Executive summary

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The Commission's goals for Medicare payment policy are to ensure that Medicare beneficiaries have access to high-quality care and that the program obtains good value for its expenditures. To achieve these goals, the Commission supports payment policies that encourage efficient use of resources. Payment-system incentives that promote the efficient delivery of care serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes, premiums, and cost sharing.

By law, the Medicare Payment Advisory Commission reports to the Congress each March on the Medicare fee-for-service (FFS) payment systems. We evaluate the adequacy of FFS Medicare's payments and make recommendations for how those payments should be updated for 2027. For each recommendation, the Commission presents its rationale, the implications for beneficiaries and providers, and how spending for each recommendation would compare with expected spending under current law. Although we include budgetary implications, our recommendations are not driven by any single budget or financial performance target but instead reflect our assessment of the payment rates needed to ensure adequate access to high-value care for FFS beneficiaries while promoting the fiscal sustainability of the Medicare program. In this report, we make recommendations for FFS payment systems for acute care hospitals, physicians and other health professionals, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and hospice providers.

The Commission is also required by law to report to the Congress each March on the Medicare Advantage (MA) program (Medicare Part C) and the Medicare prescription drug program (Part D). In this report, we provide an overview of MA, including recent trends in enrollment, plan availability, and Medicare's payment to plans, and we discuss issues such as MA coding intensity, favorable selection, and Medicare payments and MA plan costs for MA enrollees with end-stage renal disease (ESRD). We also provide a status report on Part D that reviews information on recent trends in enrollment and plan offerings and describes the major changes that have taken place since 2025, as implementation of the Inflation Reduction Act of 2022 (IRA) continues.

In this year's report, we include a chapter on trends and key issues in post-acute care and a status report on ambulatory surgical centers. We also include congressionally mandated reports on the impact of changes to the home health payment system and the performance of special-needs plans for beneficiaries who are dually eligible for Medicare and Medicaid.

In Appendix A, we list all of this year's recommendations and the commissioners' votes. A full inventory of the Commission's recommendations since 1999, with links to relevant reports, is available at medpac.gov/recommendation/. In addition to our annual recommendations on how to update Medicare payment rates for various types of providers, we also offer broader recommendations on restructuring Medicare's payment systems—for example, by adopting site-neutral payments and changing how payments for MA plans are calculated.

Context for Medicare payment policy

To provide context for the information presented in our report, Chapter 1 describes Medicare's overall financial situation and some ways that Medicare affects, and is affected by, the broader health care sector.

National health care spending grew rapidly in 2023 and 2024, by 7 percent in each of these years. By 2024, national health care spending totaled $5.3 trillion. Health care spending has made up an increasing share of the country's gross domestic product (GDP) over time, rising from about 13 percent of GDP in 2000 to 18 percent in 2024.

Medicare spending grew more rapidly than national health care spending in 2023 and 2024 (by 9 percent and 8 percent, respectively), in part due to changes in Part D financing that shifted more of the cost of prescription drug coverage from beneficiaries to the federal government. By 2024, Medicare spending totaled $1.1 trillion—equivalent to 21 percent of national health care spending and 3.8 percent of GDP.

By the mid-2030s, Medicare spending is projected to double (in nominal terms, not adjusted for inflation)

and be equivalent to over 5 percent of GDP. Continued growth in Medicare enrollment over the next decade contributes to Medicare's projected spending growth, as the baby-boom generation continues to age into Medicare. Growth in the volume and intensity of the services and items delivered to patients and growth in the average price of Part B drugs administered by clinicians are also projected to drive up Medicare spending.

Provider consolidation has been increasing—A key contextual factor in the health care sector is the ongoing consolidation of health care providers. There are several economic motivations for health care market consolidation. In commercial markets, consolidated providers are often in a stronger bargaining position when negotiating payment rates with private insurers. Certain types of consolidation can also lead to higher Medicare payment rates through exploitation of site-based payment differentials. Employing clinicians may also enable insurance plans, including MA organizations, to generate more extensive diagnosis coding on claims, which can yield higher payments to both insurers and providers in some capitated payment models. In addition, acquiring provider organizations may allow insurers operating in commercial and MA markets to shift profits to their providers to avoid the constraints of medical-loss-ratio regulations that limit the share of premiums that insurers are allowed to keep as profit. Consolidation may also help to steer patients to affiliated entities and gain provider cooperation in cost-control efforts. Conceptually, provider consolidation could improve care coordination and the efficiency of care delivery through economies of scale, electronic health record interoperability, improved adherence to clinical guidelines, and alignment with value-based payment programs.

