National Rural Health Association

# MedPAC June Report to Congress: Medicare and the Health Delivery System

MedPAC submitted its annual June Report to Congress, which includes recommendations and discussion around reducing beneficiary cost-sharing at critical access hospitals, rural provider quality measurement, updating clinician payments, utilization of Medicare Advantage supplemental benefits, nursing home characteristics, and Medicare Advantage enrollee utilization of home health services. Please find the full report here.

If you have any questions, please contact Alexa McKinley Abel (amckinley@ruralhealth.us).

**Reducing beneficiary cost sharing for outpatient services at critical access hospitals**
Medicare fee-for-service (FFS) beneficiaries that receive outpatient services at CAHs pay more in coinsurance than they would for the same services at prospective payment system (PPS) hospitals. CAH coinsurance is generally set at 20% of charges. Charges are the list prices that hospitals set for their services and can exceed the hospitals' reported costs of providing such services. As such, MedPAC investigated an alternative policy solution that would retain payments to CAHs but reduce cost sharing for FFS beneficiaries.

Findings:

- If beneficiary coinsurance for outpatient services provided at CAHs had been set at 20% of the payment amount in 2022, rather than charge amount, with the amount per line item capped at the level of the inpatient deductible, beneficiary cost-sharing liability would have been about $2.1 billion, or 60%, lower, assuming no change in care patterns.
- If enacted, the below recommendation would increase spending relative to current law by between $2 billion and $5 billion over one year and by between $25 billion and $50 billion over five years

Recommendations:

- Set FFS beneficiary coinsurance for outpatient critical access hospital (CAH) services equal to 20% of the payment amount for services that require cost sharing.
- Place a cap on CAH outpatient coinsurance equal to the inpatient deductible.

**Medicare's measurement of rural provider quality.**
MedPAC reviewed inclusion of rural providers in current Medicare FFS quality reporting programs. Medicare FFS providers participate in pay-for-reporting quality programs that account for most services furnished to Medicare beneficiaries. Providers that successfully report quality measure data are financially rewarded for doing so. CMS uses the quality data to publicly report provider performance.

Findings:

- Practical challenges to measuring rural provider quality of care associated with low patient volumes, and limited capacity for reporting or quality-improvement activities.
- Hospitals, clinicians, and inpatient rehabilitation facilities had comparable shares of rural and urban providers with publicly reported quality results.
- Rural HHAs and hospices had higher shares publicly reported quality results, while rural SNFs and dialysis facilities had lower shares publicly reported quality results.

MedPAC noted that quality measurement for rural providers should focus on metrics tailored to these providers. MedPAC identified the Medicare Beneficiary Quality Improvement Project (MBQIP) and quality-improvement organizations as initiatives that are available to help rural providers develop and participate in quality improvement programs.

**Medicare beneficiaries in nursing homes.**
Commission reviewed Medicare long-stay nursing home (NH) population data and regulations and programs CMS has implemented to improve NH quality, including specialized MA plans known as institutional special-needs plans (I-SNPs). Medicare primarily covers short-term skilled care following a hospitalization and some other services received by beneficiaries living in NHs, like physician services and lab tests.

Findings:

- In 2023, there were about 15,000 nursing homes nationwide. Nearly all provide long-term and skilled nursing care.
    - MedPAC classifies 4,069 nursing homes as rural, or 27% of all nursing homes nationwide; however, they made up much smaller shares of total days and revenues (20% and 16% respectively). This may be explained by smaller facility sizes and lower occupancy rates compared to urban facilities.
    - More rural facilities are government-owned.
    - Rural facilities have a lower share of FFS Medicare days (9%) and higher shares of Medicaid days (60%) compared to urban facilities (18% and 54% respectively).
- The industry reports low profit margins across all payers (0.4% in 2023), but that average margin may be understated due to the ways some NHs report their payments. The reported average profit margin on Medicare-covered skilled nursing facility (SNF) care is much higher, at 22% in 2023.
- Long-stay residents are more likely to live in rural areas (24%) likely in part because alternatives to nursing home care like home health aides are less available in rural communities.
- I-SNPs cover 12% Medicare NH residents. I-SNPs reduce the use of inpatient care and emergency department visits and perform better on some quality measures.
- Across the board, wow reimbursement for long-term stays incentivizes NHs to hospitalize residents to qualify for Medicare-covered SNF care and Medicaid's payment rates are often so low that typically do not cover cost of care.
- CMS introduced a star rating system, which has improved consumer choice & a payment system for SNF care includes a value-based purchasing (VBP) program that raises or lowers payment rates to SNFs based on their quality performance

Recommendation:

- Build on successes of star rating system and the relationship between NH staffing and quality, alterative designs. Examine factors which limit use of I-SNPs and consider policy changes that encourage broader use of I-SNPs.

