Executive summary

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As part of its mandate from the Congress, each June the Commission reports on improvements to Medicare payment systems and issues affecting the Medicare program, including changes to health care delivery and the market for health care services. The seven chapters of the June 2025 report cover the following topics:

- ***Reforming physician fee schedule updates and improving the accuracy of relative payment rates.*** The Commission recommends replacing the current-law updates to fee-for-service (FFS) Medicare's physician fee schedule (PFS) with an annual update based on a portion of the growth in inflation, as measured by the Medicare Economic Index (MEI). The Commission also recommends that the relative accuracy of PFS payment rates be improved by collecting and using timely data that better reflect the relative costs of delivering care.
- ***Supplemental benefits in Medicare Advantage.*** The Commission reviews trends in Medicare's spending for Medicare Advantage (MA) supplemental benefits, summarizes the types of supplemental benefits offered by MA plans, and assesses the potential utility of MA encounter data for measuring enrollees' use of these benefits.
- ***Examining home health care use among Medicare Advantage enrollees.*** Using MA home health encounter and Outcome and Assessment Information Set data, the Commission assesses use of home health care by MA enrollees.
- ***Part D prescription drug plans for beneficiaries in fee-for-service Medicare and Medicare Advantage.*** The Commission describes how MA and Part D policies and other factors may be affecting trends in plan offerings and relative costs and payments for stand-alone prescription drug plans (PDPs) and MA Prescription Drug plans (MA–PDs).
- ***Medicare beneficiaries in nursing homes.*** The Commission describes the Medicare long-stay nursing home (NH) population and reviews regulations and programs that CMS has implemented to improve NH quality, including specialized MA plans known as institutional special-needs plans.
- ***Medicare's measurement of rural provider quality.*** The Commission reviews the inclusion of rural providers in current Medicare's FFS quality-reporting programs.
- ***Reducing beneficiary cost sharing for outpatient services at critical access hospitals.*** The Commission recommends that FFS beneficiary cost sharing for outpatient services provided at critical access hospitals be based on each hospital's Medicare payment amount instead of on the hospital's charges.

Reforming physician fee schedule updates and improving the accuracy of relative payment rates

In Chapter 1, the Commission makes recommendations to replace the current-law updates to FFS Medicare's PFS with an annual update based on a portion of the growth in inflation, as measured by the MEI, and to improve the relative accuracy of PFS payment rates by collecting and using timely data that better reflect the relative cost of delivering care.

Every year, the Commission assesses the adequacy of FFS payments made under the Medicare PFS and recommends an appropriate update to those payments in our annual March report to the Congress. As part of that process, the Commission considers beneficiaries' access to clinician care. For many years, the Commission has found that this access has been as good as, or better than, that of privately insured individuals; the share of clinicians who accept new Medicare patients has been comparable with the share who accept new privately insured patients; and the volume of and spending on fee schedule services per beneficiary has consistently grown. These trends coincide with the period from 2001 to 2020 during which growth in the MEI (a measure of the growth in clinicians' input costs) exceeded payment updates under the PFS by an average of just over 1 percentage point per year, suggesting that full MEI updates have not been necessary to maintain Medicare beneficiaries' access to care.

Nevertheless, the Commission is concerned about whether payment-rate updates under current law will remain adequate to ensure continued access to

care in the future. Starting 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. Meanwhile, clinicians' input costs, as measured by the MEI, are expected to increase by an average of 2.2 percent per year from 2025 through 2034—exceeding the growth in PFS payment rates by a greater amount than in the two decades before the coronavirus pandemic. This larger gap between input-cost and payment-rate growth could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program. At the same time, the Commission is concerned about misvaluation of the PFS's relative value units (RVUs), which determine how Medicare spending is distributed among clinician services and places of service. This misvaluation likely leads to overpayment for some services and underpayment for others, which can have undesirable effects on the distribution of program spending, amount of beneficiary cost sharing, and clinicians' decisions about how and where to practice medicine. RVU misvaluation may also create incentives for vertical consolidation between hospitals and clinicians.

