CHAPTER 2

Assessing payment adequacy and updating payments in fee-for-service Medicare

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Chapter summary

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. An update is the amount (usually expressed as a percentage change) by which the base payment to all providers in a payment system is changed relative to the prior year. To determine an update recommendation, we assess the adequacy of FFS Medicare payments to providers using the most recently available data, by considering beneficiaries' access to care, the quality of care, providers' access to capital, and how Medicare payments compare with providers' costs. As part of that process, we examine whether FFS payments will support access to high-quality care and the efficient delivery of services, consistent with our statutory mandate. We then make a recommendation about what, if any, update to payments is needed in the policy year in question (for this report, 2026) to efficiently support beneficiaries' access to high-quality services. This year, we consider the adequacy of payments in FFS payment systems for the following sectors: acute care hospitals, physician and other health professional services, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and hospice.

In this chapter

- The Commission's principles for assessing payment adequacy
- Payment-adequacy analytic framework
- Anticipated payment and cost changes in 2025
- Recommendations for FFS Medicare payment in 2026

Our goal is to identify the update to payment for each sector that will ensure both beneficiary access and good stewardship of taxpayer resources. We examine consistent criteria across settings, but because data availability, conditions at baseline, and forthcoming changes between baseline and the policy year may vary, the exact criteria used for each sector, how they are incorporated into our deliberations, and therefore our recommended updates vary. We use the best available data to examine indicators of payment adequacy and update information and estimates from prior years to make sure our recommendations for 2026 accurately reflect current conditions. Because of standard data lags, our assessments for the current year are based on estimates from the most recent complete data we have, generally from two years prior to the current year (for this report, 2023). We use preliminary data from 2024 when available.

In considering updates to FFS payment rates, we may make recommendations that address specific concerns within the payment systems, such as problems that may make treating patients with certain conditions or in certain areas financially undesirable, make certain procedures unusually profitable, or otherwise result in access issues for beneficiaries or inequity among providers. We may also recommend changes to improve program integrity. Importantly, our focus is on assessing appropriate payment for the Medicare program; we do not adjust our update recommendations based on the payment rates of other health insurers.

The recommendations in this report, if adopted, could significantly change Medicare payment rates to providers. Ideally, payment rates will be set at a level that supports access to high-quality care provided by relatively efficient providers—that is, those with lower costs and higher quality—and provides incentives for all providers to control their costs and improve quality, thereby helping the Medicare program achieve greater value for its spending. Further, while our intent is to recommend FFS payment rates that support FFS beneficiaries' access to care, the Commission acknowledges that FFS Medicare rates have broader implications for health care spending because they are often used in setting payment rates for other federal and state government programs and private health insurance. Consequently, if Medicare payments are too low to support efficient provision of high-quality care, broader access to care and provider solvency could be affected over time. At the same time, maintaining appropriate fiscal pressure on health care providers through payment-rate updates can benefit not only the

Medicare program (and the beneficiaries and taxpayers who support it) but also the overall health care system.

This chapter reviews our approach to analyzing payment adequacy and making payment-update recommendations in FFS Medicare. The Commission also assesses Medicare payment systems for Part C (Medicare Advantage) and Part D (outpatient prescription drug coverage) in the March report each year and makes recommendations as appropriate. Part C and Part D, however, are outside the scope of this chapter. ■

Background

The Commission's goal for Medicare payment policy is to support beneficiary access to high-quality care while obtaining good value for the program's expenditures, which entails encouraging the efficient use of resources funded through taxes and beneficiary premiums. Appropriate payment begins with base payment rates that reflect the costs of efficiently delivering care to the average beneficiary, followed by adequate adjustments for differences in cost due to market-, service-, and patient-level variations. Payment policy can also be a mechanism for encouraging improvements in quality of care, ensuring access for beneficiaries, and pursuing other policy objectives such as ensuring program integrity.

Per statute, the Commission annually undertakes a systematic assessment of payment in sectors that provide services to Medicare beneficiaries.[1] We consider recommendations in seven fee-for-service (FFS) payment systems: acute care hospitals, physician and other health professional services, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and hospice. Our annual analysis leads to recommendations for updates to FFS Medicare payments in the upcoming year (this year, for 2026). For each sector, we analyze the most recently available data (2023 in most cases) on beneficiary access and quality of care, provider margins and access to capital, and other contextual factors to determine the adequacy of FFS Medicare payment rates. We then consider forthcoming policy and anticipated cost changes to project FFS Medicare payments and provider costs for 2025. Finally, we recommend how FFS Medicare payments for a given sector should change in aggregate for 2026, including whether payments should increase, decrease, or remain the same relative to current law.

