American College of Radiology™

**MedPAC March 2025 Report to Congress Detailed Summary**

The Medicare Payment Advisory Commission (MedPAC) released their March 2025 Report to Congress on March 13, 2025. MedPAC is a non-partisan, independent legislative branch commission created to advise Congress regarding Medicare-related issues. The report presents MedPAC's recommendations for updating provider payment rates in fee-for-service Medicare for 2026, for acute care hospital and physician services, as well as an update on the Medicare Advantage (MA) program.

**Chapter 1: Context for Medicare payment policy**

Chapter 1 provides context for the entire report, and MedPAC's work more broadly, by describing Medicare's overall financial situation and highlighting factors that contribute to growth in Medicare spending.

*National health care spending usually grows faster than GDP*
In 2023, the U.S. spent $4.9 trillion on health care. National health care spending temporarily diverged from the historical trend (health care spending growing faster than GDP) during the recent COVID-19 pandemic; sharply increasing as a share of GDP in 2020 before falling just as sharply in 2021 and 2022. Another driver of growth in national health care spending in 2023 was the increasing volume and intensity of health care services used per patient that year (particularly hospital care and clinician services) among both Medicare beneficiaries and the privately insured. Consumers also used a more expensive mix of retail prescription drugs in 2023, with more higher-cost and newer brand-name drugs, and drug prices increased faster in 2023 than in 2022.

*Medicare spending is projected to double in the next 10 years*
In 2023, growth in Medicare spending was also driven by provisions in the Inflation Reduction Act of 2022 (IRA) that increased the generosity of the Part D benefit by limiting beneficiary cost sharing for insulins and requiring coverage of vaccines with no cost sharing. In recent years, FFS Medicare enrollment has declined and enrollment in MA plans, which cost the Medicare program more per beneficiary than FFS coverage, has rapidly increased. Looking ahead, Medicare spending is projected to grow faster than spending by all other types of payers over the next decade: Between now and the early 2030s, CMS expects Medicare spending to grow by 7 percent to 8 percent per year. This increase will cause Medicare spending to nearly double over a 10-year period, growing from $1.0 trillion in 2023 to $1.9 trillion in 2032.

Medicare spending is also expected to grow due to an increase in the volume and intensity of services delivered per beneficiary, which is projected to rise by an average of 2.8 percent

per year in the coming years. An example of increasing volume and intensity of service delivery is when newer, higher-resolution computed tomography (CT) scans identify potential issues that might not have been identified by lower-resolution CT scans, and those issues are then pursued through additional clinical workup. Intensity can also increase when providers furnish more complex, higher-priced services in place of less complex, lower-priced services.

*Medicare faces a financing challenge*

The entire baby-boom generation will be old enough to enroll in Medicare by 2029 (Fiore et al. 2024). By that time, Medicare is projected to have 75 million beneficiaries—up from 65 million beneficiaries in 2022. Meanwhile, the ratio of workers helping to finance Medicare through payroll and income taxes relative to the number of Medicare beneficiaries has been declining over time and is expected to continue to do so. The declining ratio of workers to Medicare beneficiaries creates a financing challenge for the Medicare program.

Medicare Part A is mainly financed through current workers' Medicare payroll taxes, which are deposited into Medicare's Hospital Insurance (HI) Trust Fund. Medicare's Trustees currently estimate that the trust fund's balance will rise through 2029 and then decline from 2030 on, and by 2036 the trust fund will no longer carry a positive year-end balance. To extend the solvency of the HI Trust Fund beyond the mid-2030s, there are a number of options available to policymakers.

*As Medicare spending increases, so too do beneficiaries' costs*

In 2023, the Medicare program spent an average of $16,710 per beneficiary on Part A, Part B, and Part D benefits almost $3,000 more than in 2019. Cost-sharing liabilities for beneficiaries in FFS Medicare averaged $396 for Part A services and $1,621 for Part B services in 2021. Average annual cost sharing for retail prescription drugs in 2022 was $480 for beneficiaries with stand-alone Part D plans and $276 for those with drug coverage through an MA plan, but these amounts are expected to be lower in coming years. Cost sharing is a barrier for some beneficiaries. Among all Medicare beneficiaries, 6 percent reported having problems paying a medical bill, according to MedPAC analysis of CMS's 2022 Medicare Current Beneficiary Survey, but some subpopulations experienced affordability issues at notably higher rates.

*Differences in beneficiaries' access to care and health outcomes*

In response to commissioner interest, the Commission reports on differences in Medicare beneficiaries' access to care and health outcomes. Research has shown that some beneficiaries have more difficulties accessing care and experience worse outcomes than others. Medicare beneficiaries with incomes and assets low enough to qualify for Part D's low-income subsidy report more problems accessing care than other beneficiaries.