Alternative approach to updating PFS payment rates

In our March 2025 report to the Congress, the Commission recommended that the Congress, for 2026, replace current-law updates for PFS services with a single update equal to MEI minus 1 percentage point. That recommendation applies only to one year—2026—not future years. In contrast, this chapter addresses what default updates should be for future years. Changes to default PFS updates would not obviate the need for continued monitoring of access but instead would set default updates at a level the Commission determines is adequate, in the aggregate, to ensure continued beneficiary access to care, given current knowledge. The Commission will continue to monitor trends in access to clinician care and, to the extent needed, recommend higher or lower updates in the future as part of its annual payment-adequacy analysis.

In Chapter 1, the Commission recommends replacing the current-law updates to the PFS with an annual update based on a portion of the growth in the MEI, such as MEI minus 1 percentage point, based on the historical evidence suggesting that updates of full MEI have not been necessary to maintain beneficiary access to care. This recommendation would automatically adjust to changes in inflation, improve predictability for clinicians, beneficiaries, and policymakers, be simpler to administer, and balance beneficiary access with beneficiary and taxpayer financial burden. In designing the specific update, policymakers could consider a range of reasonable options, such as whether updates of MEI minus 1 percentage point should be paired with a minimum update floor (e.g., half of MEI growth or 0 percent) or update ceiling (e.g., 75 percent of MEI growth).

This recommendation is expected to maintain FFS Medicare beneficiaries' access to care by maintaining or improving clinicians' willingness and ability to treat them. We also expect that the recommendation would increase federal program spending by between $15 billion and $30 billion over five years relative to current law.

Under the approach of updating PFS rates by a portion of MEI growth, the Commission did not address how the A–APM bonus should be treated. Policymakers may choose to include some form of a bonus as an important component of payment for clinician services as they seek policy changes to improve A–APM design and performance.

Improving the accuracy of relative values under the fee schedule

Updating fee schedule rates by an amount similar to MEI minus 1 percentage point would substantially increase Medicare spending relative to current law, which would magnify the effects of problems stemming from misvalued services. Therefore, the Commission recommends that the Congress direct the Secretary to further improve the accuracy of relative values for clinician services by collecting and using timely, objective data that reflect the cost of delivering care. We discuss three illustrative approaches policymakers could explore:

- *Paying more accurately for indirect practice expenses*: When a clinician service is furnished in a facility, Medicare generally includes payments for indirect practice expenses (i.e., overhead costs) in both the PFS rate and the payment to facilities (e.g., under Medicare's hospital outpatient prospective

payment system). However, an increasing portion of clinicians may pay little or no indirect practice expenses because they do not maintain an independent office or their overhead expenses are covered by the hospital that employs them (or owns their practice). Since the PFS does not make these distinctions, Medicare on average likely overpays these clinicians for services furnished in a facility. Payment for indirect practice expenses could be better aligned with clinicians' actual costs by incorporating data that reflect more up-to-date practice patterns.

- *Updating the data used to calculate the aggregate allocation of RVUs*: The share of total RVUs allocated to clinician work, practice expenses, and malpractice insurance is based on cost data from 2006. Using more up-to-date data would produce RVUs that more accurately reflect how costs are distributed among the three RVU categories in a typical clinician practice. However, questions remain about the most appropriate data source for this purpose and how to treat the expenses of clinicians whose practice expenses are covered by other entities, such as hospitals.
- *Addressing overpayments for global surgical codes*: Current payments for 10-day and 90-day global surgical codes include payment for postoperative visits that often do not occur, resulting in substantial overvaluation. Lowering the relative values to reflect only services that are furnished or unbundling these codes into 0-day codes would improve payment accuracy.

This recommendation could improve care for beneficiaries by reducing incentives for clinicians to overprovide or underprovide certain services. Due to statutorily required budget-neutral implementation of changes to RVUs, this recommendation is not expected to affect total program spending.

Supplemental benefits in Medicare Advantage

In Chapter 2, the Commission reviews trends in Medicare's spending for MA supplemental benefits, summarizes the types of supplemental benefits offered by MA plans, and assesses the potential utility of MA encounter data for measuring enrollees' use of supplemental benefits.

In addition to covering basic Part A and Part B services, MA plans may provide "supplemental" benefits to their enrollees, such as reduced cost sharing for Part A and Part B services, reduced Part B and Part D premiums, enhanced Part D benefits, and other benefits not covered under FFS Medicare, such as dental, vision or hearing services (non-Medicare services). These supplemental benefits, which are intended to provide more generous coverage and better financial protection for MA enrollees, are a defining feature of MA, but relatively little is known about their use and associated costs.

