All Medicare-certified home health agencies (HHAs) are required to report data for the HH Quality Reporting Program (HH-QRP) or they receive a reduction in payment updates.¹⁴ These data are used to publicly report HHA quality on the Care Compare website.

**TABLE
6-5**

Public reporting of rural and urban skilled nursing facility quality in FFS Medicare, 2024

SNF-QRP quality measures	Public reporting of rural SNF quality	Public reporting of urban SNF quality
15 measures, including potentially preventable 30-day postdischarge readmission measure	45% of freestanding and hospital-based SNFs and non-CAH swing-bed facilities in rural areas had all quality measures publicly reported. 74% of them had readmission results publicly reported. CAH swing beds are not required to report data to CMS, and no CAH swing beds have all quality measures publicly reported, but 17% of CAHs with SNF swing beds have a readmission result publicly reported.	65% of freestanding and hospital-based SNFs and non-CAH swing-bed facilities in urban areas had all quality measures publicly reported. 87% of them had readmission results publicly reported.

Note: FFS (fee-for-service), SNF (skilled nursing facility), QRP (Quality Reporting Program), CAH (critical access hospital). The SNF-QRP requires SNFs to submit quality data, which CMS uses to publicly report SNF quality performance on the Care Compare website. The shares of providers that meet the requirements for public reporting include those that reported the required data and met CMS's minimum case requirement (i.e., reliability standard) for the measure. The minimum number of cases for CMS's readmission measure is 25 index admissions. We highlighted the readmission measure because this claims-based outcome measure is consistent with the Commission's principles for quality measurement. (See appendix for more details on measures included in some of the programs.) Close to a third (or about 4,700) of freestanding, hospital-based, and non-CAH swing-bed facilities are located in rural areas. Almost all of about 1,350 CAHs have swing beds, in which beneficiaries can receive acute or post-acute care.

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024.

There are 22 quality measures in the 2025 HH-QRP (Table 6-6) (Centers for Medicare & Medicaid Services 2024h). HHAs report about three-fourths of the measures to CMS directly (e.g., through the Outcome and Assessment Information Set), while the other fourth consists of claims-based outcome (e.g., readmission rates) and cost measures that CMS calculates, plus the HH-CAHPS patient-experience survey (see Table 6-A5, p. 329, in the appendix for the full list of measures and data sources). CMS also determines a minimum number of eligible cases or patients for each measure to be publicly reported. If a provider's number of cases is too low, then the result may be too variable to reliably assess performance. Also, if a provider does not report a measure result to CMS, then the provider does not have a publicly reported measure result.

In 2024, 15 percent of HHAs were classified as majority rural (i.e., beneficiaries residing in rural counties accounted for 50 percent or more of the 30-day

periods of care delivered by the agency). Based on our analysis of the CMS Care Compare data reported as of December 2024, we found that HHAs with a majority of patients residing in rural areas had more quality data publicly reported than HHAs with a majority of patients residing in urban areas (Table 6-6). Fifty-eight percent of the HHAs with a majority of patients residing in rural areas reported and met the minimum case count for all HH-QRP measures, compared with 39 percent of majority-urban HHAs. Ninety percent of HHAs with a majority of their patients residing in rural areas had the minimum case count for publicly reporting the readmission measure. This figure is higher than the 63 percent of agencies with the majority of their patients residing in urban areas that had the minimum case count for publicly reporting the readmission measure. Fifty-eight percent of HHAs with the majority of their patients residing in rural areas reported HH-CAHPS patient-experience results to CMS and met the minimum requirement of 70 completed surveys for the results to be publicly

**TABLE
6-6**

Medicare's public reporting of rural and urban home health agency quality in FFS Medicare, 2024

HH-QRP quality measures	Public reporting of rural HHA quality	Public reporting of urban HHA quality
22 measures, including potentially preventable readmission rate and patient experience	58% of HHAs with the majority of their patients in rural areas had all quality measures publicly reported; 90% of them had readmission results publicly reported; and 58% had patient-experience results publicly reported.	39% of HHAs with the majority of their patients in urban areas had all quality measures publicly reported; 63% of them had readmission results publicly reported; and 40% had patient-experience results publicly reported.

Note: FFS (fee-for-service), HH (home health), QRP (Quality Reporting Program), HHA (home health agency). The HH-QRP requires HHAs to submit quality data, which CMS uses to publicly report HHA quality performance on the Care Compare website. The shares of providers that meet the requirements for public reporting include those that reported the required data and met CMS's minimum case requirement (i.e., reliability standard) for the measure. The minimum requirement for publicly reporting the patient-experience measures is 70 completed surveys. We highlighted the readmission and patient-experience measures because they are outcome and patient-experience measures consistent with the Commission's principles for quality measurement. (See appendix for more details of measures included in some of the programs.) In 2024, 15 percent of HHAs were classified as majority rural (i.e., beneficiaries residing in rural counties accounted for 50 percent or more of the 30-day periods of care delivered by the agency).

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024.

reported. This share is higher than the 40 percent of agencies with the majority of their patients residing in urban areas that had patient-experience results publicly reported. The lower shares of both urban and rural HHAs that did not have all measures publicly reported was mainly driven by the patient-experience survey. The HH-CAHPS survey has a minimum requirement of least 70 completed surveys over a given eight-quarter period for patient-experience results to be publicly reported, which smaller agencies—whether urban or rural—may not meet.

Measuring the quality of rural inpatient rehabilitation facilities

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF-QRP) requires IRFs to submit data that CMS uses to publicly report IRF quality performance on the Care Compare website. IRFs that do not report IRF-QRP data have a 2 percentage point reduction in their annual increase factor. There are 17 quality measures in the FY 2025 IRF-QRP (Table 6-7, p. 318). IRFs report about 80 percent of the measures to CMS (e.g., the IRF Patient Assessment Instrument (IRF-PAI) and personnel vaccination rates), while the other 20 percent consists of claims-based outcome measures (e.g., readmission rates) and cost measures that CMS calculates (see

Table 6-A6, p. 330, in the appendix for the full list of measures and data sources). CMS also determines a minimum number of eligible cases that a provider must have for the measure result to be publicly reported. If a provider's number of cases is too low, then the measure result may be too variable to reliably assess performance.

In 2024, 13 percent of IRFs (or close to 140) were located in rural areas. Based on our analysis of the CMS Care Compare data reported as of December 2024, we found that IRFs in rural and urban areas had comparable quality data publicly reported. Eighty-eight percent of IRFs in rural areas reported and met the minimum case count for all 17 IRF-QRP measures, which is comparable with the 92 percent of IRFs in urban areas that had all IRF-QRP measures publicly reported (Table 6-7, p. 318). For the claims-based outcome measure of potentially preventable postdischarge readmissions, the minimum number of eligible patients is 25 index admissions. Ninety-five percent of IRFs in rural areas had the minimum case count for publicly reporting the readmission measure in December 2024. This share is comparable with the 97 percent of IRFs in urban areas that had the minimum case count for publicly reporting the readmission measure.

**TABLE
6-7**

Public reporting of rural and urban inpatient rehabilitation facility quality in FFS Medicare, 2024

IRF-QRP quality measures	Public reporting of rural IRF quality	Public reporting of urban IRF quality
17 measures, including potentially preventable readmissions	88% of IRFs in rural areas had all quality measures publicly reported; 95% of them had readmission results publicly reported.	92% of IRFs in urban areas had all quality measures publicly reported; 97% of them had readmission results publicly reported.

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), QRP (Quality Reporting Program). The IRF-QRP requires IRFs to submit quality data, which CMS uses to publicly report IRF quality performance on the Care Compare website. The shares of providers that meet the requirements for public reporting include those that reported the required data and met CMS's minimum case requirement (i.e., reliability standard) for the measure. The minimum number of cases for CMS's readmission measure is 25 index admissions. We highlighted the readmission measure because this claims-based outcome measure is consistent with the Commission's principles for quality measurement. (See appendix for more details of measures included in some of the programs.) In 2024, 13 percent of IRFs (or close to 140) were located in rural areas.

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024.

Measuring the quality of rural hospices

The Hospice Quality Reporting Program (H-QRP) requires all Medicare-certified hospices to submit data for CMS, which are then publicly reported on Care Compare. Hospices that do not report H-QRP data have a 4 percentage point reduction in their annual increase factor. This penalty increased from 2 percentage points to 4 percentage points beginning in FY 2024 (Centers for Medicare & Medicaid Services 2024d).

There are four quality measures in the FY 2025 H-QRP. The measures are calculated using the Hospice Item Set that hospices report to CMS, patient-experience surveys collected by third-party survey vendors, and Medicare claims data (Table 6-8) (see Table 6-A7, p. 331, in the appendix for the full list of measures and data sources). CMS also determines a minimum number of eligible cases that a provider must have for the measure result to be publicly reported. If a provider has too few cases, then the measure result may be too variable to reliably assess performance.

About 12 percent of hospices (or close to 800) are classified as majority rural because more than half of the beneficiaries they serve reside in a rural area. Based on our analysis of the CMS Care Compare data reported as of December 2024, we found that hospices with a majority of patients residing in rural areas had more quality data publicly reported than hospices

with a majority of patients residing in urban areas (Table 6-8). Seventy-four percent of majority-rural hospices reported and met the minimum number of eligible cases for all H-QRP measures to be publicly reported. This share is higher than the 42 percent of majority-urban hospices that had all H-QRP measures publicly reported. The lower shares of both urban and rural hospices that did not have all measures publicly reported was mainly driven by the patient-experience survey. For patient-experience results to be publicly reported, a facility must have at least 75 completed surveys over a given eight-quarter period. Smaller facilities—whether urban or rural—might not meet that minimum. Seventy-four percent of hospices with the majority of their patients residing in rural areas reported and had sufficient volume for patient-experience results to be publicly reported. This share is higher than the 43 percent of hospices with the majority of their patients residing in urban areas that did not report or did not meet the minimum case count for publicly reporting the patient-experience results.

Measuring the quality of rural dialysis facilities

The End-Stage Renal Disease Quality Incentive Program (ESRD-QIP) is a pay-for-performance program, which reduces payments to renal dialysis facilities that do not meet or exceed certain performance standards on applicable measures (Centers for Medicare & Medicaid Services 2023b). (The ESRD-QIP is included in this

TABLE
6–8

Public reporting of rural and urban hospice quality in FFS Medicare, 2024

H-QRP quality measures	Public reporting of rural hospice quality	Public reporting of urban hospice quality
4 measures, including patient experience	74% of hospices with the majority of their patients in rural areas had all quality measures publicly reported; 74% of them had patient-experience results publicly reported.	42% of hospices with the majority of their patients in urban areas had all quality measures publicly reported; 43% of them had patient-experience results publicly reported.

Note: FFS (fee-for-service), H-QRP (Hospice Quality Reporting Program). The H-QRP requires hospices to submit quality data, which CMS uses to publicly report hospice quality performance on the Care Compare website. The shares of providers that meet the requirements for public reporting include those that reported the required data and met CMS's minimum case requirement (i.e., reliability standard) for the measure. CMS requires at least 75 completed surveys over a given eight-quarter period for patient-experience results to be publicly reported. We highlighted the patient-experience measure because this claims-based outcome measure is consistent with the Commission's principles for quality measurement. (See appendix for more details of measures included in some of the programs.) About 12 percent of hospices (or close to 800) are classified as majority rural because more than half of the beneficiaries they serve reside in a rural area.

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024.

chapter on quality reporting because most of the program's quality measures are used for public reporting by CMS.) The maximum payment reduction that CMS can apply to any facility is 2 percent. This reduction applies to all payments for services performed by the facility receiving the reduction during the applicable payment year.

There are 15 quality measures in the 2025 ESRD-QIP (Table 6-9, p. 320). Dialysis facilities report about three-fourths of the measures to CMS (e.g., information abstracted from medical records), while the other quarter are claims-based outcome (e.g., readmission rates) or cost measures that CMS calculates, plus the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH-CAHPS) patient-experience survey (see Table 6-A8, p. 332, in the appendix for the full list of measures and data sources). CMS also determines a minimum number of eligible cases or patients for each measure that a provider must meet for the result to be publicly reported. If a provider's number of cases is too low, then the result may be too variable to reliably assess performance.

About 16 percent of dialysis facilities (or close to 1,200) are located in a rural area. Based on our analysis of the CMS Care Compare data reported as of December 2024, we found that dialysis facilities in rural areas had fewer quality data publicly reported than facilities in urban areas (Table 6-9, p. 320). Sixteen percent

of dialysis facilities located in rural areas met the minimum case count for all ESRD-QIP measures. This share is lower than the 28 percent of dialysis facilities located in urban areas that had all ESRD-QIP measures publicly reported. Like HHAs and hospices, the lower shares of both urban and rural dialysis facilities that did not have all measures publicly reported were mainly driven by the patient-experience survey. The ICH-CAHPS has a minimum requirement of 30 completed surveys from two survey periods for results to be publicly reported, which smaller facilities—whether urban or rural—may not meet. For the claims-based outcome measure of standardized readmission rates, the minimum number of eligible patients is 11 index hospital discharges. Ninety-three percent of dialysis facilities in rural areas had the minimum case count for publicly reporting the readmission measure. This share is comparable to the 95 percent of facilities in urban areas that had the minimum case count for publicly reporting the readmission measure. Seventeen percent of dialysis facilities in rural areas had sufficient volume for patient-experience results to be publicly reported, which is lower than the 33 percent of facilities in urban areas that had the minimum case count.

Medicare's quality measurement for accountable care organizations

Medicare ACOs are models that hold groups of providers accountable for the total cost and quality of care furnished to a defined population of FFS

**TABLE
6–9**

Public reporting of rural and urban dialysis facility quality in FFS Medicare, 2024

ESRD–QIP	Public reporting of rural dialysis facility quality	Public reporting of urban dialysis facility quality
15 measures, including standardized readmission rate and patient experience	16% of dialysis facilities in rural areas had all quality measures publicly reported; 93% of them had a readmission rate publicly reported; 17% of them had patient-experience results publicly reported.	28% of dialysis facilities in urban areas had all quality measures publicly reported; 95% of them had a readmission rate publicly reported; 33% of them had patient-experience results publicly reported.

Note: FFS (fee-for-service), ESRD–QIP (End-Stage Renal Disease Quality Incentive Program). The ESRD–QIP requires dialysis facilities to submit quality data, which CMS uses to publicly report dialysis-facility quality performance on the Care Compare website. The shares of providers that meet the requirements for public reporting include those that reported the required data and met CMS's minimum case requirement (i.e., reliability standard) for the measure. The minimum number of cases for CMS's readmission measure is 25 index admissions. CMS requires at least 30 completed surveys from two survey periods for patient-experience results to be publicly reported. We highlighted the readmissions and patient-experience measures because these measures are consistent with the Commission's principles for quality measurement. (See appendix for more details of measures included in some of the programs.) About 16 percent of dialysis facilities (or close to 1,200) are located in a rural area.

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024.

beneficiaries. Clinicians who meet participation thresholds for some ACOs designated as A–APMs do not need to participate in MIPS because their quality of care is assessed by the ACO.

Some ACOs participate in rural areas and are accountable for the quality of care provided to the beneficiaries assigned to their organization. As of January 1, 2025, more than half of all RHCs were participating in a Medicare Shared Savings Program (MSSP) ACO, as were more than half of FQHCs (including rural and urban FQHCs) and about a third of CAHs (Centers for Medicare & Medicaid Services 2025f). CMS also noted a 16 percent increase in the number of RHCs, FQHCs, and CAHs from 2024 to 2025 (Centers for Medicare & Medicaid Services 2025b). Increasing provider participation in value-based programs, such as ACOs, is consistent with the Commission's principles.

The Medicare program requires ACOs to report quality-measure results to CMS; the reported quality-measure results are used to calculate a quality-performance score, which is used to determine shared savings and losses. In 2024, ACOs participating in the MSSP, the largest Medicare ACO program, had the

option to report clinical quality-measure results to CMS in two ways: (1) report 10 CMS web-interface measures or (2) report 3 electronic clinical quality measures (eCQMs), 3 MIPS clinical quality measures (CQMs), or 3 Medicare CQMs (Centers for Medicare & Medicaid Services 2024c).¹⁵ Examples of these clinical measures include poor control of diabetes; screening for depression and follow-up; controlling high blood pressure; and tobacco use screening and cessation intervention. CMS selects a sample of an MSSP–ACO's assigned beneficiaries to use in calculating the MSSP–ACO's quality-measure results. ACOs work with their providers, which can include providers in rural areas, to gather the clinical documentation needed (e.g., screening results and lab values in medical records) for each measure, and they report results to CMS for scoring as part of the MSSP–ACO program. MSSP–ACOs must also collect patient-experience surveys from a sample of patients (which is different from the sample for the clinical measures) and are assessed on two claims-based measures (readmissions and admissions for patients with multiple chronic conditions). The rural providers that are part of those ACOs are also measured on the quality of care they provide. However, ACO quality measures may or may

not capture quality results for beneficiaries residing in rural areas who are assigned to ACOs because of the sampling approach to measurement.

Medicare's quality measurement for Medicare Advantage and Part D plans

As of 2024, more than half of eligible Medicare beneficiaries nationwide were enrolled in MA plans (Medicare Payment Advisory Commission 2025). MA enrollment patterns differ in urban and rural areas. In 2024, the majority (56 percent) of eligible urban beneficiaries were enrolled in MA compared with 47 percent of eligible beneficiaries residing in rural counties.¹⁶ However, the growth of MA enrollment in rural areas has been faster in recent years. In 2024, MA enrollment in rural areas grew by 8 percent, compared with 6 percent growth in urban areas. The predominant plan type often differs between urban and rural areas as well. In 2024, 39 percent of rural MA enrollees were in HMO plans compared with about 59 percent of urban enrollees. By contrast, 58 percent of rural enrollees were in local preferred provider organizations compared with 40 percent of urban enrollees.

In 2006, CMS introduced the MA star-rating system to give beneficiaries information about the clinical quality, administrative capability, and patient experience that an enrollee can expect from a given MA plan. Medicare currently collects over 100 MA quality measures, 42 of which are used to determine a star rating from 1 to 5 for each MA contract (Centers for Medicare & Medicaid Services 2023c). These ratings are available on the medicare.gov Plan Finder website so that beneficiaries can compare plans. Twelve of these 42 measures are also used to calculate Part D star ratings that are displayed on the Plan Finder website for each Part D organization.

However, the Commission has determined that the current system for MA quality measurement and reporting is flawed and does not provide a reliable basis for evaluating quality across MA plans (Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019). Nonetheless, these measures are the basis for the MA quality-bonus program, which increases MA payments (and program spending) by about \$15 billion annually.

A primary flaw of current MA quality reporting is that quality results for MA are reported on a contract-wide

basis, and those results are used to determine the star ratings for all plans offered under the contract.¹⁷ MA contracts often cover wide geographic areas that include multiple diverse health care markets. In January 2024, over half of MA enrollees were in contracts that spanned two or more states. A third of MA enrollees were in multistate MA contracts that spanned noncontiguous states. The largest MA contract, with 2.6 million enrollees, had over 1,000 MA enrollees in each of 46 states and over 20,000 enrollees in each of 30 states. Another multistate contract had about 200,000 enrollees in Florida; 100,000 enrollees in Indiana; 70,000 enrollees in Arizona; and 40,000 enrollees in Oregon. The star ratings for such contracts reflect performance averaged across different service areas and thus are unlikely to accurately reflect plan quality in any one of those areas.

Plan sponsors rely exclusively on administrative data (such as encounter data) as the source for many measures, but there are some “hybrid” measures for which MA organizations can or must use both administrative data and data collected from a sample of enrollee medical records (e.g., data on breast cancer screening or diabetic A1c control). To report data for hybrid measures, MA organizations collect data for a random sample of 411 enrollees, chosen at the contract level.¹⁸ Like many of the ACO measures previously described, MA plans work with providers (including those that furnish care in rural areas) to gather the information on this sample of enrollees to report the measure. However, because of the sampling approach at the contract level, MA quality measures may or may not capture quality results for beneficiaries residing in rural areas who are enrolled in MA plans.

Initiatives to improve measurement of rural providers' quality of care

While acknowledging the limitations in measuring quality of care for many small providers, including those in rural areas, we have identified several federal and multistakeholder initiatives to improve quality measurement, including identifying and developing metrics most relevant for rural providers and furnishing technical assistance to rural providers. The Commission will continue to monitor the implementation and effectiveness of these initiatives.

