American College of Radiology™

MedPAC June 2025 Report to Congress Detailed Summary

The Medicare Payment Advisory Commission (MedPAC) released its June 2025 Report to Congress on June 12, 2025. The MedPAC is an independent congressional agency that advises the United States Congress on various issues affecting the Medicare program. This report fulfills the Commission's legislative mandate to evaluate Medicare payment issues and report to the Congress. MedPAC's mission is to preserve beneficiaries' access to high-quality care, control Medicare spending growth, and provide sufficient payment for efficient providers.

Chapter 1: Reforming physician fee schedule updates and improving the accuracy of relative payment rates

> *Recommendation 1-1: Congress should replace the current–law updates to the physician fee schedule with an annual update based on a portion of the growth in the Medicare Economic Index (MEI) (such as MEI minus 1 percentage point).*
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> *Recommendation 1-2: The Congress should direct the Secretary to improve the accuracy of Medicare's relative payment rates for clinician services by collecting and using timely data that reflect the costs of delivering care.*

While MedPAC's analysis of Medicare patient access to care continues to show that Medicare beneficiaries have good access to care, the Commission recognizes that the Medicare physician fee schedule payment rate updates under current law (0.75 percent per year for clinicians participating in in advanced alternative payment models and 0.25 percent for all other clinicians beginning in 2026) will not keep up with costs as measured by the Medicare Economic Index (MEI). The MEI is expected to grow by an average of 2.2 percent each year from 2025 through 2034, a higher average than the previous two decades. MedPAC does not believe that full MEI updates are necessary to ensure Medicare beneficiary's access to care. MedPAC believes that a full MEI update could result in large financial burdens for beneficiaries and the Medicare program. The report also discusses the ideas of update ceilings and floors, but does not provide specific recommendations for what those may be.

MedPAC estimates the recommended MEI-based updates would increase federal program spending by between $15 billion and $30 billion over five years relative to current law and would also increase beneficiary premiums and cost-sharing liabilities.

MedPAC acknowledges that the current update methodology is flawed but encourages policymakers to continue to include some form of incentive bonus for clinicians who participate in advanced alternative payment models.

Improving the accuracy of relative values under the fee schedule
MedPAC believes there are serious flaws in the allocation of relative value units (RVUs) within the physician fee schedule leading to overpayment of some services and underpayment of other services and possibly incentivizing vertical consolidation between hospitals and clinicians.

MedPAC proposes the following ideas on improving RVU accuracy:

- *Pay more accurately for indirect practice expenses*: MedPAC believes that reimbursement for indirect practice expenses (i.e. overhead costs) for clinician services provided in a facility are often overestimated as many clinicians no longer maintain an independent, freestanding office or the costs of maintaining the independent office are covered by the clinician's employer.
- *Update 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. MedPAC believes that using updated data would produce RVUs that more accurately reflect how costs are distributed among the three RVU categories in a typical clinician practice; however, there are questions on the most appropriate data source for this information.
- *Address overvaluation of global surgical codes*: Current RVUs for 10-day and 90-day global surgical codes include values for postoperative visits that often do not occur, resulting in substantial overvaluation. MedPAC suggests revaluation of these global surgical codes or unbundling them to 0-day globals.

Chapter 2: Supplemental benefits in Medicare Advantage (MA)
In MA plans, supplemental benefits are services and items that go beyond what traditional Medicare (parts A & B) cover, and they are mostly paid for via rebates plans receive from Medicare. Common benefits include dental, vision, hearing, over-the-counter items, and fitness programs. In recent years, CMS and the Congress have gradually increased plans' flexibility in the types of supplemental benefits that can be offered, which has led to an increase in Special Supplemental Benefits for the Chronically Ill (SSBCI), which includes services like meal delivery, transportation, and in-home support.

In 2025, Medicare is projected to spend $86 billion on supplemental benefits, which makes up 17% of total MA payments. This is a sharp increase from 2018, where payments were $21 billion. Of the $86 billion, an estimated $39 billion will be allocated to non-Medicare

services, $27 billion will be allocated to reduced cost sharing for Medicare-covered services, and the remaining $20 billion dollars will be spent on Part D benefits/premiums.

Since plans often contract with third-party vendors, MedPAC has raised concerns about limited oversight as well as inflated costs, with the report stating that beneficiaries may not fully understand or utilize their available benefits.

In 2024, CMS began implementing a series of actions to improve utilization data, but the new requirements will not address all the limitations that hinder MedPAC's ability to assess how MA enrollees use their supplemental benefits. The Commission expects it will be several more years before the full range of data is available for analysis.