The Commission updates its payment recommendations annually, and we reflect any changes that may affect provider revenues or costs in future assessments of Medicare payments. We make our recommendations relative to current law at the time we record our votes and avoid speculating on whether and how changes in external circumstances might lead to different recommendations.

Beyond questions of payment updates, within each payment system we examine how payment rates may affect providers' ability to serve Medicare beneficiaries, taking into consideration geographic, demographic, and other characteristics. We contemplate whether payment adjustments are necessary to address differences in access, incentivize quality of care, or otherwise fairly distribute FFS payments across providers in a sector. We also identify program-integrity concerns and potential remedies.

We compare our update and other policy recommendations for 2026 with the base FFS Medicare payment rates specified in law to understand the implications for beneficiaries, providers, and the Medicare program. This chapter details our analytic framework for assessing payment adequacy, as well as our principles underlying that framework.

Notably, our update work and related recommendations are setting specific. That said, the Commission has maintained that, subject to risk differentials, payment for the same services should be comparable regardless of where the services are provided. Such "site neutrality" helps to ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions. For example, the Commission recommended in 2023 that the Congress more closely align payment rates across ambulatory settings (e.g., hospital outpatient departments, ambulatory surgery centers, and physicians' offices) for selected services that are safe and appropriate to provide in all settings and when doing so does not pose a risk to access. Because the analytic issues related to cross-setting analysis are more complex, this work is generally outside the scope of our sector-specific payment-adequacy analyses and thus is not discussed in this chapter.

Recent policy changes and environmental context

In any year, factors unrelated to the adequacy of FFS Medicare's payment rates can affect indicators of access to care, quality of care, access to capital, and Medicare payments and providers' costs in the settings where Medicare beneficiaries seek care. The previous chapter discussed the wider health care landscape and policy context. Here, we discuss how that context shapes our payment-adequacy analysis.

Lingering effects of the public health emergency and coronavirus pandemic

The public health emergency (PHE) related to the coronavirus pandemic officially expired on May 11, 2023. For the past several years, the direct and indirect effects of the pandemic on beneficiaries, PHE-related policy changes, and emergency funding for providers have made it difficult to interpret some of our indicators of the adequacy of Medicare's payment rates. The Commission recognizes that the coronavirus pandemic has had tragic effects on beneficiaries, as well as damaging impacts on the nation's health care workforce, as clinicians and other health care workers faced burnout and risks to their health and safety.

Macroeconomic trends in the wake of the pandemic—including inflation exceeding market basket updates, high interest rates, and high labor and supply costs—continue to affect providers' finances. However, our most recent measures of payment adequacy, using data primarily from 2023, indicate that the most pronounced effects of the pandemic have passed. When comparing indicators using 2023 data with indicators from earlier years that were more affected by the pandemic, we take care to interpret those changes in the appropriate context. Further, certain changes in practice patterns in response to the pandemic may prove to be long lasting. For instance, in 2020 and 2021, we saw an increase in the use of telehealth, which initially expanded as an alternative to face-to-face appointments (Medicare Payment Advisory Commission 2023a). In our 2024 survey of Medicare beneficiaries ages 65 and over, telehealth continued to be widely used, with 33 percent of beneficiaries reporting using telehealth in the past year.[2] As telehealth claims outside the context of the PHE become available for analysis, we will continue to monitor the impacts of the temporary telehealth expansions.

Growth of Medicare Advantage

Enrollment in Medicare Advantage (MA) plans continued to increase in 2024, with more than half of eligible Medicare beneficiaries enrolled in an MA plan. The extent to which the growth in MA might affect the provision of care to FFS Medicare beneficiaries is not yet clear, nor is the appropriate relationship between MA and FFS payment rates. Generally, we do not adjust our update recommendations based on payment rates of other health insurers, including MA plans. Instead, in separate work, we address issues related to the adequacy of MA payments. Chapter 11 of this report presents our current assessment of the MA program.