Identifying and developing metrics that are most relevant for rural providers

Quality measurement among rural providers could be improved by focusing on metrics that are tailored to these providers and the concerns of patients treated by them. The metrics may differ in rural and urban areas, for example, because the types of care provided in smaller rural hospitals may differ from the types of care in larger hospitals. The National Quality Forum, funded by CMS, convened a multistakeholder Rural Health Advisory Group that identified the best available measures to address the needs of rural populations—scientifically valid measures that address conditions and topics important to rural patients and are resistant to low case-volume challenges (National Quality Forum 2022, National Quality Forum 2015). In 2022, the group identified 37 key rural measures, including 21 hospital-setting measures and 16 ambulatory care-setting measures. Many of the measures the advisory group selected are included in the various Medicare quality reporting programs that we described earlier in this chapter. The advisory group selected measures with a heavy emphasis on behavioral and mental health, substance use, infectious disease, access to care, equity, and social determinants of health. The measure list also addresses admissions, readmissions, and hospital visits; care coordination; dementia, diabetes, and hypertension; kidney health; maternal health; mortality; patient experience; preventive care; and patient safety. The advisory group also identified the gaps in the updated measure list, with calls for measure development in the following areas: intentional and unintentional injury, COVID-19, HIV, telehealth-relevant measures, cancer-screening measures, and cost measures. Most of the measures identified as key measures, as well as measurement gaps, are tied to clinical outcomes, patient experience, and value, and therefore align with the Commission's principles for quality measurement.

Federal initiatives to support rural quality-improvement efforts

The Commission has maintained that the goal of improved care should extend to all patients, regardless of health status, income, and race. Those expectations are more likely to be met if they are combined with additional resources to build a provider's ability to address particularly challenging environments for care delivery. Thus Medicare should target technical

assistance to low-performing providers (Medicare Payment Advisory Commission 2018a). A number of federal programs and initiatives are available to help rural health care providers develop quality-improvement programs. We briefly describe two below. The Commission will continue to monitor the implementation and effectiveness of these initiatives.

Quality-improvement organizations (QIOs) work with health care facilities and providers on behalf of CMS to improve health care delivery and ensure high-quality, cost-efficient care (Centers for Medicare & Medicaid Services 2024k).¹⁹ Twelve quality-innovation networks—QIOs (QINs—QIOs) work directly with nursing homes, health care providers, and partnerships for community health serving rural and underserved areas to improve the quality and safety of care for Medicare beneficiaries. The QINs—QIOs help health care providers with quality initiatives by promoting evidence-based improvement strategies and supporting peer-to-peer learning. The work of QIOs is state focused and organized under regional contracts. Nine hospital quality-improvement contractors work directly with small rural and critical access hospitals to improve health care quality and safety for Medicare beneficiaries. During interviews with leadership of several CAHs, we heard some positive feedback about technical assistance provided by local QIOs to help improve readmission and sepsis rates.

The Health Resources and Services Administration created the Medicare Beneficiary Quality Improvement Project (MBQIP) to help CAHs report measures for CMS's quality reporting programs and use those data for improvement (Lahr et al. 2023). Specifically, the MBQIP aims to capture measurement data in the most relevant areas, including patient safety, inpatient and outpatient care, patient engagement, and care transitions. CAH quality-measure reporting across these domains has generally increased under the MBQIP, and CAH performance on some measures has improved. For example, under patient safety, in 2022, 91 percent of reporting CAHs fulfilled the seven antibiotic stewardship core elements, compared with 80 percent of reporting CAHs in 2019. ■

6—A

APPENDIX

Quality measures included in Medicare fee-for-service quality reporting programs

**TABLE
6-A1****Hospital Inpatient Quality Reporting Program measures
for the FY 2025 payment update (cont. next page)**

Measure	Source
National Healthcare Safety Network measures	
Influenza vaccination coverage among health care personnel	NHSN
COVID-19 vaccination coverage among health care personnel	NHSN
Claims-based complications and death measures	
Death rate among surgical inpatients with serious treatable complications (CMS recalibrated death rate among surgical inpatients with serious CMS PSI-04 treatable complications)	Claims
Hospital 30-day, all-cause, risk-standardized mortality rate following acute ischemic stroke	Claims
Hospital-level risk-standardized complication rate following primary elective total hip arthroplasty and/or total knee arthroplasty	Claims
Claims-based coordination of care measures	
Hospital-wide all-cause unplanned readmissions measure	Claims
Excess days in acute care after hospitalization for acute myocardial infarction	Claims
Excess days in acute care after hospitalization for heart failure	Claims
Excess days in acute care after hospitalization for pneumonia	Claims
Claims-based efficiency and payment measures	
Hospital-level, risk-standardized payment associated with a 30-day episode of care for acute myocardial infarction	Claims
Hospital-level, risk-standardized payment associated with a 30-day episode of care for heart failure	Claims
Hospital-level, risk-standardized payment associated with a 30-day episode of care for pneumonia	Claims
Hospital-level, risk-standardized payment associated with an episode of care for primary elective total hip arthroplasty and/or total knee arthroplasty	Claims
Medicare spending per beneficiary: Hospital	Claims
Chart-abstracted clinical process of care measures	
Elective delivery	Chart abstraction
Severe sepsis and septic shock management bundle (composite measure)	Chart abstraction
Structural measures	
Maternal morbidity structural measure	Web-based tool
Hospital commitment to health equity*	Web-based tool
Electronic clinical quality measures	
Admit decision time to ED departure time for admitted patients	EHR
Exclusive breast milk feeding	EHR
Discharged on antithrombotic therapy	EHR
Anticoagulation therapy for atrial fibrillation/flutter	EHR
Antithrombotic therapy by the end of hospital day	EHR
Discharged on statin medication	EHR
Venous thromboembolism prophylaxis	EHR
Intensive care unit venous thromboembolism prophylaxis	EHR
Hospital harm: Severe hypoglycemia*	EHR
Hospital harm: Severe hyperglycemia*	EHR
Cesarean birth*	EHR
Severe obstetric complications*	EHR
Safe use of opioids: Concurrent prescribing	EHR

**TABLE
6-A1**

**Hospital Inpatient Quality Reporting Program measures
for the FY 2025 payment update (cont.)**

Measure	Source
Patient experience of care survey measure	
Hospital Consumer Assessment of Healthcare Providers and Systems survey	Patient survey
Hybrid measures	
Hybrid hospital-wide all-cause readmissions*	EHR and claims
Hybrid hospital-wide all-cause risk-standardized mortality*	EHR and claims
Process/structural measures	
Screening for social drivers of health*	Web-based tool
Screen positive rate for social drivers of health*	Web-based tool

Note: FY (fiscal year), NHSN (National Healthcare Safety Network), PSI (patient-safety indicator), ED (emergency department), EHR (electronic health record).

* Measure not publicly reported. .

Source: Centers for Medicare & Medicaid Services 2024e.

**TABLE
6-A2****Hospital Outpatient Quality Reporting Program
measures for the CY 2025 payment update**

Measure	Source
MRI lumbar spine for low back pain	Claims
Abdomen CT: Use of contrast material	Claims
Cardiac imaging for preoperative risk assessment for noncardiac low-risk surgery	Claims
Median time from ED arrival to ED departure for discharged ED patients	Chart abstraction
ED: Patient left without being seen (numerator/denominator one time per year for the previous year)	Web-based tool
Head CT or MRI scan results for acute ischemic stroke or hemorrhagic stroke patients who received head CT or MRI scan interpretation within 45 minutes of arrival	Chart abstraction
Appropriate follow-up interval for normal colonoscopy in average-risk patients	Web-based tool
Cataracts: Improvement in patient's visual function within 90 days following cataract surgery*	Web-based tool
Facility seven-day risk-standardized hospital visit rate after outpatient colonoscopy	Claims
Admissions and ED visits for patients receiving outpatient chemotherapy	Claims
Hospital visits after hospital outpatient surgery	Claims
OAS-CAHPS*	Patient survey
COVID-19 vaccination coverage among health care personnel	NHSN
Breast cancer screening recall rates	Claims
STEMI*	eCQM

Note: CY (calendar year), CT (computed tomography), ED (emergency department), MRI (magnetic resonance imaging), OAS-CAHPS (Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems), NHSN (National Healthcare Safety Network), STEMI (ST-elevation myocardial infarction), eCQM (electronic clinical quality measure). Chart abstraction involves reviewing medical records to collect data for specific quality measures, which providers then submit to CMS.

* Hospitals may voluntarily submit data for CY 2025 payment determination but will not be subject to a payment reduction with respect to this measure during the voluntary reporting period. The STEMI measure is not publicly reported.

Source: Centers for Medicare & Medicaid Services 2025c.

**TABLE
6-A3**

Rural Emergency Hospital Quality Reporting Program measures for CY 2024

Measure	Source
Median time from ED arrival to ED departure for discharged ED patients	Chart abstraction
Abdomen CT: Use of contrast material	Claims
Hospital visits within seven days after hospital outpatient surgery	Claims
Facility seven-day risk-standardized hospital visit rate after outpatient colonoscopy	Claims

Note: CY (calendar year), ED (emergency department), CT (computed tomography). Chart abstraction involves reviewing medical records to collect data for specific quality measures, which providers then submit to CMS.

Source: Centers for Medicare & Medicaid Services 2024n.

**TABLE
6-A4****Skilled Nursing Facility Quality Reporting Program for the FY 2025 payment update**

Measure	Source
Changes in skin integrity post-acute care: Pressure ulcer/injury	MDS
Percent of residents experiencing one or more falls with major injury (long stay)	MDS
Discharge mobility score for medical rehabilitation patients	MDS
Discharge self-care score for medical rehabilitation patients	MDS
Drug regimen review conducted with follow-up for identified issues	MDS
Transfer of health information to the provider post-acute care	MDS
Transfer of health information to the patient post-acute care	MDS
Discharge function score	MDS
Patient/resident COVID-19 vaccine	MDS
Medicare spending per beneficiary	Claims
Discharge to community	Claims
Potentially preventable 30-day postdischarge readmissions measure	Claims
SNF health care–associated infections requiring hospitalization	Claims
COVID-19 vaccination coverage among health care personnel	NHSN
Influenza vaccination coverage among health care personnel	NHSN

Note: FY (fiscal year), MDS (Minimum Data Set), SNF (skilled nursing facility), NHSN (National Healthcare Safety Network).

Source: Centers for Medicare & Medicaid Services 2024j.

**TABLE
6-A5****Home Health Quality Reporting Program for the CY 2025 payment update**

Measure	Source
Improvement in ambulation/locomotion	OASIS
Percent of residents experiencing one or more falls with major injury (long stay)	OASIS
Percent of patients with an admission and discharge functional assessment and a care plan that addresses function	OASIS
Improvement in bathing	OASIS
Improvement in bed transferring	OASIS
COVID-19 vaccine: Percent of patients/residents who are up to date	OASIS
Drug regimen review conducted with follow-up for identified issues: Post-acute care	OASIS
Discharge function score	OASIS
Improvement in dyspnea	OASIS
Influenza immunization received for current flu season	OASIS
Improvement in management of oral medications	OASIS
Changes in skin integrity post-acute care	OASIS
Timely initiation of care	OASIS
Transfer of health information to provider: Post-acute care	OASIS
Transfer of health information to patient: Post-acute care	OASIS
Acute care hospitalization during the first 60 days of HH	Claims
Discharge to community	Claims
Emergency department use without hospitalization during the first 60 days of HH	Claims
Total estimated Medicare spending per beneficiary (MSPB)	Claims
Potentially preventable 30-day postdischarge readmissions measure	Claims
Home health within-stay potentially preventable hospitalization	Claims
HH-CAHPS survey (experience with care)	Survey
· How often did the HH team give care in a professional way	
· How well did the HH team communicate with patients	
· Did the HH team discuss medicines, pain, and home safety with patients	
· How do patients rate the overall care from the HHA	
· Will patients recommend the HHA to friends and family	

Note: CY (calendar year), OASIS (Outcome and Assessment Information Set), HH (home health), CAHPS (Consumer Assessment of Healthcare Providers and Systems), HHA (home health agency).

Source: Centers for Medicare & Medicaid Services 2024h.

**TABLE
6-A6**

**Inpatient Rehabilitation Facility Quality Reporting
Program for the FY 2025 payment update**

Measure	Source
Changes in skin integrity post-acute care: Pressure ulcer/injury	IRF-PAI
Percent of residents experiencing one or more falls with major injury (long stay)	IRF-PAI
IRF functional outcome measure: Discharge mobility score for medical rehabilitation patients	IRF-PAI
IRF functional outcome measure: Discharge self-care score for medical rehabilitation patients	IRF-PAI
Drug regimen review conducted with follow-up for identified issues	IRF-PAI
Transfer of health information to the provider post-acute care	IRF-PAI
Transfer of health information to the patient post-acute care	IRF-PAI
Discharge function score	IRF-PAI
COVID-19 vaccine: Percent of patients/residents who are up to date	IRF-PAI
Catheter-associated urinary tract infection outcome measure	NHSN
Facility-wide inpatient hospital-onset <i>Clostridium difficile</i> infection outcome measure	NHSN
Influenza vaccination coverage among health care personnel	NHSN
COVID-19 vaccination coverage among health care personnel	NHSN
Medicare spending per beneficiary	Claims
Discharge to community	Claims
Potentially preventable 30-day postdischarge readmission measure	Claims
Potentially preventable within-stay readmission measure for IRFs	Claims

Note: FY (fiscal year), IRF-PAI (Inpatient Rehabilitation Facility–Patient Assessment Instrument), IRF (inpatient rehabilitation facility), NHSN (National Healthcare Safety Network).

Source: Centers for Medicare & Medicaid Services 2024i.

**TABLE
6-A7****Hospice Quality Reporting Program for the FY 2025 payment update**

Measure	Source
Hospice and palliative care composite process measure: Comprehensive assessment measure at admission	Chart abstraction
Hospice visits in last days of life	Claims
Hospice care index	Claims
Consumer Assessment of Healthcare Providers and Systems (CAHPS), hospice	Survey

Note: FY (fiscal year). Chart abstraction involves reviewing medical records to collect data for specific quality measures, which providers then submit to CMS.

Source: Centers for Medicare & Medicaid Services 2024d.

**TABLE
6-A8****End-Stage Renal Disease Quality Incentive Program payment year 2025 measures**

Measure	Source
In-center hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH-CAHPS)	Survey
Standardized readmission ratio	Claims
Standardized hospitalization ratio	Claims
Percentage of prevalent patient waitlisted	Chart abstraction
Kt/V dialysis adequacy	Chart abstraction
Vascular access: Standardized fistula rate	Chart abstraction
Vascular access: Long-term catheter rate	Chart abstraction
Standardized transfusion ratio	Claims
Bloodstream infection	NHSN
Clinical depression screening and follow-up	Chart abstraction
Hypercalcemia	Chart abstraction
Ultrafiltration rate	Chart abstraction
Dialysis event reporting	Chart abstraction
Medication reconciliation	Chart abstraction
COVID-19 vaccination among health care personnel	NHSN

Note: NHSN (National Healthcare Safety Network). "Kt/V" refers to a measure of dialysis adequacy, specifically the efficiency of urea clearance, calculated as the product of dialyzer clearance (K), dialysis time (t), divided by the volume of urea distribution (V). Data sources listed in the tables are primary data sources. Other data sources may also be used to determine quality results. Chart abstraction involves reviewing medical records to collect data for specific quality measures, which providers then submit to CMS.

Source: Centers for Medicare & Medicaid Services 2022.

Endnotes

- 1 Using survey data from 2013 through 2017, the Census Bureau found that the median household income in mostly urban counties was higher than that of mostly rural counties (\$60,000 vs. \$47,000); however, the range in median household incomes across mostly urban counties (\$21,000 to \$130,000) and mostly rural counties (\$20,000 to \$95,000) was wide (Guzman et al. 2018). (The Census Bureau defines an area as “mostly rural” if most of its census tracts are not in urbanized areas (Ratcliffe et al. 2016).) In a separate analysis, the Census Bureau found that median incomes for rural households in the Northeast and Midwest were actually higher than those of their urban counterparts; in contrast, median incomes for rural households in the South and West were lower compared with urban households in the same regions (Bishaw and Posey 2016). One caveat is that the incomes used by the Census Bureau are not adjusted for the cost of living. An earlier study that compared rural and urban poverty rates found that the poverty rates—prior to any adjustment for the cost of living—were higher in rural areas, but after adjusting for the cost of living, poverty rates were lower in rural areas (Jolliffe 2006). We are not aware of any updates to this dated finding that adjusts rural and urban incomes or poverty rates by the cost of living.
- 2 In this chapter, “Medicare’s quality programs” broadly refers to quality reporting programs and value-based pay-for-performance programs.
- 3 A quality measure may be considered “topped out” if performance is such that a large majority of providers or entities perform at or very near the top of the distributions; therefore, the majority of providers or entities can no longer improve their performance. For example, CMS defines topped-out clinician process measures as “those with a median performance rate of 95 percent or higher, while nonprocess measures are considered topped out if the truncated coefficient of variation is less than 0.10 and the 75th percentile and 90th percentile are within two standard errors” (Centers for Medicare & Medicaid Services 2024b).
- 4 CMS currently sets minimum case counts for each measure used in Medicare quality programs based on reliability or industry standards. If a provider does not meet the minimum case count for the designated reporting period, then the measure result is not publicly reported or scored. CMS employs some mechanisms to increase case counts for provider-level measure results in order to compensate for the effect of low volume on statistical reliability. One method is pooling the measurement data for low-volume providers over a number of years. MedPAC’s chapter on ensuring reliable results for quality measures in a SNF–VIP describes the pros and cons of pooling quality data over time (Medicare Payment Advisory Commission 2021).
- 5 CMS reports Care Compare data on the Provider Data Catalog website (<https://data.cms.gov/provider-data/>).
- 6 There are also three hospital pay-for-performance programs: the Hospital Readmission Reduction Program (HRRP), the Hospital Value-Based Purchasing (VBP) Program, and the Hospital-Acquired Conditions Reduction Program (HACRP) (see the Commission’s *hospital Payment Basics* for more information on the programs). Critical access hospitals cannot receive a penalty from the HRRP or the HACRP, nor do they receive a reward or penalty as part of the Hospital VBP Program.
- 7 CAHs are limited to 25 beds and primarily operate in rural areas. Unlike traditional hospitals (which are paid under prospective payment systems), Medicare pays CAHs based on each hospital’s reported costs.
- 8 Nine of the FY 2025 IQRP measures and one of the FY 2025 OQRP measures are not publicly reported because they are new measures or there have been changes to the measure.
- 9 The footnote in Care Compare is applied when a hospital (1) elected not to submit data for the entire reporting period, (2) had no claims data for a particular measure, or (3) elected to suppress a measure from being publicly reported.
- 10 The Medicare Beneficiary Quality Improvement Project (MBQIP) focuses on quality-improvement efforts in the 45 states that participate in the Flex Program. Through Flex, MBQIP supports more than 1,370 small, mainly rural, hospitals certified as CAHs to voluntarily report quality measures that are aligned with those collected by CMS and other federal programs.
- 11 FQHCs are required to report to the Health Resources and Services Administration (HRSA) on a core set of measures each calendar year as defined by the Uniform Data System (UDS). HRSA uses UDS data to assess the impact and performance of the Health Center Program and to promote data-driven quality improvement. UDS data on health centers include patient characteristics, services provided, clinical processes and health outcomes, patients’ use of services, staffing, costs, and revenues.
- 12 The MIPS exceptional payment adjustment is a positive payment adjustment for clinicians who demonstrate exceptional performance in MIPS, potentially exceeding

the standard bonus. However, for the 2025 payment year, there is no exceptional-performance adjustment because congressional funding for it expired after the 2024 payment year.

