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MedPAC Holds January 2025 Meeting

On January 16 and 17, 2025, the Medicare Payment Advisory Commission (MedPAC) held a virtual public meeting. The sessions in this meeting focused on chapters that will be included in MedPAC's March 2025 Report to Congress, which will be released by March 15, 2025. Sessions include:

- Assessing payment adequacy and updating payments: Physician and other health professional services;
- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services;
- Assessing payment adequacy and updating payments: Skilled nursing facility services; home health agency services; inpatient rehabilitation facility services; outpatient dialysis services; and hospice services;
- Eliminating Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities;
- Medicare prescription drug program (Part D): Status report;
- Ambulatory surgical center services: Status report;
- The Medicare Advantage program: Status report; and
- Reducing beneficiary cost-sharing for outpatient services at critical access hospitals.

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

MEDPAC ASSESSES AND VOTES ON PAYMENT ADEQUACY AND UPDATES FOR PHYSICIANS AND OTHER PROFESSIONAL HEALTH SERVICES

By law, the Commission reviews Medicare's fee-for-service (FFS) payment policies each year and makes payment update recommendations. In this session, the Commission reviewed its assessment of payment adequacy and updates for physician and other

health professional services. The Commission then voted on recommendations that were initially proposed during the December 2024 meeting.

The MedPAC meeting reviewed key aspects of the Physician Fee Schedule (PFS), highlighting trends in use and spending. With 1.4 million clinicians, 666 million encounters, and 28.2 million patients, total payments from Medicare and FFS beneficiaries amounted to $92.4 billion. Recent increases in payment rates for office visits have led to necessary adjustments, including decreases to the overall conversion factor to offset the additional costs.

The Commission's assessment of the adequacy of payment rates for clinician services is based on key measures: Beneficiaries' Access to Care, Quality of Care, and Clinician Revenues and Costs. These measures provide insights into the accessibility of care for Medicare beneficiaries, the effectiveness of data collection, and the sustainability of clinician practices under current payment.

Medicare beneficiaries generally have good access to clinician care. A 2024 survey found that beneficiaries aged 65 and older reported access comparable to, or in many cases better than, privately insured individuals aged 50-64. A similar proportion of clinicians accept Medicare and private insurance, and the total number of clinicians is rising, though the mix of clinician types is evolving. Additionally, the number of clinicians encounters per FFS beneficiary increased by 4.3 percent in 2023, indicating broadened access to care.

Assessing the quality of clinician care is challenging due to significant geographic variation in rates of ambulatory care-sensitive hospitalizations and emergency department visits. While patient experience scores remain relatively stable, these variations complicate a clear evaluation of care quality.

Clinicians' revenues and costs showed mixed trends in 2023. Spending per Medicare FFS beneficiary increased by 4.2 percent, while the ratio of private insurance payment rates to Medicare rates rose slightly to 140 percent. Median compensation grew by 3 percent for physicians and 6 percent for advanced practice providers. Additionally, while the Medicare Economic Index (MEI) peaked at 4.4 percent growth in 2022, it is expected to slow to 2.3 percent by 2026.

The draft recommendation aims to balance maintaining beneficiary access to quality care while avoiding excessive payment that burden taxpayers and beneficiaries. It considers current positive access indicators, rising input costs, and challenges faced by low-income beneficiaries. The recommendation proposes a two-part strategy: (1) replacing current-law updates with a single increase tied to the MEI minus one percentage point, resulting in a 1.3 percent increase; and (2) enacting a safety-net add-

on payment policy for services delivered to low-income beneficiaries. This would boost average clinician fee schedule payments by 3 percent, with primary care clinicians seeing a 5.7 percent increase and other clinicians a 2.5 percent increase. They also recommend establishing 15 percent add-ons for primary care and 5 percent for other clinicians serving low-income Medicare beneficiaries. The proposed changes could increase Medicare spending by $2 billion to $5 billion in one year, and $10 billion to $25 billion over five years, while improving access to care for low-income beneficiaries and supporting clinicians' ability to treat them.

