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MedPAC Holds December 2024 Meeting

On December 12 and 13, 2024, the Medicare Payment Advisory Commission (MedPAC) held a virtual public meeting. By law, the Commission reviews Medicare's fee-for-service payment policies each year and makes payment update recommendations. The meeting included sessions on MedPAC's assessment of payment adequacy and draft recommendations for updating payments for the following:

- Physician and other health professional services;
- Hospital inpatient and outpatient services; and mandated report on rural emergency hospitals;
- Skilled nursing facility services;
- Inpatient rehabilitation facility services;
- Home health care services;
- Hospice services; and
- Outpatient dialysis services.

The full agenda for the meeting and the presentations for the sessions are available here.

MEDPAC RECOMMENDS PHYSICIAN PAYMENTS BE UPDATED TO HELP ALIGN PAYMENTS WITH INFLATION

In this session, the Commission focused on assessing payment adequacy and updating payments for physician and other health professional services. The main objective is maintaining beneficiary access to quality care without placing unnecessary financial burdens on beneficiaries and taxpayers. A primary concern is the disparities in healthcare access, particularly for low-income beneficiaries. The Commission has proposed recommendations to balance the need for sustainable healthcare funding with ensuring equitable access. Overall, MedPAC found generally positive access to care, uncertain quality of care metrics, and mixed financial outcomes, suggesting a complex but somewhat stable healthcare ecosystem with ongoing challenges and opportunities for improvement

In 2023, the Medicare Physician Fee Schedule (PFS) demonstrated significant utilization and spending across the healthcare landscape. The system encompassed 1.4 million clinicians who conducted 666 million patient encounters, serving 28.2 million patients and generating $92.4 billion in Medicare and Fee-For-Service (FFS) beneficiary payments. Recent policy adjustments have created notable shifts in payment structures. CMS implemented payment rate increases in 2021 that required a 6.8% budget-neutrality adjustment, and Congress subsequently authorized temporary payment increases from 2021 to 2024. These temporary increases led to a unique scenario where the conversion factor (CF) has declined while payment rates have increased through the use of add-on codes. To determine its impact on payment adequacy, the Commission looks at multiple measures including beneficiaries' access to care, quality of care, and clinicians' revenues and costs.

For 2024, Medicare beneficiaries' access to clinician care was nuanced with generally positive indicators. Overall, Medicare beneficiaries experience care access that is comparable to, and even better than, privately insured individuals, with 89% of clinicians accepting new Medicare patients and wait times averaging 1-2 weeks for primary care and fewer than 6 weeks for specialists. However, a critical disparity emerges for low-income beneficiaries, who report worse access to care, primarily due to limited revenue through state Medicaid programs. The clinician landscape shows modest growth, though a slight decrease in primary care encounters was a point of concern for the Commission.

The Commission's assessment of quality measurement presented a complex landscape, citing challenges in ability to assess quality within the current system. MIPS creates an extensive but difficult-to-compare evaluation framework with over 200 pick and choose measures; to add, many clinicians remain exempt from these measures – making comparison of quality difficult. MedPAC focuses on two primary quality indicators: Ambulatory Care-Sensitive Hospitalizations and Emergency Department Visits and Patient Experience Scores. Ambulatory Care-Sensitive Hospitalizations and Emergency Department Visits showed declining rates in 2023; however, this decline is underscored by a large geographic variation in rates, indicating potential areas of improvement. The FFS Medicare patient ratings remain stable, with overall healthcare experience scoring 83 out of 100 and healthcare quality at 85 out of 100, highlighting consistent patient satisfaction, despite the complexities of measuring care quality.

Clinician payments and revenues experienced growth in 2023, with aggregate payments per FFS beneficiary increasing across most service types. Private PPO payment rates remained significantly higher than Medicare rates, reaching 140% of FFS Medicare rates in 2023, up from 136% in 2022. Despite lower Medicare reimbursement, clinicians continue to accept these rates due to factors like available capacity, patient treatment desire, and prompt payment.