The majority of the supplemental benefits provided by MA plans are financed by the rebates that plans receive from Medicare. Medicare spending on plan rebates has increased sharply in recent years. Our analysis of plan rebates shows that, in 2025, Medicare paid MA plans approximately $86 billion to provide supplemental benefits, up from $21 billion in 2018.

According to their 2025 bid projections, plans expect to use about $39 billion (equivalent to about $100 per member per month (PMPM)) to provide non-Medicare services to their enrollees and about $27 billion ($64 PMPM) to reduce enrollees' cost sharing for Medicare-covered services (such as doctors' visits). Though plans' bids indicate how they intend to use rebate dollars, projections may vary from actual experience, and little is known about how MA rebate dollars are actually spent. Because Part D benefit enhancements and Part D and Part B premium reductions are adjudicated directly between CMS and MA plans, there is less uncertainty about plans' spending for these supplemental benefits. For 2025, we estimate that MA plans will use about $15 billion of the rebates they receive from Medicare to enhance Part D benefits and reduce Part D premiums (equivalent to about $37 PMPM), and about $5 billion ($10 PMPM) to reduce their enrollees' Part B premiums.

Different types of MA plans tend to offer different types of supplemental benefits. Conventional MA plans (i.e., nonemployer, non-special-needs plans) typically allocate the largest share of their rebate dollars to reducing enrollee cost sharing for Part A and Part B services. In contrast, special-needs plans (SNPs) report allocating a small share of their rebates to reducing cost sharing because most of their enrollees are dually eligible for Medicare and Medicaid and so will have

their out-of-pocket (OOP) costs covered by Medicaid and other programs. Instead, SNPs allocate most of their rebate dollars to the provision of non-Medicare services.

In recent years, CMS and the Congress have gradually increased plans' flexibility in the types of supplemental benefits that can be offered, and plans can now target supplemental benefits to enrollees with a particular health status or disease state. Plans can also provide chronically ill enrollees with supplemental benefits that are not primarily health related; these benefits—which include services such as meals, nonmedical transportation, and pest-control services—are known as special supplemental benefits for the chronically ill.

These new flexibilities, combined with the growth in rebate dollars, have allowed MA plans to significantly expand the number of supplemental benefits they offer. We find that across almost every type of supplemental benefit, the share of MA enrollees in plans offering these benefits has increased since 2018. Growth in the share of SNP enrollees in plans offering the newer forms of benefits has been particularly dramatic. According to plans' bid data, SNPs now intend to devote more rebate dollars to other non-Medicare services than to dental, vision, hearing, and transportation benefits combined.

As Medicare spending for MA supplemental benefits grows, it becomes increasingly valuable for policymakers to fully understand their use. CMS requires MA organizations (MAOs) to submit encounter records for all health care items and services, including supplemental benefits, provided to their enrollees. Accordingly, MA encounter data should be the most detailed source of information for assessing MA enrollees' use of services. However, the Commission has found that encounter data for some MA plans and for some services (including inpatient, home health, and skilled nursing facility services) are incomplete. And to the best of our knowledge, no studies have used encounter data to assess MA enrollees' use of supplemental benefits—likely because the reliability of the data has been unclear.

Indeed, until 2024, the system that CMS used to collect encounter records was not configured to accept encounter records for dental services. For this report, we used data from the Medicare Current Beneficiary Survey (MCBS) to assess how enrollees use and pay for dental care. Survey data, however, offer limited insight into how MA enrollees use and pay for dental care, underscoring the need for better encounter data pertaining to the services.

We analyzed encounter data for 2021 to assess whether plans are submitting records for other supplemental benefits and whether the submission rates are suggestive of problems with the reliability of the data. Our analysis is a preliminary and exploratory first step toward using encounter data to assess the use of supplemental benefits. As such, we did not attempt—at this stage—to measure utilization rates or draw conclusions about access or value based on our findings. Instead, we focused on assessing whether plans are submitting records and characterizing the potential uses or limitations of the data.

We identified significant limitations to using encounter data to assess supplemental benefits. First, as noted above, few encounter records have been collected for dental services, which are one of the largest categories of supplemental benefits. Second, MA plans have reported that the supplemental-benefit encounter records that they do submit are incomplete because of confusion surrounding reporting requirements and how to populate the records for services that do not have well-established procedure codes. Third, the encounter data system does not contain a way to distinguish which records are for basic or supplemental services or to distinguish which records are for optional or mandatory supplemental benefits.