During the Commission's discussion, there was a focus on clarifying the wording of the recommendation, particularly around resetting the payment baseline and the need to track payment impacts by specialties, with an emphasis on geriatricians. There was strong support for the safety-net add-on payment. The Commission acknowledged feedback from the American Medical Association (AMA) and RVS Update Committee (RUC), suggesting the possibility of attending a future RUC meeting. Some members expressed concerns about using physician compensation as the sole measure of payment adequacy, suggesting it may not fully capture the broader factors like benefits and total compensation. The recommendation was seen as a reasonable compromise, with recognition that it could help support the shift toward value-based care and outcomes-based approaches. Despite concerns about rising physician compensation amidst inflation, commissioners unanimously approved the recommendation.

MEDPAC ASSESSES AND VOTES ON PAYMENT ADEQUACY AND UPDATES FOR INPATIENT AND OUTPATIENT HOSPITAL SERVICES

By law, the Commission reviews Medicare's fee-for-service payment policies each year and makes payment update recommendations. The Commission reviewed its assessment of hospital inpatient and outpatient services under Medicare. The Commission then voted on recommendations that were initially proposed during the December 2024 meeting.

The Commission highlighted key aspects of hospital use and spending under FFS in 2023. Inpatient services under the Inpatient Prospective Payment System (IPPS) involved 3,145 hospitals, serving 4.2 million people with 6.6 million stays, resulting in payments totaling $102.6 billion. Outpatient services under the Outpatient Prospective Payment System (OPPS) were provided by 3,110 hospitals, reaching 15.9 million people and delivering 123.8 million services, with payments amounting to $49.6 billion. Additionally, there were significant other payments, including $6.7 billion for uncompensated care under IPPS and $20.4 billion for separately payable items under

OPPS. The Commission discussed these trends to assess payment adequacy and consider updates for hospital services under Medicare.

The Commission's review of payment adequacy indicators for hospital care focused on beneficiary access to hospital care, quality of hospital care, hospitals' access to capital, and hospitals' FFS Medicare margin.

Beneficiary access to hospital care was generally stable, with the number of hospitals remaining steady at around 4,500. While slightly more hospitals closed than opened, 15 were converted to rural emergency hospitals. Hospital capacity increased slightly, with employment rising by 3 percent and bed availability growing by 1 percent, maintaining a steady occupancy rate of 69 percent. The number of patients leaving the emergency department without being seen remained steady at 2 percent. Additionally, FFS volume increased, with inpatient stays rising by 1.5 percent and outpatient services by 2.4 percent. Financially, FFS Medicare payments continued to exceed hospitals' variable costs, providing an incentive for hospitals to treat Medicare beneficiaries.

The quality of hospital care in 2023 showed mixed results. The FFS mortality rate improved slightly, with a 7.6 percent risk-adjusted rate, down by 0.3 percentage points. However, the FFS readmission rate worsened, rising by 0.4 percentage points to 15.0 percent. Patient-experience scores showed improvement overall, though many measures remained relatively low despite the positive trends.

Hospitals' access to capital was positive in 2023, with gradual improvement expected. The all-payer operating margin increased from 2.7 percent to 5.1 percent, reflecting stronger financial performance. Hospital bond yields also improved at a slower pace than the general market, and the all-payer total margin rose to 6.4 percent. Preliminary data suggests further gradual improvement, with large hospital systems projecting slight increases in operating margins for 2024, a decrease in relative borrowing costs, and rating agencies expecting continued improvement for nonprofit hospitals in 2025.

Hospitals' FFS Medicare margin remained negative in 2023 between -12.6 percent and -13.0 percent overall. Even relatively efficient hospitals, which consistently performed well on quality while managing costs, experienced negative margins. The median FFS Medicare margin for these hospitals was -1 percent with relief funds and -2 percent without them. The margin is expected to remain low, with projections for 2025 indicating an aggregate margin of -13 percent and a -2 percent margin for the median efficient hospital.

The Commission aims to balance several objectives: ensuring payments are high enough to maintain beneficiary access to care, while keeping them aligned with hospitals' costs to provide high-quality, efficient care for taxpayers. It also emphasizes

maintaining fiscal pressure on hospitals to control costs and limiting the need for large, across-the-board payment increases.