- 13 Under the SNF-VBP program, Medicare adjusts SNF payments based on quality performance prior to the fiscal year. In FY 2025, only one quality measure, readmission rate, is scored in the SNF-VBP, but the measure set will expand in future years. CAH swing beds are also excluded from the SNF-VBP program.
- 14 All Medicare-certified HHAs are also required to participate in the HH Value-Based Purchasing (HH-VBP) Program (the first payment year is calendar year 2025 based on 2023 performance). However, to account for HHAs with different volumes, HHAs are grouped into either small-volume or large-volume cohorts, and an HHA's performance is measured within its cohort (Centers for Medicare & Medicaid Services 2023d). Cohort assignment is based on unique HH-CAHPS survey-eligible beneficiaries for each HHA. The smaller-volume cohort is the group of competing HHAs that had fewer than 60 unique HH-CAHPS survey-eligible beneficiaries in the calendar year before the performance year. The larger-volume cohort is the group of competing HHAs that had 60 or more unique HH-CAHPS survey-eligible beneficiaries in the calendar year before the performance year. Grouping HHAs in cohorts that are of similar size and more likely to receive scores on the same set of measures is

more equitable for purposes of setting quality-performance benchmarks and achievement thresholds and for determining payment adjustments.

- 15 CMS has set a goal of advancing quality measurement by transitioning quality measures used in its reporting programs to digital quality measures. Digital quality measures are organized as self-contained measure specifications and code packages that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems.
- 16 In 2023, 15 percent of MA enrollees and 20 percent of FFS enrollees resided in rural areas.
- 17 The contract is the agreement entered into between an MA organization and CMS. The contract is the administrative unit for various aspects of CMS's administration of the MA program, such as the collection and reporting of quality measures, the determination of network adequacy, and for auditing and compliance. An organization that has an MA contract can offer a single plan or multiple plans under the contract. Currently, MA contracts offer from 1 to 250 plans, with the median contract offering 4 plans.
- 18 These sampling requirements are specified by the National Committee for Quality Assurance.
- 19 Additionally, QIOs investigate complaints made by beneficiaries concerning quality of care.

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C H A P T E R

7

**Reducing beneficiary cost
sharing for outpatient services
at critical access hospitals**

R E C O M M E N D A T I O N

For fee-for-service Medicare beneficiaries, the Congress should:

- Set coinsurance for outpatient services at critical access hospitals equal to 20 percent of the payment amount for services that require cost sharing; and
- Place a cap on critical access hospitals' outpatient coinsurance equal to the inpatient deductible.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Reducing beneficiary cost sharing for outpatient services at critical access hospitals

Chapter summary

Critical access hospitals (CAHs) are small rural hospitals with 25 or fewer acute care beds that receive cost-based reimbursement for most of the care they provide to Medicare beneficiaries, rather than the prospective payment system (PPS) rates received by other hospitals. For many CAHs, the higher rates associated with cost-based payments are necessary to remain financially viable. The Commission estimates that Medicare's cost-based fee-for-service (FFS) payments to CAHs averaged about \$4 million more per CAH than would have been paid under the inpatient and outpatient PPSs in 2022. The additional \$4 million in payments was about 10 percent of the average CAH's \$40 million in all-payer revenue and far higher than the average CAH's net profit of about \$1 million. If CAHs had been paid standard PPS rates, many would have incurred significant losses.

However, FFS beneficiaries pay substantially more coinsurance at CAHs than they do for the same services at PPS hospitals. For most outpatient services, CAH coinsurance is set at 20 percent of charges. Charges are the list prices that hospitals set for their services, and they typically far exceed most hospitals' reported costs of providing those services. Charges can be seen as arbitrary and not a good proxy for cost or value. The Commission's analysis of outpatient cost-sharing liabilities at CAHs found

In this chapter

- Background
- Cost-based FFS Medicare payments provide significant financial support to CAHs
- Beneficiaries pay substantially more coinsurance for CAH outpatient services
- Setting CAH outpatient cost sharing at 20 percent of Medicare's payment
- Appendix: Charge-based coinsurance at rural health clinics

that cost sharing averaged 52 percent of total FFS Medicare payments for CAH outpatient services in 2022; however, cost sharing varied widely across services and CAHs. This variation reflects a wide difference in markups (the ratio of charges to costs) across CAHs and across services within CAHs. For some services, cost-sharing liability was less than 30 percent of the total payment, while in other cases (where charges were highest relative to costs) cost sharing was equal to 100 percent of the total payment. This variation among CAHs creates inequities in cost sharing paid by beneficiaries depending on whether they receive services at a CAH with high or low markups and may subject CAH patients to cost sharing that is much higher than what they would be liable for if they had received care at a hospital where coinsurance equals 20 percent of Medicare's payment rate for the service at that specific hospital.

FFS beneficiaries who receive outpatient services in hospitals paid under Medicare's outpatient PPS (OPPS) also receive financial protection in the form of a cap on coinsurance. Under the OPPS, coinsurance for an outpatient procedure (e.g., a drug, CT scan, emergency department visit, or surgery) provided at most hospitals cannot be greater than Medicare's inpatient hospital deductible (\$1,676 in 2025). However, there is no cap on cost sharing for FFS beneficiaries who receive outpatient services at CAHs. We found that, in 2022, about 200,000 CAH outpatient line items (out of 26 million line items) had coinsurance that exceeded the OPPS cap. The most common services with coinsurance above the inpatient deductible were orthopedic surgeries (e.g., knee replacements) and Part B drug injections (e.g., pembrolizumab for cancer, infliximab for arthritis). If Medicare had imposed a cap on CAH coinsurance for each line item in 2022, the coinsurance on the 200,000 claims would have been reduced by an average of about \$2,000 per line item.

In a majority of cases, CAH coinsurance for beneficiaries in FFS Medicare is paid for by the beneficiary's supplemental insurer. However, we estimate that about 16 percent of rural FFS beneficiaries do not have supplemental insurance and are directly billed 20 percent of charges when they receive outpatient services at a CAH. And, even when a beneficiary has supplemental insurance that directly shields them from high coinsurance amounts, the cost of that coverage may be passed on in the form of higher premiums in states with CAHs. The higher supplemental insurance premiums are borne by all policyholders, whether or not they receive outpatient services at CAHs.

The Commission recommends that CAH coinsurance for outpatient services received by FFS beneficiaries be set at 20 percent of the outpatient payment

amount (rather than 20 percent of charges) and subject to a cap per service equal to the inpatient deductible. This change would protect beneficiaries from excessive coinsurance and would make CAH cost sharing more consistent with Medicare cost sharing for outpatient services in other hospitals.

If beneficiary coinsurance for outpatient services provided at CAHs had been set at 20 percent of the payment amount in 2022, with the amount per line item capped at the level of the inpatient deductible, beneficiary cost-sharing liability would have been about \$2.1 billion lower (60 percent lower), assuming no change in care patterns. Assuming that CAHs would retain their current level of cost-based reimbursement, the \$2.1 billion reduction in beneficiary cost sharing would have resulted in a \$2.1 billion annual increase in FFS Medicare program payments, which would have been funded by taxpayers and beneficiaries who pay Part B premiums. The benefits of this policy change would accrue primarily to FFS beneficiaries without supplemental coverage who receive outpatient services at CAHs, as well as purchasers of supplemental policies in states with CAHs. ■

Most rural communities in the U.S. have low population density and experience longer travel times for services, both of which can pose challenges for delivery of and access to medical care.¹ To help address these challenges, the Congress enacted the critical access hospital (CAH) program in 1997. The program provides cost-based Medicare payments to certain rural hospitals with 25 or fewer beds that provide care to beneficiaries in fee-for-service (FFS) Medicare. The cost-based outpatient rates are far higher than payments under Medicare's prospective payments systems and help CAHs remain financially viable. However, beneficiary cost-sharing liability for most FFS Medicare outpatient CAH services is also higher than at other hospitals since it is set at 20 percent of charges rather than 20 percent of the Medicare payment amount. Charges are the list prices that hospitals set for their services, and they typically exceed most hospitals' reported costs of providing those services; these charges can be seen as arbitrary and not a good proxy for cost or value.

In this chapter, we explain how CAH cost sharing works and recommend a new method of setting cost sharing based on allowable payment amounts. While this chapter focuses on CAHs, rural health clinics (RHCs) also have charge-based coinsurance. Similar to findings on charge-based coinsurance at CAHs, we found that beneficiary coinsurance at RHCs is often high and varies considerably across them. To provide a more complete picture of cost-based coinsurance in rural areas, information on RHCs is provided as an appendix to this chapter (pp. 360–367).

Given the wide array of Medicare's payment policies for rural hospitals, there may be more efficient ways to distribute additional funding to isolated rural hospitals in need of support and opportunities to harmonize or consolidate the large number of special rural payments. The Commission's recommendation in this chapter to modify cost-sharing liability for FFS beneficiaries who use CAHs does not preclude larger efforts to reform rural payments in the future.

Background

In rural areas, population density is often too low to support the provision of certain health care services,

creating challenges for both rural residents and their health care providers. The Commission has a long history of monitoring rural beneficiaries' access to care and developing recommendations designed to preserve or improve that access (Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2018, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2001). In 2012, the Commission established a set of principles designed to guide expectations and policies with respect to rural access, quality, and payment. The Commission determined that rural payment adjustments should be designed to preserve access rather than to preserve all hospitals, be empirically justified, maintain incentives for cost control, and have low-volume adjustments limited to the isolated providers that are needed to preserve access to care (see text box on the Commission's principles concerning special payments, p. 346).

Medicare's approach to preserving rural beneficiaries' access to hospital care has historically focused on increasing payments for services furnished by rural hospitals. Currently, Medicare's special inpatient and outpatient payments for rural hospitals fit into three conceptual models. A majority of rural hospitals are designated CAHs and paid under a cost-based model, with beneficiary cost sharing for outpatient hospital services based on the hospital's charges. Most other rural hospitals receive add-on payments to their prospective payment rates or a combination of a monthly fixed payment and prospective payment rates.

Low population density poses challenges for rural hospitals

Rural communities across the U.S. are diverse in terms of income and demographics. For example, though residents of rural areas have lower average incomes relative to the national average, the range of rural incomes across the country is wide, and some rural areas have average incomes that exceed national averages.² What most rural areas have in common is low population density, resulting in low patient volumes for local health care providers. Population density is often too low to support certain specialized services, meaning that rural beneficiaries must travel farther for some types of care, especially for subspecialized services. In our annual focus groups, beneficiaries residing in rural areas largely accepted having to choose between a rural way of life and the

The Commission's principles for rural special payments

The Medicare program has a long history of using special payments to support rural hospitals. In our 2012 report on rural Medicare payment policy, we created a series of principles to guide our payment policies (Medicare Payment Advisory Commission 2012). The Commission established that payment adjustments for rural providers should:

- be designed to preserve access rather than preserve all providers,
- be empirically justified,
- have incentives for cost control, and
- limit low-volume adjustments to isolated providers.

The overarching objective of these principles is to preserve equitable access to high-quality care for rural beneficiaries in a fiscally prudent manner. To promote efficient use of Medicare's resources, rural payment adjusters should be empirically justified and designed in a way that encourages cost control (Medicare Payment Advisory Commission 2012). In the case of low-volume adjusters, special payments should be limited to isolated providers since maintaining two low-volume hospitals in neighboring communities could be costly and raise quality concerns due to the volume-outcomes relationship observed at rural hospitals (Joynt et al. 2015, Joynt et al. 2013, Medicare Payment Advisory Commission 2012, Moscovice and Casey 2011, Silber et al. 2010). ■

desire to have quick access to a wide range of health services (Campanella et al. 2023).

While rural and urban beneficiaries use similar levels of care, on average, beneficiaries who reside in rural areas travel farther to receive health care services for two reasons (Medicare Payment Advisory Commission 2021). First, certain services are not available in some rural areas. Second, rural FFS beneficiaries often bypass their local rural hospital and instead choose to receive nonemergency service at a larger, more urban hospital (Medicare Payment Advisory Commission 2021). These two phenomena make it difficult for rural hospitals to create economies of scale, which results in higher cost per unit of service. Higher unit costs make it more difficult for hospitals to turn a profit, increasing the likelihood of closure. In prior work, we examined the 40 rural hospitals that closed between 2015 and 2019 to determine whether common factors contributed to closure. We found that the closed hospitals experienced a 54 percent decline in admissions, on average, and about a 10 percent decline in outpatient services during the decade prior to closure (Medicare

Payment Advisory Commission 2021). Volume declined primarily due to increased bypass of local hospitals for low-complexity admissions.³

FFS Medicare programs that support rural hospitals

To preserve isolated rural beneficiaries' access to emergency, outpatient, and, in some cases, inpatient care, the Congress has instituted several enhancements to Medicare payment rates for rural hospitals. Medicare's current special inpatient and outpatient payments for rural hospitals fit into three conceptual models (Table 7-1, pp. 348–349). (Note that about 150 rural hospitals (6 percent) do not receive special rural payment adjustments.)

- **Add-ons to prospective payment rates.** One model increases prospective payment rates to rural hospitals. Examples of this approach include sole community hospitals (SCHs), Medicare-dependent hospitals (MDHs), and designated low-volume hospitals. These hospital types receive payments for inpatient services that are based in part on

standard rates paid under the inpatient prospective payment systems (IPPS). An SCH receives inpatient operating payments equal to the higher of standard IPPS rates or the hospital's costs per stay in a base year updated to the current year and adjusted for the current-year case mix. (An SCH also receives a 7.1 percent add-on to its outpatient prospective payment system (OPPS) rates.) An MDH's inpatient operating payments are equal to the higher of standard IPPS rates or a blend of standard IPPS rates (25 percent) and the hospital's historical costs updated to the current year and adjusted for changes in case mix (75 percent). A hospital that is designated low volume receives up to a 25 percent increase to its IPPS payments (including geographic- and case-mix-adjusted operating and capital base payments, plus any additional payments such as payments for uncompensated care, outliers, and disproportionate-share hospitals).

- **Payments based on current costs.** Under this model, CAHs receive cost-based reimbursement for inpatient, outpatient, and lab services and for post-acute care provided in swing beds. More detail on cost-based payments made to CAHs is provided below.
- **Fixed payments combined with per service payments based on prospective payment rates.** Under this model, rural emergency hospitals (REHs), which are small, outpatient-only hospitals with 24/7 emergency departments, receive fixed monthly payments to help cover emergency standby costs in addition to payments that are set at 105 percent of standard OPPS rates for each outpatient service provided. (For more information on REHs, see our March 2024 report to the Congress.)

Given the wide array of rural hospital payment policies, there may be more efficient ways to distribute additional funding to isolated rural hospitals in need of support and opportunities to harmonize or consolidate the large number of rural special payments. However, in this chapter, we focus specifically on potential improvements to the largest rural hospital program, the CAH program, and within that program we will focus on the issue of cost sharing. In the appendix at the end of the chapter, we also discuss coinsurance at

rural health clinics (RHCs) because of the similarity of the issues.

A majority of rural hospitals receiving special payments are designated critical access hospitals

A majority of rural hospitals receiving special payments are designated CAHs and paid under a cost-based model, with beneficiary cost sharing based on hospital charges.⁴ The Congress created the CAH category in the Balanced Budget Act of 1997. To qualify for the CAH program, a hospital had to be at least 35 miles by primary road or 15 miles by secondary road from the nearest hospital or be declared a “necessary provider” by the state. Because states could waive the distance requirement, the CAH program became an option for almost all small rural hospitals, rather than being limited to isolated hospitals. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) eliminated states’ ability to declare additional hospitals “necessary providers” starting in January 2006. However, existing CAHs retained their CAH status even if they did not meet the distance criteria. CMS has authorized a modest number of additional CAHs since 2006 because most hospitals that meet the distance and size criteria had already converted to CAH status by 2006.⁵ In 2025, there are about 1,370 CAHs nationwide.

CAHs are limited to 25 beds and must have an average acute care length of stay of no more than four days.⁶ But CAHs’ capabilities vary widely: Some small CAHs offer no surgical services and have less than one acute care discharge a week, while larger CAHs may employ orthopedic surgeons and radiologists, have an average daily inpatient census of over 15 patients, and offer a wide variety of services, including MRI imaging and dialysis.

As noted above, CAHs are paid for FFS Medicare patients on the basis of their costs. Each CAH receives 101 percent of its costs for outpatient, inpatient, laboratory, and therapy services, as well as post-acute care in the hospital's swing beds.⁷ The cost of treating Medicare patients is estimated using cost-accounting data from Medicare cost reports. CMS's cost-accounting methodology allocates costs among patients based on a combination of factors such as the number of days a patient stays in the hospital and the dollar value of charges the patient incurs for ancillary

**TABLE
7-1**

Rural-focused hospital payment models (cont. next page)

Program	Primary eligibility requirements	Payment adjustment methods	Annual FFS cost, 2022 ^a (in billions)	Outpatient cost sharing
Payments based on IPPS rates				
Sole community hospital (can also be low volume) (n ≈ 450) ^b	35 miles or more from an IPPS hospital or at least 15 miles from IPPS hospitals and must meet other criteria	Inpatient operating payments based on the higher of IPPS rates or historical costs trended forward from 1982, 1987, 1996, or 2006; outpatient add-on of 7.1%; 60% of SCHs also received the low-volume adjustment in 2022	\$1.5 ^c (includes LVH add-ons for SCHs)	20% of SCH payment amount
Medicare-dependent hospital (can also be low volume) (n ≈ 170) ^b	Rural or reclassified as rural, 100 or fewer beds, and 60% of days or discharges were for Medicare beneficiaries	Inpatient operating payments equal to the higher of IPPS rates or 25% of the IPPS rate plus 75% of historical costs trended forward; historical costs are based on 1982, 1987, or 2002 cost reports; 59% of SCHs also received the low-volume adjustment in 2022	0.2 (includes LVH add-ons for MDHs)	20% of standard OPPS payment amount
Low-volume hospital (n ≈ 230 hospitals have only LVH status) ^b	Under 3,800 total discharges and more than 15 miles from another IPPS hospital (it can be next to a CAH)	Increases IPPS payments for inpatient care by up to 25% (linear decline between 500 and 3,799 discharges); hospitals can receive low-volume adjustments and either SCH or MDH adjustments	0.1 (for non-SCHs/non-MDHs)	20% of standard OPPS payment amount
Payments based on current costs				
Critical access hospital (n ≈ 1,350)	25 or fewer beds, designated a “necessary provider” by the state before 2006, or meets certain criteria for being isolated from other hospitals (e.g., 35+ miles by primary road from other hospitals)	Paid approximate cost for inpatient, outpatient, and post-acute swing services; lab and therapy services; on-call costs; an extra add-on for physician payments	≈ 5 ^d	20% of charges

services. Outpatient interim payments are computed by multiplying the charges on a claim by the facility’s average outpatient cost-to-charge ratio across all cost centers, and inpatient interim payments are made on a per diem basis. After the end of the fiscal year, during cost-report settlement, final payments are determined by multiplying charges on each claim by the cost-to-charge ratio for the relevant cost center. For example, the payment for a lab service will be

computed by multiplying the charge for the lab test by the cost-to-charge ratio for the laboratory cost center. Beneficiaries pay the standard hospital deductible for inpatient services (\$1,676 in 2025) and cost sharing equal to 20 percent of charges (not costs) for outpatient services.

Medicare’s cost-based payments to CAHs (including beneficiary cost sharing) were \$12 billion in 2022, representing 6 percent of all Medicare inpatient

**TABLE
7-1**

Rural-focused hospital payment models (cont.)

Program	Primary eligibility requirements	Payment adjustment methods	Annual FFS cost, 2022 ^a (in billions)	Outpatient cost sharing
Fixed payments in addition to OPPS payments				
Rural emergency hospital (n ≈ 40)	CAH or small rural hospital that ceases to provide inpatient services	Paid a fixed monthly payment (equivalent to \$3.4 million per year in 2025) plus 105% of OPPS rates for outpatient care	N/A (program started in 2023)	20% of standard OPPS payment amount
Hospitals that do not have special inpatient or outpatient payments				
IPPS rural hospitals without special inpatient or outpatient payments (n ≈ 150)	Too large or too close to other hospitals to qualify for the low-volume adjustment	Standard PPS	No extra payments	20% of standard OPPS payment amount

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), SCH (sole community hospital), LVH (low-volume hospital), MDH (Medicare-dependent hospital), CAH (critical access hospital), OPPS (outpatient prospective payment system), N/A (not applicable). Eligibility requirements are current as of February 2025.

^a The costs shown in this table are FFS costs. They have the secondary effect of increasing Medicare Advantage benchmarks in rural areas. Therefore, the total cost for the taxpayer will be higher than the figures shown.