For some services—particularly vision and hearing services—there are fewer technical limitations to submitting encounter data, and submission rates follow patterns in line with what can reasonably be expected based on survey data about MA enrollees' use of vision and hearing services. Thus, it may be feasible to use encounter data to explore MA enrollees' use of supplemental vision and hearing benefits.

For other types of supplemental benefits, however, we found few encounter records, and the submission rates were well below the utilization rates suggested by survey data. Considering the well-documented data limitations and the discrepancies between encounter data and other sources, we can conclude that—for most supplemental benefits other than vision and hearing

benefits—available encounter data are insufficient for characterizing enrollees' use of the benefits. In 2024, CMS began implementing a series of actions to improve and increase the amount of data that plans report regarding utilization of and spending for supplemental benefits. The Commission will monitor these changes and assess the extent to which they address limitations of the currently available data.

Medicare does not collect information about the businesses or community-based organizations with which MAOs contract to provide or administer some supplemental benefits. To better understand how supplemental benefits are administered, we reviewed the websites of MAOs and entities that administer MA supplemental benefits. We found that many MAOs contract with dental and/or vision insurers that manage the supplemental dental and vision benefits on behalf of the MA plan, and with for-profit vendors to provide nonmedical supplemental benefits. Plans may also contract with community-based organizations, though information about these arrangements was harder to find. We also found that MAOs frequently administer supplemental benefits through entities with which the insurer is vertically integrated, and in several instances, MAOs structure their supplemental benefits to be provided exclusively by providers owned by the plan's parent organization.

Altogether, our review of numerous data sources pertaining to MA supplemental benefits reveals a fundamental lack of transparency about how often enrollees use the benefits and plans' spending for the benefits. The data that Medicare collects are currently insufficient for examining the use of most of these benefits. The lack of reliable data makes it difficult to answer many important questions about how the rebates Medicare pays to MA plans are used. The Medicare program currently relies on competition between insurers to incentivize plans to offer benefits that enrollees will value and use. But, because of different challenges in the program, including the complexity of the choice environment and the absence of reliable data, it is unclear to what extent supplemental benefits address enrollees' needs or affect outcomes. Without reliable information about how the benefits are used or administered, it is difficult for policymakers to assess the adequacy of the access provided or to know whether the spending provides good value to enrollees and the taxpayers who fund the program. Better information could be used to help beneficiaries navigate the options available to them and could help policymakers identify ways of making the program work more efficiently.

Examining home health care use among Medicare Advantage enrollees

In Chapter 3, the Commission assesses home health care use rates and visits per user among MA enrollees using MA home health encounter and the Outcome Assessment Information Set (OASIS) data.

Home health care is the most frequently used post-acute care (PAC) setting among FFS beneficiaries, and the Commission regularly assesses their use of FFS home health care paid for by Medicare's home health prospective payment system (PPS). Many published studies have examined home health care use among MA enrollees, frequently with the goal of contrasting use with FFS beneficiaries. However, these studies have relied on data that have limitations for drawing nationally representative conclusions. Home health care use by MA enrollees is reported in the home health MA encounter data submitted by plans and in the OASIS records submitted by home health agencies (HHAs). Although CMS requires that both data sources be reported for all Medicare beneficiaries receiving home health care, prior Commission work has found that both data sets are incomplete. Combining these data sources allows for a more complete view of nationwide home health care use among MA enrollees than either data source alone: Among MA enrollees with a home health encounter record or an OASIS record in 2021, 88 percent had both types of data, 7 percent had only a home health encounter record, and 5 percent had only an OASIS record.

Using these data sources and incorporating beneficiary, plan, and provider characteristics, we conducted multivariable regressions to estimate the probability of home health care use among FFS and MA beneficiaries in 2021 and, among those who used home health care, visits per beneficiary. We found that, after adjusting for beneficiary characteristics, the overall home health use rate among MA enrollees was slightly lower than among FFS beneficiaries (8.3 percent vs. 8.6 percent, respectively). However, there were differences

depending on whether beneficiaries had an acute care hospitalization during the year. For those with a hospitalization, the adjusted probability of home health care use was 3.2 percent higher among MA enrollees than FFS beneficiaries (41.7 percent vs. 40.4 percent), which could suggest that home health care is sometimes used in MA as a substitute for other types of PAC, such as costlier skilled nursing facility (SNF) stays. 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 percent vs. 4.2 percent), which could be related to plans' implementation of prior authorization and home health cost sharing (which do not exist in FFS) or to HHAs' preferences for admitting FFS beneficiaries.