**Physician Fee schedule (PFS)**
Absent congressional action, in 2026, payment rates will increase by 0.75 percent per year for qualifying clinicians participating in advanced alternative payment models (A-APMs) and by 0.25 percent for all other clinicians. Comparatively, clinicians' input costs, measured by Medicare economic index (MEI) are expected to increase by an average of 2.2% per year from 2025 through 2034, exceeding the growth of PFS payment rates.

The growing gap between costs and payment rates may incentivize clinicians to reduce the number of Medicare beneficiaries served, stop participating in Medicare, or vertically consolidate with hospitals. MedPAC also notes its concern around the PFS relative value units (RVUs), which determine how Medicare spending is distributed among clinician services and places of service. The misvaluation of RVUs likely leads to overpayments for some services and underpayments for others.

Recommendations to update PPS:

- Replace current-law updates to the PFS with an annual update based on a portion of the growth in MEI, such as MEI minus 1 percentage point, based on historical evidence.
    - This recommendation would automatically adjust rates to changes in inflation, improve predictability of PFS rates, reduce administrative burden, and maintain beneficiary access to provider care.
    - Recommendation expected to increase federal program spending by $15-$30 billion over five years, relative to current law.
- Improve the accuracy of RVUs to reduce spending associated with misvalued services by paying more accurately for indirect practice expenses, updating data used to calculate the aggregate allocation of RVUs, or addressing overpayments for global surgical codes.

**Supplemental benefits in Medicare Advantage (MA)**

The Commission reviewed trends in Medicare spending for supplemental benefits, summarized the type of supplemental benefits offered across MA plans, and assessed the utility of MA encounter data to measure enrollee's use of supplemental benefits. Supplemental benefits are used to reduce cost sharing for part A and B services, reduce part B and part D premiums, provide enhanced part D benefits, and cover benefits not covered under fee-for-service (FFS) Medicare (dental, vision, hearing).

Findings:

- The majority of supplemental benefits provided by MA plans are financed by rebates that plans receive from Medicare. In 2025, Medicare is projected to pay MA plans approximately $86 billion in rebates for supplemental benefits, but little is known about how this money is spent. Some projections show that MA plans will use $15 billion of rebates to enhance part D benefits and reduce part D premiums and about $5 billion to reduce enrollees part B premiums.
- Conventional MA plans allocate the largest share of rebate dollars to reducing part A and B enrollee cost sharing. In contrast, special-needs plans (SNP) beneficiaries allocate most rebate dollars to provision of non-Medicare services.
- MA organizations (MAOs) are required to submit encounter records for all health care items and services, including supplemental benefits to enrollees. The Commission has found that encounter data for some services is incomplete or missing. Reasons for missing or incomplete encounter reports included confusion surrounding reporting requirements and around population of records for services that do not have well-established procedure codes.
- MedPAC found that there is a lack of transparency about how often MA enrollees use supplemental benefits and plans' spending for the benefits.

**Home health care use among Medicare Advantage enrollees**

Using MA home health encounter data, MedPAC assessed home health care use rates and visits among MA enrollees.

Findings:

- Home health rate use among MA enrollees was lower than among FFS beneficiaries (8.3% vs. 8.6% respectively). For such beneficiaries with a reported hospitalization, adjusted probability of home health care was 3.2% higher among MA enrollees than FFS beneficiaries (41.7% vs. 40.4% percent). Among beneficiaries without a hospital stay, the probability of home health care use was 13.7 percent lower among MA enrollees than FFS beneficiaries (3.7% vs. 4.2%).
- Among rural beneficiaries, 8.4% of rural MA enrollees use home health which is similar to 8.3% of rural Medicare FFS beneficiaries.
- Enrollment in MA was associated with fewer average visits per beneficiary per year compared with FFS (18.2 vs. 20.4). After controlling for HHA treating the beneficiary, MedPAC found that home health users in MA received 1.8 fewer visits than those in FFS.