Compensation also saw steady growth, with physicians earning a median of $352,000 and advanced practice providers earning $138,000 in 2023. The Medicare Economic Index (MEI) indicates that clinician input costs, which accelerated in recent years, are now starting to moderate. The Commission's projections suggest MEI growth of 3.3% in 2024, 2.8% in 2025, and declining to 2.3% by 2026 – reflecting a potentially stabilizing economic environment for providers.

Draft Recommendation and Commission Discussion

The Chair's Draft Recommendation aims to balance maintaining beneficiary access to quality care while preventing unnecessarily high payment rates that could create burdens for beneficiaries. The proposal has two key strategies: first, adjusting the Medicare base payment rate for physicians and health professionals in 2026 by using the MEI minus one percentage point, which would effectively increase base payment rates by approximately 1.3%; second, implementing safety-net add-on payments for services delivered to low-income Medicare beneficiaries. These add-on payments would provide a 15% increase for primary care clinicians and a 5% increase for other clinicians, specifically targeting improved access for low-income beneficiaries without increasing their cost-sharing or requiring offsetting payment cuts elsewhere. The combined approach is projected to result in a total payment increase of 1.7%, with primary care clinicians seeing a 4.4% increase and other clinicians a 1.2% increase.

The Commission discussion began by examining whether Medicare Advantage and FFS are adequately reflected in quality care measures. While separating MA and FFS is challenging in general reporting, NCBS survey data allows for distinctions that could provide clarity. The commissioners emphasized that disaggregation should be a priority for future work. They also raised questions about comparing MA and FFS to private insurance, particularly PPO versus HMO plans, noting the variability involved. Additional concerns included whether low-income individuals are at higher risk of living in ambulatory care deserts, the need for age group comparisons between privately insured and Medicare beneficiaries, and the financial impact of new add-on codes. Secondary versus primary coverage differences also raised concern as they could affect access to care; although, the MedPAC survey lacks this information while NCBS survey may provide additional insight. The discussion also touched on Medicaid expansion and its financial adjustments, suggesting a need to clarify whether they should flow to hospitals, individual providers, or both.

The Commission strongly supported a 1 percentage point increase in the Medicare Economic Index (MEI) for the next few years to help align payments with inflation and address financial pressures as provider consolidation trends continue. The group noted that providers are consolidating into larger groups due to factors like electronic medical record (EMR) demands and care coordination needs. They expressed strong support for

the Medicare safety net add-on to address challenges faced by low-income populations and improve primary care access, especially given concerns about fewer medical students entering primary care fields. Additionally, they highlighted the importance of modernizing the FFS Medicare system and positioning CMS as a stronger regulator of public funds in the private market. While the MEI recommendation was supported, it was acknowledged as more controversial and will only extend through 2026, with the possibility of future discussions on its extension.

MEDPAC RECOMMENDS PAYMENT INCREASE FOR INPATIENT AND OUTPATIENT HOSPITALS

In this session, the Commission focused on assessing payment adequacy and exploring updates for hospital inpatient and outpatient services. The Commission also looked to address the financial challenges faced by rural and safety-net hospitals. This component included a review of the mandated report on rural emergency hospitals and potential implementation of strategies to better support vulnerable beneficiaries. Ultimately, the Commission made recommendations to ensure continued access, value, and equity to beneficiaries, while ensuring that hospitals have the fiscal ability and support necessary to sustain themselves and enhance these objectives. The Commission assessed beneficiary assess to care, quality of care, access to capital, and FFS Medicare payments and costs to make its recommendations.

In 2023, hospital use and spending under fee-for-service (FFS) Medicare reflected significant utilization and financial demands. Medicare's Inpatient Prospective Payment System (IPPS) covered 3,145 hospitals, serving approximately 4.2 million beneficiaries with 6.6 million inpatient stays. Meanwhile, the Outpatient Prospective Payment System (OPPS) included 3,110 hospitals and served 15.9 million beneficiaries via 123.8 million outpatient services. Total payments for services were substantial; IPPS accounting for $102.6 billion and OPPS for $49.6 billion. Additional payments included $6.7 billion for uncompensated care under IPPS and $20.4 billion for separately payable items under OPPS. These figures highlight the continued financial pressures on hospitals, driven by the high volume of services and the need to address uncompensated care.