With these in mind, the Commission discussed the June 2023 recommendation, using the Medicare Safety-Net Index (MSNI) to better target funding to hospitals that serve a higher proportion of low-income Medicare patients. The MSNI considers the share of Medicare hospital volume for low-income beneficiaries, the share of uncompensated-care costs relative to all-payer volume, and Medicare's share of total inpatient and outpatient volume. Hospitals with a higher MSNI generally have lower all-payer operating margin; the MSNI has proven to be a better predictor of operating margins than current measures. In 2023, hospitals in the lowest MSNI quartile had an all-payer operating margin of 7.6 percent, while those in the highest quartile had a margin of just 3.7 percent. The Commission's shift toward using the MSNI would help direct additional Medicare funds to hospitals in need of support.

The Commission also discussed expanding the Bipartisan Budget Act (BBA) of 2015's site-neutral payment policy to improve incentives for providing care in the lowest-cost, safe, and appropriate setting. This policy aligns payment rates for certain services across all hospital outpatient departments (HOPDs) and off-campus provider-based departments (PBDs). Expanding the policy to include all OPPS services in off-campus PBDs would have reduced Medicare OPPS payments by $1.3 billion and beneficiary cost-sharing by $0.3 billion in 2023, before budget neutrality.

The Commission then reviewed and discussed earlier draft recommendations, which were voted upon in this January 2025 meeting. The draft recommendation proposes that Congress update the 2025 Medicare base payment rates for general acute care hospitals by the amount specified in current law, plus an additional 1 percent, for 2026. It also suggests redistributing existing disproportionate share hospital (DSH) and uncompensated-care payments through the Medicare Safety-Net Index (MSNI) mechanism, as outlined in the March 2023 report, and adding $4 billion to the MSNI pool. The implications of this recommendation include an increase in spending, with costs rising by $5 billion to $10 billion in the first year and $25 billion to $50 billion over five years, or about 2.2 percent above current law. This would help ensure continued access to care for FFS Medicare beneficiaries, enhancing hospitals' ability to treat beneficiaries, particularly those with low incomes.

The Commission discussed and voted on the draft recommendation, with broad support for the need for disproportionate share payments, although some members raised concerns about the complexity of site-neutral payments, which were clarified as not part of the recommendation. It was noted that FFS payments remain below costs, even for efficient hospitals, underscoring the need for both recommendations. The issue of separately examining OPPS and IPPS was highlighted as significant. One

member did not support the recommendation, citing concerns over its impact on retail pharmacies with 340B and lack of transparency, while some others remained unconvinced about site-neutral payments. Concerns about consolidation in the healthcare sector and limitations in the focus of the recommendation were also discussed. A roll call vote followed, with one member voting no and the rest voting yes, allowing the recommendation to pass.

COMMISSION VOTES ON PAYMENT RECOMMENDATIONS FOR SNF, HOME HEALTH, IRF, OUTPATIENT DIALYSIS, AND HOSPICE

By law, the Commission reviews Medicare FFS payment policies and makes payment update recommendations to Congress. In the December meeting, Commissioners examined information on the program for each setting and discussed the Chair's draft update recommendations. In the January meeting, MedPAC Commissioners briefly reviewed payment adequacy indicators for each service and voted on the draft recommendations. Commissioners covered payment updates for skilled nursing facility services, home health agency services, inpatient rehabilitation services, outpatient dialysis services, and hospice services.

Skilled Nursing Facility (SNF) Services

MedPAC briefly reviewed payment adequacy indicators for these services. Payment adequacy measures show that there was a slight decrease in supply as well as decreased volume, however, quality measures remained stable. The 2023 FFS Medicare margin was 21.9 percent, and the 2023 all-payer margin improved from 2022 to 0.4 percent.

In the December 2024 meeting, the Chair recommended that Congress should reduce the Medicare base payment rates for skilled nursing facilities by 3 percent, given the current high average profit margin. One commissioner noted the ongoing work that is occurring surrounding how payment and quality outcomes are connected in SNFs. Despite the comment, all commissioners voted in support of the recommendation. MedPAC expects that relative to current law, spending would decrease between $2 billion and $5 billion over one year and between $10 billion and $25 billion over five years. Additionally, there are no expected adverse effects on access to care, and providers should continue to be willing and able to treat beneficiaries.

Home Health Care Services

MedPAC briefly reviewed payment adequacy indicators for these services. Beneficiaries have adequate access to care as 98 percent of beneficiaries live in a zip code that has two or more home health agencies (HHAs); however, the total volume has decreased. The beneficiaries' risk adjusted discharge to community rate improved slightly, and

patient experience measures remained high and stable. In 2023, the FFS Medicare margin was 20.2 percent, and the all-payer margin was 8.2 percent.