^b Among the 450 SCHs, 60 percent also received the LVH adjustment. Among 170 MDHs, 59 percent also received the LVH adjustment.

^c The cost of SCH special payments is a combination of about \$500 million from the 7.1 percent outpatient add-on to program payments plus approximately \$1 billion in the combined value of low-volume- and SCH-specific inpatient payments. The count of SCHs includes SCHs that choose the standard PPS rate plus SCHs that choose historical costs trended forward. The count also includes SCHs that now are considered to be in urban areas but have been reclassified to rural areas. Similarly, the MDH payments include the combined value of the low-volume- and MDH-specific inpatient payments, and the count includes all currently designated MDHs.

^d This figure represents a rough estimate of the difference between cost-based payments and what payments (including cost sharing) would have been if CAHs were paid PPS rates. The largest difference is the approximately \$3 billion in additional payments that CAHs received in 2022 for outpatient services because of cost-based reimbursement and higher beneficiary coinsurance. The second-largest difference is payments for post-acute swing-bed services, which are about \$1.5 billion higher than PPS rates due to cost-based reimbursement. These post-acute swing-bed payments are fully funded by the Medicare program.

Source: MedPAC analysis of IPPS final rules. MedPAC analysis of inpatient and outpatient CAH claims and hospital cost reports.

and outpatient payments to hospitals. The average Medicare payment per CAH for acute inpatient, post-acute swing-bed, and outpatient services was \$9 million in 2022.

Cost-based FFS Medicare payments provide significant financial support to CAHs

CAHs are willing to accept restrictions on their number of beds and lengths of stay because their cost-based payments are substantially higher than what their payments would be under Medicare's PPSs. Higher cost-based payments for many of the services CAHs provide to Medicare beneficiaries are funded in part

by taxpayers through higher program payments and in part by beneficiaries and their supplemental insurers through higher cost sharing.

CAHs' financial health often depends on receiving these higher-than-PPS payment rates. The extra FFS Medicare payments that CAHs receive are considerably higher than all-payer profits at most CAHs. In addition, findings from our site visits suggest that, because Medicare Advantage (MA) plans reportedly have rates that are based on Medicare's cost-based payments, CAH status also increases these facilities' MA payments above standard PPS rates (even with greater numbers of claims denials).

Medicare's cost-based payments are about equal to the cost of providing care to FFS Medicare patients, and

Medicaid rates, too, are often close to the cost of care. As a result, CAHs often operate at close to breakeven on their patients with public insurance. Because these hospitals are breaking even on patients with government insurance, their profitability often hinges on making enough profit on commercial patients, local government support, donations, and the 340B program to cover losses incurred when providing care to patients without insurance.⁸

While there is a wide range of revenue and profitability at CAHs, on average in 2022 CAHs had about \$40 million of revenue from all payers and about \$1 million of profit.⁹ In 2022, FFS Medicare accounted for about \$10 million, or 25 percent, of CAH revenue, on average, compared with an average of about 16 percent in other acute care hospitals.¹⁰ CAHs' FFS revenue included about \$5 million in outpatient revenue, about \$2 million in acute inpatient revenue, almost \$2 million in post-acute swing-bed revenue, and about \$1 million in other FFS Medicare revenue. On our site visits (discussed below), most CAHs reported that MA revenue in aggregate was slightly below FFS revenue because MA represents a slightly smaller share of patients than FFS and because of more denials of claims from MA.

Cost-based FFS payments help CAHs remain viable

To estimate the average increase in Medicare payments that CAHs receive from cost-based payments relative to what they would have received under PPS rates, we repriced CAH claims using standard PPS payment rates. We found that CAHs' outpatient cost-based payments were about double what they would have been under OPPS rates.¹¹ The post-acute swing-bed payment rate was about 400 percent of post-acute swing-bed rates at PPS hospitals. By contrast, CAH payment rates for acute inpatient services were similar to IPPS payment rates. On average, we estimate that FFS Medicare revenues per CAH would have been about \$4 million (or 40 percent) lower if CAHs had been paid PPS rates, reducing CAH all-payer revenue by 10 percent, all else equal.

Rural hospitals report that CAH status raises MA payment rates

For many years, MedPAC has conducted site visits to rural communities to meet with rural clinicians and hospital administrators. In 2023 and 2024, we conducted eight site visits to rural hospitals in

three states and telephone interviews with four administrators in other communities that we could not visit in person. The objective was to hear the perceptions and concerns of those running PPS hospitals, CAHs, REHs, RHCs, and rural ambulance services.

As part of our site visits, we interviewed hospital administrators and financial officers about how MA plans pay for in-network and out-of-network patients. All our interviewees reported that MA plans typically base rates on CAHs' reported costs. While there are some claim denials and payment delays, CAH executives we interviewed stated that MA payment rates are usually close to FFS rates. A recent report by the American Hospital Association asserts that CAHs' payment-to-cost ratios for MA patients averaged 95 percent of CAHs' payment-to-cost ratios for FFS patients in 2023 (American Hospital Association 2025). This finding is consistent with past research suggesting that MA plans often base payment rates on FFS Medicare rates—in part due to the governing statute requiring the MA plan to pay FFS rates if a patient receives necessary care at a CAH that the plan does not contract with (Berenson et al. 2015, Mason et al. 2005).¹² But actual collections can be below FFS rates due to claims denials.

According to our site visit and telephone interviews, Medicare administrative contractors (MACs) periodically provide CAHs with a “rate letter” that sets out the preliminary payment rates that the CAH will receive for Medicare FFS claims based on estimates of how much services will cost. The CAHs we interviewed forward their rate letters to the MA plans that they contract with. MA plans then update their rates (after a potential delay) to reflect a per diem payment for inpatient services and a discount-to-charge rate for outpatient services that matches the interim payment rates in the letter from the MAC.¹³ Consequently, the CAHs we spoke with have contracts with MA plans that set rates close to CAH FFS rates for MA patients. While our site visits were limited to the experience of eight CAHs, those eight responses are consistent with the literature and a past CAH survey that found hospitals often contracted for payment rates from MA plans that were close to FFS rates (Baker et al. 2016, Berenson et al. 2015, Chen et al. 2018, Maeda and Nelson 2017, Mason et al. 2005). While the contracted price is similar to the FFS price, the CAH administrators

we interviewed reported that in some cases, MA plans apply payment reductions or deny payment when the plan determines that the service lacked medical necessity. CAH administrators told us that claim denials and delays can result in the CAH receiving less, on average, for services covered under MA than for services covered under FFS (Zionts 2025). Despite the claim denials and delays, our site visits suggest that the net rates MA plans pay CAHs (even after denials) are still generally higher than traditional PPS rates for outpatient care. Rates for inpatient care appear to be similar to FFS rates, though MA rates paid for post-acute swing-bed care are less well-documented.

Beneficiaries pay substantially more coinsurance for CAH outpatient services

When the Congress established the payment mechanism for outpatient services provided by CAHs, it chose a formula that was the standard for hospital outpatient payment in the early years of the Medicare program. Before the implementation of the OPPOS, Medicare paid all hospitals the lesser of either costs or charges for many outpatient services (Medicare Payment Advisory Commission 1999).¹⁴ The program paid 80 percent of the allowed amount, and beneficiaries paid coinsurance equal to 20 percent of charges.¹⁵ Charges are the list prices that hospitals set for their services, which typically exceed their reported costs of providing those services. Charges can be seen as arbitrary and not a good proxy for cost or value. For CAHs, payment is set at 101 percent of the provider's allowable FFS Medicare costs, split into the program payment and the beneficiary's cost-sharing liability. After the beneficiaries' Part B annual deductible is met, beneficiary coinsurance for CAH services equals 20 percent of charges (with no limit), with the Medicare program paying the remainder of the outpatient payment:

Medicare's CAH program payment = 101 percent of costs – 20 percent of charges billed as coinsurance

Thus, although the total payment received by the CAH cannot exceed 101 percent of allowable costs, the beneficiary's portion of the total payment is greater

than 20 percent for any service for which charges exceed costs. Because charges vary widely across hospitals and services, both for the same services and across services, beneficiary cost-sharing liability for CAH services also varies—and can far exceed 20 percent of the total payment amount. We found that cost-sharing liability at CAHs averaged about half of total Medicare payments for CAH outpatient services in 2022 and varied widely, reflecting wide differences in markups (ratio of charges to costs) across CAHs and across services within CAHs. By contrast, beneficiary cost-sharing liability for outpatient services at most other hospitals that are paid under the OPPOS is set at 20 percent of the hospitals' payment rate. Further, there is no cap on CAH coinsurance for outpatient services, which is not the case for services paid under the OPPOS. The variation in beneficiaries' cost-sharing liability raises concerns about equity within and across CAHs.

In most cases, CAH coinsurance for beneficiaries in FFS Medicare is paid by the beneficiary's supplemental insurer. However, about 16 percent of rural FFS beneficiaries do not have supplemental insurance and are billed 20 percent of charges when they receive outpatient services at a CAH (Medicare Payment Advisory Commission 2024a). Further, even when beneficiaries have supplemental insurance that directly shields them from high coinsurance amounts, the cost of that coverage may be passed on to beneficiaries in the form of higher Medigap premiums in states with CAHs; those higher premiums are borne by all policyholders, whether or not they receive outpatient services at CAHs.

MedPAC's predecessor commission, the Prospective Payment Assessment Commission (ProPAC), identified this problem when it considered Medicare's former cost-based payment system for the hospital outpatient services in 1995 (Prospective Payment Assessment Commission 1995):

Because payments for these services were not prospective and thus not known until annual cost reports are settled, copayments are calculated as 20 percent of charges, rather than 20 percent of payments. Historically, payments and charges were similar, so the beneficiary's share was not excessive. Over time, however, charges have grown significantly

faster than Medicare payments, resulting in an increasing portion of payments coming from the beneficiary.

Concerned that the beneficiary's share of hospital-provided outpatient payments had become excessive, ProPAC recommended that beneficiary coinsurance for these services be reduced from 20 percent of charges to 20 percent of payments (Prospective Payment Assessment Commission 1995). In the Balanced Budget Act (BBA) of 1997, the Congress made changes to beneficiary cost-sharing liability for outpatient services that were consistent with ProPAC's recommendation (Medicare Payment Advisory Commission 1999). CMS implemented this change by freezing copayment amounts if they were larger than 20 percent of the total payment. Eventually, as the allowed amounts for each outpatient service increased, the coinsurance percentage across outpatient services declined to 20 percent.

From 2012 to 2022, coinsurance increased from 48 percent to 52 percent of CAH outpatient payments

Previously, the Commission contracted with RTI to evaluate the level of CAH cost sharing. RTI found that, because charges at CAHs were far higher than costs, beneficiaries and their supplemental insurers paid coinsurance that averaged 48 percent of estimated total payments for Medicare-covered outpatient services in 2012 (Freeman 2016). The Inspector General of the Department of Health and Human Services also noted the high cost sharing and encouraged "CMS to seek legislative authority to modify how coinsurance is calculated for outpatient services received at CAHs" (Office of Inspector General 2014).

To update RTI's work, we examined cost sharing at CAHs from 2018 to 2022. We estimated not only coinsurance levels but whether that coinsurance was paid by beneficiaries, paid by supplemental insurance, or went unpaid (resulting in bad debt).

In 2022, about 1.9 million unique beneficiaries received 26 million CAH outpatient services for which coinsurance was set at 20 percent of charges.¹⁶ We found that beneficiaries' coinsurance liability for these services was \$3.3 billion, about 52 percent of the total payment—higher than the 48 percent share reported by RTI for 2012 because charges at CAHs rose slightly faster than costs from 2012 to 2022.

Because hospitals' charges vary widely, so does the share of the total payment billed to the beneficiary (or their supplemental insurer). For the 10 percent of CAHs with the lowest markups over costs, less than 33 percent of the total payment was billed to beneficiaries. In contrast, for the 10 percent of CAHs with the highest markups, more than 79 percent of the payment was charged to the beneficiary. To illustrate how markups affect coinsurance, in Table 7-2 we show the actual distribution of markups at CAHs in 2022 applied to a hypothetical service that cost \$600 at three different hospitals. For this hypothetical service, a low-markup hospital (with a markup at approximately the 10th percentile of the distribution among all CAHs) would charge about \$1,000 and have coinsurance of \$200. In contrast, a high-markup hospital (at approximately the 90th percentile of the markup distribution) would charge \$2,400 for a service that cost it \$600 to deliver. The result would be coinsurance of \$480. Thus, coinsurance billing could vary substantially depending on whether the beneficiary lived near a low-markup or a high-markup CAH.

Hospitals in smaller towns tend to have smaller markups

To see how beneficiary cost-sharing liability varied across rural markets, we examined differences across Rural-Urban Commuting Areas (RUCAs) (a census tract-based classification), which categorize areas based on the size of the town in which people in the county commute to work. Among CAHs located in RUCAs categorized as the most rural (an area without a town of more than 2,500 people), the average beneficiary coinsurance amount equaled 44 percent of payments. CAHs in larger rural towns (2,500 to 24,999 people) had an average beneficiary coinsurance amount of 53 percent of payments. In micropolitan and metropolitan areas, the average beneficiary coinsurance amount was approximately 60 percent of payments.¹⁷ (Note that, because the payment rate for CAHs is set at 101 percent of costs, an average beneficiary coinsurance amount of 60 percent of payments is equal to about 60 percent of costs.) The high level of coinsurance reflects high charges, which were set at about 300 percent of costs, on average, in these communities.

During MedPAC site visits and interviews, small rural hospitals reported that their commercial payment

**TABLE
7-2**

How CAH markups affect coinsurance and program payments: Illustrative example

	Low-markup CAH (10th percentile)	Median-markup CAH (50th percentile)	High-markup CAH (90th percentile)
Approximate ratio of CAH's charges to costs	167%	250%	400%
Cost of hypothetical line item	\$600	\$600	\$600
Charges	\$1,000	\$1,500	\$2,400
Coinsurance (20% of charges)	\$200	\$300	\$480
Program payments (101% of costs less coinsurance) × 98% (due to sequester)	\$398	\$300	\$124
Share of payment paid by coinsurance	33%	50%	79%

Note: CAH (critical access hospital). The payment assumes that the CAH receives 20 percent of the cost as coinsurance. The program payment is equal to 101 percent of cost, less coinsurance, all reduced by 2 percent due the assumption that the sequester is in place. The 10th, 50th, and 90th percentiles represent rounded numbers from the actual distribution of CAH markups.

Source: MedPAC analysis of fee-for-service claims and cost-report data.

rates are often set at a discount to charges, which creates incentives to increase charges. However, during our site visits to hospitals in very small towns, administrators also reported that they felt social pressure to restrain markups because “everyone in the town knows everyone else.” This phenomenon could partially explain why markups tend to be lower in RUCAs anchored by towns with fewer than 2,500 people than in micropolitan and metropolitan areas where the core town has 25,000 or more people.

At the extreme, beneficiaries can pay more than 100 percent of the total payment

Our analysis found that a few CAHs charged as much as or greater than five times estimated costs on average. For beneficiaries receiving outpatient services in these CAHs, their cost-sharing liability was equal to or more than the total allowed payment amount (101 percent of costs), resulting in the beneficiary being responsible for the entire payment. When a beneficiary (or a supplemental insurer on the beneficiary’s behalf) pays coinsurance that is more than 100 percent of the allowed amount, the CAH must return a portion of those funds back to the Medicare program at cost-

report settlement. In such cases, because the Medicare program did not make any payment for the service, and the program received a portion of the funds paid by (or on behalf of) the beneficiary at cost-report settlement (bringing the payment down to the allowed amount), the Medicare program realizes net negative spending for the service. In 2022, for about 1 million outpatient line items (4 percent of all CAH outpatient line items with coinsurance), the beneficiary was responsible for 100 percent or more of the total allowed amount for the line item on the claim. The average amount paid by the beneficiary or their supplemental insurer for these services was \$226 per line item; the aggregate amount of these line items in 2022 was \$243 million.

No cap on coinsurance for beneficiaries who receive care in CAHs, unlike the coinsurance cap for care received at OPPS hospitals

Under the OPPS, beneficiary cost-sharing liability for a single line item (e.g., a drug, CT scan, emergency department visit, or surgery) is capped at the inpatient deductible (\$1,676 in 2025).¹⁸ However, no such limit on cost sharing applies to outpatient services provided

by CAHs. In 2022, about 200,000 CAH outpatient line items (out of 26 million line items) had coinsurance that exceeded the inpatient deductible that year. The most common services with coinsurance above the cap were orthopedic surgeries (e.g., knee replacements) and Part B drug injections (e.g., pembrolizumab for cancer, infliximab for arthritis). If a line-item cap on CAH coinsurance had been in effect in 2022, the coinsurance on the 200,000 line items would have been reduced by an average of about \$2,000 per line item, resulting in roughly \$400 million less in beneficiary liability.

Most, but not all, coinsurance liabilities are paid by supplemental insurance

About 84 percent of rural beneficiaries in FFS Medicare have supplemental insurance, such as Medigap, Medicaid, or employer-sponsored coverage, that may cover beneficiaries' cost-sharing liability.¹⁹ However, even when beneficiaries have supplemental insurance that directly shields them from high coinsurance amounts, the cost of that coverage may be passed on to beneficiaries in the form of higher premiums in states with CAHs; those higher premiums are borne by all policyholders, whether or not they receive outpatient services at CAHs.

About 16 percent of rural FFS Medicare beneficiaries do not have supplemental insurance and are billed directly for coinsurance if they receive outpatient services in a CAH (Medicare Payment Advisory Commission 2024a). Ideally, we would analyze the outpatient CAH claims for this 16 percent of beneficiaries to better understand the financial liability they face. However, we do not have patient-level data on supplemental insurance that can be linked to claims. Instead, we rely on other sources to create upper-, midrange-, and lower-bound estimates of the number of beneficiaries without supplemental insurance who receive outpatient care in CAHs and the total amount of coinsurance billed to them.

An upper-bound estimate of CAH use among beneficiaries without supplemental insurance

About 1.9 million beneficiaries used 26 million CAH outpatient services in 2022, and about 16 percent of rural beneficiaries did not have supplemental insurance. If we assume that rural beneficiaries without supplemental coverage are as likely to use outpatient CAH services as other rural beneficiaries, then about

300,000 (16 percent of 1.9 million) FFS beneficiaries who received a CAH outpatient service in 2022 would have received cost-sharing bills equal to 20 percent of charges. This finding implies that about 300,000 beneficiaries would have been billed 20 percent of charges for about 4 million line items (16 percent of 26 million total CAH FFS line items). On average, \$126 in coinsurance was billed for each line item; therefore, the upper-bound estimate of coinsurance billed to patients without supplemental insurance is about \$500 million ($4 \text{ million} \times \$126$). As we show below in our discussion of bad debts, at least \$106 million of that coinsurance was not paid by beneficiaries.

A midrange estimate of CAH use among beneficiaries without supplemental insurance

Research suggests, however, that beneficiaries without supplemental insurance use about 25 percent fewer outpatient services (Medicare Payment Advisory Commission 2012).²⁰ Using this assumption would reduce the estimate of 4 million CAH line items to about 3 million line items on outpatient claims (a 25 percent reduction). Given that CAH coinsurance per service averaged \$126 in 2022, those beneficiaries without supplemental insurance would have been billed about \$380 million in coinsurance ($\$126 \times 3 \text{ million services}$).²¹ If rural beneficiaries without supplemental insurance were 25 percent less likely to use a CAH at all, there would have been 225,000 beneficiaries without supplemental insurance using a CAH for outpatient services ($300,000 \times 0.75$).²²

A lower-bound estimate of CAH use among beneficiaries without supplemental insurance

For a lower-bound estimate, we used hospital-reported data on bad debt to estimate the number of FFS beneficiaries without supplemental insurance who were billed for, but did not pay, CAH coinsurance. In 2022, CAHs reported \$106 million in bad-debt expenses for outpatient services to FFS patients who were not dually eligible for Medicare and Medicaid. There was another \$147 million in cost sharing not paid by Medicaid for dually eligible beneficiaries, resulting in a total bad debt of \$253 million.²³ Because some CAHs do not claim bad debts (due to Medicare bad-debt expenses being lower than the expected administrative costs of collecting Medicare bad-debt payments), the \$106 million in bad debt is a

lower bound on the amount of coinsurance that was billed by CAHs for FFS Medicare service and was not paid by the beneficiary. The average coinsurance billed to beneficiaries was \$1,750 during 2022, implying that over 60,000 beneficiaries were billed outpatient coinsurance, did not have Medigap or other supplemental insurance, and did not pay the coinsurance bill (\$106,000,000 / \$1,750).