Consolidation among providers has been shown to result in higher payments in both commercial and Medicare markets. However, there is no published empirical evidence evaluating the direct effect of payer–provider consolidation on payers' spending and only limited evidence of the effect of consolidation between payers and pharmacy benefit managers on spending. Regarding private equity–provider consolidation, literature is still emerging but generally shows that higher payments result. Evidence about the effects of consolidation on quality and access to care for Medicare beneficiaries is mixed, albeit limited.

Medicare draws on an increasing share of the country's tax revenues—Over the past decade, Medicare spending per beneficiary has been growing more quickly for items and services covered under Part B than under Part A or Part D. For example, there has been an increase in the number of clinician encounters per beneficiary (paid for under Part B), while there has been a decline in the number of inpatient hospital stays and skilled nursing facility stays per beneficiary (paid for under Part A). As a result, Medicare Part A has constituted a declining share of Medicare spending while Part B has grown as a share of program spending. By 2024, Part B constituted 49 percent of Medicare spending (up from 45 percent in 2015), Part A constituted 38 percent (down from 43 percent in 2015), and Part D constituted 12 percent (similar to the 13 percent it constituted in 2015).

The shift in the mix of items and services that beneficiaries receive has reduced pressure on Medicare payroll tax revenues, which are deposited into Medicare's Hospital Insurance Trust Fund to pay for Medicare Part A. However, it has put more pressure on the country's general revenues (e.g., income taxes) and beneficiaries' premiums, which pay for Part B (and for drug coverage under Part D). As the amount of general revenues needed to finance Medicare increases, less revenue is available for deficit reduction or investments in other priorities. The increasing amount of general revenues spent on the Medicare program also contributes to the nation's debt since the total amount the federal government spends per year (about $7 trillion in 2024) exceeds the amount it collects in revenues (about $5 trillion).

When Medicare spending increases, beneficiaries' costs also increase—Medicare spending growth affects beneficiaries' ability to afford health care by raising their premiums and cost sharing. The typical Medicare beneficiary has relatively modest resources to draw on when paying for premiums and cost sharing: According to CMS's Medicare Current Beneficiary Survey, beneficiaries' median household income (from all sources, including investments) was about $50,000 in 2023. CMS's survey also found that 18 percent of beneficiaries were food insecure. It is therefore important to keep in mind that when

Medicare payment rates for providers increase, premiums and cost sharing also increase for Medicare beneficiaries—some of whom already have a hard time affording health care.

The health care workforce plays an important role—Ensuring that beneficiaries have access to high-quality health care remains an important focus of the Commission. Because numerous studies have found a clear relationship between care quality and having a sufficient supply of nurses, nursing assistants, and other types of health care staff, this year's chapter explores that workforce—which includes over 14 million workers.

Among the workforce we call "health care staff," the most common and fastest-growing occupation is home health or personal care aide, which was nearly 4 million people's occupation in 2024, followed by registered nurse (RN) (3.3 million) and health technologist or technician (2.5 million). The Bureau of Labor Statistics projects that what it calls the "healthcare support" occupational group (a similar set of occupations as the ones we focus on) will grow the fastest of any occupational group between 2023 and 2033 as the baby-boom generation ages and their need for health care services increases. As this workforce grows, the U.S. is projected to experience shortages of some types of health care staff and surpluses of others. A shortage of RNs and LPNs is projected nationally, but the extent of the shortage will vary by state, with some states projected to have an oversupply of nurses. Shortages of staff also vary by setting. According to Medicare's Care Compare website, about half of nursing homes' nursing staff (which primarily consists of nursing assistants) leave their jobs in a given year. This statistic is concerning since researchers have found that nursing homes with higher staff turnover provide lower-quality care.

Assessing payment adequacy and updating payments in FFS Medicare

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional FFS payment systems. An update is the amount (usually expressed as a percentage change) by which the base payment to all providers in a payment system is changed, generally relative to the prior year. As explained in Chapter 2, we determine update recommendations by first assessing the adequacy of FFS Medicare payments to providers using the most recently available data, by considering beneficiaries' access to care, the quality of care, providers' access to capital, and how Medicare payments compare with providers' costs. We then make a recommendation about what, if any, update to payments is needed in the policy year in question (for this report, 2027) to efficiently support beneficiaries' access to high-quality services.