The Commission's principles for assessing payment adequacy

The Commission has long maintained that Medicare should institute payment policies that improve the program's value to beneficiaries and taxpayers. Historically, FFS Medicare policies created strong incentives to increase the volume of services without regard to their value and disincentives for providers to work together toward common goals. The introduction of new prospective payment systems (PPSs), alternative payment models such as accountable care organizations, and pay-for-performance programs has shifted provider incentives toward the provision of high-value, coordinated care, yet disjointed, inefficient, and low-value care remains a concern.

Payment rates should be sufficient to provide high-quality care for beneficiaries but also be based on efficient delivery of services. We assess the adequacy of FFS Medicare payments for relatively efficient providers where possible. Efficiency is greater if the same inputs are used to produce a higher-quality output or if fewer inputs produce an output of the same quality. The Commission judges the extent to which payment rates are adequate for relatively efficient providers to achieve high value. Thus, our recommendations may indicate an increase, decrease, or no change in payment rates relative to the updates specified in current law.

The Commission is also committed to the accuracy of payments, which might lead us to make recommendations that redistribute payments within a sector. These recommendations aim to better target FFS Medicare payments. For instance, in 2018, the Commission recommended that the payment weights in the skilled nursing facility (SNF) PPS be adjusted to increase payments for medically complex patients and decrease payments for patients receiving rehabilitation therapy unrelated to their care needs (Medicare Payment Advisory Commission 2018b). In 2020, we recommended that CMS replace existing adjustments in the end-stage renal disease PPS for

low-volume and rural facilities with a single payment adjustment that would direct additional payments to dialysis facilities that are isolated and have low volume (Medicare Payment Advisory Commission 2020). In 2023, we recommended that current disproportionate-share-hospital and uncompensated-care payments be redistributed using the Commission-developed Medicare Safety-Net Index (MSNI) and that additional funding for Medicare safety-net payments be authorized to support hospitals that are key sources of care for low-income Medicare beneficiaries (Medicare Payment Advisory Commission 2023b). We continue to use the MSNI when evaluating payment adequacy and equity.

Finally, we note that our primary concern is the appropriateness of FFS Medicare payments to support FFS beneficiaries' access to care, not the adequacy of payments across all payers. We situate our analysis in the wider health care and economic context, but we do not seek to set FFS Medicare payments based on over- or underpayments by other payers.

Payment-adequacy analytic framework

The Commission bases its payment update recommendations on an assessment of the adequacy of current FFS Medicare payments. For each sector, we make an assessment by examining indicators of the following: beneficiaries' access to care, quality of care, providers' access to capital, and FFS Medicare payments and providers' costs. The direct relevance, availability, and quality of each type of information vary among sectors, and no single measure provides all the information needed for the Commission to judge payment adequacy. We use a combination of administrative data, surveys, and other sources to inform our assessments, aiming to incorporate as many high-quality data sources as possible. Figure 2-1 (p. 52) illustrates our payment-adequacy framework, including examples of the types of indicators used for each sector (as available and applicable).