As for total visits received by home health care users, we found that enrollment in MA was associated with fewer average visits per beneficiary per year compared with FFS (18.2 vs. 20.4 visits per user, respectively) after controlling for beneficiary characteristics. This difference in visits per beneficiary was similar regardless of whether beneficiaries had a prior acute care hospital stay.

We examined how home health care use differed among MA enrollees by plan attributes. We found that enrollment in plans with home health cost sharing was associated with both lower rates of home health care use and a lower average number of visits per user compared with enrollment in plans without home health cost sharing. Enrollment in preferred provider organization (PPO) plans (vs. HMO plans) was associated with more visits per user but no change in the probability of any home health care use. We did not find any differences in the probability of home health care use for those enrolled in provider-sponsored plans relative to other types of plans, but we did find that beneficiaries enrolled in provider-sponsored plans tended to have fewer visits in the year compared with those not enrolled in these plans.

Overall, fewer HHAs treated MA enrollees (4,600 HHAs treated at least 20 MA enrollees) than FFS beneficiaries (7,000 HHAs treated at least 20 FFS beneficiaries). After controlling for the HHA treating the beneficiary, we found that home health users in MA received 1.8 fewer visits than those in FFS.

We emphasize that it is not possible to draw conclusions on the appropriateness of care based solely on observing differences in use (and most of the differences we observed are relatively modest). Home health care is one component of the broader PAC landscape, and its use is likely to be affected by the availability of other PAC providers, the prior hospitalization (if there is one), and other factors such as types of MA plans, their provider networks, and the supplemental benefits they offer. In future work, we plan to incorporate analyses of MA enrollees' use of other PAC settings (including SNFs and inpatient rehabilitation facilities).

Part D prescription drug plans for beneficiaries in fee-for-service Medicare and Medicare Advantage

In Chapter 4, the Commission describes how MA and Part D policies and other factors may be affecting trends in plan offerings and relative costs and payments for prescription drug plans (PDPs) and MA–PDs.

Beneficiaries can choose among Medicare coverage options that include traditional FFS Medicare and an array of MA plans. Beneficiaries who opt for FFS Medicare can obtain Part D prescription drug coverage by enrolling in a PDP. (Many FFS beneficiaries also purchase a Medigap plan to reduce their cost-sharing liability for medical services.) With MA, beneficiaries generally do not separately enroll in a prescription drug plan because their plan is an MA–PD plan that includes prescription drug coverage.

The Part D program has evolved since its inception, and the numerous changes have altered the dynamics in the PDP and MA–PD markets. Consistent with the shift in enrollment from FFS to MA in the broader Medicare program, Part D's enrollment has also shifted from PDPs to MA–PDs. While the average number of PDPs available in 2025 was the lowest since the program began, FFS beneficiaries will continue to have at least 12 PDPs from which to choose.

Four trends raise concerns about the long-term stability of the PDP market. Those trends reveal differences that may affect competition both within and between the two sectors and the benefits that PDPs and MA–PDs offer to Medicare beneficiaries.

First, the Commission found that Part D premiums for the basic benefits charged by PDPs have tended to exceed those of MA–PDs. Second, in some areas of the country, the number of PDPs qualifying as "benchmark" plans (premium-free for FFS beneficiaries with low income and limited assets) has continued to decline. Third, drug costs, on average, have been higher among PDPs compared with MA–PDs, but average risk scores for PDPs have been lower. Because risk scores are intended to reflect average drug costs across a group of individuals, this finding suggests that Part D's payment system may not have adequately adjusted for PDPs' higher costs before 2025. Finally, PDPs have been more likely to incur losses in Part D's risk corridors compared with MA–PDs.