**Chapter 2: Assessing payment adequacy and updating payments in fee-for-service Medicare**

*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 Commission judges the extent to which payment rates are adequate for relatively efficient providers to achieve high value. The Commission's recommendations may indicate an increase, decrease, or no change in payment rates relative to the updates specified in current law. Payment rates should be sufficient to provide high-quality care for beneficiaries but also be based on efficient delivery of services.

*Payment-adequacy analytic framework*
The Commission bases its payment update recommendations on an assessment of the adequacy of current FFS Medicare payments. The MedPAC 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.

*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. MedPAC analysis uses claims and other administrative data, but also MedPAC uses survey 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. MedPAC does acknowledge 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.

Provider capacity, supply, and staffing
Medicare beneficiaries' access to care depends in part on providers' ability to meet demand with current supply. Low provider capacity, long waiting 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. The MedPAC has noticed that providers have modified excess capacity in response to payment-policy changes.

Volume of services
The MedPAC 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 beneficiaries can indicate adequate access to services and payment. In areas where 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.

FFS Medicare marginal profit
FFS Medicare marginal profit reflects the costs to treat Medicare that vary with volume in the short term. The MedPAC believes Medicare FFS payment should support an appropriate portion of fixed cost of efficient care delivery, but they 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*
The MedPAC noted that payment policy should support beneficiaries accesso to high quality care, but that it is not a direct relationship.

Providers' access to capital
Providers must have access to capital to maintain and modernize their facilities and to improve patient-care delivery. 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.

*FFS Medicare payments and providers' costs*
The MedPAC 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. The COVID-19 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.

Use of FFS Medicare margins
The MedPAC demonstrates 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. To assess the distribution of payments and any need for targeted support, the MedPAC calculate FFS Medicare margins for certain subgroups of providers

that have unique roles in the health care system or that receive special payments. The MedPAC noted that 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.

Assessing current costs
The MedPAC 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. Lack of fiscal pressure is more common in markets where a few providers dominate and have negotiating leverage over payers. The Commission generally does not recommend lowering FFS Medicare payments because payments from private plans are higher or raising them if other payers pay less.

*Anticipated payment and cost changes in 2025*
The MedPAC estimates FFS Medicare payments and providers' costs for 2025 to inform the Commissions update recommendations for 2026. In general, to estimate payments, the MedPAC first apply the annual payment updates specified in law for 2024 and 2025 to their base data. Then MedPAC model the effects of other policy changes that will affect the level of FFS Medicare payments in 2025.

*Recommendations for FFS Medicare payment in 2026*
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.

**Chapter 3: Hospital inpatient and outpatient services**

The following recommendation is included in this chapter:

The Congress should:

- For 2026, update the 2025 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1 percent; and
- Redistribute existing disproportionate-share-hospital and uncompensated care payments through the Medicare Safety Net Index (MSNI)-using the mechanism

described in MedPAC's March 2023 report- and add $4 billion to the MSNI pool.

*Assessment of payment adequacy*

Indicators of payment adequacy for FFS Medicare beneficiaries in 2023 were mixed. Whie beneficiary access to care remained good overall and the hospitals' all-payer margin was improved, quality indicators were mixed. FFS Medicare payments remained well below hospitals' costs.

*Beneficiaries' access to care*

Indicators of beneficiaries' access to hospital inpatient and outpatient care suggest that FFS Medicare beneficiaries maintained good access to care. Hospital employment and the number of hospital beds both increased, with occupancy rates remaining stable at 69 percent. The supply of hospitals remained relatively steady in 2023, though slightly more hospitals closed than opened. In FY2024, 4 additional hospitals opened, 15 closed, and 17 converted to rural emergency hospitals (REHs).

Medicare beneficiaries' use of hospital outpatient services per capita increased but still remained below pre-pandemic levels. In CY2023, hospital outpatient services per FFS beneficiary increased 2.4%, up to 5.2 services per beneficiary. The increase in outpatient services primarily resulted from small volume increases in evaluation & management (E&M), imaging, and procedure services that collectively more than offset the large drop in the number of COVID-19 test collection services. Despite this increase, the number of outpatient services per capita remained 2.8% lower than the immediate pre-pandemic period. MedPAC evaluated hospitals' marginal costs compared to Medicare payments and found that hospitals' FFS Medicare marginal profit continued to be positive in 2023.

*Quality of care*

In fiscal year 2023, FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved 0.3 percentage points in 2023, and it improved relative to pre-pandemic levels. FFS Medicare beneficiaries' risk-adjusted readmission rate was slightly worse in 2023 than in 2022 but about 0.5% better than the immediate pre-pandemic period. However, most patient-experience measures improved in 2023 but continued to be at least 1% lower than pre-pandemic levels.