Beneficiaries' access to care

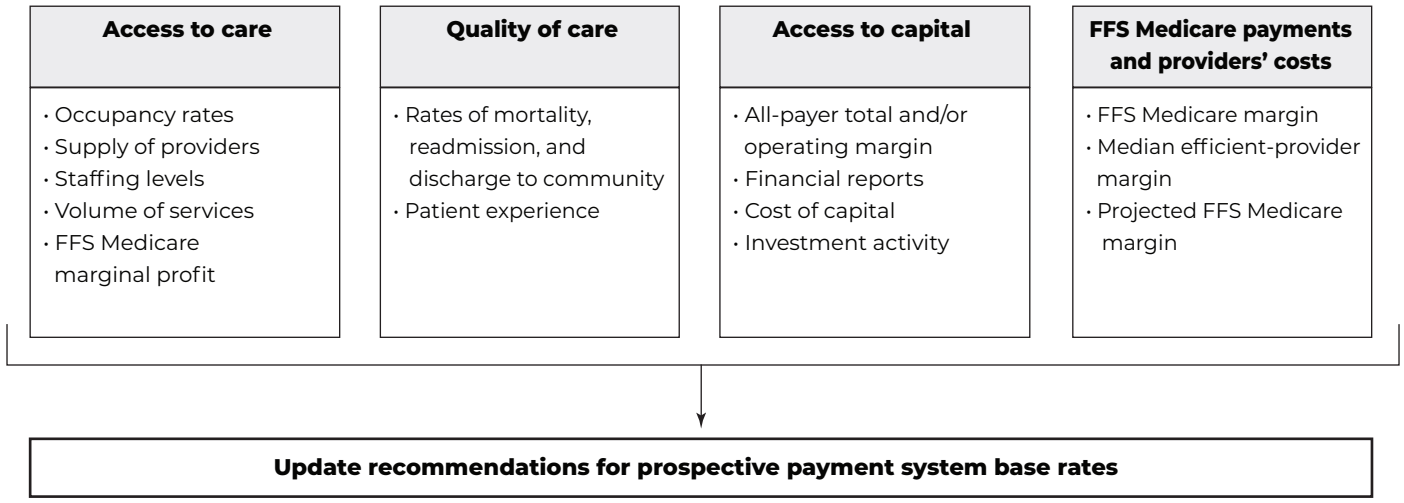
Access to care is an important signal of providers' willingness to serve Medicare beneficiaries and the adequacy of Medicare payments. Poor access could indicate that Medicare payments are too low. The measures we use to assess beneficiaries' access to care depend on the availability and relevance of information in each sector. Broadly speaking, we consider provider capacity and staffing, service volume, and FFS Medicare marginal profit as measures of access. Much of our analysis uses claims and other administrative data, but we also use results from several surveys to assess the willingness of physicians and other health professionals to serve FFS Medicare beneficiaries and FFS beneficiaries' ability to access physician and other health professional services when needed. However, factors unrelated to Medicare's payment policies may also affect access to care, such as Medicare's coverage policies, changes in the delivery of health care services, local market conditions and barriers to access, and supplemental insurance, so we exercise judgment when interpreting information for this domain.

Provider capacity, supply, and staffing

FFS Medicare beneficiaries' access to care depends in part on providers' ability to meet demand with current supply. Low provider capacity, long wait times, and difficulty maintaining staffing levels can indicate inadequate payment rates. By contrast, rapid provider entry into a sector may indicate that payments are too high. Technological changes are a factor in that they can increase capacity in ways that reduce costs. For example, as a surgical procedure becomes less invasive, it might be more frequently performed in lower-cost outpatient settings, freeing up some inpatient hospital capacity. Likewise, as the prices of new technologies fall, providers can more easily purchase them, increasing the capacity to provide certain services.

We have observed that providers have modulated excess capacity in response to payment-policy changes. For example, in 2016, many long-term care hospitals (LTCHs) closed following a significant reduction in Medicare payment rates for certain cases. However, the closures occurred primarily in market areas with multiple LTCHs, indicating that closures were a result of excess capacity rather than a cause of access issues. But provider capacity is not always a clear indicator of payment adequacy. For instance, if FFS Medicare is not the dominant payer for a given provider type (e.g., ambulatory surgical centers), changes in the number of providers may be influenced more by other payers and their enrollees' demand for services and less indicative of the adequacy of FFS Medicare payments.

FIGURE 2–1 The Commission's framework for assessing FFS Medicare payment adequacy



Note: FFS (fee-for-service). We use multiple measures of margins for different purposes in our payment-adequacy analysis (see text box). We define "FFS Medicare marginal profit" as ((FFS Medicare payments – costs that vary with volume) / FFS Medicare payments). This marginal profit is an indicator of beneficiaries' access to care. The "all-payer total margin," defined as ((payments from all payers and sources – costs of providing services) / payments from all payers and sources), is a measure of a sector's access to capital. For the hospital sector, we also evaluate the "all-payer operating margin," which is defined as ((payments from all payers and sources except investments and donations – costs of providing services) / payments from all payers and sources except investments and donations). "FFS Medicare margin," defined as ((FFS Medicare payments for services – allowable costs of providing services) / FFS Medicare payments for services), is a sector-wide measure of the relationship between FFS Medicare's payments and providers' costs for services.

Source: MedPAC.

The PHE and related policies had both positive and negative impacts on provider capacity and supply. On the one hand, waivers of payment rules, expansion of telehealth access, and supplemental payments supported the expansion of supply in some areas. On the other hand, critical staffing shortages constrained supply, including the ability to use existing infrastructure, in others. Changes in the capacity and supply of providers during the acute phase of the pandemic were not uniform and did not necessarily indicate inadequate FFS Medicare payment rates. We will continue to monitor any long-term changes resulting from pandemic policy or practice patterns.