The Chair recommended that 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. In the January meeting, one commissioner had a concern about home health aide services, as there have been reports that people are not getting aide services because of challenges with going into people's homes for various reasons. There was no follow-up discussion to this comment. Despite the concern, all commissioners voted in favor of the 7 percent reduction.

MedPAC expects that relative to current law, spending would decrease by between $750 million to $2 billion in one year and between $10 billion and $25 billion over five years. There are no expected adverse impacts on access to care as providers should continue to be willing and able to treat beneficiaries.

Inpatient Rehabilitation Facility (IRF) Services

MedPAC reviewed payment adequacy indicators for IRF services. Beneficiaries' access to care is adequate with a stable occupancy rate of 69 percent. For quality of care the discharge to community rate was stable at 67.2 percent and the facility rate of potentially preventable readmissions was 8.8 percent. The 2023 FFS Medicare margin was 14.8 percent, and the all-payer freestanding margin was 10 percent.

The chair's draft recommendation for fiscal year 2026 proposed a 7 percent 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. All commissioners voted in support of the 7 percent reduction in base payment rates for IRFs. MedPAC expects that relative to current law, spending would decrease by between $750 million to $2 billion in one year and between $10 billion and $25 billion over five years. There are no expected adverse impacts on access to care as providers should continue to be willing and able to treat beneficiaries.

Outpatient Dialysis Services

MedPAC reviewed payment adequacy indicators for outpatient dialysis services, and they showed that there was a steady capacity in 2023. The FFS Medicare marginal profit was 17 percent. In 2023, there was an increase in use of home dialysis for FFS beneficiaries, but ED visits, admissions and readmissions remained stable. The all-payer margin for 2023 was 15 percent and the 2023 FFS Medicare margin was negative 0.2 percent.

In the December MedPAC meeting, the Chair recommended 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 percent. There should be no effect on spending relative to current law and no adverse effect on access to care. Based on this information, 15 commissioners voted in favor of the recommendation and two abstained, no one voted against the recommendation.

Hospice Services

MedPAC briefly reviewed the payment adequacy indicators for hospice services. The indicators show an increase in provider supply, length of stay, and share of people using hospice. In 2023 there was an FFS Medicare marginal profit of 14 percent. For quality of care, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores were stable, and the visits at the end of life for 2023 were stable or increased slightly. The 2022 FFS Medicare margin was 9.8 percent.

The Chair recommends that Congress should eliminate the update to the 2025 base payment rates for hospice. Based on the information above, commissioners unanimously voted in favor of the recommendation. MedPAC expects relative to current law that spending would decrease by between $250 million and $750 million over one year and between $1 billion and $5 billion over five years. Additionally, there should be no adverse effect on access to care.

However, there were some concerns discussed. Multiple commissioners expressed that although the payment indicators are positive, there are several other indicators that are concerning. A commissioner suggested that there may be a need for more oversight based on some quality ratings.

MEDPAC SUPPORTS ELIMINATING THE 190-DAY LIFETIME LIMIT FOR FREESTANDING IPF CARE

Medicare imposes a 190-day lifetime limit for care in freestanding Inpatient Psychiatric Facilities (IPFs), as well as limiting the number of IPF days available during the initial benefit period by the number of freestanding IPF days used in the prior 150 days. Congress originally implemented the 190-day limit when Medicare was created in 1965, at a time when state and local governments were the predominant providers of inpatient psychiatric care. However, since then, the mix of IPF providers has drastically changed to favor hospital-based IPFs. As of 2023, only 40 percent of all Medicare-covered IPF days are in freestanding IPFs, and only 4 percent of total Medicare-covered free standing IPF days are in government-run IPFs. Though the population who are affected by this rule has diminished drastically, MedPAC's analysis found that approximately 50,000 Medicare beneficiaries were at or near this limit (defined as within 15 days of the limit) and were identified as highly vulnerable. Beneficiaries dually eligible for Medicaid and with appropriate supplemental Medicare Advantage (MA) benefits may provide additional care past the 190-day limit, however MedPAC's

analysis found that approximately 80 percent of Medicare beneficiaries may lack coverage for additional freestanding IPF days. Despite the shift in the provider landscape, MedPAC staff presented research demonstrating that, in practice, beneficiaries approaching the limit tend to receive less care, by an average of 2.2 days annually. Hospital-based IPF usage increases among these affected beneficiaries, suggesting the 190-day limit imposes additional burden on hospitals who may not be sufficiently equipped to treat severe behavioral health conditions, as well as leaving beneficiaries scrambling if a hospital-based IPF is not available. If the limit were eliminated, MedPAC staff estimated that Medicare fee-for-service spending would increase by approximately $40 million annually; while also touching on the importance of improving care in freestanding IPFs, and transitions from IPFs to the community.