Setting CAH outpatient cost sharing at 20 percent of Medicare's payment

To prevent beneficiaries from being liable for charge-based coinsurance, CAH coinsurance could be set at 20 percent of the payment amount (rather than 20 percent of charges) and be subject to a cap per service that is equal to the inpatient deductible. The cap would be identical to the cap used in the OPPOS: For high-cost services where 20 percent of the payment amount exceeds the inpatient deductible (\$1,676 in 2025), coinsurance would be set at the amount of the deductible. This cost-sharing policy would be more equitable for beneficiaries and would reduce incentives to bypass CAHs.

In 2022, CAHs provided 26 million outpatient services for which cost sharing was set at 20 percent of charges. Beneficiary coinsurance for these services was about \$3.3 billion, Medicare program payments were about \$3.2 billion, and total payments were almost \$6.5 billion.²⁴ To estimate the effects of setting coinsurance equal to 20 percent of payments, assuming the total payments to CAHs remain constant, we consider the effects of the new coinsurance policy on:

- FFS beneficiary coinsurance for CAH services,
- Medicare FFS program spending,
- Medicare bad-debt payments to CAHs,
- Part B premiums for all beneficiaries, and
- FFS beneficiary Medigap premiums.

These estimates assume no change in care patterns, and the effects may be higher or lower depending on how providers and beneficiaries respond to changes in financial incentives.

FFS beneficiary coinsurance for CAH outpatient services would be reduced by about 60 percent

In 2022, shifting CAH coinsurance for outpatient services from 20 percent of charges to 20 percent of payments would have reduced beneficiary (including supplemental insurers') cost-sharing liability by about 60 percent—from an average of 52 percent of payments to 20 percent of payments. Implementing the cap on coinsurance equal to the inpatient deductible would have reduced coinsurance by another \$55 million or about 1 percent of payments. On net, coinsurance billed to CAH patients and their supplemental insurers would have been about \$1.2 billion or 19 percent of total payments in 2022, equal to a \$2.1 billion reduction.

While adding a coinsurance cap would have decreased coinsurance liability by an additional \$55 million in 2022, the total estimate of reduced cost-sharing liability would still round to \$2.1 billion. Because costs are lower than charges, the cap would have been binding on fewer cases under payment-based coinsurance. The number of services that would have been affected if a cap had been applied to CAH coinsurance would have been about 50,000 line items (out of 26 million), down from approximately 200,000 line items under charge-based coinsurance. In future years, the cap could be binding on more services if more high-cost drugs or services are provided in CAH outpatient departments.

FFS program spending would increase

If the allowed cost-based amount paid to CAHs did not change, then a \$2.1 billion reduction in beneficiary cost sharing in 2022 would imply an offsetting increase in FFS program payments of almost \$2.1 billion (Table 7-3, p. 356).²⁵

Because Medicare's payments to MA plans are based on benchmarks that are linked to per beneficiary FFS program spending, increases in FFS spending will cause increases in payment to MA plans. We estimate that this increase would have been about \$1.3 billion if the policy had been implemented in 2022.²⁶ The combined initial direct effect of the policy on FFS and MA program spending would have been about \$3.4 billion in 2022 (\$2.1 billion in FFS spending and \$1.3 billion in MA spending). For an in-depth discussion of MA benchmarks and bids, see our March 2024

**TABLE
7-3****Estimated net increase in 2022 Medicare program spending due to changing coinsurance to 20 percent of the payment amount**

Financial effect in 2022	Government spending (in billions)	Part B premiums (in billions)	Taxpayer + beneficiary spending (in billions)
Additional FFS program payments to CAHs	\$1.6	\$0.5	\$2.1
Increased program payments to Medicare Advantage plans	1.0	0.3	1.3
Change in Medicare payments to CAHs for bad debts	-0.15	-0.05	-0.20
Estimated cost in 2022	2.5	0.8	3.2

Note: FFS (fee-for-service), CAH (critical access hospital). The cost estimate in this table does not include the potential additional costs of shifting volume. Components may not sum to totals due to rounding.

Source: MedPAC analysis of FFS claims, cost-report data, and Medicare Advantage enrollment data.

report to the Congress (Medicare Payment Advisory Commission 2024b).

CAHs would see a reduction in bad debts

This estimated \$3.4 billion in increased FFS and MA spending in 2022 would have been partly offset by lower FFS Medicare payments for bad debt. FFS Medicare pays hospitals 65 percent of cost-sharing amounts that are billed to beneficiaries or their supplemental insurers (including Medicaid) but not paid.²⁷ For the 1,320 CAHs for which we have 2022 cost-report data, 1,162 sought bad-debt reimbursement. (Some CAHs do not claim bad debt if they believe the value of such payments is less than the administrative cost of attempting to collect unpaid coinsurance.) In aggregate, CAHs reported \$253 million in Medicare outpatient bad debts in 2022 and received \$164 million in bad-debt payments (65 percent of bad debts) from FFS Medicare. If CAH coinsurance had been 20 percent of Medicare payments in 2022 (down 62 percent from our current estimate of 52 percent of Medicare payments), we estimate that the amount of bad-debt payments would have declined by \$102 million (\$164 million $\times$ 0.62).

In counties with one or more CAHs in 2022, 48 percent of beneficiaries with both Part A and Part B coverage were enrolled in an MA plan. Therefore, we expect that the effect on MA benchmarks of reduced FFS bad-debt payments would have been about 92 percent

(48 percent / 52 percent) of \$102 million, or almost \$94 million.²⁸ Adding the effect of lower FFS bad-debt payments (\$102 million) and associated lower MA benchmarks (almost \$94 million), we estimate a reduction in spending of about \$0.2 billion in 2022 under the alternative coinsurance plan (Table 7-3).

Federal spending on Part B services would increase

Medicare Part B is funded through a combination of beneficiary premiums (25 percent) and general revenues (75 percent); therefore, any changes in Part B spending affect beneficiary premium amounts and the amount required from federal general revenues (taxes). We estimate that the modified CAH coinsurance policy's direct financial impact on government spending in 2022 net of reduced bad-debt payments would have been about \$3.2 billion (Table 7-3). Of that amount, about \$2.5 billion would have been funded through general revenues, and beneficiaries or their supplemental insurers (including Medicaid) would have paid about 25 percent of the \$3.2 billion cost, or \$0.8 billion, in higher Part B premiums. There were about 60 million beneficiaries with Part B coverage in 2022 (Boards of Trustees 2023). Therefore, we estimate that annual Part B premiums for each Medicare beneficiary (both in FFS Medicare and in MA) would have increased by about \$13 per beneficiary in 2022 (\$3.2 billion $\times$ 25 percent / 60 million) if the alternative policy had been in effect.

We examined growth in coinsurance for outpatient services at CAHs from 2018 to 2022 and found that the amount grew 7.4 percent per year on average between 2018 and 2022. Therefore, we expect that the increased program spending associated with reducing CAH coinsurance to 20 percent of cost-based payments will continue to grow over time.

FFS Medigap premiums would decrease

Table 7-3 presents the aggregate increase in spending by the program. We now shift focus to how the stakeholders would benefit from a policy that sets coinsurance for outpatient CAH services at 20 percent of the payment amount. Beneficiaries who purchase Medigap policies in rural states or have other supplemental insurance, such as through an employer, would benefit because those policies would be liable for reduced coinsurance amounts, which would ultimately result in lower premiums for Medigap and other forms of supplemental coverage. As noted above, we estimated that beneficiary coinsurance for CAHs would have declined by \$2.1 billion in 2022 if coinsurance had been set at 20 percent of Medicare payments rather than 20 percent of charges. CMS reported that 34.3 million FFS beneficiaries had Part B coverage in June 2022, meaning the \$2.1 billion is the equivalent of decreasing FFS cost sharing by about \$61 per year per person on average (\$2.1 billion / 34.3 million FFS beneficiaries). For modeling purposes, we assumed that Medigap premiums decline by \$1 for every \$1 reduction in coinsurance costs borne by the Medigap plan. For Medigap Plan G, which had an average premium in 2022 of \$137 per month for a 70-year-old (Medicare Supplement 2024), we estimate an average premium reduction of \$5 per month, or about 4 percent.²⁹ Given the shares of rural Medicare beneficiaries with some type of supplemental coverage, we estimate that the \$2.1 billion reduction in beneficiaries' coinsurance liability would have resulted in (1) about \$0.6 billion less spending for employer-sponsored supplemental insurers (about 27 percent of rural FFS beneficiaries) in 2022, (2) about \$0.9 billion in reduced Medigap premiums (44 percent of rural FFS beneficiaries), (3) about \$0.3 billion in lower billings to Medicaid (some of which is not paid), and (4) about \$0.3 billion in reduced cost sharing billed to those without supplemental insurance (some of which is not paid). We estimate that the cost sharing paid by beneficiaries without

Medicaid, Medigap, or another form of supplemental insurance would be reduced to closer to \$200 million because a material portion of these coinsurance bills are not paid (Table 7-4, p. 358).

Effects on Medigap premiums vary by state

In examining Medigap plan premiums in counties with CAHs, we found that rates are often set statewide. Therefore, if CAH coinsurance were reduced to 20 percent of payments, we would expect to see larger reductions in Medigap premiums in states where more beneficiaries use CAHs. In states without CAHs, Medigap premiums should not be affected. In states where CAH services represent a material share of hospital spending, there would be a material decrease in Medigap premiums. For example, we estimate that monthly Medigap premiums in Iowa and Kansas would have been \$10 to \$20 lower in 2022 if CAH coinsurance had been set at 20 percent of payments. Given current Medigap costs in Iowa and Kansas, this difference would imply about a 10 percent reduction in Medigap premiums (Blue Cross Blue Shield of Kansas 2024, Wellmark Blue Cross Blue Shield 2024). Both rural and urban beneficiaries who purchase Medigap plans in those states would realize the savings.

Little effect on CAHs' finances

The proposed policy is designed to maintain the payment rates CAHs currently receive for services provided to FFS beneficiaries. However, while payment rates would not change, there are two largely offsetting secondary effects on CAHs' revenue. CAHs reported \$253 million in outpatient bad debts from FFS Medicare patients in 2022. (About 200 CAHs did not report Medicare bad debts; therefore, the amount of bad debts may be a bit higher than \$253 million.) We estimate that about \$89 million of reported bad debts were not paid by the program (35 percent of \$253 million). If cost sharing were reduced by 62 percent (from 52 percent of costs to 20 percent of costs), then we would expect unreimbursed bad debts to decline by about \$55 million (62 percent of \$89 million). However, that \$55 million in reduced bad debts would largely be offset by the effects of the sequester, which reduces Medicare program payments by 2 percent. The sequester would not reduce cost-sharing payments paid by the beneficiaries and their supplemental insurers. Therefore, shifting payments from the beneficiary to the program slightly

**TABLE
7-4****Groups and entities affected by the estimated \$3.2 billion
in additional program spending in 2022**

Affected group	Financial implication	Amount (in billions)
FFS beneficiaries/employers	Reduced Medigap and retiree premiums	\$1.5
State Medicaid programs	Reduced cost sharing for Medicare beneficiaries who are also eligible for Medicaid	0.3
FFS beneficiaries without supplemental insurance	Reduced cost sharing paid to CAHs*	0.2
CAHs	Change in bad debts; additional payments subject to the sequester	0.0
MA plans and their beneficiaries	Increased payments to MA plans for Part A and Part B spending and supplemental benefits**	1.3
Total effect in 2022 (funded by taxpayers and Part B premiums)		3.2

Note: FFS (fee-for-service), CAH (critical access hospital), MA (Medicare Advantage). The initial effects do not include the potential effects of shifting volume. Components may not sum to totals due to rounding.

* Beneficiaries would have paid \$0.2 billion less in coinsurance; this result does not include the psychological benefit of not receiving a bill that the beneficiary cannot or will not pay.

** The MA plan would receive a higher benchmark. Past research suggests this increase would result in both higher bids for the Part A and Part B benefit (which could be used to expand networks and/or increase profits, within limits) and more supplemental benefits for MA beneficiaries. It is uncertain how much of the higher benchmark would result in higher bids as opposed to additional benefits (see the section on "Effect on MA plan benefits" above).

Source: MedPAC analysis of fee-for-service CAH claims, cost-report data, MA enrollment data, and Medicare Current Beneficiary Survey data on supplemental insurance.

reduces the combined cost-sharing and program payments the CAH would receive. The net effect on CAHs' revenue would be close to zero: The effects of lower bad debts (+\$55 million) would be offset by the effects of the sequester adjustment on the additional program payments (-\$42 million), resulting in a net increase in CAH payments of only \$13 million (less than \$1,000 per CAH).

Effect on beneficiary site-of-service decisions

When cost sharing changes, beneficiaries may make different decisions about where they receive care. We discussed the direction of volume changes on program costs, but we did not estimate the magnitude of these effects.

To the extent that reduced CAH coinsurance resulted in a shift of FFS volume to CAHs, the Medicare program would incur additional costs. The increased cost

would be partially (but not fully) offset by the effect of increasing volume on reported CAH costs per outpatient service provided. Increasing volume would reduce CAHs' costs per visit and payment per visit, but because less than 30 percent of CAHs' outpatient charges are for FFS Medicare beneficiaries, increased volume would have a small effect on reported Medicare costs for other services, and net Medicare program costs would increase.³⁰ While a volume shift to CAHs could theoretically increase program costs above the rough estimate shown in Table 7-3 (p. 356), we expect that the magnitude of this effect would be small because FFS coinsurance is expected to have a small effect on site-of-care decisions, as discussed above.

Recommendation

Most rural communities in the U.S. have low population density and longer travel times for services, both of which can pose challenges for delivery of and access

to medical care. In 1997, the Congress enacted the CAH program to help address these challenges. CAHs receive cost-based payments for services provided to FFS Medicare beneficiaries, a policy that helps the facilities remain financially viable. But because coinsurance in CAHs is based on charges, beneficiaries who use CAHs face much higher cost-sharing liability than beneficiaries who use other hospitals.

RECOMMENDATION

For fee-for-service Medicare beneficiaries, the Congress should:

- **Set coinsurance for outpatient services at critical access hospitals equal to 20 percent of the payment amount for services that require cost sharing; and**
- **Place a cap on critical access hospitals' outpatient coinsurance equal to the inpatient deductible.**

RATIONALE

Basing coinsurance on CAH charges results in substantially higher beneficiary cost sharing than cost sharing for the same services provided in other hospitals, and that cost sharing varies widely across CAHs and services. About 16 percent of rural FFS beneficiaries do not have supplemental insurance and are billed 20 percent of charges when they receive outpatient services at a CAH. Even when beneficiaries

have supplemental insurance that directly shields them from high coinsurance amounts, the cost of that coverage may be passed on to beneficiaries in the form of higher premiums in states with CAHs; those higher premiums are borne by all policyholders, whether or not they receive outpatient services at CAHs. Setting coinsurance at 20 percent of the CAH payment amount, with the amount per line item capped at the level of the inpatient deductible, would reduce liability for FFS beneficiaries who lack supplemental insurance and make CAH coinsurance more equitable for all FFS beneficiaries who receive care at CAHs.

IMPLICATIONS

Spending

- This recommendation would increase spending relative to current law by between \$2 billion and \$5 billion over one year and by between \$25 billion and \$50 billion over five years.

Beneficiary and provider

- The recommendation would reduce cost-sharing liability for beneficiaries who use CAH services, reduce premiums for supplemental insurance for all FFS beneficiaries in states with CAHs, and increase Part B premiums for all beneficiaries in both FFS Medicare and MA. We do not expect this recommendation to have a material impact on CAHs' revenues or their willingness or ability to treat beneficiaries. ■

7 — A

APPENDIX

Charge-based coinsurance at rural health clinics

Rural health clinics (RHCs) were established under the Rural Health Clinics Services Act in 1977 to increase access to health care in rural areas by providing direct reimbursement for services furnished by nurse practitioners and physician assistants (General Accounting Office 1982). An RHC is an outpatient clinic that must initially be located in a nonurbanized area that qualifies as a primary care health professional shortage area, medically underserved area, or governor-designated shortage area. In 2022, fee-for-service (FFS) Medicare beneficiaries had about 9.5 million visits at 4,800 RHCs. Most visits include evaluation and management services, such as office visits or visits to beneficiaries in nursing homes. Historically, RHCs have predominantly furnished primary care, but because of changes finalized in December 2024, they now have the flexibility to furnish more specialty care.³¹ As with critical access hospitals (CAHs), beneficiary coinsurance at RHCs is based on charges. The Commission has found that beneficiary coinsurance at RHCs is often high and varies considerably across them, leaving beneficiaries vulnerable. We also found that charge-based coinsurance may undermine recent payment reforms.

Medicare's payment system for RHCs

Medicare's RHC payment system generally bundles all professional services furnished in a single day into one payment. Medicare pays RHCs a facility-specific cost-based all-inclusive rate (AIR), subject to the limits described below, for each visit.³² A facility's AIR is calculated annually by dividing the facility's total allowable costs by the total number of visits for all its patients, subject to certain conditions.³³ The AIR is not adjusted for the mix of services furnished or patients' case mix. The AIR is subject to limits that vary based on whether an RHC is independent or provider based, whether a provider-based RHC is part of a hospital with fewer than 50 beds, and when the RHC enrolled in Medicare. FFS Medicare pays 80 percent of the AIR, subject to payment limits.

The AIRs for independent RHCs, provider-based RHCs that are part of a hospital with 50 or more beds, and RHCs of any type that enrolled in

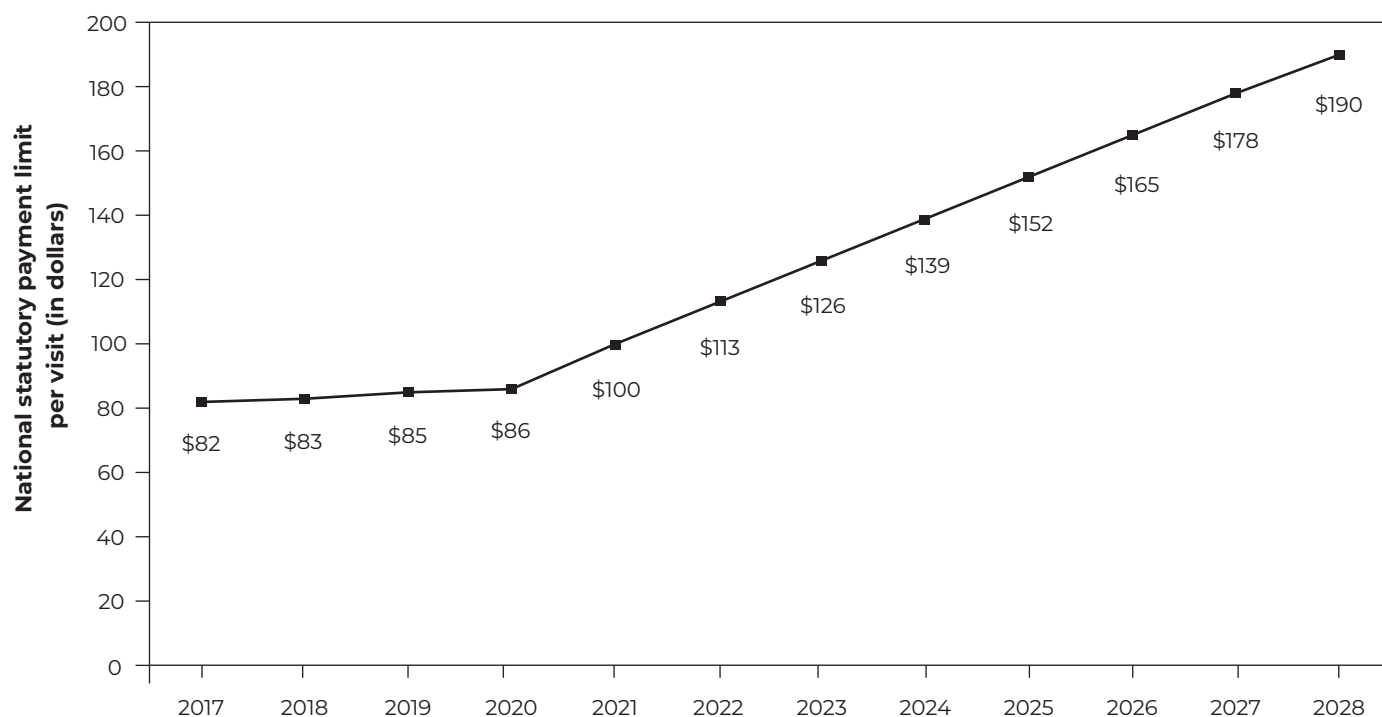
Medicare after December 31, 2020, are subject to the national statutory payment limit. The Consolidated Appropriations Act (CAA), 2021, instituted large increases in the national statutory payment limit. Beginning in April 2021, the national statutory payment limit increased by 14 percent to \$100 per visit and will increase incrementally until it reaches \$190 per visit in 2028 (Figure 7-A1, p. 362). Cumulatively, from 2020 to 2028, the national statutory payment limit will increase by 120 percent. In 2029 and beyond, the payment limit will be increased annually based on growth in the Medicare Economic Index (MEI).