Beneficiaries access to care remained positive; specifically, the Commission evaluated hospital capacity and supply, volume of FFS Medicare Inpatient and hospital outpatient service and FFS Medicare marginal profit. Hospital capacity remained stable in 2023 as hospitals maintained capacity to meet beneficiary needs. Employment in hospitals increased by 3%, totaling 4.7 million employees, while inpatient capacity grew slightly by 1%, adding 674,000 inpatient beds. The aggregate occupancy rate for inpatient beds remained steady at 69%, and available emergency department capacity was sufficient, with only 2% of patients leaving the ED without being seen – an unchanged rate from

2022. The supply of hospitals generally remained steady in 2023, with approximately 10 more hospitals closing than opening, primarily due to low patient volume, leading to a -0.2% closure rate. Additionally, around 15 hospitals converted to rural emergency hospitals during the same period. FFS Medicare utilization saw increases, with inpatient stays for Medicare FFS beneficiaries rising by 1.5% and outpatient services increasing by 2.4% per capita. Hospitals continued to experience financial incentives to serve FFS Medicare beneficiaries in 2023, as Medicare payments were greater than their variable costs. FFS Medicare payments covered 85% of the costs of providing services, while the variable costs of those services were estimated to be between 75% and 85%. These dynamics created a positive marginal profit, incentivizing hospitals to continue serving Medicare beneficiaries.

The quality of hospital care showed mixed performance across indicators in 2023. The FFS Medicare mortality rate slight improved, with the risk-adjusted mortality rate at 7.6%. Conversely, the FFS readmission rate showed mixed trends, standing at 15% risk-adjusted readmissions. Additionally, patient experience measures were mixed but generally positive, with most indicators showing improvement relative to 2022. Notably, almost all patient experience measures were at least 1 percentage point higher compared to 2019 levels, reflecting ongoing efforts to improve care in hospitals.

Hospital access to capital was generally positive in 2023, as hospitals demonstrated financial improvements despite ongoing challenges. The all-payer operating margin increased by 2.4 percentage points, driven by growth in operating revenues, although there was variation across hospital types and regions. Operating margins varied by hospital type. All-payer total margins also improved, rising to 6.4% in 2023, primarily due to investment income. Borrowing costs increased, though this rise was lower than expected market trends. Financial statements indicate a continuing trend of improvement.

Hospital FFS Medicare payments and costs showed continued financial strain in 2023. Hospitals' aggregate FFS Medicare margin remained low in 2023, reflecting ongoing financial pressures. The stable FFS Medicare margin indicated offsetting financial challenges from 2022 to 2023 when excluding relief funds. The financial performance varied across different hospital types and geographic settings. Projections indicate that the overall FFS Medicare margin will likely remain similar through 2025, with the aggregate margin projected at -13.0% and relatively efficient hospitals maintaining a median margin of -2%. These findings highlight the need to identify opportunities for hospitals to address the ongoing financial strain from Medicare payment challenges.

Draft Recommendation, Mandated Report on Rural Emergency Hospitals, and Commission Discussion

The Chair's draft recommendation proposes that Congress take two key actions. First, for fiscal year 2026, the recommendation suggests updating the 2025 Medicare base payment rates by the amount specified in current law plus an additional 1%. Second, it proposes redistributing existing disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index (MSNI), as detailed in the March 2023 report, while adding $4 billion to the MSNI pool.

The primary goals of this recommendation are to ensure beneficiaries maintain access to care, sustain hospital payments close to the costs of high-quality, efficient care, and apply fiscal pressure on hospitals to manage costs effectively. Additionally, by directing a portion of these increases toward safety-net hospitals—those treating higher shares of low-income Medicare patients—the recommendation aims to limit the need for large, across-the-board payment rate increases. The Commission believes that the MSNI is a refined tool that identifies hospitals most in need of financial support by considering factors like the low-income share of beneficiaries, uncompensated care costs, and Medicare's share of all-payer volume. Hospitals with higher MSNI scores often face greater financial strain and lower all-payer operating margins. Recommended since 2023, the MSNI offers a more accurate way to predict financial risk and hospital closures, ensuring resources are targeted to hospitals serving vulnerable populations while supporting financial stability and quality care.

