



## **MedPAC March Report to Congress: Medicare Payment Policy**

The Medicare Payment Advisory Commission (MedPAC) recently sent its annual March Report on Medicare Payment Policy to Congress. The Report covers several rural relevant issues such as Medicare Advantage, Rural Emergency Hospitals, and recommendations to improve payment for clinicians and hospitals.

You can access the Report [here](#). If you have any questions, please contact Alexa McKinley ([amckinley@ruralhealth.us](mailto:amckinley@ruralhealth.us)).

### **Medicare FFS Payment Adequacy and Updates**

Congress requires MedPAC to annually make payment update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. The goal of this update is to identify the base payment rate for each sector that will ensure both beneficiary access and good stewardship of taxpayer resources.

#### Hospital inpatient and outpatient services

For FY2025, MedPAC recommends that Congress **increase base hospital payment rates for all hospitals and direct an enhanced pool of special payments to hospitals with high shares of Medicare patients, particularly low-income Medicare patients**. Specifically, MedPAC recommends:

- Congress should update the 2024 Medicare base payment rates for general acute care hospitals **by the amount specified in current law plus 1.5%**. In addition, the Congress should:
  - begin a transition to redistribute disproportionate share hospital and uncompensated care payments through the [Medicare Safety-Net Index \(MSNI\)](#);
  - add \$4 billion to the MSNI pool;
  - scale fee-for-service MSNI payments in proportion to each hospital's MSNI and distribute the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems; and
  - pay commensurate MSNI amounts for services furnished to Medicare Advantage (MA) enrollees directly to hospitals and exclude them from MA benchmarks.

#### Physician and other health professional services

In 2022 and 2023, most clinician payment adequacy indicators remained positive or improved, but clinicians' input costs are estimated to have grown faster than the historical trend. **Urban and rural Medicare beneficiaries reported comparable experiences and satisfaction levels on most questions, but there were observed differences between them in the mix of clinicians they saw.**

- A higher share of rural Medicare beneficiaries reported receiving all or most of their primary care from nurse practitioner or physician assistant (29%) compared with urban beneficiaries (17%).
- A smaller share of rural beneficiaries reported seeing multiple specialists in the past year (42%) compared with urban beneficiaries (55%). And a smaller share of rural beneficiaries

reported trying to find a new specialist in the past 12 months (23%) compared with urban beneficiaries (34%).

MedPAC key recommendations to Congress include:

- for calendar year 2025, update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50% of the projected increase in the Medicare Economic Index; and
- enact the Commission's [March 2023 recommendation](#) to establish safety-net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries.

#### Skilled nursing facility (SNF) services

MedPAC notes that rural SNFs make up the minority of all SNFs (27%), SNF stays, and SNF spending. While not specific to rural SNFs, MedPAC found that the supply of SNFs nationwide declined slightly in 2023 and stated that this is likely related to a shift to home- and community-based care, low Medicaid reimbursement, and patient preferences.

MedPAC found that Medicare margins for urban SNFs were 1 percentage point higher than rural SNFs. MedPAC also found that indicators for payment adequacy for SNFs were positive. Thus, for fiscal year 2025, **MedPAC recommends that the Congress should reduce the 2024 Medicare base payment rates for SNFs by 3%.**

#### The Medicare Advantage programs: Status report

To monitor program performance, MedPAC examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for beneficiaries enrolled in traditional FFS Medicare. Key findings:

- Between July 2022 and July 2023, enrollment in MA plans grew by 8 percent—or 2.4 million enrollees—to 31.6 million enrollees.
- Between 2022 and 2023, MA enrollment rose from 49 percent to 52 percent of eligible Medicare beneficiaries.
- Enrollment patterns differ in urban and rural areas. The majority (54%) of eligible urban beneficiaries are enrolled in MA compared with 44% of eligible beneficiaries residing in rural counties. However, the growth of MA plans in rural areas has been much faster in recent years. In 2023, MA enrollment in rural areas grew by 12% (compared with 8% growth in urban areas).
- Aggregate Medicare payments to MA plans have always been substantially higher than what estimated spending would have been in FFS Medicare.

MedPAC key recommendations to Congress include:

- Replace the existing mandatory minimum coding intensity adjustment (which has reduced MA risk scores by 5.9% since 2018), has three parts:
  - develop a risk-adjustment model that uses two years of FFS and MA diagnostic data,



- exclude diagnoses that are documented only on health risk assessments from either FFS or MA, and
- apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.
- The Commission also recommended that the value incentive program address the variation in the demographics of MA enrollees across plans. By accounting for differences in enrollees' social risk factors by stratifying plan enrollment into groups of beneficiaries with similar social risk profiles, plans with higher shares of these enrollees would not be disadvantaged in their ability to receive quality-based payments, while actual differences in the quality of care would not be masked.

### **Mandated Report: Rural emergency hospitals**

The first annual update on payments to REHs, the chapter provides context on the evolution of Medicare's support for rural hospitals and gives background on the REH designation and the hospitals that have converted to REHs. Overall, 21 hospitals converted to REHs. Before converting, these hospitals often furnished a low (and declining) volume of inpatient care, received enhanced payments from Medicare, were located relatively close to other hospitals, and had financial difficulties. The REH designation has been seen as a way to overcome financial difficulties and retain local access to emergency and outpatient services in communities that cannot support a full-service hospital.

MedPAC analyzed why the 8 rural hospitals that closed in 2023 did so instead of converting to REHs. Reasons identified include:

- Two hospitals are considering reopening as REHs, but they did not have time to convert prior to closure.
- One hospital became an outpatient facility of another hospital with a 24/7 ED but cannot convert to an REH because the state has not yet put REH regulations in place.
- One hospital converted to an outpatient department of a neighboring hospital owned by the same hospital system.
- One hospital is less than two miles from another CAH.
- Three hospitals have more than 50 beds (making them ineligible to convert to REHs) and 2 of these hospitals are in the process of reopening as full-service hospitals.

MedPAC will continue to monitor the volume of hospitals that transition to REHs, speak with representatives of rural hospitals that are considering converting, and analyze data to inform any future policy considerations. As part of that ongoing monitoring, the Commission will consider possible modifications to the REH designation in the future.