With more than half of Part D beneficiaries receiving their drug coverage through MA–PDs, certain MA and Part D policies that were primarily intended to guide plan operations in the MA market may be having unintended effects on PDP and MA–PD offerings and benefits:

- MA–PDs have an additional funding source ("MA rebates") that can be used to enhance their Part D plan offerings or to reduce their premiums.
- MA–PDs may adjust their premiums after CMS publishes Part D subsidy amounts, allowing them to better target particular premium amounts.
- MA–PDs can offer dual-eligible special-needs plans (D-SNPs) that are open only to individuals who are dually eligible for Medicaid and Medicare, which allows them to restrict enrollment to enrollees who receive Part D's low-income subsidy (LIS) and to tailor their benefits more effectively to balance enrollees' needs and plans' financial goals.

The effects of these policies may result, over time, in the PDP market becoming less attractive to insurers. Other differences may also be at work between PDPs and MA–PDs. For example, compared with PDPs, MA–PDs may be able to manage drug costs more effectively through their contractual relationships with clinicians who prescribe medicines to their enrollees; face different incentives for managing drug spending, particularly for medications that affect medical spending; or employ diagnostic coding practices that, on average, increase Medicare's relative payments to MA–PDs. Such differences create a divergence between the relative costs and payments for MA–PDs and PDPs and could compound the effects of MA and Part D policies discussed above.

We conducted further analyses of PDP and MA–PD drug costs and risk scores between 2019 and 2023 to understand why risk-standardized costs—that is, costs divided by risk scores—were lower for MA–PDs than for PDPs in those years. Our analysis of plans' formularies did not find evidence that MA–PDs achieved lower costs compared with PDPs by having more narrow formularies, higher cost sharing, or greater use of utilization management. Our estimates for 2019 through 2023 show that, relative to the overall Part D population, differences in coding intensity produced higher risk scores for MA–PD enrollees and lower risk scores for PDP enrollees on average. Those differences imply that systematic differences in coding practices by MA–PDs and PDPs affected the ability of Part D's risk-adjustment model to accurately predict costs for either sector in those years. While differences in coding intensity explain some of the difference in average risk-standardized costs between MA–PDs and PDPs, a substantial difference persisted in all years between 2019 and 2023, which suggests that there are other factors that differentially affect spending in the two markets.

Finally, the redesign of the Part D benefit significantly increased plan liability for benefit spending. As more of Medicare's subsidies to Part D plans take the form of risk-adjusted capitated payments rather than cost-based payments, the difference in coding intensity between PDPs and MA–PDs and other factors that affect risk-score trends in the two markets could be amplified. In 2025, CMS began applying separate normalization factors for MA–PDs and PDPs to adjust for the diverging risk-score trends in these two markets. The use of separate normalization factors is expected to increase risk scores for PDPs (and decrease risk scores for MA–PDs) on average and, consequently, may decrease the difference in risk-standardized costs between the two plan types. However, the use of separate normalization factors alone may still result in inaccuracies in Part D's risk adjustment at the individual plan level. In turn, those inaccuracies could affect enrollee premiums and payments to plans. At the same time, CMS's Part D

Premium Stabilization Demonstration, which provides additional subsidies to PDPs beginning in 2025 to stabilize their enrollee premiums, may help moderate some of the effects of the redesign. The Congressional Budget Office expects that the additional subsidies paid to PDPs under the demonstration would increase federal spending for Part D by roughly $5 billion in 2025.

For FFS beneficiaries, PDPs are the only options available for obtaining Part D's drug coverage; for FFS beneficiaries who receive the LIS, benchmark PDPs are the only premium-free options for Part D coverage. Because of these critical roles, the Commission plans to continue to assess the drivers of differences in average risk-standardized costs between MA–PDs and PDPs and monitor the availability of PDPs—particularly benchmark PDPs—as plans adjust to the new Part D benefit structure.

Medicare beneficiaries in nursing homes

In Chapter 5, the Commission describes the Medicare long-stay NH population and reviews regulations and programs CMS has implemented to improve NH quality, including specialized MA plans known as institutional special-needs plans (I–SNPs).

About 1.2 million beneficiaries live in NHs due to functional and/or cognitive impairments that prevent them from living in the community. Medicare's coverage of NH care is largely limited to coverage of short-term skilled care after a hospitalization, although Medicare covers other services received by beneficiaries living in nursing homes, such as physician and other clinician services and ancillary services (for example, lab tests and physical therapy). More than 80 percent of Medicare beneficiaries in NHs are also covered by Medicaid, the predominant payer for NH care.