The Commission also provided a mandated report on Rural Emergency Hospitals (REHs). MedPAC first recommended the creation of outpatient-only hospitals in 2018 to address declining inpatient volumes at some rural hospitals to ensure access to emergency care in rural communities. The *Consolidated Appropriations Act (CAA), 2021* established the REH designation to support these needs. REHs are required to maintain a 24/7 staffed emergency department and offer hospital observation care services but cannot sustain acute inpatient beds or swing beds. They may also provide distinct-part skilled nursing facility services and other outpatient care. Starting in 2025, REHs will receive fixed monthly payments of $286,000 ($3.4 million annually) to support fixed costs, with FFS Medicare outpatient payments covering marginal costs. Additionally, REHs will receive 105% of OPPS rates for OPPS services and standard rates for other services such as laboratory tests.

The CAA also mandated that MedPAC annually report on payments to REHs. In the March 2023 report, MedPAC analyzed 2023 calendar data, finding that 21 hospitals converted to REH status. FFS Medicare outpatient payments totaled about $10 million, while fixed payments amounted to roughly $30 million, highlighting the impact of the REH program to support rural healthcare access.

Round 1 of the Commissioner's Discussion emphasized the need to examine urban versus rural hospital closures more closely, highlighting an important distinction. There

were questions about whether patient safety measures should be included in the analysis, suggesting to consider their addition. Participants inquired about consolidation trends, and while some data is available, a precise definition of a "merger" has not been established. There was skepticism about market efficiency, particularly given that only 6% of the market is considered efficient—a figure many found troubling, especially given the COVID-19 impact in recent years. Another point of concern was the implementation of the MSNI. Participants expressed confusion about why MSNI has yet to be adopted despite prior recommendations. There was clarification that the proposed law update involves a 2% increase, with a recommendation to move to about a total of 4.2%, though this would need to be specified. Participants also raised questions about correlations between performance scores, bed numbers, and diseconomies of scale as a contributing factor. Compliance costs and regulatory burdens were also noted as gaps in data—citing these costs could be driving Medicare cost inefficiencies, yet they are unquantified. Finally, questions were raised about the effects of redistribution proposals on specific hospitals and whether definitive analysis could better define fixed costs, particularly given disagreements on rural provider claims of 75% versus the Commission's percentage of 20%. An appendix was suggested to provide additional analysis.

The second round of discussion focused on feedback regarding the Chair's recommendation. Many participants expressed support for the recommendation, particularly the MSNI component. There was a suggestion to separate payer margins from DSH margins to better assess financial performance and address inequities. Patient experience measures were discussed, however, opinions of commissioners were mixed opinions. While data showed minimal change, others highlighted concerns that many measures are poor indicators of patient quality and administrative burdensome. Medication performance measures were noted as an area of particular concern, having worsened over time. The discussion shifted to addressing systemic issues like readmissions and penalties, with participants arguing that penalties haven't been sufficient to mitigate risk or improve outcomes. Many participants opposed combined OPPS and IPPS service updates, stating these failed to align with reality and ignored site neutrality concerns. Some participants argued that IPPS rates may be too low while OPPS rates may be too high, suggesting a need for separate updates. Opinions on the overall recommendation were varied, reflecting broader uncertainty about its effectiveness and adaptability. Many participants called for more dynamic approaches to address these systemic challenges while improving clarity and outcomes.

MEDPAC ANALYZES STAFFING REQUIREMENTS, RECOMMENDS LOWER SNF PAYMENT RATE

MedPAC staff presented data on skilled nursing facility (SNF) quality of care, accessibility, and profitability, before moving on to analyze data relating to the incoming staffing requirements. Occupancy rates, with a median of 84%, and likely higher in urban areas, reflect a strong demand for skilled nursing facilities, the supply for which the recent staffing requirements could jeopardize. Quality metrics such as discharge to community and preventable readmissions rates remained stable. The nursing staff turnover rate remains high at 53%. Margins for SNFs were high at 21.9% overall; however, that figure is mainly driven by high volume, for-profit SNFs. Nonprofit SNFs had safe margins at 7.3%.