The commissioners expressed unanimous support for eliminating the 190-day limit and 150-day lookback adjustment, primarily on the grounds they are not appropriate for present-day care conditions and to support vulnerable populations. One commissioner acknowledged the existing regulation was established to limit Medicare spending by focusing on acute care but emphasized that they disagreed with this rationale in the modern context and supported removing the limit. Another commissioner asked MedPAC staff if they found any rationale behind why beneficiaries were not selecting Medicare Advantage plans with supplemental coverage if they needed additional IPF days. MedPAC staff have not examined this question and added this is an area for potential further research. Two commissioners followed up on this topic, suggesting these beneficiaries were underrepresented in Medicare Advantage plans given the difficulty they may have in navigating and participating in a complex enrollment process.

MEDPAC REVIEWS STATUS OF MEDICARE PART D, NOTING IMPACT OF INFLATION REDUCTION ACT

In this session, MedPAC continued its discussion on the status of the Medicare Prescription Drug Program (Part D) and its evolving structure and trends, specifically under the Inflation Reduction Act (IRA) of 2022. The Commission previously analyzed challenges within Part D, including high program costs and inequities in beneficiary access to affordable medications. Recent updates highlight the redesigned Part D benefit structure, rising program costs, market stability challenges, and the implications of the Inflation Reduction Act (IRA) on affordability, access, and innovation.

Medicare Part D provides outpatient prescription drug coverage through private plan sponsors who manage standalone prescription drug plans (PDPs)and MA–PDs, supported by subsidies and risk-sharing mechanisms. Recent data indicates that while overall Part D program spending has increased, average premiums have remained

stable due to the Part D Premium Stabilization Demonstration, though significant variations among individual plans persist. In 2025, a redesigned benefit structure, aligned with previous MedPAC suggestions, introduced a $2,000 out-of-pocket cap and shifted more financial responsibility to plan sponsors, aiming to improve affordability. IRA provisions and underlying price and utilization trends have increased Medicare's subsidy, expected benefit costs, and plan bids compared to 2024.

Commissioners discussed various ongoing challenges, including pharmacy closures disproportionately affecting underserved and rural areas, concerns about the stability of the PDP market, and the administrative costs associated with prior authorization processes. Additionally, concerns have been raised about the potential abuse of the 340B program, including its impact on pharmacies and patient access to affordable medications. They further debated the balance between encouraging innovation, managing drug costs, and ensuring equitable access to care.

Looking forward, commissioners expressed interest in closely monitoring the implementation of IRA provisions, addressing vertical integration and its impact on pharmacy costs, and exploring reforms to improve market stability. While acknowledging the complexity of the evolving Part D landscape, commissioners stressed the need for policy adjustments to align incentives, ensure affordability, and support innovation in the prescription drug market.

Chair Commissioner Michael Chernew closed the session by noting that the Commission is reporting on the status of Part D in this chapter, rather than making recommendations, and that the Commission is not yet making recommendations related to the IRA as it is in the early stages of implementation.

MEDPAC REVIEWS RECOMMENDATIONS FOR AMBULATORY SURGICAL CENTER SERVICES

During the January 20205 session, MedPAC staff presented recommendations to address policies for Ambulatory Surgical Centers (ASCs), with a focus on improving transparency, ensuring site-neutral payment, and promoting efficiency while emphasizing equity in access to high-quality care. Over recent years, MedPAC has studied ASC trends highlighting the need for cost reporting, improved quality metrics, and alignment of incentives across care settings.