Our goal is to make payment-update recommendations that balance beneficiary access to high-quality care with good stewardship of taxpayer and beneficiary resources. We use the best available data to examine indicators of payment adequacy and update information and estimates from prior years to make sure our recommendations for 2027 accurately reflect current conditions. Because of standard data lags, our assessments for the current year are based on estimates from the most recent complete data we have, generally from two years prior to the current year (for this report, 2024). We use preliminary data from 2025 when available. In developing our update recommendations, we generally apply consistent criteria across settings. However, in analyzing evidence, we acknowledge that factors differ across settings, including data availability, underlying payment policy, and forthcoming policy changes. Therefore, our analyses of payment adequacy, and our recommended updates, will vary to reflect those differences.

The recommendations in this report, if adopted, could significantly change Medicare payment rates to providers. Ideally, payment rates will be set at a level sufficient to support efficient delivery of high-quality care for beneficiaries, thereby helping the Medicare program achieve greater value for its spending. Our focus is on appropriate FFS payment rates that support FFS beneficiaries' access to care, so we do not adjust our update recommendations based on other payers' policies. However, the Commission is aware that FFS Medicare's payment rates have broader implications for health care spending because they are often used as a benchmark for rate setting by other federal and state government programs and private health insurers. Consequently, if Medicare payments are too low to support the efficient provision of high-quality care, broader access to care and provider solvency could be affected over time. At the same time, maintaining appropriate fiscal pressure on health care providers

through payment-rate updates can benefit not only the Medicare program (and the beneficiaries and taxpayers who support it) but also the overall health care system.

Hospital inpatient and outpatient services

General acute care hospitals primarily provide inpatient medical and surgical care to patients needing an overnight stay and provide outpatient services, including procedures, tests, evaluation and management services, and emergency care. To pay hospitals for the facility share of providing these services, FFS Medicare generally sets prospective payment rates under the inpatient prospective payment systems (IPPS) and the outpatient prospective payment system (OPPS). In 2024, the FFS Medicare program and its beneficiaries spent $185 billion on services paid under the IPPS and OPPS, including nearly $6 billion in uncompensated-care payments made under the IPPS and $22 billion on separately payable drugs and other inputs under the OPPS. As described in Chapter 3, in fiscal year (FY) 2024, FFS Medicare payment-adequacy indicators for general acute care hospitals were mixed. Beneficiary access to care remained good overall, and hospitals' all-payer margin increased to 6.5 percent. However, quality indicators were mixed. Hospitals' FFS Medicare margin improved slightly to −12.1 percent and to −1 percent for the median relatively efficient hospital.

Beneficiaries' access to care—Hospitals continued to have available capacity in FY 2024: The number of inpatient beds remained relatively stable at about 674,000, hospitals' occupancy rate remained below capacity (71 percent), the median time from patients' emergency department arrival to departure remained relatively stable at about 150 minutes, and hospital employment increased. FFS Medicare beneficiaries' use of inpatient and hospital outpatient services increased in 2024. In FY 2024, FFS Medicare beneficiaries had 208.3 inpatient stays per 1,000 beneficiaries, a 1.5 percent increase from 2023 but still nearly 15 percent below the level in 2019. In calendar year (CY) 2024, FFS Medicare beneficiaries had 3.0 hospital outpatient encounters per beneficiary, a 4.0 percent increase from 2023 but still in line with the 2019 level (within 0.1 encounters per beneficiary).

Quality of care—Quality of hospital care in FY 2024 was mixed. FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved to 7.4 percent, a 0.2 percentage point improvement from 2023. FFS Medicare beneficiaries' risk-adjusted readmission rate was 15.4 percent in 2024, 0.3 percentage points worse than in 2023. Most patient-experience scores remained the same in 2024.

Providers' access to capital—Hospitals' access to capital improved in FY 2024, and preliminary data suggest continued improvement in 2025. Hospitals' all-payer operating margin increased to 6.5 percent, a 1.3 percentage point increase from 2023, and preliminary data from eight large hospital systems suggest an increase in 2025. Other measures of hospitals' access to capital also improved or remained positive in both 2024 and 2025: Hospitals' investment income increased, and investors' risk premium on hospital bonds decreased slightly.