*Providers' access to capital*

Hospitals' FFS Medicare marginal profit on IPPS and OPPS services was 6.4% in FY2023, up from 2.3% in 2022. Hospitals' all-payer operating margin increased from 2.7% to 5.1%. The

total margin increased more than the operating margin because hospitals received about $13 billion in investment income in 2023, compared to $7B in investment losses in 2022. Hospitals' borrowing costs increased by less than the general market, and mergers and acquisitions continued. Preliminary data indicates that there could be further improvement in hospitals' access to capital in FY2024.

*FFS Medicare payments and providers' costs*
FFS Medicare payments for inpatient and outpatient services continued to be below hospitals' costs in FY2023. Exclusive of coronavirus relief funds, hospitals' FFS Medicare margin was stable from 2022 to 2023. For-profit hospitals' FFS Medicare margin remained positive and much higher than nonprofit hospitals' margin but fell in 2023. FFS Medicare margin remained higher at hospitals with higher Medicare Safety Net Index (MSNI) values. The FFS Medicare payment rates for services provided in hospital outpatient departments (HOPDs) are generally higher than rates for services performed in freestanding physician offices and ambulatory surgical centers (ASCs). MedPAC found that these payment differences encourage arrangements among the providers, such as consolidation of physician practices with hospitals, which result in care being billed from settings with the highest payment rates. This leads to increased Medicare spending and beneficiary cost without material improvements in patient outcomes. The Commission contends that the Medicare program should not pay more for services provided in a high-cost setting when it is safe and appropriate to provide those same services in a low-cost setting when doing so does not pose a risk to access.

MedPAC modeled the effect of aligning payment rates across settings of care for 66 ambulatory payment classifications (APCs) to illustrate their recommendation for site-neutral payments. The Commission found that, without a budget neutrality adjustment, expanding the site-neutral policy to all OPPS-covered services (excluding separately payable drugs) would reduce payments to hospitals for OPPS services by 3.2%. MedPAC reported that applying this policy to services furnished in 2023 without a budget-neutrality adjustment would have lowered combined IP and OP FFS Medicare revenue by 0.9%, Medicare spending would have been $1.3 billion lower, and beneficiary cost-sharing obligations would have been $0.3 billion lower. Applying a budget neutrality adjustment would cause no change in aggregate IP and OP revenue, but it would cause rural hospitals to gain a small amount and urban hospitals to lose a small amount.

*Mandated report on rural emergency hospitals*
The Consolidated Appropriations Act (CAA) of 2023 requires MedPAC to report annually on payments to rural emergency hospitals (REHs). In CY2023, 21 hospitals converted to

REHs. Since CY2024 claims data were not available for the Commission to analyze, they utilized 2023 claims data for the 21 REHs in 2023.

In CY2023, FFS Medicare paid about $10 million for OP hospitals services at REHs, over $8 million of which was paid through the OPPS. Since REHs get paid 105% of standard OPPS rates, this translates to aggregate payments of about $400,000 above standard OPPS rates. The OPPS services that accounted for the highest share of spending were ED visits, drug-administration services, intraocular procedures, and imaging services. The Commission continues to monitor the implementation and uptake of the new REH designation.

**Chapter 4: Physician and other health professional services**

The following recommendation is included in this chapter:

The Congress should:

- for calendar year 2026, replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the Medicare Economic Index minus 1 percentage point; 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.

In 2023, physician fee schedule services accounted for just under 17 percent of FFS Medicare spending. Between Medicare and beneficiary payments to 1.4 million clinicians, fee schedule services for 28.2 million beneficiaries amounted to $92.4 billion, an increase of $0.7 billion over 2022 spending. From 2022 to 2023, there was a 3.3% decrease in the number of beneficiaries and 4.2% increase in spending per fee for service beneficiary.

*Assessment of payment adequacy*
MedPAC's annual Medicare beneficiary survey again showed that beneficiaries report comparable access to privately unsured people. The survey added questions about wait times per a request from the House Committee on Appropriations with the responses indicating that wait times for appointments with clinicians are comparable or better than wait times reported by privately insured people. There are disparities with access to care with beneficiaries under age 65 and those with low incomes more likely to report having trouble getting health care and to report delaying care due to cost compared with other Medicare beneficiaries.

MedPAC reports a shift in the types of clinicians billing through the Medicare physician fee schedule with a decrease in primary care physicians, an increase in specialists and a dramatic increase in in the number of non-physician providers (e.g. APRNs, PAs).

In 2023, preferred private insurer payment rates for clinician services were, on average, 140 percent of FFS Medicare's payment rates, up from 136 percent in 2022. Since there is no comprehensive data on provider revenues and costs, MedPAC uses clinician compensation levels to determine profitability. Physician compensation has grown by 3.3% per year from 2019 to 2023. The Commission recognizes that since providers accept a variety of types of insurance, clinician compensation is not a direct measure of Medicare payment adequacy. MedPAC reports a 4.2% increase in imaging spending in 2023.