Volume of services

The Commission analyzes the volume of services provided to FFS beneficiaries as another indicator of access. A stable or increasing volume of services relative to the number of FFS beneficiaries can indicate adequate access to services and, by extension, payment. However, it does not necessarily demonstrate that those services are necessary or appropriate. A more rapid increase in volume relative to the number of FFS beneficiaries could suggest that FFS Medicare's payment rates are too high. By contrast, reductions in the volume of services per capita can sometimes be a signal that revenues are inadequate for providers to continue operating or to provide the same level of service. In sectors whose services can be substituted for one another, changes in volume by site of service may suggest distortions in payment and raise questions about payment equity.

It is important to note that changes in the volume of services are not direct indicators of access; increases and decreases can be explained by factors such as population changes, changes in disease prevalence among beneficiaries, dissemination of new and

MedPAC uses several definitions of "margin" when assessing FFS Medicare payment adequacy

Margins are a measure of profitability and are calculated as the difference between revenue and cost, divided by revenue ((revenue – costs) / revenue). A positive margin indicates that a line of business is profitable, while a negative margin indicates a financial loss on a line of business. Unless otherwise indicated, all margins reported by MedPAC are calculated in aggregate across all included providers. The Commission uses several definitions of "margin" when assessing FFS Medicare payment adequacy:

Fee-for-service Medicare margin

The percentage of revenue from fee-for-service (FFS) Medicare that is left as profit after accounting for the allowable costs of providing services to FFS Medicare patients.

FFS Medicare marginal profit

The percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable variable costs of providing services to FFS Medicare patients. Variable costs are those that vary with the number of patients treated. By contrast, fixed costs are those that are the same in the short run regardless of the number of patients treated (e.g., building costs). If the FFS Medicare marginal profit is positive, a provider with excess capacity has a financial incentive to care for an additional FFS beneficiary; if the FFS Medicare marginal profit is negative, a provider may have a financial disincentive to care for an additional FFS beneficiary.

All-payer total margin

The percentage of revenue from all payers and sources that is left as profit after accounting for all costs.

All-payer operating margin

The percentage of revenue from all payers and sources exclusive of investments and donations that is left as profit after accounting for all costs. ■

improved medical knowledge and technology, deliberate policy interventions, and beneficiaries' preferences. A change in aggregate volume, for instance, could be attributable either to a change in services per beneficiary or a change in the number of beneficiaries. We analyze per beneficiary service use as well as the total volume of services to isolate these effects.

FFS Medicare marginal profit

Another factor we consider when evaluating access to care is whether providers have a financial incentive to expand the number of FFS Medicare beneficiaries they serve. In deciding whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (e.g., the FFS Medicare payment) with its marginal costs. That is to say, the FFS Medicare marginal profit reflects the costs to treat Medicare beneficiaries that vary with volume in the short term. Although we believe Medicare FFS payment should support an appropriate portion of fixed cost of efficient care delivery, we acknowledge that if FFS Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider with excess capacity has a financial incentive to increase its volume of FFS Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for FFS Medicare beneficiaries.

Quality of care

It is important for Medicare payment policy to support beneficiaries' access to high-quality care. However, the relationship between quality of care and the adequacy of Medicare payment is not direct. Simply increasing payments through an update for all providers in a sector is unlikely to influence the overall quality of

care that beneficiaries receive because there is no imperative for providers to devote the additional revenue to actions that are known to improve quality. Thus, within our framework, we consider whether changes in FFS Medicare's rates would meaningfully affect the quality of care that beneficiaries receive in a particular sector. Indeed, historically, FFS Medicare payment systems created little or no incentive for providers to spend additional resources on improving quality. Over the past decade or more, the Medicare program has implemented FFS quality-reporting programs for almost all major provider types and several pay-for-performance programs that tie FFS payment to a provider's performance on quality standards. Throughout the years, measures developed and used in public and private quality programs have proliferated, which has created confusion and increased reporting burden. The Commission is concerned that many of these measures focus on processes that are not associated with meaningful outcomes for beneficiaries.