The session reviewed MedPAC's analysis of Medicare carrier claims and enrollment data, revealing key trends. ASCs were less likely to serve beneficiaries who were dually eligible, disabled, or aged 85 and older, raising concerns about equitable access. MedPAC staff recommended a comprehensive assessment of payment adequacy to ensure all beneficiaries have access to high-quality care. The analysis further highlighted a significant payment misalignment, with ASC payment rates for most

services being 46 percent lower than Outpatient Prospective Payment System (OPPS) payment rates. Commissioners emphasized the importance of implementing site-neutral payment policies to reduce financial incentives that drive inappropriate shifts in care settings.

Another key recommendation was to require ASCs to report cost data to Medicare, addressing the current lack of transparency in estimating fee for service (FFS) Medicare margins. MedPAC staff noted that collecting cost data would enhance Medicare's ability to evaluate ASC payment systems and improve resource allocation. Commissioners broadly supported this recommendation but stressed the importance of minimizing administrative burdens, particularly for standalone ASCs who would require extended deadlines to meet cost reporting requirements.

Commissioners also discussed the ASC Quality Reporting Program (ASCQR), noting its current framework lacks accountability and emphasized the need for expanded quality measures. Additionally, Commissioners raised concerns about regional disparities in access to ASCs, with facilities predominantly located in urban areas, potentially leaving rural and underserved populations at a disadvantage.

MedPAC staff will continue to monitor and discuss these topics going forward.

COMMISSION REVIEWS STATUS OF MEDICARE ADVANTAGE AND DISCUSSES COST VERSUS VALUE, CODING INTENSITY, AND FAVORABLE SELECTION

MedPAC staffers reviewed the status of Medicare Advantage (MA), specifically examining concerns regarding quality, vertical integration, the Quality Bonus Program (QBP), coding intensity, favorable selection, and an estimated comparison to fee-for-service (FFS) spending. MA enrollment has been steadily increasing over the past 14 years, reaching 54 percent of eligible beneficiaries enrolled in Medicare in 2024. Staff began their presentation by stressing their support for the inclusion of private plans in Medicare, highlighting the primary trade-offs of additional supplemental benefits and potential lower out-of-pocket spending for Medicare Advantage plans, in contrast to a broader choice of providers and fewer constraints on utilization in traditional fee-for-service. Next, they presented statistics demonstrating the heavy concentration of enrollment for MA plans at both the national and local levels, that MA organizations are increasingly vertically integrated, and that levels of monthly rebates are at near record highs. MedPAC staff also reiterated their previous (June 2020) recommendations regarding improving the MA QBP, including that it should be replaced by a program that focuses on local markets, uses a smaller number of measures, and distributes plan-

financed rewards. The QBP is currently funded with additional program dollars, unlike FFS quality programs.

The remainder of the presentation by MedPAC staff focused on updates to their analyses of MA coding intensity and favorable selection, culminating in their comparison of MA and FFS spending. MedPAC's analysis found that 2025 MA risk scores are projected to be 16 percent higher than if these beneficiaries were enrolled in FFS Medicare, amounting to an estimated $40 billion impact in 2025. Though coding intensity varies among MA organizations, MedPAC's research found over 85 percent of MA enrollees had higher coding intensity relative to risk adjusted FFS beneficiaries, discussed potential reasons for the difference in coding intensity, cited additional recent governmental analyses that reached similar conclusions, and reviewed previous recommendations to address MA coding intensity. Next, the presentation shifted focus to favorable selection, which is defined as the number of beneficiaries (on average) with lower-than-expected spending that choose MA over FFS. MedPAC staff highlighted relevant MA plan benefits and beneficiary preferences that may affect beneficiary behavior and updates to their methodology. Their analysis found that favorable selection was responsible for 10 percent additional spending relative to FFS spending in 2022, a result that is in line with the academic literature. Finally, MedPAC staff presented an analysis combining the impact of both coding intensity and favorable selection, with a headline statistic that MA payments will be 20 percent above what FFS spending would have been in 2025, or $84 billion dollars.