The new staffing requirements are set to begin in mid-2026 to 2027, with two stages. First, the 24/7 on-site requirements and total hours per registered day (HPRD) requirements will go into effect in May 2026. Second, the specifics HPRD requirements for registered nurses (RNs) and nurse aides (NAs) will go into effect in 2027. MedPAC has not taken an official position on the requirements. Of nonexempt urban facilities, about half currently meet the two major requirements which will become active in May 2026; facilities with less volume are less likely to meet the requirements. Only about one quarter of nonexempt facilities meet all the requirements, including the specific Nurse Aid and Registered Nurse hours per registered day minimums.

Draft Recommendation and Commission Discussion

The Chair recommends that Congress should reduce the Medicare base payment rates for skilled nursing facilities by 3%, given the current high average profit margin. The recommendation found broad support among commissioners. The commissioners were very critical of the staffing requirements, drawing attention to the low proportion of SNFs that currently meet all requirements. They note that the current occupancy rates are high, and that the high turnover rate in SNFs presents a particular challenge in terms of how management handles staffing. Some commissioners stated that Medicare & Medicaid are subsidizing Medicare Advantage, which one commissioner strongly condemned as a perverse situation. More commissioners expressed concern at what seems to be private equity profiteering off of SNFs and the funds they receive from CMS.

MEDPAC RECOMMENDS REDUCTION IN INPATIENT REHABILITATION FACILITY PAYMENTS

In this session, MedPAC addressed inpatient rehabilitation facilities (IRFs), assessing the payment systems, performance, and draft recommendations for future Medicare fee-for-service (FFS) payment updates. IRFs provide rehabilitative care for conditions

requiring physical, occupational, and speech therapy. In 2023, around 1,200 IRFs served 358,000 Medicare FFS beneficiaries across 404,000 stays. Payments totaled around $9.6 billion. 69% of IRFs were hospital-based, while freestanding IRFs showed robust financial performance, making up 31% of IRFs.

MedPAC staff presented IRF payment adequacy through four indicators: access to care, quality of care, access to capital, and payment-cost relationships. The staff found sufficient access, with a 2% increase in IRF numbers and a 7% rise in stays in 2023, on par with pre-pandemic levels. Occupancy rates stayed stable at 69%. Financial incentives for Medicare patients were strong, with hospital-based IRFs reporting an 18% marginal profit and freestanding IRFs 40%.

Quality measures, including risk-adjusted discharge to the community and preventable readmissions, also stayed stable, though MedPAC staff mentioned gaps in functional and patient experience data. Regarding access to capital, hospital-based IRFs benefitted from parent institution resources, while freestanding IRFs demonstrated strong financial health, expanding beds and facilities. The all-payer margin for freestanding IRFs rose to 10% in 2023, which shows positive market conditions.

Financial data showed a stable Medicare margin of 14.8% in 2023, which should rise to 16% by 2025 with higher payment growth than costs. Freestanding IRFs maintained significantly higher margins (24%) compared to hospital-based IRFs (1%), prompting discussions on potential disparities in cost allocation and operational efficiency.

Draft Recommendation and Commission Discussion

The chair's draft recommendation for fiscal year 2026 proposed a 7% reduction in Medicare base payment rates for IRFs. This would decrease Medicare spending without adversely affecting patient access but could increase financial pressures on providers, particularly hospital-based IRFs. The panel debated the differences between freestanding and hospital-based IRFs, emphasizing the need for further analysis on cost allocation, staffing, and patient demographics to refine policy recommendations. Even though IRFs have been performing well, the commissioners cautioned work needed to be done to tackle disparities and optimize the efficiency of Medicare payments.

The discussion among the commissioners centered around recommendations and observations about IRFs compared to skilled nursing facilities (SNFs). Many commissioners support the chair's recommendations to monitors IRF trends, address disparities between freestanding and hospital-based facilities, and fixing certain methodologies and policies. Commissioners were concerned about the rapid growth of freestanding IRFs, particularly driven by a single company, and the potential

overpayment for IRF care. This raises questions about whether these facilities are serving patients with genuine need or expanding into less critical cases.