In 2023, there were about 15,000 nursing homes nationwide. Nearly all NHs operate as both nursing facilities that provide long-term custodial care and as SNFs that provide short-term skilled care. The industry is characterized by independent providers and regional chains. The industry reports low profit margins across all payers (0.4 percent 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 SNF care is much higher, at 22 percent in 2023.

The quality of care provided to NH residents is a long-standing and well-documented problem. The National Academies have described the financing, delivery, and regulation of NH care as "ineffective, inefficient, fragmented, and unsustainable." Among other problems, NHs have a financial incentive to hospitalize residents so they qualify for Medicare-covered SNF care, and Medicaid's payment rates are often low and typically do not cover the cost of care.

CMS has made a variety of efforts to improve care for beneficiaries in NHs. NHs are subject to regular quality and safety inspections, but evaluations have concluded that these inspections sometimes fail to identify serious quality problems and may not lead to effective corrections. To encourage NHs to improve their care, CMS publicly reports a star rating (ranging from 1 to 5) for each NH, which evaluators have found modestly helps consumers select NHs with higher ratings and encourages NHs to improve. Additionally, the 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. CMS has made several improvements that address some of the issues raised by the Commission in 2021 regarding the design of the SNF–VBP, but the VBP program still has important design flaws that would require congressional action to correct.

I–SNPs are specialized plans that serve MA beneficiaries who need NH care. I–SNPs now cover about 12 percent of Medicare NH residents. These plans aim to reduce the use of expensive services such as inpatient care by using teams of physicians and nurse practitioners to deliver more preventive and coordinated care within the NH and reimbursing NHs in ways that encourage facilities to deliver more care on-site. The available evidence is somewhat limited but suggests that I–SNPs reduce the use of inpatient care and emergency department visits and perform better on some quality measures. Enrollment in I–SNPs has been growing, but their ultimate reach may be limited.

The Commission may consider future work in two areas. First, building on the modest success of the star-rating system and the clear relationships between NH staffing and quality, alternative designs could elevate the role of staffing in calculating the overall rating of NHs. Second, given the limited but favorable evidence for I–SNPs, new work could examine factors that

currently limit the use of I–SNPs and consider potential policy changes that encourage broader use of I–SNPs and reduce barriers to expansion, while enabling more rigorous measurement and oversight of I–SNPs.

Medicare's measurement of rural provider quality

In Chapter 6, the Commission reviews the inclusion of rural providers in current Medicare FFS quality-reporting programs.

The Commission supports Medicare's measurement of the quality of care furnished by providers to monitor performance, inform patients and payers, and incentivize high-quality care. However, there are practical challenges in measuring some individual rural providers' quality of care and in holding these providers accountable in quality-reporting programs because of low patient volumes in many rural health care settings. For example, low patient volume means that it is difficult to produce reliable and valid estimates on quality measures for some rural providers. In addition, low-volume providers may have limited staff and funds available for quality-improvement activities.

The Commission acknowledged these difficulties when it established specific principles to guide expectations about quality in rural areas: First, expectations for quality of care in rural and urban areas should be equal for the nonemergency services that rural providers choose to deliver. Second, all providers should be evaluated on the full range of services they provide (emergency and nonemergency alike), and the quality measures for the services should be collected and reported publicly.

Because of the Commission's continued interest in rural provider quality, we expanded our reporting of provider quality to include comparisons of rural and urban areas, where relevant and available, in our March 2025 report on the adequacy of payments in the FFS payment systems. In general, the comparisons of provider quality in rural and urban areas were mixed across and within settings. For some quality measures, rural quality was better than urban; for others, urban quality was better; and for others, the quality results were similar.

The Congress has enacted pay-for-reporting quality programs for FFS provider types that account for a large majority of services furnished to Medicare beneficiaries. In these programs, providers that successfully report designated quality-measure data are financially rewarded (or not penalized). CMS uses the quality data to publicly report provider performance on the Care Compare website to hold providers accountable to consumers and encourage improvement. Some rural providers may not be required to participate in the Medicare quality payment programs; however, the majority of rural providers do have at least some Medicare quality results publicly reported.

We reviewed the requirements of quality-reporting programs and used Care Compare data files to determine participation by rural and urban providers. Hospitals, clinicians, and inpatient rehabilitation facilities had comparable shares of rural and urban providers with publicly reported quality results. Rural SNFs and dialysis facilities had lower shares of providers with publicly reported quality results compared with their urban counterparts; in contrast, rural HHAs and hospices had higher shares of providers with publicly reported quality results compared with their urban counterparts.