Currently, Medicare Economic Index (MEI) growth is projected to be 3.3 percent in 2024 and 2.8 percent in 2025. MedPAC anticipates that increases in clinicians' input costs in 2024 and 2025 will be larger than the increases in FFS Medicare payment rates that are scheduled under current law. MedPAC points out that while past conversion factor updates have not kept pace with the growth in clinician's costs, the volume and intensity of services per beneficiary have increased substantially over time, suggesting that the payment rates have not impeded patient access to care.

*How should payment rates change in 2026?*
Current law mandates a 0.75% update for clinicians participating in advanced alternative payment models and 0.25% for all other clinicians. The Commission recommends, for calendar year 2026, that the Congress replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the MEI minus 1 percentage point. MedPAC recommends that this be a permanent update without a scheduled expiration date. Based on current MEI projections, the 2026 update would be 1.3%.

In addition, the Commission recommends a new, permanent add-on payment for clinician services furnished to low-income Medicare beneficiaries defined as those enrolled in both Medicare and Medicaid or receiving the Part D low-income subsidy. These add-on payments would increase Medicare payment rates by 15 percent for primary care clinicians and by 5 percent for all other clinicians for fee schedule services furnished to FFS Medicare beneficiaries with low incomes.

**Chapter 11: The Medicare Advantage program: status report**

In 2024, the Medicare Advantage (MA) program included 5,678 plan options offered by 175 organizations, enrolled about 33.6 million beneficiaries, and paid MA plans an estimated

$494 billion (not including Part D drug payments). The majority of (54%) Medicare beneficiaries are now enrolled in MA plans. In 2025, MedPAC estimates that Medicare will spend 20% more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates to a projected $84 billion. The rebates plans use to finance extra benefits to enrollees have nearly doubled since 2018 and account for a projected 17% of all payments to all MA plans in 2025. CMS lacks information about beneficiaries' use of these extra benefits. The Commission estimates that Part B premium payments will be about $13 billion higher in 2025 because of higher payments to Medicare plans, which are financed by the taxpayers and beneficiaries who fund the program. While MedPAC has always strongly supported the inclusion of these private plans in the Medicare program, the Commission contends that important reforms are needed to improve Medicare's policies of paying and overseeing MA plans.

*Medicare's payments to plans*
In 2025, Medicare's payments to MA plans will total a projected $538 billion, which is $84 billion more (about 20% higher) than if MA enrollees were enrolled in FFS Medicare. Higher payments to MA plans stem from two factors: favorable selection of beneficiaries and coding intensity.

*Favorable Selection*
Favorable selection refers to the tendency of beneficiaries with lower spending than predicted by their risk score to enroll in MA. The effects of favorable selection (prior to any coding differences) have consistently caused the risk scores of MA enrollees to overpredict what their spending would have been in FFS Medicare, which increases MA payments by an estimated 11%, or $44 billion, above FFS spending in 2025.

*Risk Adjustment and Coding Intensity*
Coding intensity refers to the tendency for MA plans to record more diagnosis codes for their enrollees, which causes risk scores and Medicare payments to be higher. Diagnostic coding by MA plans overstates the health differences between MA and FFS enrollees assumed in risk scores, which further increases MA payments by an estimated 10%, or $40 billion, above FFS spending in 2025. These higher payments relative to FFS Medicare vary significantly across MA organizations (MAOs), as shown by factors such as the variation in the effects of coding intensity across MAOs.

The Commission acknowledges within the report that a portion of the increased payments to MA plans are used to provide additional benefits and better financial protection to MA enrollees. However, the Commission estimates that Part B premium payments will be

about $13 billion higher in 2025 because of these increased payments to Medicare plans, which are financed by the taxpayers and beneficiaries who fund the program.

*Quality in MA*

Medicare currently collects almost 100 MA quality measures, over 40 of which are used to determine a star rating from 1 to 5 for each MA contract. The MA quality-bonus program increases MA payments by about $15 billion annually. In 2025, 69% of MA enrollees are in a plan that received a quality bonus increase to its benchmark. Simultaneously, beneficiaries in MA and FFS report similar satisfaction with their coverage. The Commission expressed concerns over CMS's coding-intensity adjustment not being adequate to address the higher level of MA diagnostic coding, meaning the resulting higher payments to MA plans generates inequity across MAOs. MedPAC has repeatedly made these recommendations to improve MA payment policies: fully account for MA coding intensity, improve encounter data accuracy and completeness, replace the quality-bonus program, and establish more equitable benchmarks.