In our June 2018 report to the Congress, we formalized principles for designing Medicare quality-incentive programs that address these issues (Medicare Payment Advisory Commission 2018a). In 2019, we applied these principles to recommend a hospital value-incentive program that scores a small set of outcome, patient-experience, and cost measures (Medicare Payment Advisory Commission 2019). In 2021, we made related recommendations for Medicare to eliminate the current SNF value-based-purchasing program and to establish a new SNF value-incentive program (Medicare Payment Advisory Commission 2021b).

Providers' access to capital

Providers must have access to capital to maintain and modernize their facilities and to improve patient-care delivery. One indicator of a sector's access to capital is its all-payer profitability, reflecting income from all sources. We refer to this amount as the sector's all-payer margin, which is calculated as aggregate income, minus costs, divided by income. All-payer margins can inform our assessment of a sector's overall financial condition and hence its access to capital.

Widespread ability to access capital throughout a sector may reflect the adequacy of FFS Medicare payments, but it is more indicative in some sectors than others. For instance, hospitals require large capital investments, and the ability to finance those investments can indicate the adequacy of payment. Other sectors, such as home health care, are not as capital intensive, so access to capital is a more limited indicator. Similarly, when FFS Medicare represents a relatively small share of a sector's volume, access to capital is a weak indicator of FFS Medicare payment adequacy. In recent years, access to capital may be more reflective of turbulent credit markets or other macroeconomic phenomena.

FFS Medicare payments and providers' costs

While we do consider all-payer margins as an indicator of providers' financial health, we primarily assess the adequacy of FFS Medicare payments relative to the costs of treating FFS beneficiaries, and the Commission's recommendations address a sector's FFS Medicare payments, not total payments. For providers that submit cost reports to CMS—acute care hospitals, SNFs, home health agencies, outpatient dialysis facilities, inpatient rehabilitation facilities, and hospices—we estimate total Medicare-allowable costs and assess the relationship between FFS Medicare's payments and those costs for FFS beneficiaries. This report uses cost-report data from 2023 (2022 for hospices, due to data lags).

The coronavirus pandemic and PHE-related policy changes primarily affected FFS Medicare payments and providers' costs from 2020 until the expiration of the PHE in May 2023.[3] However, MedPAC has not considered relief funds as Medicare revenue under the relevant payment system because they are not specifically tied to FFS Medicare payments per case. As a result, FFS Medicare margins in those years could appear lower than they would, all else equal, if relief-fund revenue were considered Medicare payment. In contrast, supplemental payments or policies to waive Medicare's payment rules during the PHE may have subsidized providers that would have otherwise exited the market. In sectors where relief-fund revenue was substantial, we calculate a FFS Medicare margin exclusive of PHE relief funds (assuming all else equal), as well as a FFS Medicare margin inclusive of relief funds. To make this latter calculation, we allocated to FFS Medicare payments a portion of relief funds received by a provider, using measures of Medicare's

market share in 2019 (such as the ratio of FFS Medicare to all-payer revenue).

Use of FFS Medicare margins

We typically express the relationship between payments and costs as a FFS Medicare margin, which is calculated as aggregate FFS Medicare payments for a sector, minus the allowable costs of providing services to FFS Medicare patients, divided by FFS Medicare payments.[4] Margins for individual providers will always be distributed around that aggregate, and a judgment of payment adequacy does not mean that every provider has a positive FFS Medicare margin. To assess the distribution of payments and any need for targeted support, we calculate FFS Medicare margins for certain subgroups of providers that have unique roles in the health care system or that receive special payments. For example, because location and teaching status enter into the payment formula used to pay acute care hospitals under the inpatient prospective payment systems, we calculate FFS Medicare margins based on where hospitals are located (in urban or rural areas) and their teaching status (major teaching, other teaching, or nonteaching).

Multiple factors can contribute to changes in the FFS Medicare margin, including changes in providers' efficiency, changes in coding that may influence payments, and other changes in the delivery of a product or service that may affect a provider's overall pool of patients (e.g., reduced lengths of stay at inpatient hospitals). Knowing whether these factors have contributed to margin changes may inform decisions about whether and how much to recommend changes to a sector's base payment rate.

In sectors where the data are available, the Commission makes a judgment when assessing the adequacy of FFS Medicare payments relative to costs. No single standard governs this relationship for all sectors, and margins are only one indicator for determining payment adequacy. Moreover, although payments can be ascertained with some accuracy, there may be no "true" value for the portion of reported costs that are attributed to providing care for FFS Medicare patients. Attributing reported costs to FFS Medicare patients is challenging and reflects in part the accounting choices made by providers (such as allocations of costs to different services) and the relationship of service volume to capacity in a given year. Further, even if costs are accurately reported, they reflect strategic investment decisions of individual providers, and Medicare—as a prudent payer—may choose not to recognize some of these costs or may exert financial pressure on providers to encourage them to reduce their costs.