FFS Medicare payments and providers' costs—In FY 2024, FFS Medicare payments for inpatient and outpatient services continued to be well below hospitals' costs in aggregate but near hospitals' costs for the median relatively efficient hospital, and we project hospitals' FFS Medicare margin to increase slightly in 2026. In FY 2024, hospitals' FFS Medicare margin was −12.1 percent, a 0.5 percentage point increase from 2023. However, among hospitals we identified as "relatively efficient"—those that achieved relatively low costs while maintaining relatively high quality during a baseline period—the median FFS Medicare margin was −1 percent, an increase from last year (−2 percent). For 2026, we project that hospitals' FFS Medicare margin will increase to about −10 percent and to 1 percent for the median relatively efficient hospital.

Medicare Safety-Net Index—The Commission-developed Medicare Safety-Net Index (MSNI) continued to be a better predictor of hospitals' all-payer operating margin than the current disproportionate-share (DSH) metric. While hospitals with higher values on the MSNI generally already have higher FFS Medicare margins (since most receive some additional FFS Medicare DSH and uncompensated-care payments), the MSNI would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing financial challenges. Our recommended MSNI implementation would include direct payments to hospitals for both their FFS and MA patients. (Our definition of "Medicare safety-net hospital" used

for the purpose of supporting hospitals that are key sources of care for low-income Medicare beneficiaries is Medicare-centric by design; safety-net definitions used for other purposes by Medicaid and other payers would likely differ. For example, DSH computations could still be made to determine eligibility for certain programs, such as the 340B program.)

Recommendation—Because some of our IPPS and OPPS payment indicators are intertwined and there are analytic challenges to calculating FFS Medicare margins separately for services paid under the IPPS and OPPS, we make a single update recommendation. The current-law updates to payment rates for 2027 will not be finalized until later in 2026, but CMS's current-law forecasts and other required updates are projected to increase the IPPS and OPPS base rates by over 2 percent. Based on our assessment of the payment-adequacy indicators listed above, the Commission recommends that the Congress (1) for 2027, update the 2026 Medicare base payment rates for general acute care hospitals by the amount reflected in current law and (2) implement the MSNI described in our March 2023 report, with $1 billion added to the MSNI pool.

Rural emergency hospitals—The Consolidated Appropriations Act (CAA), 2021, created a new rural emergency hospital (REH) designation, effective January 2023, and requires the Commission to report annually on payments to REHs. During CY 2024, there were 38 REHs, and they received over $100 million in enhanced Medicare payments, almost all of which were from fixed monthly payments intended to help cover REHs' standby costs.

Medicare should move toward more site-neutral payments—The Commission has twice recommended more closely aligning Medicare payment rates for selected services that are safe and appropriate to provide in all settings when doing so does not pose a risk to beneficiary access to care. In CY 2017, CMS began site-neutral payments for hospital outpatient services provided in certain off-campus locations and expanded the scope of these policies in 2019. In 2024, site-neutral policies reduced payments for FFS Medicare outpatient services provided at hospital off-campus locations by $1.2 billion. CMS expanded the scope of site-neutral payments in 2026, which CMS estimated will result in an additional $290 million in savings. However, there remain additional opportunities to expand site-neutral policies to align Medicare's payment rates for similar services across ambulatory settings. Two possibilities that build on CMS's current site-neutral policies include implementing site-neutral payments for clinic services provided in on-campus locations and further expanding site-neutral payments for hospital outpatient services in off-campus locations. Another possible direction for site-neutral payments can be found in our June 2023 recommendation, which aligns payments rates for services across hospital outpatient departments, ambulatory surgical centers, and/or freestanding physician offices when safe and appropriate and when doing so does not pose a risk to access.

Physician and other health professional services

In 2024, FFS Medicare's physician fee schedule (PFS) paid for about 9,000 types of medical services provided by clinicians across a variety of care settings. These services included office visits, surgical procedures, imaging, and tests delivered in physician offices, hospitals, skilled nursing facilities, and other settings. The clinicians who are paid to deliver these services include not only physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs) but also chiropractors, physical therapists, psychologists, and other types of health professionals. The Medicare program and its beneficiaries paid $93.8 billion in 2024 for fee schedule services billed by about 1.5 million clinicians. Spending on clinician services by FFS Medicare and its beneficiaries was $1.4 billion higher in 2024 than in 2023, representing a 1.5 percent increase in total spending. This increase is largely attributable to 4.1 percent growth in spending per FFS beneficiary, which was partially offset by a 2.5 percent decrease in the number of beneficiaries enrolled in FFS Medicare.