During discussion, several commissioners questioned details of the coding intensity and favorable selection analysis, and raised additional factors that may affect these results. Regarding coding intensity, a few commissioners highlighted a 2011 CMS report on the demographic estimate of coding intensity (DECI) risk model (which MedPAC used for this analysis), that found it had low predictive ability. Chairman Chernew objected to this assertion, stating that these commissioners were referencing statistics about individual predictive accuracy (which is low), versus population-level predictive accuracy. He added that additional analyses yielded comparable results, in addition to published academic literature. Several commissioners also discussed favorable selection, including research that lower out-of-pocket costs drives beneficiary selection, as well drawing attention to the impact and "value" of supplemental benefits. This question of "value" became a point of discussion between commissioners, with Chairman Chernew stressing the importance of value versus cost in comparing MA and FFS, and that this analysis looked exclusively at expenditures, not value. Commissioners also discussed the heterogeneity of MA plans, and the role of low or $0 premiums affecting selection in favor of MA; including that beneficiaries may elect for MA if they cannot afford applicable FFS supplemental coverage.

Commissioners also discussed the merits of MA versus FFS as a whole; including the financial health of MA plans, the role of prior authorization in MA plans, and how to best spend the United States' healthcare dollars. Several commissioners disagreed on the overall financial state of MA plans, with a few commissioners citing an external report that argued MA plans were losing money in 2024. Commissioners also offered varied thoughts about how to allocate overall healthcare spending, with some commissioners highlighting the innovation and supplemental benefits MA plans provide, while others saw opportunities to modify policies to recoup MedPAC's estimated $84 billion in MA overpayments and redistribute these potential savings. Several commissioners also put a spotlight on prior authorization requirements that frequently come with MA plans, and how these may affect utilization, as well as contribute to provider burnout.

MEDPAC FOCUSES ON REDUCING BENEFICIARY COST SHARING FOR OUTPATIENT SERVICES AT CRITICAL ACCESS HOSPITALS

Based on the January MedPAC meeting, the Commission discussed and recommended reducing beneficiary cost-sharing for outpatient services at critical access hospitals (CAHs). Their proposal aims to ease financial burdens on Medicare beneficiaries in rural areas and improve access to essential care while supporting the sustainability of CAHs.

The Commission began by providing an overview of various rural special payment types for healthcare facilities, including:

- Add-on payments to PPS rates, such as the low-volume hospital add-on and sole community hospitals
- Fixed payment plus PPS rates, like the rural emergency hospital model
- Cost-based payment rates, including:
    - Critical Access Hospitals (CAHs), reimbursed at 101 percent of costs
    - Rural Health Clinics (RHCs), where payments are capped at 80 percent of costs and other payment limits

The Commission then discussed the current payment structure for CAHs. The current coinsurance structure for CAHs requires beneficiaries to pay 20 percent of charges for outpatient services; this significantly increases their out-of-pocket costs. CAH program payments are set at 101 percent of the hospital's costs but are reduced by the beneficiary's coinsurance. Since coinsurance is based on the list price, often much higher than the actual costs or payment rates, this leads to greater cost-sharing for beneficiaries. The markup between charges and costs varies widely among CAHs and across services within hospitals, further complicating the financial burden. In contrast, coinsurance for services at Prospective Payment System (PPS) hospitals is capped at 20

percent of the payment rate, which helps limit beneficiary costs, while coinsurance for services at CAHs are not.

In 2022, Medicare beneficiaries were billed an average of $1,750 in cost-sharing for outpatient services at CAHs; for many, this represented more than half of the total outpatient payment. Concerningly, 6 percent of rural Medicare beneficiaries lack supplemental insurance, leaving them vulnerable to high out-of-pocket costs. In some cases, beneficiaries were charged the full cost of services as coinsurance. This substantial financial gap between CAHs and PPS hospitals (where coinsurance is capped), could push patients to seek care at PPS hospitals to avoid the higher costs at CAHs.

To address this issue, MedPAC proposed a policy option in September to eliminate charge-based coinsurance for CAH services: reducing beneficiary cost-sharing to 20 percent of the payment. Under this, total payment to CAHs would remain the same, but beneficiaries would pay less. This shift would align CAH coinsurance with the structure with PPS hospitals and reduce inequities in cost-sharing. In 2022, if this policy had been in place, beneficiary coinsurance would have been $2.1 billion lower. However, program spending would increase by $3.2 billion, as higher program payments to CAHs would be required, along with higher MA benchmarks and spending.

The Chair's draft recommendation on CAH coinsurance states that Congress should set the coinsurance for outpatient services at 20 percent of the payment amount, aligning it with the structure used by PPS hospitals. Additionally, the recommendation proposes placing a cap on CAH outpatient coinsurance, equal to the inpatient deductible.