Assessing current costs

Our assessment of the relationship between FFS Medicare's payments and providers' costs is complicated by differences in providers' efficiency, responses to changes in payment incentives, the introduction of new technologies, and cost-reporting accuracy. Assessing the efficiency of costs is particularly difficult in new payment systems, where past performance cannot be used as a benchmark. Solutions to some policy problems can generate new ones. For example, in 2020, the PPSs for home health services and SNF services were modified to improve payment accuracy. In both settings, the new payment systems (the home health Patient-Driven Payment Model and the SNF Patient-Driven Groupings Model) were intended to be budget neutral; that is, they were not intended to raise or lower payments relative to what would have been paid under the former payment systems. However, in both settings, CMS estimated that implementation resulted in payments higher than the budget-neutral amount because of changes in provider behavior. To assess whether reported costs reflect the efficient provision of service, we examine recent trends in the average cost per unit, variation in standardized costs and cost growth, and evidence of changes in the products and services delivered during a unit of care.

Our analysis focuses on the appropriateness of FFS Medicare payment rates, but ascertaining whether payments are adequate to cover the costs of efficiently providing high-quality care for Medicare beneficiaries is challenging. Assessing payments relative to costs is complicated because costs can change in response to financial pressure and strategic decisions made by providers. Analyses by MedPAC and other researchers have found that providers that face financial pressure to constrain costs generally have lower costs than those who face less pressure (Medicare Payment Advisory Commission 2011, Robinson 2011, Stensland et al. 2010, White and Wu 2014). Providers might also strategically make costly investments in an effort to

appeal to higher-paying privately insured patients. Studies have shown that hospitals with more revenue, or more potential revenue, from private patients tend to have higher costs (Garthwaite et al. 2022, Wang and Anderson 2022). As a result, providers with higher revenues can have higher cost structures and, all other things being equal, lower margins on FFS Medicare patients.[5] Those providers with high revenues and high costs often have lower margins on their FFS Medicare patients (because of their higher costs) but higher all-payer margins (because their higher revenues from non-Medicare patients more than offset those higher costs) (Medicare Payment Advisory Commission 2021a). That view stands in contrast to arguments that costs are largely outside the control of providers and that providers (for example, hospitals) shift costs onto private insurers to offset FFS Medicare losses.

Lack of fiscal pressure is more common in markets where a few providers dominate and have negotiating leverage over payers. This situation is becoming more common as providers continue to consolidate. The Commission generally does not recommend lowering FFS Medicare payments because payments from private plans are higher or raising them if other payers (e.g., Medicaid) pay less. Moreover, we recognize that in some sectors, FFS Medicare itself can, and should, exert greater pressure on providers to reduce costs. We rely on our other indicators of payment adequacy, especially beneficiary access to and quality of care, to ensure that FFS beneficiaries are not adversely affected by policy responses aimed at constraining costs.

Efficient-provider analysis

In accordance with our authorizing statute, the Commission also, when feasible, computes a FFS Medicare margin for relatively efficient providers.[6] In the sectors for which this analysis is possible, we identify a group of providers—for instance, hospitals—that perform relatively well on a set of quality metrics (e.g., measures of mortality and readmissions) while keeping unit costs relatively low. We refer to the group of hospitals identified by our method as "relatively efficient" because these hospitals had to perform relatively better than their peers on selected measures of quality and cost for inclusion.

However, our method does not seek to identify all efficient providers. For example, we screen out hospitals that have few Medicare or Medicaid patients or that have poor performance on our measures in a single year, even though these hospitals may be relatively efficient. In addition, we note that the hospitals we identify as relatively efficient perform relatively well in the domains we are measuring. Use of other quality and cost measures (e.g., hospital-acquired conditions, transition to post-acute care, or spending per episode) to identify relative efficiency likely would yield a different set of hospitals. Still, the median margin for our group of relatively efficient hospitals provides one source of information about whether FFS Medicare's payments are adequate to cover the costs of providing efficient hospital care.