MA plans, Part D plans, and accountable care organizations (ACOs) are also required to report quality-measure data, typically calculated based on the experience of a sample of patients across participating providers, to CMS. Beneficiaries residing in rural areas who are assigned to ACOs or are enrolled in MA plans may or may not be included in the quality-measure results that CMS currently collects for those entities because of sampling methodologies.

There are several federal and stakeholder initiatives to drive improved quality measurement of rural providers, including identifying and developing the most relevant metrics for rural providers and making technical assistance available to rural providers for quality measurement and improvement. The Commission will continue to monitor the implementation and effectiveness of these initiatives.

Reducing beneficiary cost sharing for outpatient services at critical access hospitals

In Chapter 7, the Commission recommends setting FFS beneficiary cost sharing for outpatient services

provided at critical access hospitals (CAHs) based on each hospital's Medicare payment amount instead of the hospital's charges.

The CAH program provides cost-based reimbursement to certain rural hospitals with 25 or fewer acute care beds who provide care to Medicare beneficiaries rather than the PPS rates received by other hospitals. For many CAHs, the higher rates associated with cost-based payments are necessary to remain financially viable. The Commission estimates that Medicare's cost-based FFS payments to CAHs averaged about $4 million more per CAH than would have been paid under the inpatient and outpatient PPSs in 2022. If CAHs had been paid standard PPS rates, many would have incurred significant losses.

However, FFS beneficiaries pay substantially more coinsurance at CAHs than they do for the same services at PPS hospitals. For most outpatient services, CAH coinsurance for FFS beneficiaries is set at 20 percent of charges. Charges are the list prices that hospitals set for their services, and they typically far exceed CAHs' reported costs of providing those services. Charges can be seen as arbitrary and can vary widely across hospitals and services. According to our analysis of outpatient cost-sharing liabilities at CAHs, cost sharing averaged 52 percent of total FFS Medicare payments for CAH outpatient services in 2022; however, cost sharing varied widely across services and CAHs. This variation among CAHs creates inequities in beneficiaries' cost sharing depending on whether they receive services at a CAH with high or low markups (the ratio of charges to costs) and may subject CAH patients to cost sharing that is much higher than what they would be liable for if they had received care at a hospital where coinsurance equals 20 percent of Medicare's payment rate for the service at that specific hospital.

FFS beneficiaries who receive outpatient services in hospitals paid under Medicare's outpatient PPS (OPPS) also receive financial protection in the form of a cap on coinsurance. Under the OPPS, coinsurance for an outpatient procedure provided at most hospitals cannot be greater than Medicare's inpatient hospital deductible ($1,676 in 2025). However, there is no cap on cost sharing for FFS beneficiaries who receive outpatient services at CAHs. We found that, in 2022, about 200,000 (out of 26 million) CAH outpatient line items had coinsurance over the OPPS cap. If Medicare had imposed a cap on CAH coinsurance for each line item in 2022, the coinsurance on the 200,000 claims would have been reduced by an average of about $2,000 per line item.

In a majority of cases, CAH coinsurance for beneficiaries in FFS Medicare is paid for by the beneficiary's supplemental insurer. However, we estimate that about 16 percent of rural FFS beneficiaries do not have supplemental insurance and are directly billed 20 percent of charges when they receive outpatient services at a CAH. And, even when a beneficiary has supplemental insurance that directly shields them from high coinsurance amounts, the cost of that coverage may be passed on in the form of higher supplemental insurance premiums in states with CAHs. The higher supplemental insurance premiums are borne by all policyholders, whether they receive outpatient services at CAHs or not.

The Commission recommends that CAH coinsurance for outpatient services received by FFS beneficiaries be set at 20 percent of the payment amount (rather than 20 percent of charges) and be subject to a cap per service equal to the inpatient deductible. This change would protect beneficiaries from excessive amounts of coinsurance and would make CAH cost sharing more consistent with Medicare cost sharing for outpatient services in other hospitals. If beneficiary coinsurance for outpatient services provided at CAHs had been set at 20 percent of the payment amount in 2022, 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 lower (60 percent lower), assuming no change in care patterns. If enacted, the 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. ■