As described in Chapter 4, based on our assessment of the latest available data, the Commission's indicators of the adequacy of clinician payments have remained positive or improved since last year, although input cost inflation remains slightly elevated.

Beneficiaries' access to care—In the Commission's 2025 survey, Medicare beneficiaries reported access to clinician services that was generally better than that of privately insured people. Our findings are consistent

with findings of other national surveys, which have found that people ages 65 and older (almost all of whom have Medicare coverage) report better access to care than younger adults; Medicare beneficiaries of any age are also more likely than privately insured people to rate their insurance coverage positively.

Other surveys indicate that the share of clinicians accepting Medicare is comparable with the share accepting private insurance, despite private health insurers' higher payment rates. And almost all clinicians who bill Medicare accept PFS amounts as payment in full and do not seek to increase total payments for fee schedule services by balance billing beneficiaries as "nonparticipating" providers. In addition, very few clinicians forgo all Medicare payments by electing to "opt out" of the program; these clinicians choose the price they charge to patients.

The supply of most types of clinicians billing Medicare's PFS has been growing in recent years, although the composition of the clinician workforce continues to change. Over the last several years, the number of primary care physicians billing the fee schedule has slowly declined, the number of specialists has steadily increased, and the number of APRNs and PAs has climbed rapidly. The number of clinicians per FFS beneficiary has grown, partially because of a decline in the number of FFS beneficiaries.

Interest in becoming a clinician remains high. Over the last 40 years, the number of applicants to U.S. medical schools has grown, exceeding population growth, and applicants to medical schools continue to far exceed first-year enrollment. The number of APRNs and PAs has grown rapidly, suggesting robust interest in becoming these types of clinicians.

The number of clinician services furnished per FFS beneficiary has increased over time, with faster growth from 2023 to 2024 (7.1 percent) compared with the average annual growth rate from 2019 to 2023 (2.3 percent). Growth varied by type of service. From 2023 to 2024, the number of evaluation and management (E&M) services per FFS beneficiary increased by 10.9 percent, while treatments and nonmajor procedures increased by 7.6 percent and 3.6 percent, respectively. Imaging, tests, major procedures, and anesthesia saw somewhat smaller growth of 3.3 percent, 3.2 percent, 3.1 percent, and 1.7 percent, respectively.

Quality of care—The quality of clinician care is difficult to assess, but the indicators we track suggest it has remained relatively stable. In 2024, risk-adjusted rates of ambulatory care–sensitive hospitalizations and emergency department visits remained below (that is, better than) prepandemic levels and continued to vary across health care markets. Between 2023 and 2024, patient-experience scores for FFS Medicare were relatively stable.

Clinicians' revenues and costs—Clinicians do not submit annual cost reports to CMS, so we are unable to calculate their profit margins from delivering services to Medicare beneficiaries. Instead, we rely on indirect measures of how Medicare payments compare with the costs of providing services.

PFS spending per FFS beneficiary grew for most types of services in 2024, despite payment rates for many types of services declining from 2023 to 2024. Among broad service categories, growth rates were 5.1 percent for E&M services, 4.0 percent for imaging, 2.2 percent for other (i.e., nonmajor) procedures, 4.9 percent for treatments, and 3.7 percent for tests. Spending per FFS beneficiary on major procedures and anesthesia each declined by 0.3 percent. Changes in spending are driven by changes in volume, mix of services (including billing for new codes designed to support care management), and changes in payment rates, which include a 2 percent across-the-board payment-rate reduction because of a required budget-neutrality adjustment.

Growth in clinicians' input costs as measured by the Medicare Economic Index (MEI) has moderated from recent highs during the coronavirus pandemic and is expected to moderate further in the coming years. Currently, MEI growth is projected to be 2.7 percent in 2025 and 2.2 percent in 2026. Although past updates have not kept pace with the growth in clinicians' input costs, the volume and intensity of clinician services per FFS beneficiary have increased substantially over time, which has resulted in markedly higher PFS spending. As part of a broader review of access to care and fee schedule updates in our June 2025 report to the Congress, the Commission concluded that, to date, below-MEI updates have not impeded access.