Historically, provider-based RHCs that were part of a hospital with fewer than 50 beds were not subject to payment limits. However, beginning April 1, 2021, the CAA, 2021, implemented a payment limit per visit for RHCs that were part of a hospital with fewer than 50 beds and were enrolled as of December 31, 2020. These limits are equal to the greater of their 2020 AIR, increased annually by MEI growth, or the national statutory payment limit.³⁴ These RHCs are referred to as "specified" provider-based RHCs. We estimate that, as of 2020, the average AIR for specified provider-based RHCs was \$255 per visit. Unlike the national statutory payment limit, the limits for specified provider-based RHCs vary substantially: For example, one RHC might have a payment limit of \$200 per visit while another might have a limit of \$400 per visit. The variation in payment limits per visit is largely due to substantial variation in costs per visit that predated the CAA, 2021. However, by using 2020 as the permanent base year for payment limits—when costs per visit increased because the number of visits temporarily declined due to the coronavirus public health emergency (PHE)—the law locked in higher payment limits, and RHCs with greater declines in volume generally benefited more.³⁵

In the few years before the CAA, 2021, the total number of RHCs billing FFS Medicare increased moderately. All of that growth resulted from increases in provider-based RHCs since the number of independent RHCs billing FFS Medicare was declining. After the payment limits were raised per the CAA, 2021, growth in the total number of RHCs billing FFS Medicare accelerated, driven by continued growth in the number of provider-based RHCs and new growth in independent RHCs. For example, the number of independent RHCs billing FFS Medicare declined from 1,327 to 1,273 (4 percent) from

**FIGURE
7-A1**

**Rural health clinics' national statutory payment limit
per visit increased rapidly beginning in 2021**



Note: Figures rounded to the nearest dollar. In 2021, the payment limit was \$87.52 through March. Beginning in April 2021, the national statutory payment limit increased to \$100. Medicare's rural health clinic payment system generally bundles all professional services furnished in a single day into one payment, with limited exceptions (e.g., a qualified medical visit and a qualified mental health visit on the same day). We use the term "per visit" to reflect this payment unit.

Source: MedPAC analysis of Medicare regulations.

2018 to 2020 (prior to the law's passage) but increased from 1,273 to 1,484 (17 percent) from 2020 to 2022 (after the law's passage) (Table 7-A1). The entry of new independent RHCs suggests that operators, including some owned by private-equity (PE) firms, find the new RHC payment limits enacted under the CAA, 2021, to be attractive.

Charge-based coinsurance for RHC services

As noted above, FFS Medicare pays 80 percent of the RHC's AIR, subject to payment limits. However, beneficiary cost sharing for RHC services is equal

to 20 percent of RHC charges, not 20 percent of the AIR amount.^{36,37} RHCs set their own charges, and their charges are not limited based on their AIRs or payment limits.³⁸ As with CAHs, charge-based beneficiary coinsurance can subject beneficiaries to substantially different coinsurance amounts for similar services furnished by different RHCs. However, in contrast to Medicare's payment formula for CAHs, in which higher beneficiary coinsurance lowers program payments, Medicare's payment formula for RHCs holds the program's payment constant even as beneficiary coinsurance increases. As a result, the RHC's total payment (program payments plus beneficiary coinsurance) increases as charges increase, and total payments may exceed the AIR and payment limits. This

**TABLE
7-A1****Number of independent RHCs billing FFS Medicare increased after implementation of higher payment limits in 2021**

Year	RHC type		Total
	Independent	Provider based	
2018	1,327	2,645	3,972
2019	1,288	2,778	4,066
2020	1,273	2,968	4,241
2021	1,295	3,154	4,449
2022	1,484	3,270	4,754

Note: RHC (rural health clinic), FFS (fee-for-service). Counts of RHCs are based on unique CMS Certification Numbers that billed at least one Medicare FFS claim in a given year after excluding certain claims, such as those with payments equal to zero. These totals exclude RHCs that did not bill FFS Medicare; RHCs excluded from this table may include CMS-certified RHCs that specialize in pediatrics.

Source: MedPAC analysis of RHC claims for FFS beneficiaries.

payment formula gives RHCs an incentive to increase their charges and subjects beneficiaries to high and variable cost-sharing liability.

Table 7-A2 provides an illustrative example of beneficiary cost-sharing liability and total payments for three independent RHCs with different levels of charges, highlighting the impact of charge-based beneficiary coinsurance and a payment formula that holds program payments constant. RHC 1's charges

are equal to the 2025 national statutory payment limit of \$152. RHC 1 thus receives a total payment equal to \$152: Medicare pays 80 percent of the payment limit, or \$121.60 ($\$152 \times 0.80$), and the beneficiary pays 20 percent of charges, or \$30.40 ($\$152 \times 0.20$). If an RHC has higher charges, both the beneficiary's coinsurance and the total payment for the same service will increase. For example, RHC 3, which has charges equal to \$225, will receive a total payment per visit of \$166.60: Medicare pays 80 percent of the payment limit, or

**TABLE
7-A2****Illustrative example of how higher charges result in higher FFS Medicare beneficiary coinsurance and total payments to rural health clinics, 2025**

RHC	RHC AIR (subject to payment limits)	RHC charge per visit	FFS Medicare payment per visit (80% of AIR, subject to payment limits)	Beneficiary coinsurance per visit (20% of RHC charges)	Total per visit payment to RHC (Medicare payment + beneficiary coinsurance)
1	\$152.00	\$152.00	\$121.60	\$30.40	\$152.00
2	152.00	175.00	121.60	35.00	156.60
3	152.00	225.00	121.60	45.00	166.60

Note: FFS (fee-for-service), RHC (rural health clinic), AIR (all-inclusive rate). Examples are of independent RHCs, do not include the effect of sequestration, and assume that RHCs' average cost per visit is higher than the national statutory payment limit and that the beneficiary has already met their Part B deductible. Medicare's RHC payment system generally bundles all professional services furnished in a single day into one payment, with limited exceptions (e.g., a qualified medical visit and a qualified mental health visit on the same day). We use the term "per visit" to reflect this payment unit.

Source: MedPAC analysis of CMS regulations.

**TABLE
7-A3****FFS Medicare beneficiary coinsurance exceeded 20 percent of the average estimated interim AIR per visit at independent RHCs in 2022**

RHC type	Visits (in millions)	Average estimated interim AIR per visit	Average Medicare payment per visit	Average beneficiary coinsurance per visit	Average beneficiary coinsurance per visit as a percent of estimated interim AIR	Total payment per visit (Medicare payment + beneficiary coinsurance)
Independent	1.7	\$111	\$88	\$38	34%	\$126
Nonspecified provider based	0.4	113	89	43	38	132
Specified provider based	4.5	259	205	44	17	249

Note: FFS (fee-for-service), AIR (all-inclusive rate), RHC (rural health clinic). "Provider-based" RHCs are those owned by and operated as an integral part of another Medicare-certified facility, such as a hospital. "Specified provider based" RHCs are those that are part of a hospital with fewer than 50 beds and were enrolled in Medicare as of December 31, 2020 (or had submitted an application for enrollment that was received no later than December 31, 2020); all other provider-based RHCs are "nonspecified." Independent RHCs are freestanding clinics that do not qualify for, or have not sought, provider-based status. Specified provider-based RHCs are generally subject to higher payment limits than other RHCs. Medicare's RHC payment system generally bundles all professional services furnished in a single day into one payment, with limited exceptions (e.g., a qualified medical visit and a qualified mental health visit on the same day). We use the term "per visit" to reflect this payment unit. "Visits" represent unique claims. Claims were limited to those paid on an AIR basis where full beneficiary coinsurance was applicable. Outliers were trimmed. About 1 percent of claims were excluded because we could not classify provider-based RHCs as specified or not. Estimated interim AIRs are calculated by summing Medicare program payments on each claim and then dividing that total by 0.80, with an adjustment for sequestration. Numbers are rounded to the nearest dollar or percent.

Source: MedPAC analysis of FFS Medicare RHC claims and cost-report data.

\$121.60 ($\$152 \times 0.80$), but the beneficiary pays 20 percent of the higher charges, or \$45.00 ($\$225 \times 0.20$).

To examine the extent to which basing coinsurance on RHC charges affects beneficiary coinsurance, we analyzed FFS Medicare RHC claims for 2022. We limited our analysis to claims paid on an AIR basis for which full beneficiary coinsurance was applicable.³⁹ To calculate beneficiary coinsurance, we summed actual beneficiary coinsurance per claim. To calculate each RHC's AIR, subject to payment limits, we used a claims-based proxy because actual AIRs are not calculated until cost-report reconciliation at year's end. Specifically, we summed Medicare program payments on each claim and then divided that total by 0.80, with an adjustment for sequestration. We call this proxy the "estimated interim AIR."⁴⁰ We then divided the beneficiary coinsurance by the estimated interim AIR to arrive at the share of the estimated interim AIR paid by beneficiaries. Then we analyzed the extent

to which beneficiary coinsurance varied by type of RHC: independent, nonspecified provider based, and specified provider based.⁴¹

We found that, in aggregate, the beneficiary share of the estimated interim AIR in 2022 was higher at nonspecified provider-based RHCs (38 percent) and independent RHCs (34 percent) and lower at specified provider-based RHCs (17 percent) (Table 7-A3). Because FFS Medicare's program payments to RHCs do not change based on beneficiary coinsurance, the total payments per visit were higher than the estimated interim AIR for independent and nonspecified provider-based RHCs and lower than the estimated interim AIR for specified provider-based RHCs. For example, the average estimated interim AIR for independent RHCs was \$111 per visit, but the total payment amount per visit (including both beneficiary and program payments) was \$126 because independent RHCs' charges far exceeded the estimated interim AIR

(which results in coinsurance of more than 20 percent of the estimated interim AIR).

Relative to other RHCs, the beneficiary share of the estimated interim AIR was lower among specified provider-based RHCs in 2022, not because their charges or beneficiary coinsurance at these RHCs was lower but because the average estimated interim AIR per visit was higher. For example, the average beneficiary coinsurance per visit was slightly higher among specified provider-based RHCs (\$44) compared with independent RHCs (\$38).

These findings demonstrate that beneficiary coinsurance at RHCs is not limited by AIRs or payment limits. Instead, coinsurance varies based on RHCs' charges.

Next, we examined the variation in charges by RHC type. We found that RHC charges (and therefore beneficiary coinsurance) varied substantially across and within types of RHCs. For example, within independent RHCs, the RHC at the 25th percentile had charges per AIR visit of \$140 compared with \$235 at the 75th percentile and \$345 at the 95th percentile (Figure 7-A2, p. 366). We observed similar variation among nonspecified provider-based RHCs and specified provider-based RHCs (Figure 7-A2). Because RHC charges are directly tied to beneficiary coinsurance, we also observed similar variation in beneficiary coinsurance (data not shown).

Some variation in charges could be due to the number or mix of services furnished per AIR visit. However, after controlling for the number and mix of services by limiting our analysis to revenue-center charges for the most common RHC service—an evaluation and management office visit for an established patient (Healthcare Common Procedure Coding System code 99214)—wide variation in charges persisted. For example, charges for this service at specified provider-based RHCs ranged from \$185 at the 25th percentile to \$284 at the 75th percentile and \$384 at the 95th percentile (Figure 7-A2, p. 366).

One type of RHC with particularly high charges and beneficiary coinsurance was RHCs owned by a PE firm. There is no comprehensive source of PE ownership of RHCs. However, we identified a group of about 100 RHCs as owned by one PE firm based on their new participation in Medicare and information

on the RHCs' public websites. Among these PE-owned RHCs, the median charge per AIR visit was about \$326, which is far higher than other types of RHCs (Figure 7-A2, p. 366). These higher charges translated into higher beneficiary coinsurance: Beneficiaries at PE-owned RHCs paid about 70 percent more per visit in coinsurance compared with the average among independent RHCs in 2022 (data not shown).⁴²

These data suggest that beneficiaries often face high cost sharing because their coinsurance is based on charges. In addition to being higher, RHC charges vary widely across facilities. This situation leaves beneficiaries vulnerable to very high cost sharing and could create inequities across beneficiaries. The charging behavior of new PE-owned RHCs further highlights that basing coinsurance on facility charges and allowing total payments to increase as charges increase creates an incentive to raise charges and does not protect beneficiaries from excessive cost sharing.

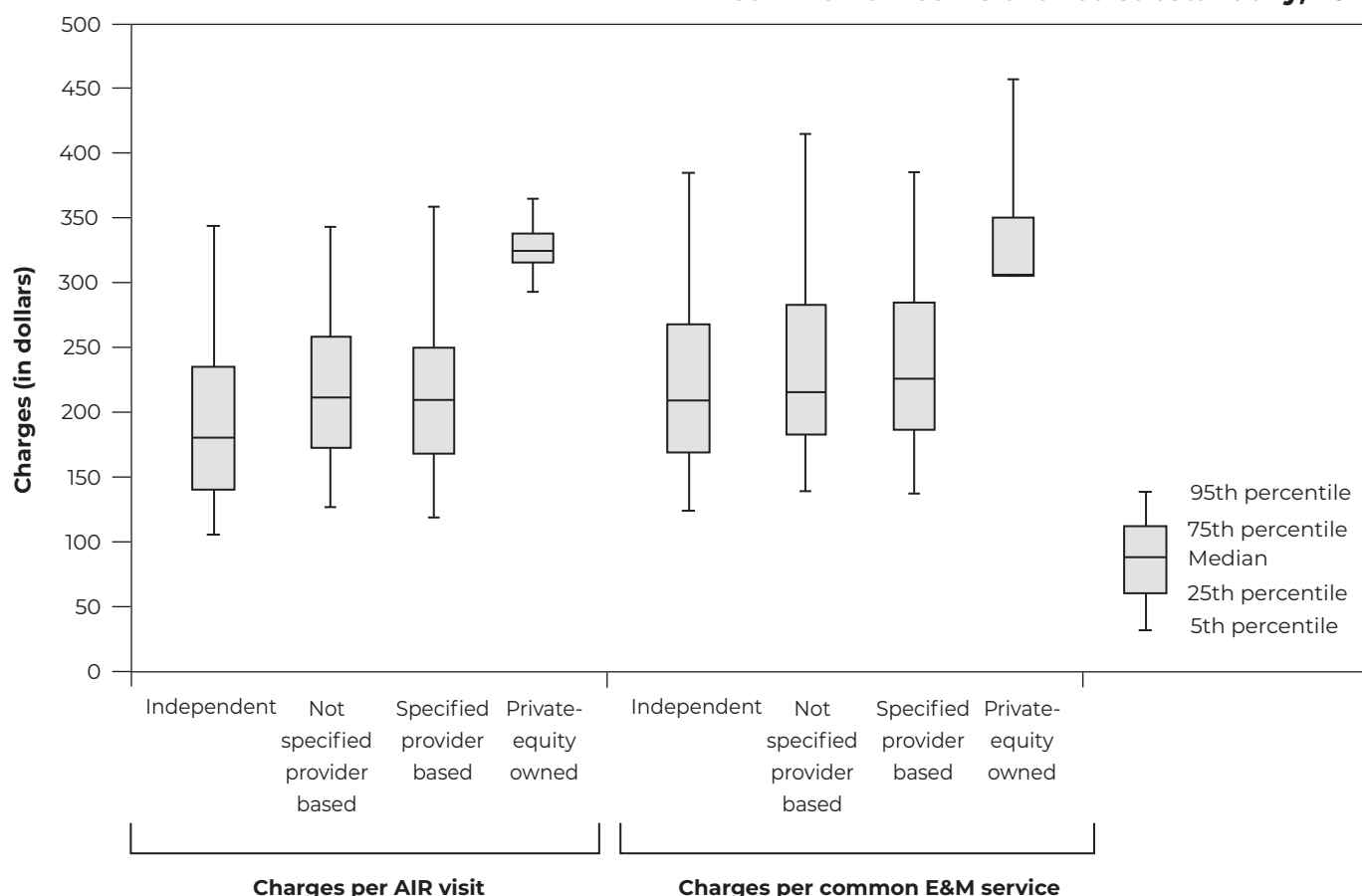
Charges are list prices and are often seen as arbitrary and not a good proxy for cost or value, which is one reason why most other Medicare payment systems have moved away from basing payments or beneficiary cost sharing on charges. Two other Medicare payment systems that pay for clinician services already limit beneficiary coinsurance to 20 percent of the payment amount. For example, the physician fee schedule (PFS) and the payment system for federally qualified health centers (FQHCs) both pay for clinician services furnished to rural beneficiaries. The PFS limits beneficiary coinsurance to 20 percent of the lesser of the payment rate or actual charges; beneficiary coinsurance at FQHCs is limited to 20 percent of the lesser of actual charges or the prospective payment amount.

An option to reduce beneficiary coinsurance for RHC services

To set more uniform and predictable coinsurance levels, beneficiary coinsurance could be capped at 20 percent of the lower of an RHC's AIR, subject to payment limits, or 20 percent of actual charges. Using 2022 claims, we simulated the effect of such a policy on two outcomes—beneficiary coinsurance and total

**FIGURE
7-A2**

Rural health clinics' charges per AIR visit and common office visit varied substantially, 2022



Note: AIR (all-inclusive rate), E&M (evaluation and management). "Provider-based" RHCs are those owned by and operated as an integral part of another Medicare-certified facility, such as a hospital. "Specified provider-based" RHCs are those that are part of a hospital with fewer than 50 beds and were enrolled in Medicare as of December 31, 2020 (or had submitted an application for enrollment that was received no later than December 31, 2020); all other provider-based RHCs are "nonspecified." Independent RHCs are freestanding clinics that do not qualify for, or have not sought, provider-based status. Medicare's RHC payment system generally bundles all professional services furnished in a single day into one payment, with limited exceptions (e.g., a qualified medical visit and a qualified mental health visit on the same day). We use the term "per visit" to reflect this payment unit. "Visits" represent unique claims. For the analysis of charges per AIR visit, claims were limited to those paid on an AIR basis in which full beneficiary coinsurance was applicable. Outliers were trimmed. About 1 percent of claims were excluded because we could not classify provider-based RHCs as specified or not. We also excluded RHCs with fewer than 100 AIR visits to reduce the appearance of variation that is based on relatively few claims. For the analysis of charges for a common E&M service, we analyzed all RHC revenue center lines with Healthcare Common Procedure Coding System Code 99214 after excluding claims with no payments. For private-equity-owned RHCs, charges per common E&M service was the same at the 5th percentile, 25th percentile, and median.

Source: MedPAC analysis of FFS Medicare RHC claims and cost-report data.

FFS Medicare payments received by RHCs (beneficiary coinsurance plus program payments).⁴³

We estimate that such a cap would have reduced FFS beneficiary coinsurance in 2022 by 19 percent overall. The reduction in beneficiary coinsurance would have been much larger for services furnished at independent RHCs and nonspecified provider-based

RHCs. We estimate that such a cap would have reduced FFS beneficiary coinsurance in 2022 by 43 percent at independent RHCs, 49 percent at nonspecified provider-based RHCs, and 8 percent at specified provider-based RHCs.