Anticipated payment and cost changes in 2025

For most payment sectors, we estimate FFS Medicare payments and providers' costs for 2025 to inform our update recommendations for 2026. In general, to estimate payments, we first apply the annual payment updates specified in law for 2024 and 2025 to our base data (2023 for most sectors). We then model the effects of other policy changes that will affect the level of FFS Medicare payments in 2025.

Next, for each sector, we review evidence about the factors that are expected to affect providers' costs. To estimate 2025 costs, we consider the rate of input price inflation or historical cost growth, and, as appropriate, we adjust for changes in the intensity of the unit of service (such as fewer visits per episode of home health care) and trends in key indicators (such as changes in the distribution of cost growth among providers). When considering the change in input price inflation, we refer to the price index that CMS uses for that sector.[7] For each sector of facility providers (e.g., hospitals, SNFs), we start with the forecasted increase in a sector-specific index of national input prices, called a "market basket index." For physician services, we start with a CMS-derived weighted average of price changes for inputs used to provide physician services (the Medicare Economic Index). Forecasts of these indexes approximate how much providers' costs are projected to change in the coming year if the quality and mix of inputs they use to furnish care remains

constant—that is, if there were no change in efficiency. Other factors considered may include the trends in actual cost growth, which could be used to inform our estimates if they differ significantly from the projected market basket.

Recommendations for FFS Medicare payment in 2026

The Commission's assessments about payment adequacy, policy changes in the intervening years, and expected cost changes result in an update recommendation for each FFS payment system. The Commission does not start with any presumption that an update is needed or that any increase in costs should automatically be offset by a payment update. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a FFS payment system is changed relative to the prior year. For example, if the statutory base payment for a sector was $100 in 2025, an update recommendation of a 1 percent increase for a sector means that we are recommending that the base payment in 2026 for that sector be 1 percent greater, or $101.

The Commission's recommendations may be to increase, decrease, or maintain payment levels relative to current law. When indicators of payment adequacy are positive and Medicare's payments are substantially above costs, the Commission often recommends a reduction in payment levels relative to current law to promote greater value for Medicare program resources. Alternatively, if indicators of payment adequacy are mixed or negative, the Commission may recommend increased payments to ensure beneficiary access to high-quality care. These recommendations inherently involve judgment and weighing many factors and pieces of information.

When our recommendations differ from current law or regulation, as they often do, the Congress or the Secretary of Health and Human Services must actively change law or regulation to implement them. The Congress and the Secretary are under no obligation to adopt the Commission's recommendations; in the absence of other action from the Congress and/or the Secretary, current law will continue to apply.

Budgetary consequences

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Commission to consider the budgetary consequences of our recommendations. Therefore, this report documents how spending for each recommendation would compare with expected spending under current law. The Commission contends that FFS Medicare payment rates should achieve access to high-quality care for FFS beneficiaries by efficiently allocating the resources funded by taxpayers and beneficiary premiums. Our recommendations are not driven by any specific budget target but instead reflect our assessment of the level of payment to ensure that FFS beneficiaries have access to high-quality, appropriate care delivered efficiently. ■

Endnotes

1 The Medicare Payment Advisory Commission is authorized under Title XVIII of the Social Security Act.

2 The results of this survey are described in more detail in Chapter 4 of this report.

3 Some policies have been extended beyond the expiration of the PHE.

4 In most cases, we assess FFS Medicare margins for the services furnished in a single sector (e.g., SNF or home health care services) and covered by a specific payment system. However, in the case of hospitals, we include in our FFS Medicare margin all services paid under either the inpatient or outpatient prospective payment systems (see Chapter 3 for more detail). The hospital update recommendation in Chapter 3 applies to hospital inpatient and outpatient payments; the updates for other distinct units of the hospital, such as SNFs, are covered in separate chapters.

5 For-profit providers may prefer to keep costs low to maximize returns to stockholders and, indeed, often have higher FFS Medicare margins than similar nonprofit providers.

6 Section 1805(b)(2)(B) of the Social Security Act [42 U.S.C. 1395b–6]:

> Specifically, the Commission shall review payment policies under parts A and B, including—
>
> (i) the factors affecting expenditures for the efficient provision of services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees, (ii) payment methodologies, and (iii) their relationship to access and quality of care for Medicare beneficiaries.

7 These indexes are estimated quarterly; we use the most recent estimate available when we do our analyses.

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