MedPAC suggests improving transparency in how benefits are delivered and who provides them, implementation of standardized reporting of benefit utilization and outcomes, considering limits on related-party transactions to prevent abuse, and enhancing beneficiary education to ensure informed plan choices.

Chapter 4: Part D prescription drug plans (PDPs) for beneficiaries in fee-for-service Medicare and Medicare Advantage (MA)
Beneficiaries in traditional Medicare must enroll separately in a Part D plan for prescription drug coverage, while MA enrollees typically receive drug coverage through their all-in-one MA–Prescription Drug (MA–PD) plan. Part D enrollment has also shifted from Part D plans to MA-PDs in the same way Medicare beneficiaries have shifted from enrolling in traditional FFS Medicare to MA plans.

The following trends raise concerns about the long-term stability of the PDP market, revealing potential issues affecting the competition both within and between PDPs and MA-PDs:

- Premiums charged by PDPs, on average, exceed premiums for MA-PDs
- Fewer PDPs qualifying as premium-free to beneficiaries with the LIS (Low Income Subsidy)
- PDPs, on average, have higher gross drug spending but lower risk scores than MA-PDs
- PDPs are more likely than MA-PDs to incur losses.

With more than 50% 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. The effects of these policies may be that, over time, the PDP market will become less attractive to insurers.

The Commission found that from 2019 to 2023, MA–PD plans had higher risk scores than PDPs due to more intensive diagnostic coding, which affected the accuracy of Part D's risk adjustment model. While these coding differences don't increase Medicare's aggregate payments to Part D plans, they can lead to lower subsidies and higher premiums for plans with less aggressive coding.

The Part D benefit was redesigned for 2025, increasing financial responsibility for plans and shifting more subsidies to risk-adjusted payments, which could potentially amplify the effects of the aforementioned coding intensity differences between MA–PDs and PDPs. CMS addressed this by using separate normalization factors this year to better align risk scores and launched the Part D Premium Stabilization Demonstration to help offset premium increases for PDP enrollees. MedPAC notes that despite these changes made by CMS, individual plan-level inaccuracies in risk adjustment may still occur. The Congressional Budget Office (CBO) expects that the additional subsidies paid to PDPs under the demonstration will increase federal spending for Part D by roughly $5 billion in 2025.

Chapter 6: Medicare's measurement of rural provider quality
Due to low patient volumes in many rural healthcare settings, challenges arise in collecting reliable quality data. Existing metrics do not reflect the realities of rural care delivery, and low-volume providers may lack the funds and staff to dedicate to burdensome data collection and reporting. MedPAC has previously acknowledged these difficulties by establishing specific principles in 2012 to guide expectations about quality of care in rural areas.

In this chapter, the Commission reviews the inclusion of rural providers in the current Medicare fee-for-service (FFS) quality reporting programs. Some rural providers may not be required to participate in the Medicare quality payment programs; however most rural providers do have at least some Medicare quality results publicly reported via the Care Compare website.

Rural SNFs and dialysis facilities had lower shares of providers with publicly reported quality results compared with their urban counterparts; in contrast, rural home health agencies (HHAs) and hospices had higher shares of providers with publicly reported quality results compared with their urban counterparts.

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. MedPAC will continue to monitor the implementation and effectiveness of these initiatives.

Chapter 7: Reducing beneficiary cost sharing for outpatient services at critical access hospitals (CAHs)

MedPAC's Recommendation:
For fee-for-service Medicare beneficiaries, Congress should:

- *Set coinsurance for outpatient services at critical access hospitals equal to 20 percent of the payment amount for services that require cost sharing; and*
- *Place a cap on critical access hospitals' outpatient coinsurance equal to the inpatient deductible.*

The Commission estimates that Medicare's cost-based fee-for-service (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. FFS Medicare beneficiaries pay substantially more coinsurance at CAHs than they do for the same services at PPS hospitals.

The Commission's analysis of outpatient cost-sharing liabilities at CAHs found that cost sharing averaged 52% of total FFS Medicare payments for CAH outpatient services in 2022; however, cost sharing varied widely across services and CAHs. The variation in markups (the ratio of charges to costs) across CAHs created inequities in cost sharing paid by beneficiaries depending on where they receive services.

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. However, there is no cap on cost sharing for FFS beneficiaries who receive outpatient services at CAHs.

MedPAC found that about 200,000 CAH outpatient line items had coinsurance that exceeded the OPPS cap in 2022. The most common services with coinsurance above the inpatient deductible were orthopedic surgeries and Part B drug injections. If outpatient coinsurance at CAHs had been limited to 20% of the payment amount in 2022, beneficiaries would have paid about $2.1 billion less—a 60% reduction in cost-sharing. **This reduction would have been offset by a $2.1 billion increase in Medicare payments, funded by taxpayers and Part B premium payers.**