Some commissioners suggested analyzing the changing distribution of diagnoses in IRFs, examining payer mix, staffing levels, and research on outcomes between IRFs and SNFs. Commissioners emphasized that IRFs address crucial functional needs for patients with conditions like strokes or spinal injuries, which speed up rehabilitation significantly. Expanding qualifying conditions for IRF admissions could improve access while addressing profitability concerns.

Commissioners also raised some methodological concerns, such as differences in variable and fixed cost accounting for IRFs versus hospitals. There was consensus on the need for more in-depth data collection on case mix, patient outcomes, and market dynamics. Other questions include whether IRFs' growth reflects true demand or profit-driven market shifts and whether their expansion benefits Medicare beneficiaries by improving independence and quality of life.

While there is strong support for the recommendations, the Commission would like to see continued monitoring and research to ensure policy decisions are fair and reasonable.

MEDPAC RECOMMENDS A 7% PAYMENT DECREASE FOR HOME HEALTH SERVICES

MedPAC staff presented an assessment of beneficiaries' access to care, quality of care, access to capital, and Medicare payments and costs, and then provided a draft recommendation.

Home health access remained adequate in 2023. The number of agencies increased in 2023, but if Los Angeles County, CA was excluded, home health agencies decreased by 2.8%. Additionally, the rate of home health use after inpatient hospital stay remained above pre-pandemic levels in 2023. The quality of home health care was found to be stable in 2023, and the share of patients discharged to the community increased slightly in 2023. Staff discussed that health care is less capital intensive than other sectors and the all-payer margin was 8.2% in 2023. For payments and costs, the FFS Medicare margin in 2023 was 20.2% and is projected to remain high in 2025.

Draft Recommendation and Commission Discussion

Finally, MedPAC presented their recommendation to Congress for the calendar year 2026. Congress should reduce 2025 Medicare base payment rates for home health care

services by 7 percent. Spending would decrease relative to current law, but according to the MedPAC chair, there would be no adverse effect on access to care.

Most, if not all, of the commissioners were supportive of the MedPAC chair's recommendation for the payment decrease. However, there were some suggestions and concerns with how certain measures were examined.

Many commissioners wanted a further breakdown of how accessible home health is in rural areas since there was a 10% decrease of the use of home health in 2023 for rural areas. They would like to separate, if possible, micropolitan areas from the rest of rural areas because there might be more use or access to home health in micropolitan areas. Additionally, commissioners wanted to keep working on why there are widely reported disparities in rural home health, but less severe disparities reflected in the data. Other suggestions or places that the Commission wanted to examine further included the differences between nonprofit and for-profit home health agencies. Commissioners wanted to understand why nonprofit home health agencies tend to perform better.

Separate from the home health update recommendation, the Commission also discussed why Congress does not take the Commission's recommendations, and whether the Commission should be rating itself on how well they are doing in influencing policies. There was large disagreement of whether there should be "score cards" that MedPAC should use to grade themselves and figure out what they can be doing differently to make a bigger impact. However, other Commissioners noted that it is their job to provide recommendations, but not to decide the payment decrease amounts, so a scorecard is not necessary.

MEDPAC RECOMMENDS ELIMINATING HOSPICE PAYMENT INCREASE

MedPAC staff presented an assessment of beneficiaries' access to care, quality of care, access to capital, and Medicare payments and costs, and then provided a draft recommendation. The supply of hospices increased by about 10%, most of which was the entry of new for-profit hospices. Utilization of hospices increased, and indicators of access to hospices trended upward. Hospice profit margins decreased from the prior year but remain profitable at 9.8% profit margin; however, this profitability is concentrated in the for-profit and freestanding hospices. Nonprofit hospices nearly break even, averaging 0.3% profit margin, and hospital-based hospices have a significant negative margin of -23.5%.

Draft Recommendation and Commission Discussion

The Chair's draft recommendation was to eliminate the update to the 2025 Medicare base payment rates for hospice, which would be a relative decrease in spending.

MedPAC made a similar recommendation last year which was not followed by Congress. Should Congress follow their recommendation, non-profit hospitals could go negative or potentially decrease their quality of care, whereas hospital-based hospices would become a deeper sink for hospitals.