As for the effect on RHC revenues, we estimate that such a cap in 2022 would have reduced FFS Medicare

payments to RHCs by about 3.9 percent overall: 12.9 percent for independent RHCs, 15.8 percent at nonspecified provider-based RHCs, and 1.4 percent for specified provider-based RHCs. The effect on specified provider-based RHCs was small because such RHCs generally had significantly higher estimated interim AIRs (and similar charges) relative to other RHCs, and therefore beneficiary coinsurance was already frequently equal to or less than 20 percent of their estimated interim AIRs. As a result, about two-thirds of such RHCs were not impacted at all, and even among those that were impacted, the effect was often small (because beneficiary coinsurance was often just above 20 percent of their estimated interim AIRs). Across all types of RHCs, all of the decline was due to lower beneficiary coinsurance because Medicare program payments to RHCs remain the same regardless of the amount of the beneficiary's cost-sharing liability.

However, the effects on independent RHCs and nonspecified provider-based RHCs would likely be much smaller if such a policy were implemented because growth in the national statutory payment limit is likely to outpace growth in charges per visit over the next few years (thereby reducing the share of total payments attributed to beneficiary coinsurance). To estimate the effect on independent RHCs in 2026 and in 2028 (when the CAA, 2021, increases to the national statutory payment limit are fully phased in), we increased beneficiary coinsurance per visit based on the average growth in charges per visit from 2018 to 2022 (5 percent per year) and program payments per visit by amounts stipulated in the CAA, 2021.^{44,45} We used 2022 volume for both simulations. For 2026 and 2028, we estimate that capping beneficiary coinsurance at 20 percent of the lower of an RHC's AIR, subject to payment limits, or 20 percent of actual charges

would reduce independent RHCs' total FFS Medicare payments by 8.4 percent and 7.3 percent, respectively. Furthermore, these effects are for FFS Medicare only (so the effects on all-payer revenue will be smaller). Even if beneficiary coinsurance was capped in this manner, we would still expect rapid growth in FFS Medicare payments at independent RHCs because the 120 percent growth in the national statutory payment limit from 2020 to 2028 would more than outweigh the 7 percent or 8 percent decrease in payments due to reduced cost sharing.

While we estimate that the effect of capping beneficiary coinsurance would have been small at specified provider-based RHCs in 2022 (1.4 percent), charge-based coinsurance could undermine the new payment limits that the CAA, 2021, implemented for these RHCs by allowing faster growth in beneficiary coinsurance to offset slower growth in payment limits. AIRs for these providers have historically grown based on the increase in costs per visit, which has been faster than growth in the MEI. Now that these RHCs' payment limits increase based on MEI growth, they could face pressure to reduce cost growth or increase charges. For example, if the MEI grew by 3 percent and an RHC's cost per visit grew by 5 percent, the RHC would have an incentive to increase charges. In this example, an RHC that had historically set its charges equal to its AIR (e.g., an AIR of \$250 per visit and charges of \$250 per visit) would need to increase their charges (and therefore beneficiary coinsurance) by 13 percent to offset the effects of the new MEI-based cap on total payments per visit. Such a response would undermine the payment limits (by allowing total payments per visit to exceed the limits and reduce the incentive to hold down cost growth) and shift the burden of the new payment limits to beneficiaries. ■

Endnotes

- 1 In this chapter, we follow the most common CMS definition of “rural” for payment-policy purposes, which comprises all counties outside of metropolitan areas. Because types of rural areas vary widely, we also subdivide these areas into distinct types, using rural-urban commuting areas. Further distinguishing rural areas allows us to compare rural areas with larger core areas (e.g., micropolitan areas with a city population between 25,000 and 50,000) and more remote areas where the largest town has fewer than 2,500 people.
- 2 Using survey data from 2013 through 2017, the Census Bureau found that the median household income in mostly urban counties was higher than that of mostly rural counties (\$60,000 vs. \$47,000); however, the range in median household incomes across mostly urban counties (\$21,000 to \$130,000) and mostly rural counties (\$20,000 to \$95,000) was wide (Guzman et al. 2018). (The Census Bureau defines an area as “mostly rural” if most of its census tracts are not in urban areas (Ratcliffe et al. 2016).) In a separate analysis, the Census Bureau found that median incomes for rural households in the Northeast and Midwest were actually higher than those of their urban counterparts; in contrast, median incomes for rural households in the South and West were lower compared with urban households in the same regions (Bishaw and Posey 2016). One caveat is that the incomes used by the Census Bureau are not adjusted for the cost of living. An earlier study that compared rural and urban poverty rates found that the poverty rates—prior to any adjustment for the cost of living—were higher in rural areas, but after adjusting for the cost of living, poverty rates were lower in rural areas (Jolliffe 2006). We are not aware of any updates to this dated finding that adjusts rural and urban incomes or poverty rates by the cost of living.
- 3 For each of the seven most common diagnosis-related groups at the closed small rural hospitals (pneumonia, heart failure, chronic obstructive pulmonary disease, nutritional and metabolic disorders, esophagitis and digestive disorders, kidney and urinary tract infections, and septicemia), volume declined by between 40 percent and 84 percent from 2005 to 2014.
- 4 CAHs must be in rural areas or reclassified by CMS as rural. States have the ability to declare areas rural, which allows CAHs to apply to CMS for rural reclassification (42 CFR Sec. 412, Prospective Payment Systems for Inpatient Hospital Services). Because all new CAHs must be more than 35 miles from another facility (or more than 15 miles on secondary roads or in mountainous terrain), almost all of them are located outside of metropolitan statistical areas.
- 5 For more details about the evolution of the CAH program, see MedPAC’s June 2005 report to the Congress.
- 6 Most CAH beds are “swing beds,” in which beneficiaries can receive acute or post-acute care. In some states, these beds can also be used for the long-term care of Medicaid or private-pay residents of the hospital. In addition to 25 acute care/swing beds, CAHs are allowed to have distinct-part skilled nursing facilities (SNFs), 10-bed psychiatric units, 10-bed rehabilitation units, and home health agencies (HHAs). However, these distinct-part departments of the CAH are paid through Medicare’s prospective systems for SNFs, inpatient psychiatric facilities, inpatient rehabilitation facilities, and HHAs.
- 7 CAHs may not receive the full 101 percent of their costs under current law due to payment reductions imposed by a budget sequester on Medicare payments and limits on the share of hospital bad-debt payments that are reimbursable by Medicare.
- 8 CAHs vary widely in their financial resources and their level of profitability. CAHs with donations and government support can afford higher cost structures because cost-based payments act as a matching grant for donations and government support. For example, if a hospital uses \$10 million in government support or donations to build a new facility and buy equipment, when that facility and equipment are depreciated over time, Medicare reimburses the CAH for Medicare’s share of the facility’s depreciation expense. This mechanism partially explains how communities with more favorable payer mixes and more outside support have been able to build new hospitals in recent years. However, not all communities have a significant amount of non-patient-care revenue. Among the approximately 1,350 CAHs in 2022, 25 percent had all-payer total profit margins below –2 percent, and 25 percent had all-payer total margins above 9 percent. There have been 13 CAH closures over the past five years (2020 to 2024).
- 9 These profits exclude COVID-19 relief funds and represent a profit margin of about 2.5 percent in 2022. In 2023, total (all-payer) margins increased to close to 5 percent for CAHs and IPPS hospitals.
- 10 This revenue excluded physician fees from hospital-owned physician practices.
- 11 This amount represents the difference between the CAH payment rate and what the rate would have been if the hospital had been paid basic OPPS rates in the county.

However, it may somewhat overstate the payment differential because if the hospital had not become a CAH, it may have engaged in other changes to increase its payment rates, such as reclassifying to a different area with a higher wage index. We do not have a precise counterfactual.

- 12 Section 1866(a)(1)(o) of the Social Security Act states that a CAH should “accept as payment in full for services that are covered under this title and are furnished to any individual enrolled with a Medicare+Choice organization under part C, with a PACE provider under section 1894 or 1934, or with an eligible organization with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967[596], or under section 222(a) of the Social Security Amendments of 1972[597], which does not have a contract (or, in the case of a PACE provider, contract or other agreement) establishing payment amounts for services furnished to members of the organization or PACE program eligible individuals enrolled with the PACE provider, the amounts that would be made as a payment in full under this title (less any payments under sections 1886(d)(11) and 1886(h)(3)(D)) if the individuals were not so enrolled.” Sections 1886(d)(11) and 1886(h)(3)(D)) refer to payments for graduate medical education, which are paid directly by the Medicare program; the MA plan is not expected to make those payments.
- 13 This process may not represent the rate setting experience at all CAHs.
- 14 In some cases, outpatient care was paid based on a blend of costs and a fee schedule.
- 15 For inpatient services, cost sharing is set at a fixed deductible that does not vary with charges or local wages. The fixed inpatient deductible is the same for CAHs and PPS hospitals.
- 16 Other services such as lab tests and certain vaccines do not require coinsurance.
- 17 CAHs can be in a metropolitan area if the state declares the CAH’s location as rural for some purpose.
- 18 The limit on outpatient coinsurance was enacted as part of the Balanced Budget Refinement Act in 1999, and the House Ways and Means Committee report stated that the rationale was to limit excessive outpatient coinsurance (U.S. House of Representatives 1999). A potential additional concern is that if a beneficiary does not have supplemental insurance, the hospital may have an incentive to shift the patient to inpatient status to avoid large losses on unpaid coinsurance.
- 19 In some cases, Medicaid will pay the cost sharing for dually eligible patients. However, if the Medicare program payment is higher than the Medicaid payment rate, then Medicaid may refuse to pay any cost sharing. The unpaid coinsurance is then deemed a bad debt, and the Medicare program pays the CAH 65 percent of the unpaid coinsurance as a “bad-debt payment.”
- 20 The lower use could reflect less need for services or a greater deferral or delay of care due to not having supplemental insurance. In our examination of data from the 2021 Medicare Current Beneficiary Survey, we found that 10.6 percent of beneficiaries without supplemental coverage stated they had a health problem or condition about which they thought they should have seen a doctor or other health professional but did not. In contrast, 5.7 percent of those with Medigap coverage did not see a physician despite a concern that they needed medical attention.
- 21 This illustrative example is dependent on many assumptions about CAH use by beneficiaries without supplemental insurance and is not a precise estimate.
- 22 This estimate is by necessity imprecise. We assume that there was a 25 percent reduction in CAH users, while the research suggests a 25 percent reduction in overall use. Nevertheless, the 25 percent from the literature provides a rough estimate of the number of beneficiaries directly affected by charge-based coinsurance.
- 23 In some states, Medicaid pays the cost sharing for dual-eligible patients. However, in some states, Medicaid rates are set below 80 percent of rural hospitals’ costs. In these cases, Medicaid can choose not to pay the cost sharing by stating that the Medicare program payments are already above what the Medicaid program views as a full payment. CAHs then often report the unpaid coinsurance as a bad debt for dual-eligible patients, and the Medicare program then pays the hospital 65 percent of this unpaid cost sharing as a bad-debt expense. The level of bad debt from dually eligible patients varies widely by state.
- 24 CMS estimates what the actual cost will be for each claim. It then pays the CAH the estimated costs less the beneficiary cost sharing. After the close of the cost-reporting year, CMS will estimate costs using cost-report data and then provide a final settlement so that total program payments will equal 101 percent of allowed costs, less beneficiary cost sharing, less 2 percent for the sequester.
- 25 The offsetting increase in program spending did not factor in the sequester, which is why we describe that offset as almost \$2.1 billion. In 2022, the sequester was not in effect for the first three months of the year, partially in effect for three months of the year (a 1 percent reduction), and fully in effect for six months of the year (a 2 percent reduction). If we had

factored in the sequester using 2022 sequester data, the \$2.1 billion increase in program spending would be reduced by about 1.25 percent, resulting in increased program spending of \$2.07 billion rather than the \$2.1 billion reported here.

- 26 The increased payments to MA plans would reflect increases in MA bids for providing standard Part A and Part B services (e.g., physician visits) and/or increased plan spending on supplemental benefits (e.g., vision benefits). Song and colleagues estimate that, for every dollar increase in MA benchmarks, MA plans' bids for standard Part A and Part B services increase by 50 cents and spending on supplemental benefits increases by 30 cents to 40 cents (Song et al. 2013). Using these estimates, we approximate that the \$2.1 billion in additional FFS spending in 2022 due to the change in CAH coinsurance policy would have increased program payments to MA plans by about \$1.3 billion (Table 7-3, p. 356).
- 27 Before 2013, CAHs were paid 100 percent of bad-debt expenses. At that point, high charges and high bad-debt payments did not affect CAHs' net revenue. That changed in 2013 when the Congress enacted reduced payments of bad-debt amounts.
- 28 The effect of the lower benchmark on program spending would be slightly less than \$94 billion because of how benchmarks affect bids and supplemental benefits, as discussed above.
- 29 This example assumes that a \$1 reduction in medical losses by the Medigap plan would reduce premiums by \$1. It is possible that if the Medigap plan is already at the minimum medical loss ratio of 65 percent, it may have to reduce premiums by more than \$1 if its cost of insurance declines by \$1.
- 30 For example, assume a service costs \$220 at the CAH with a fixed cost percentage of 50 percent, or \$110, and 30 percent of outpatient charges are for FFS Medicare patients (these were the approximate averages in 2022). The cost per service to all payers would be reduced by $\$110 / V$, where V is the volume. As a result, Medicare costs on existing services would be reduced by $(\$110 / V) \times (V \times 0.30)$, or 30 percent of \$110, or \$33. The net difference in payments to CAHs relative to payments to PPS hospitals was \$110, or about half of the cost at the CAH. Thus, shifting one service from a PPS hospital to a CAH would directly cost about \$110 on average and save about \$33 through reduced unit costs at the CAH. On net, shifting volume to CAHs would further increase program costs (\$110 in higher price paid less \$33 in lower cost allocation across other services).
- 31 Historically, CMS enforced the standard that RHCs must be primarily engaged in providing primary care services. However, in a December 2024 final rule, CMS reinterpreted the Social Security Act to allow RHCs to furnish a higher share of specialty care services. Specifically, RHCs are now required to provide primary care, but CMS will no longer require that RHCs primarily engage in furnishing primary care services.
- 32 In certain cases, RHCs may receive multiple payments for services furnished on the same day, such as a qualified medical visit and a qualified mental health visit on the same day. Other services furnished at RHCs are not paid under the RHC AIR methodology, such as certain vaccines, laboratory tests, technical components of imaging services, telehealth services unrelated to behavioral health, and certain care-coordination services.
- 33 Historically, RHCs were subject to productivity standards, which effectively lowered RHCs' AIRs if clinicians did not furnish a minimum number of visits per year. However, CMS eliminated RHC productivity standards effective for cost-reporting periods ending after December 31, 2024.
- 34 To qualify for an AIR-based payment limit, an RHC must have been enrolled in Medicare as of December 31, 2020, or have submitted an application for enrollment that was received no later than December 31, 2020.
- 35 In 2020 (and broadly during the PHE), more RHCs received exemptions from productivity standards than in previous years. Such exemptions further allowed costs per visit to increase and to be permanently included in provider-based RHCs' payment limits.
- 36 Before meeting their outpatient deductible, beneficiary cost sharing is based on RHC charges.
- 37 The Medicare program also pays RHCs bad-debt payments equal to 65 percent of unpaid beneficiary cost sharing.
- 38 RHC coinsurance must not exceed 20 percent of the RHC's "reasonable customary charge" (Sec. 405.2410).
- 39 Based on these criteria, we excluded non-behavioral health telehealth services, virtual communications services, care-coordination services, telehealth originating-site fees, claims for which Medicare was a secondary payer, claims that were part of a demonstration, claims in the deductible phase of the benefit, preventive services for which cost sharing is not applicable, and claims for which cost sharing was waived during the coronavirus PHE. We also implemented outlier trims. After all exclusions and trims, our universe of claims included 6.7 million claims (or about 70 percent of all FFS Medicare RHC claims) and \$1.4 billion in total spending (or about 73 percent of all FFS Medicare RHC spending).

- 40 Using claims data to estimate interim AIRs rather than information from cost reports produces different results for some RHCs. However, we used a claims-based approach for multiple reasons. Any limit on beneficiary coinsurance would likely be implemented using interim AIRs because that information is available at the point of care. In contrast, cost-report-based AIRs are not available until after reconciliation at year's end. We also expect the overall difference between interim and final AIRs, subject to payment limits, to be similar in the future because all AIRs are now subject to payment limits.
- 41 Provider-based RHCs are those owned by and operated as an integral part of another Medicare-certified facility, such as a hospital. "Specified" provider-based RHCs are those that are part of a hospital with fewer than 50 beds and were enrolled in Medicare as of December 31, 2020 (or had submitted an application for enrollment that was received no later than December 31, 2020); all other provider-based RHCs are "not specified." Independent RHCs are freestanding clinics that do not qualify for, or have not sought, provider-based status.
- 42 Since 2022, this PE firm has continued to increase the number of RHCs it owns. In addition, other PE firms purchased RHCs after 2022 (Business Wire 2024, MyTown Health 2024).
- 43 Simulations were limited to RHC claims paid on an AIR basis where full beneficiary coinsurance was applicable.
- 44 Because nonspecified provider-based RHCs are subject to the national statutory payment limit and their charges per visit grew at slightly slower rates compared with independent RHCs from 2018 to 2022, results of a similar simulation for these providers would be directionally consistent with the simulation for independent RHCs.
- 45 We also simulated the effect on reductions in beneficiary coinsurance. At independent RHCs, we estimate that beneficiary coinsurance would be reduced by 32 percent in 2026 and 29 percent in 2028.

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A P P E N D I X

A

**Commissioners' voting
on recommendations**



Commissioners' voting on recommendations

In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Congress required MedPAC to call for individual Commissioner votes on each recommendation and to document the voting record in its report. The information below satisfies that mandate.

Chapter 1: Reforming physician fee schedule updates and improving the accuracy of relative payment rates

- 1-1** The Congress should replace the current-law updates to the physician fee schedule with an annual update based on a portion of the growth in the Medicare Economic Index (MEI) (such as MEI minus 1 percentage point).

Yes: Barr, Casale, Casalino, Chernew, Cherry, Damberg, Dusetzina, Kan, Konetzka, Liao, Miller, Navathe, Poulsen, Rambur, Riley, Sarra, Upchurch

- 1-2** The Congress should direct the Secretary to improve the accuracy of Medicare's relative payment rates for clinician services by collecting and using timely data that reflect the costs of delivering care.

Yes: Barr, Casale, Casalino, Chernew, Cherry, Damberg, Dusetzina, Kan, Konetzka, Liao, Miller, Navathe, Poulsen, Rambur, Riley, Sarra, Upchurch

Chapter 2: Supplemental benefits in Medicare Advantage

No recommendations

Chapter 3: Examining home health care use among Medicare Advantage enrollees

No recommendations

Chapter 4: Part D prescription drug plans for beneficiaries in fee-for-service Medicare and Medicare Advantage

No recommendations

Chapter 5: Medicare beneficiaries in nursing homes

No recommendations

Chapter 6: Medicare's measurement of rural provider quality

No recommendations

Chapter 7: Reducing beneficiary cost sharing for outpatient services at critical access hospitals

For fee-for-service Medicare beneficiaries, the Congress should:

- Set coinsurance for outpatient services at critical access hospitals equal to 20 percent of the payment amount for services that require cost sharing; and
- Place a cap on critical access hospitals' outpatient coinsurance equal to the inpatient deductible.