The implications include an increase in program spending, compared to current law. However, it would benefit beneficiaries by reducing their cost-sharing liabilities for CAH services, lowering Medigap premiums, and potentially increasing Part B premiums for all beneficiaries. The recommendation would not have a significant impact on CAHs' revenues or willingness to treat Medicare beneficiaries.

The Commission also discussed the current coinsurance structure for Rural Health Clinics (RHCs), which is set at 20 percent of charges. In 2022, RHCs billed Medicare FFS for approximately 9.5 million visits, totaling $1.9 billion in payments. RHCs provide outpatient services in nonurbanized areas designated as Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), or governor-designated shortage areas. Medicare pays RHCs an all-inclusive rate (AIR) per visit, subject to annual payment limits which vary depending on whether an RHC is independent, or provider based.

One issue is that RHCs' charge-based coinsurance can increase beneficiary liability and total payments to RHCs. Medicare pays 80 percent of the AIR; however, beneficiaries are responsible for the remaining 20 percent of the RHC's charges, which can be much higher. This results in varying beneficiary coinsurance rates across different types of RHCs, creating significant disparities in beneficiary costs. This charge-based coinsurance structure increases beneficiary out-of-pocket costs and total payments to RHCs, with coinsurance varying widely depending on RHC ownership.

The committee examined the potential effects of capping beneficiary coinsurance at 20 percent of the AIR, subject to payment limits. In 2022, this change would have substantially reduced beneficiary liability, with reductions of 43 percent at independent RHCs, 49 percent at nonspecific provider-based RHCs, and 8 percent at specified provider-based RHCs. However, the committee also estimated that capping coinsurance would have reduced total FFS payments to RHCs: independent RHCs seeing a 12.9 percent reduction, nonspecific provider-based RHCs a 15.8 percent reduction, and specified provider-based RHCs a 1.4 percent reduction. These reductions are expected to be smaller in the future due to growth in payment limits. By 2028, the effect on total FFS payments to independent RHCs are estimated to be a 7 percent decrease, which is small compared to the projected 120 percent increase in payment limits over the same time.

The Chair's draft recommendation, which was not voted on, proposes that Congress set coinsurance for outpatient services at CAHs at 20 percent of the payment amount for services that require cost-sharing. Additionally, the recommendation suggests placing a cap on CAH outpatient coinsurance, equal to the inpatient deductible. Based on the discussion and feedback received, the Commission may vote on this recommendation in the Spring. An RHC recommendation was not discussed at the meeting.

The first round of discussion focused on the causes of higher coinsurance at CAHs, with a key point being the significant markup on charges, especially when compared to PPS hospitals. Commissioners noted that the markup at CAHs varies depending on the local market, with more urban hospitals typically having lower markups compared to rural ones. A concern was raised about the impact of commercial insurance usage at CAHs, as these rates cannot be "bottomed out." There was a call for clarity about whether certain numbers in the report were based on actual data or hypothetical comparisons, asking for more clarity. Another concern raised was the potential financial impact on Medicare, with commissioners emphasizing that any reduction in beneficiary liability would result in higher Medicare spending. While some commissioners noted that this was a significant ask, others pointed out that reducing beneficiary bad debt could offset some of the financial burden. Overall, there was broad support for the proposal.

In the second round, commissioners expressed strong support for the equitable focus of the recommendation. However, some raised concerns about the potential increase in MA rebates, which could drive up MA spending in rural areas. There was a suggestion to explore limiting rebate plans in these regions to make the system more equitable. Many commissioners emphasized that this was a significant issue of equity and urged that the recommendation be passed. The proposal to cap CAH coinsurance was widely seen as a step toward a better system, and the examples and comparisons provided in the chapter were appreciated. However, some commissioners expressed concerns about inadvertently accelerating consolidation in the CAH sector and potentially pushing hospitals toward closure. They requested additional analysis on this point, though they acknowledged that more time would be needed for this. There was a consensus that addressing the issue of CAH coinsurance was crucial, though commissioners also emphasized that any solution must be carefully implemented. It was clarified that the RHC issue was not being voted on today. When asked whether any commissioners were considering keeping CAH coinsurance based on charges, the response was overwhelmingly "no." The proposal was widely supported by the Commission.

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