Commissioners voted in favor of the Chair's recommendation, but they expressed concern over the large increase of private, for-profit entities into hospice care. One commissioner brought up consistent problems in quality of care and suggested more strict enforcement of quality measures, a comment which others echoed. Chair Michael Chernew stated that it is difficult to gauge quality.

MEDPAC RECOMMENDS OUTPATIENT DIALYSIS PAYMENT BE UPDATED BY CURRENT LAW FOR 2026

Outpatient dialysis services help treat patients with end-stage renal disease (ESRD). Medicare uses a bundled payment system which covers treatments, drugs, and certain services. In 2023, around 262,000 fee-for-service (FFS) beneficiaries had to use dialysis, costing Medicare $8.1 billion. However, Medicare Advantage (MA) enrollment among dialysis beneficiaries has increased since the 21st Century Cures Act allowed unrestricted ESRD enrollments in MA plans. Near the end of 2023, 52% of dialysis beneficiaries were enrolled in MA, up from 27% in 2020.

MedPAC staff presented an assessment of beneficiaries' access to care, quality of care, access to capital, and Medicare payments and costs, and then provided a draft recommendation. From 2022 and 2023, capacities at dialysis treatment facilities stayed stable, even though there were declining ESRD incidence rates, increased home dialysis use, and excess mortality during the COVID-19 pandemic. Marginal profit for FFS dialysis providers was 17%, showing the financial benefit of serving beneficiaries. Staff also reported stable use of erythropoietin-stimulating agents (ESAs) and shifts toward alternative products, likely from competition and costs. CMS monitoring also found no negative effects on beneficiary health outcomes due to changes in drug use.

Quality factors of outpatient dialysis care such as dialysis adequacy, anemia management, hospitalizations, and emergency visit rates, which were all stable in 2023. Staff praised home dialysis use for its link to a better quality of life and its increase in usage, especially as the number of kidney transplants continue to rise. Finances are of some concern with smaller dialysis facilities reporting higher costs per treatment. In 2023, the increase of the FFS Medicare margin to -0.2% from -1.1% is linked to moderate cost growth. The 2025 Medicare margin is projected to get to 0%.

Draft Recommendation and Commission Discussion

The draft recommendation proposes that Congress update the 2025 ESRD prospective payment system (PPS) base rate by the amount determined under current law. Based on current estimates, this would increase the base payment by 1.7%. There should be no effect on spending relative to current law and no adverse effect on access to care.

Commissioners focused on how MA plans, dialysis services, and care access would be affected by regulatory changes. One commissioner emphasized how changes in MA rules, particularly concerning plan switching, impact patients and the healthcare system. A new CMS regulation will limit MA plan switching to reduce disruptions in patient care, such as changes to vendor contracts and prior authorizations. Commissioners also noted insufficient outreach regarding rights to Medigap policies for patients with end-stage renal disease (ESRD).

Regarding pricing and regulatory standards for ESRD-related drugs and devices, commissioners mentioned discrepancies in CMS's criteria for covering devices versus drugs, which the commissioners thought needed clarification. Some concerns about vertical integration in the healthcare industry were raised, particularly the potential conflicts of interest as large dialysis organizations also develop related drugs and technologies. Commissioners brought up scenarios where healthcare providers own ancillary service facilities, emphasizing a need for oversight.

Several commissioners spoke on the importance of access to dialysis services, especially emphasizing the how CMS can better care for beneficiaries in various geographic and urban-rural contexts. They noted challenges such as transportation to dialysis centers and capacity concerns need further thought and analysis. Additionally, the commissioners stressed the need for more beneficiary education, particularly for those transitioning to MA plans, as affordability often drives this shift.

There was general support for the current law recommendation, but commissioners acknowledged issues that need to be fixed in the future, particularly concerning MA plan dynamics, access measurement, and the duopoly's impact. Some payment policy concerns were raised about the adequacy of the proposed 1.7% payment update with staff noting the projected Medicare margins will be near zero. Commission discussion also touched on end-of-life care practices and potential overuse of dialysis in "non-palliative" contexts, which has ethical concerns. Additionally, the role of living donor support and transplant policies was briefly discussed as a potential area for future policy exploration.

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