Yes: *Barr, Casale, Casalino, Chernew, Cherry, Damberg, Dusetzina, Kan, Konetzka, Liao, Miller, Navathe, Poulsen, Rambur, Riley, Sarra, Upchurch*

Acronyms

Acronyms

A-APM	advanced alternative payment model	DECI	demographic estimate of coding intensity
ACA	Affordable Care Act of 2010	D-SNP	dual-eligible special-needs plan
ACO	accountable care organization	E&M	evaluation and management
ADL	activity of daily living	ECI	Employment Cost Index
AG	authorized generic	eCQM	electronic clinical quality measure
AIR	all-inclusive rate	ED	emergency department
AIDS	acquired immunodeficiency syndrome	EDPS	Encounter Data Processing System
ALF	assisted living facility	EDS	encounter data set
AMA	American Medical Association	EGWP	employer group waiver plan
APM	alternative payment model	EHR	electronic health record
APRN	advanced practice registered nurse	ESRD	end-stage renal disease
ARC	Actuarial Research Corporation	ESRD-QIP	End-Stage Renal Disease Quality Incentive Program
ASC	ambulatory surgical center	FFS	fee-for-service
ASC-QRP	ASC Quality Reporting Program	FI-SNP	facility-based institutional special-needs plan
ASPE	Assistant Secretary for Planning and Evaluation	Flex	Medicare Rural Hospital Flexibility Program
BBA	Balanced Budget Act	FQHC	federally qualified health center
BBP	base beneficiary premium	FY	fiscal year
BIMS	Brief Interview for Mental Status	GAO	Government Accountability Office
CAA	Consolidated Appropriations Act	GDP	gross domestic product
CAH	critical access hospital	GLP-1	glucagon-like peptide-1 receptor agonist
CAHPS	Consumer Assessment of Healthcare Providers and Systems	HACRP	Hospital-Acquired Conditions Reduction Program
CBO	Congressional Budget Office	HCBS	home- and community-based services
CBO	community-based organization	HCC	hierarchical condition category
CFR	Code of Federal Regulations	HCPCS	Healthcare Common Procedure Coding System
CLASS	Community Living Assistance Services and Supports Act of 2010	HEI	Health Equity Index
CMS	Centers for Medicare & Medicaid Services	HEDIS	Healthcare Effectiveness Data and Information Set
CMS-HCC	CMS hierarchical condition category	HH	home health
CMS-RxHCC	CMS prescription drug hierarchical condition category	HHA	home health agency
CNS	clinical nurse specialist	HH-CAHPS	Home Health Care Consumer Assessment of Healthcare Providers and Systems
COPD	chronic obstructive pulmonary disease	HHI	Herfindahl-Hirschman index
COVID-19	coronavirus disease 2019	HHS	Department of Health and Human Services
CPI	Consumer Price Index	HI-SNP	hybrid institutional special-needs plan
CPR	customary, prevailing, and reasonable	HIPAA	Health Insurance Portability and Accountability Act of 1996
CPT	Current Procedural Terminology	HMO	health maintenance organization
CQM	clinical quality measure	HOPD	hospital outpatient department
C-SNP	chronic-condition special-needs plan	HOS	Health Outcomes Survey
CT	computed tomography		
CY	calendar year		

HPRD	hours per resident day	MIPPA	Medicare Improvements for Patients and Providers Act of 2008
HRRP	Hospital Readmission Reduction Program	MLR	medical loss ratio
HRSA	Health Resources and Services Administration	MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
HRSN	health-related social needs	MMP	Medicare–Medicaid Plan
ICH–CAHPS	In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems	MMTA	Medication Management, Teaching, and Assessment
IE–SNP	institutional-equivalent special-needs plan	MOOP	maximum out of pocket
IMPACT	Improving Medicare Post-Acute Care Transformation Act of 2014	MP	malpractice
IPPS	inpatient prospective payment systems	MSPB	Medicare spending per beneficiary
IRA	Inflation Reduction Act of 2022	MSS	medical social services
IRF	inpatient rehabilitation facility	MSSP	Medicare Shared Savings Program
IRF–PAI	Inpatient Rehabilitation Facility–Patient Assessment Instrument	N/A	not applicable
I–SNP	institutional special-needs plan	NA	nurse aide
JAMA	(formerly) Journal of the American Medical Association	NAMBA	national average monthly bid amount
KFF	(formerly) Kaiser Family Foundation	NCQA	National Committee for Quality Assurance
LIS	low-income subsidy	NDC	national drug code
LOS	length of stay	NF	nursing facility
LPN	licensed practical nurse	NH	nursing home
LTCI	long-term care insurance	NHIS	National Health Interview Survey
LTSS	long-term services and supports	NHSN	National Healthcare Safety Network
LVH	low-volume hospital	NORC	(formerly) National Opinion Research Center
MA	Medicare Advantage	NP	nurse practitioner
MAC	Medicare administrative contractor	OASIS	Outcome and Assessment Information Set
MA–CAHPS	Medicare Advantage Consumer Assessment of Healthcare Providers and Systems	OIG	Office of Inspector General
MACPAC	Medicaid and CHIP Payment and Access Commission	OOP	out of pocket
MACRA	Medicare Access and CHIP Reauthorization Act of 2015	OPPS	outpatient prospective payment system
MAO	Medicare Advantage organization	OT	occupational therapy
MA–PD	Medicare Advantage Prescription Drug [plan]	OTC	over the counter
MBQIP	Medicare Beneficiary Quality Improvement Project	PA	physician assistant
MCBS	Medicare Current Beneficiary Survey	PA	prior authorization
MDH	Medicare-dependent hospital	PAC	post-acute care
MDS	Minimum Data Set	PACE	Program of All-Inclusive Care for the Elderly
MedPAC	Medicare Payment Advisory Commission	PAI	patient assessment instrument
MEI	Medicare Economic Index	PAMA	Protecting Access to Medicare Act of 2014
MEPS	Medical Expenditure Panel Survey	PDP	prescription drug plan
MGMA	Medical Group Management Association	PE	practice expense
MIPS	Merit-based Incentive Payment System	PE	private equity
		PFS	physician fee schedule
		PHE	public health emergency
		PRHB	primarily health-related benefits

PMPM	per member per month	RUCA	Rural–Urban Commuting Area
POS	point of sale	RVU	relative value unit
PPI	Physician Practice Information	RxHCC	prescription drug hierarchical condition category
PPO	preferred provider organization	S/HMO	social HMO
PBD	provider-based department	SAS	Service Annual Survey
PROMIS	Patient-Reported Outcome Measurement Information System	SCH	sole community hospital
PPP	Paycheck Protection Program	SDOH	social determinants of health
PPS	prospective payment system	SFF	Special Focus Facility [Program]
PRF	Provider Relief Fund	SGR	sustainable growth rate
ProPAC	Prospective Payment Assessment Commission	SLP	speech–language pathology
PSA	prostate-specific antigen	SNF	skilled nursing facility
PSI	patient-safety indicator	SNF–QRP	SNF Quality Reporting Program
QBP	quality-bonus program	SNP	special-needs plan
QIN	quality-innovation network	SOC	start of care
QIO	quality-improvement organization	SSBCI	special supplemental benefits for the chronically ill
QIP	quality-incentive program	ST	step therapy
QL	quantity limit	STEMI	ST-elevation myocardial infarction
QPP	Quality Payment Program	TA	target amount
QRP	quality reporting program	TBD	to be determined
RBRVS	Resource-Based Relative Value Scale	TPN	total parenteral nutrition
REACH	Realizing Equity, Access, and Community Health	UDS	Uniform Data System
REH	rural emergency hospital	UM	utilization management
REIT	real estate investment trust	U.S.	United States
RHC	rural health clinic	VBID	value-based insurance design
RICS	reduction in cost sharing	VBP	value-based purchasing
RN	registered nurse	VIP	value-incentive program
ROC	resumption of care	VPS	volume performance standard
RSPB	risk-standardized plan bid		
RUC	Relative Value Scale Update Committee		

More about MedPAC

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Commissioners' biographies

Lynn Barr, MPH, is the director of the Barr-Campbell Family Foundation, which focuses on rural health, the underserved, education, and the environment. Previously, she recruited and organized small rural hospitals across three states to form the first National Rural accountable care organization (ACO). To manage the ACO's services, she founded and led Caravan Health and was awarded a \$30 million Transformation of Clinical Practice Initiative grant from CMS to provide similar services to rural providers and small practices who were not yet ready to participate in value-based payments. In March 2022, Ms. Barr sold Caravan Health to Signify, a division of CVS Health. Prior to forming Caravan Health, Ms. Barr shepherded four start-up companies and 12 medical inventions through the Food and Drug Administration and worldwide markets. Prior to that, she led the group purchasing of electronic medical records for California's rural hospitals, including individual needs assessments, vendor selection, negotiations, contracting assistance, and financing. Ms. Barr earned her master of public health degree from the University of California, Berkeley.

Paul N. Casale, MD, MPH, is a professor of population health sciences in the Division of Health Policy and Economics and a professor of clinical medicine in the Division of Cardiology at Weill Cornell Medicine (originally Cornell University Medical College), as well as an adjunct professor of medicine at Columbia University Vagelos College of Physicians and Surgeons. He has been the executive director of NewYork Quality Care, an ACO that is a joint initiative of NewYork-Presbyterian, Columbia University, and Weill Cornell Medical College for the past eight years. Dr. Casale has served on many national committees, including the chair of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and a member of the Advisory Council of the Agency for Healthcare Research and Quality. Dr. Casale's research focuses on clinical cardiology, value-based care, and payment reform. He has held multiple leadership positions in a variety of health care settings, including a rural private practice, a regional health system, and a large urban academic medical center. Dr. Casale earned his medical degree from Weill Cornell Medicine and his master of public health from the Harvard School of Public Health.

Lawrence Casalino, MD, PhD, is emeritus professor of public health at Weill Cornell Medicine, where he served as the Livingston Farrand Professor of Public Health and chief of the Division of Health Policy and Economics in the Department of Population Health Sciences. His research focuses on the intended and unintended effects of public and private policies on the types of provider organizations that exist, on the processes they use to provide care, on the quality and cost of care, and on the impact of policies and organizational processes on socioeconomic and racial/ethnic disparities. Dr. Casalino has served as senior adviser to the director of the Agency for Healthcare Research and Quality, as chair of the Academy Health Annual Research Meeting, as a member of the Panel of Health Advisers for the Congressional Budget Office, on the FAIR Health board of directors, and on many other national committees, technical advisory panels, and nonprofit boards. Prior to academia, Dr. Casalino worked full time as a primary care physician for 20 years and, before that, as a community organizer.

Michael E. Chernew, PhD, is the Leonard D. Schaeffer Professor of Health Care Policy and the director of the Healthcare Markets and Regulation Lab in the Department of Health Care Policy at Harvard Medical School. Dr. Chernew's research examines several areas related to improving the health care system, including studies of novel benefit designs, Medicare Advantage, alternative payment models, low-value care, and the causes and consequences of rising health care spending. He is also a member of the Congressional Budget Office's Panel of Health Advisors and a member of the Massachusetts Health Connector Board. Dr. Chernew is a member of the National Academy of Sciences, a research associate at the National Bureau of Economic Research, and a MITRE fellow. He is currently a coeditor of the *American Journal of Managed Care*. He has served on a number of CMS technical advisory panels reviewing the assumptions used by Medicare actuaries to assess the financial status of the Medicare trust funds. Dr. Chernew previously served on the Commission from 2008 to 2014 and was vice chair from 2012 to 2014. He earned his undergraduate degree from the University of Pennsylvania and his PhD in economics from Stanford University.

Robert A. Cherry, MD, MS, is chief medical and quality officer at UCLA Health in Los Angeles, CA. Dr. Cherry has extensive experience in quality and safety improvements and value-based care in health systems located in different parts of the U.S. He has coordinated innovative analytical methods to increase clinical quality of care, improve patient experience, and provide value to patients. He also has served on the board of many organizations, including the California Community Foundation, and was appointed to the California Health Facilities Financing Authority, which helps nonprofit organizations with financing, construction, and remodeling of health facilities. A trauma and critical care surgeon, Dr. Cherry earned his medical degree from Columbia University and a master in health care management degree from Harvard University.

Cheryl L. Damberg, PhD, is director of the RAND Center of Excellence on Health System Performance, distinguished chair in health care payment policy, and a principal senior economist at the RAND Corporation in Santa Monica, CA. Her research explores the impact of strategies to drive cost and quality improvements in health care. She also studies how providers are redesigning health care delivery in response to new payment models and increased accountability for cost and quality and the effects of health care consolidation on health care spending and quality performance. Her work has focused on improving the design of value-based payment systems to address disparities and improve health equity. Dr. Damberg is an international expert in value-based payment reforms and has advised the Congress and federal agencies on these and other issues. She earned her PhD in public policy from the Pardee RAND Graduate School of Public Policy Studies and a master of public health degree from the University of Michigan.

Stacie B. Dusetzina, PhD, is a professor of health policy and an Ingram Professor of Cancer Research at Vanderbilt University Medical Center in Nashville, TN. She has conducted extensive research on topics related to Medicare coverage for prescription drugs, including studies focused on drug pricing, Medicare Part D benefit design, and Medicare formulary coverage policies. Dr. Dusetzina has served as a committee member for the National Academies of Sciences, Engineering, and Medicine on the topic “Ensuring Patient Access to Affordable Drug Therapies” and as an expert witness for the Senate Special Committee

on Aging. She received her PhD in pharmaceutical sciences from the Eshelman School of Pharmacy at the University of North Carolina at Chapel Hill and postdoctoral training in the Department of Health Care Policy at Harvard Medical School.

Kenny Kan, FSA, CPA, CFA, MAAA, is vice president and chief actuary of Horizon Blue Cross Blue Shield (BCBS) of New Jersey in Newark, where he recently helped launch a Medicare Advantage plan. Prior to joining Horizon BCBS, Mr. Kan was chief actuary for two other large health plans, where he oversaw efforts to assess payment and delivery innovations designed to improve quality and reduce cost. He also served for six years on the Maryland Health Care Commission. He is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. Mr. Kan earned his master's degree in professional accounting from the University of Texas.

R. Tamara Konetzka, PhD, is the Louis Block Professor of Public Health Sciences at the University of Chicago, with a secondary appointment in the Department of Medicine, Section of Geriatrics and Palliative Medicine. She is also the codirector of the Health Policy Data Lab and an associate director of the Center for Chronic Disease Research and Policy at the University of Chicago. She also serves as the editor-in-chief of *Medical Care Research and Review*. Her research addresses the incentives created by health care payment policy on the quality of post-acute and long-term care, including the effects of public reporting of quality and the costs and benefits of home-based care. She received her PhD in health economics from the University of North Carolina at Chapel Hill and completed a postdoctoral fellowship at the University of Pennsylvania and the Philadelphia VA.

Joshua Liao, MD, MSc, is professor of medicine and division chief of general internal medicine at the University of Texas Southwestern Medical Center. He also leads the Program on Policy Evaluation and Learning, holds the Walter Family Distinguished Chair in Internal Medicine, and serves on the faculty at the University of Texas Southwestern O'Donnell School of Public Health. In addition, Dr. Liao is an adjunct senior fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania. He is an internal medicine physician with research and evaluation interests in health care payment, care-

delivery redesign, and practice transformation. Dr. Liao earned his medical degree from Baylor College of Medicine, completed his clinical training at Brigham & Women's Hospital/Harvard Medical School, and obtained his master of science in health policy research from University of Pennsylvania.

Brian Miller, MD, MBA, MPH, is an associate professor of medicine at Johns Hopkins University and a nonresident fellow at the American Enterprise Institute. His research focuses on the Medicare Advantage program, the Food and Drug Administration's (FDA's) regulation of pharmaceutical products and medical devices, and competition in health care markets. His research leverages his previous experience at CMS, the FDA, and the Federal Trade Commission. A practicing hospital-medicine physician, Dr. Miller earned his medical degree from Northwestern University, a master of public health degree from Johns Hopkins University, and a master's degree in business administration from the University of North Carolina at Chapel Hill.

Amol Navathe, MD, PhD, is founding director of The Parity Center, codirector of the Healthcare Transformation Institute, and associate director of the Center for Health Incentives and Behavioral Economics in the Department of Medical Ethics and Health Policy at the University of Pennsylvania's Perelman School of Medicine. He is also a professor at Penn and staff physician at the Corporal Michael J. Crescenzo VA Medical Center in Philadelphia, PA. Dr. Navathe's research center designs, tests, and evaluates payment models for public and private payers, including national insurers and state Blue Cross Blue Shield plans. His work led to the founding of Embedded Healthcare, a health care-technology company that accelerates high-value practice using behavioral economics. Dr. Navathe received his MD from the University of Pennsylvania and his PhD in health care management and economics from the Wharton School at the University of Pennsylvania.

Gregory P. Poulsen, MBA, is senior vice president at Intermountain Healthcare, an integrated health system based in Salt Lake City, UT. He has vast experience in strategy and policy for providing higher-quality health care while reducing health care costs. In addition, Mr. Poulsen was a key architect of many innovations at Intermountain Healthcare, including

offering a Medicare Advantage plan and assisting with the transition to a value-based integrated health care delivery system. Mr. Poulsen was a founding member of the Commonwealth Fund Commission on a High Performance Health System, has been a board and executive committee member for the American Hospital Association, and a trustee for the American Board of Internal Medicine Foundation. He is a national guest scholar at Stanford University. He has also been a member of several other value-focused boards and task forces. He earned his master of business administration degree from Brigham Young University.

Betty Rambur, PhD, RN, FAAN, is the Routhier Endowed Chair for Practice and professor of nursing in the College of Nursing at the University of Rhode Island, where she has conducted research on such topics as alternative payment models, telehealth nursing, and value-based workforce redesigns. Before joining the University of Rhode Island, Dr. Rambur served on the Green Mountain Care Board—a five-member regulatory, innovation, and evaluation board that has broad responsibility for cost containment and oversight of Vermont's transition to post-fee-for-service provider reimbursement. Previously, Dr. Rambur served as dean of the College of Nursing and Health Sciences at the University of Vermont and was chairperson for the North Dakota Health Task Force, a statewide health care-financing reform initiative. Dr. Rambur received her PhD in nursing from Rush University.

Wayne J. Riley, MD, MPH, MBA, is president of the State University of New York (SUNY) Downstate Health Sciences University, tenured professor of internal medicine and of health policy and management, and the chair of the board of the New York Academy of Medicine. Immediately prior to joining Downstate, Dr. Riley served as clinical professor of medicine and adjunct professor of health care management at Vanderbilt University and as the 10th president and chief executive officer of Meharry Medical College. He began his career at Baylor College of Medicine, where he completed residency training in internal medicine and held several key administrative posts, including vice president and vice dean for health affairs and governmental relations, assistant dean for education, and assistant chief of medicine at Ben Taub Hospital—a leading public safety-net teaching hospital. Dr. Riley is a member of the National Academy of Medicine

(NAM) of the National Academy of Sciences, where he served as vice chair and chair of the NAM section on the Administration of Health Services, Education and Research. He is also president emeritus of the American College of Physicians, and president of the Society of Medical Administrators. He is an independent director of HCA Healthcare Inc., Compass Pathways PLC, and HeartFlow Group Inc. Dr. Riley earned a BA in anthropology from Yale University, an MPH in health systems management from the Tulane University School of Public Health and Tropical Medicine, an MD from Morehouse School of Medicine, and an MBA from Rice University's Jesse H. Jones Graduate School of Business.

Scott Sarran, MD, MBA, is the founding chief medical officer of Harmonic Health, a start-up company focused solely on revolutionizing the dementia care journey for patients, caregivers, and providers. Dr. Sarran is also the principal at Triple Aim Geriatrics, where he provides consultative services to managed care entities (payers and providers) to improve systems of care and outcomes for Medicare and dually eligible beneficiaries. His leadership experiences include chief medical officer roles across the payer sector—both large (Blue Cross Blue Shield IL, Health Care Service

Corporation) and small (MoreCare IL, Fidelis Senior Care)—and provider sectors (Advocate Health Care, University of Chicago, Cook County Health). In all these roles, his focus has been the intersection of improving care for high-risk patients while enabling win-win payer-provider partnerships.

Gina Upchurch, RPh, MPH, is the founder and executive director of Senior PharmAssist, a nonprofit organization that helps older adults obtain and manage medication and provides Medicare benefits counseling and tailored community referrals in Durham, NC. Ms. Upchurch is a registered pharmacist and has participated in various committees at the state and national levels, such as the American Geriatrics Society Public Policy Committee and several working groups for the North Carolina Institute of Medicine. She received her bachelor of science degree in pharmacy and her master of public health degree from the University of North Carolina at Chapel Hill, where she also completed her residency in geriatric pharmacy practice and still holds adjunct positions. In 2001, she was named a Robert Wood Johnson Community Health Leader for her patient advocacy and health literacy efforts. Ms. Upchurch began her career as a science teacher with the U.S. Peace Corps in Botswana.

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