Since the Commission lacks data that would allow us to determine whether providers' revenues are greater than their costs and whether delivering

clinician services is therefore profitable, we examine clinician compensation levels as a rough proxy for all-payer profitability. Clinician compensation levels suggest that providing clinician services is profitable. From 2023 to 2024, median physician compensation increased 6 percent (to $369,000)—twice as fast as inflation (3 percent)—according to SullivanCotter compensation data. Meanwhile, median compensation for nonphysician practitioners increased more slowly than inflation—by 2.5 percent for physician assistants (to $133,000) and by 2.3 percent for nurse practitioners (to $129,000), according to the U.S. Bureau of Labor Statistics. We note that clinician compensation is only an indirect measure of Medicare's payment adequacy since Medicare payments constitute only a portion of the revenue most clinicians receive, and many employed physicians' compensation may not be directly tied to fee schedule payments.

To gain further insight into clinicians' revenues and incomes and to assess clinicians' incentives to treat Medicare beneficiaries versus patients with other types of insurance, we compare Medicare payment rates with private-insurance rates. In 2024, preferred provider organizations' payment rates for clinician services were, on average, 147 percent of FFS Medicare's payment rates—up from 140 percent in 2023. A 2024 survey by the American Medical Association suggests that providers are increasingly consolidating into larger organizations to improve their ability to negotiate higher payment rates from private insurers (and to gain access to costly resources and help complying with payers' regulatory and administrative requirements).

Recommendation—In 2027, current law calls for PFS payment rates to decline by 1.7 percent for clinicians in advanced alternative payment models (A-APMs) (e.g., accountable care organization models that involve some financial risk) and to decline by 2.2 percent for all other clinicians, relative to 2026 payment rates. These declines reflect the net effects of two statutory provisions: (1) the expiration of a one-year increase of 2.5 percent that applies in 2026 only and (2) positive updates of 0.75 percent and 0.25 percent for clinicians in A-APMs and all other clinicians, respectively, in 2027 pursuant to the Medicare and CHIP Reauthorization Act of 2015 (MACRA).

Based on our indicators, current payments to clinicians appear to be adequate to ensure access to care. However, going forward, clinicians are projected to face moderate rates of input cost growth. While evidence suggests that full MEI updates have not been necessary to maintain access to care, ongoing cost increases that substantially exceed payment updates could be difficult for clinicians to absorb.

Given these concerns, for calendar year 2027, the Commission recommends that the Congress increase current-law updates to Medicare payment rates for physician and other health professional services by 0.5 percentage points more than current law. After the expiration of 2026's temporary 2.5 percent update, this recommendation would increase payment rates in 2027 by a total of 1.25 percent for clinicians participating in A–APMs and by a total of 0.75 percent for other clinicians. After accounting for the expiration of the temporary 2.5 percent increase at the end of 2026, net payment rates for 2027 would be 1.2 percent and 1.7 percent lower, respectively, than in 2026. These net reductions would be smaller than what would otherwise occur under current law. The Commission's recommendation would be a permanent update that would be built into subsequent years' payment rates, not a temporary update (like the 2.5 percent update that applies in 2026 only). The Commission maintains that this recommendation balances the need to provide adequate payments to clinicians with the need to limit growth in beneficiaries' cost sharing and premiums.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals who have ESRD. In 2024, about 240,500 beneficiaries with ESRD and on dialysis were covered under FFS Medicare and received dialysis from more than 7,600 dialysis facilities. In 2024, the FFS Medicare program and its beneficiaries spent $7.6 billion for outpatient dialysis services. As described in Chapter 5, our payment-adequacy indicators for outpatient dialysis services were generally positive.

Beneficiaries' access to care—The capacity of dialysis facilities appears to be aligned with demand from Medicare beneficiaries on dialysis. Between 2023 and 2024, the number of in-center treatment stations declined, but so did the number of Medicare beneficiaries on dialysis enrolled in either FFS Medicare or MA. In addition, over the last decade (2012 to 2022), the growth in the number of patients newly diagnosed

with ESRD (across all insurance types) slowed. Between 2023 and 2024, the share of FFS beneficiaries dialyzing at home continued to increase. The 8 percent decline in FFS treatments between 2023 and 2024 is largely due to the shift of beneficiaries on dialysis from FFS Medicare to MA. Despite the decline in the number of FFS beneficiaries on dialysis and the number of treatments provided, the average number of dialysis treatments per FFS beneficiary per week remained steady at 2.8 in 2024. At the same time, the per treatment use of ESRD drugs in the payment bundle (including selected erythropoiesis-stimulating agents used in anemia management) has continued to decline since 2010 with little to no measurable impact on beneficiaries' health outcomes.

Quality of care—Between 2023 and 2024, fluid management (as measured by dialysis adequacy) and anemia management for FFS beneficiaries on dialysis remained steady, as did rates of all-cause hospitalization, but emergency department use increased. While the mortality rate among FFS beneficiaries on dialysis was steady between 2023 and 2024, it remained elevated compared with prepandemic rates (2019). Measures of patient experience with receiving in-center hemodialysis remained steady. The share of beneficiaries dialyzing at home, which is associated with better patient satisfaction, continued to grow.

Providers' access to capital—Information from investment analysts suggests that access to capital for dialysis providers continues to be strong. The two largest dialysis organizations (which accounted for three-quarters of facilities and FFS Medicare treatments in 2024) have continued to grow through acquisitions of and mergers with midsize dialysis organizations. In 2024 and 2025, facility closures and consolidations by each of the two largest dialysis organizations aimed to reduce unused capacity related to the increasing use of home dialysis and the decline in patient census in some markets.

FFS Medicare payments and providers' costs—Between 2023 and 2024, FFS Medicare payment per treatment in freestanding dialysis facilities (which provide the vast majority of FFS dialysis treatments) grew by 2 percent, while cost per treatment declined by 3 percent. In 2024, a decline in cost growth was observed across overhead and ESRD-drug cost categories. Consequently, the FFS Medicare margin rose from −0.2 percent in 2023 to 4.5 percent in 2024. We project a 2026 aggregate Medicare margin of 4 percent. This projection does not account for the add-on payments for new ESRD drugs and phosphate binders in 2025 and 2026, which may increase FFS Medicare payments relative to facilities' costs.

Recommendation—Under current law, the Medicare FFS base payment rate for dialysis services is projected to increase by 1.6 percent in 2027. Given that most of our indicators of payment adequacy are positive, the Commission recommends that, for calendar year 2027, the Congress eliminate the update to the 2026 base payment rate.

Post-acute care: Trends and key issues

Beneficiaries who require recuperative or rehabilitative care may be treated in skilled nursing facilities (SNFs), by home health agencies (HHAs), and in inpatient rehabilitation facilities (IRFs). While all three settings provide rehabilitation, skilled nursing, and personal care, the level of care varies. Generally, IRFs can provide the most intensive level of care, while HHAs provide the least, and SNF care falls between the two. The three settings differ in terms of Medicare benefits and cost-sharing requirements under FFS Medicare, which can shape service use.

As described in Chapter 6, aggregate FFS spending on post-acute care (PAC) declined slightly over the past decade, due in part to the shift in enrollment from FFS to MA. In addition, declines in acute care hospital stays, which precede much PAC, have reduced referrals to PAC. Staffing shortages have also constrained the supply of open and staffed SNF beds and home health visits. For a host of reasons, there is some overlap in the types of patients treated in the three settings. But comparing the patients treated and their outcomes is complicated by several factors, such as the unobserved differences in the patients treated across providers. Data limitations—including the lack of patient-experience data for SNFs and IRFs as well as the inaccurate reporting of patient-assessment information that may reflect payment and other incentives rather than actual differences in patients—undermine comparisons within and across settings. Reflecting these limitations, studies examining outcomes by setting have reached mixed conclusions.

By its nature, FFS has incentives for providers to increase volume: SNFs may extend stays, HHAs may trigger second 30-day periods, and IRFs may admit patients who qualify for the care but could be treated in a less intensive setting. Medicare's cost-sharing rules for SNF and HHA services may also encourage unnecessary care. FFS incentives may be stronger when margins are high, and Medicare FFS margins for SNFs, HHAs, and IRFs have been in the double digits for 20 years. Because updates to prospective payment system (PPS) payment rates are in statute, CMS does not have the authority to rebase payment rates without congressional action. The Commission has routinely recommended reductions to base payment rates across Medicare's PAC payment systems.

The Commission has explored two policies that could improve the efficiency of PAC value-based purchasing (VBP) programs and establish site-neutral payment rates across PAC settings. By adjusting payment rates based on the quality of care provided, VBP programs create incentives for providers to furnish high-quality care. But the current financial incentives of the SNF and HHA VBP programs are too small to encourage providers to improve quality. Policies that would establish more equal FFS Medicare payments for similar cases treated in different settings, such as a unified payment system for providers in the three settings, could establish reasonably accurate payment rates but would be complex to implement. The Commission has also considered more targeted alignment of Medicare's prices for certain types of cases treated in IRFs and SNFs but has been stymied by a lack of solid evidential basis to lower prices for a select group of conditions.

APMs, such as accountable care organizations and bundled-payment initiatives, create incentives to shift higher-cost IRF use to SNFs, to shorten SNF stays, and to shift care to HHAs for beneficiaries who can go home, as well as to avoid some PAC use altogether. Such changes in PAC use could reflect more efficient service use, but it could also mean that some beneficiaries do not get the care they need. However, APMs have shown promise in lowering program spending without compromising quality. The Commission will continue to monitor the impact of APMs on PAC use.

The shift in enrollment away from FFS Medicare to MA has important implications for PAC providers and beneficiaries. Because MA plans are paid a monthly per member amount, they have an incentive to lower their costs by using lower-cost PAC, shortening SNF stays, and prolonging hospital stays to avoid PAC altogether. MA plans typically use prior authorization and provider networks to manage service use by their enrollees. These utilization-management tools may be beneficial for enrollees to the extent that they result in improved transitions between care settings, better coordination of care, and elimination of unnecessary care. However, such management tools can also create hurdles for providers and beneficiaries that can delay the start of needed PAC or deny it altogether. The Commission plans to continue examining the use of PAC in MA, including examining differences in FFS and MA use of SNF and IRF services for beneficiaries who did and those who did not have a prior hospital stay.

Skilled nursing facility services

Medicare covers short-term skilled nursing and rehabilitation services for beneficiaries in SNFs after a recent inpatient hospital stay. Most SNFs also furnish long-term care services not covered by Medicare. In 2024, about 14,400 SNFs furnished about 1.5 million Medicare-covered stays to 1.1 million FFS beneficiaries. In 2024, the FFS Medicare program and its beneficiaries spent $31 billion for SNF services. (FFS Medicare and its beneficiaries paid an additional $2 billion for SNF care provided in hospital swing beds.) As described in Chapter 7, the indicators of Medicare payment adequacy for SNF care were mostly positive. Although supply and admissions declined, these outcomes do not reflect the adequacy of Medicare's FFS payments.

Beneficiaries' access to care—Changes in the indicators of access to SNFs were mostly positive. The number of SNFs declined by about 1 percent in 2024. Given that Medicare is a small share of most nursing homes' business (13 percent of total facility revenue) and that its payment rates are high relative to costs, it is unlikely that the closures reflect the adequacy of Medicare's payments. In 2024, 88 percent of Medicare beneficiaries lived in a county with three or more SNFs or swing-bed facilities—the same share since 2018. However, beneficiaries who live in counties with high average occupancy rates or who require specialized services could face access problems. SNF use by FFS beneficiaries has been declining for many years. That decline continued in 2024, when Medicare-covered

SNF admissions per 1,000 FFS beneficiaries decreased by 4 percent. However, Medicare-covered SNF days per 1,000 FFS beneficiaries increased by 1 percent in 2024. Occupancy rates remained high, at about 83 percent in 2024. Many providers reported closing beds and denying admissions due to workforce challenges.

Quality of care—Quality indicators were stable. In the two-year period from 2023 through 2024, the median facility risk-adjusted rate of discharge to the community from SNFs was 51.3 percent, similar to the rate for the 2022 and 2023 two-year period (50.9 percent). Also in the 2023 and 2024 two-year period, the median facility risk-adjusted rate of potentially preventable readmissions was 10.7 percent, similar to the rate in the two-year period from 2022 through 2023. Staffing levels of registered nurses and nursing staff turnover rates remain concerning. Lack of data on patient experience and concerns about the accuracy of provider-reported function data limit our set of SNF quality measures.

Providers' access to capital—The sector continues to be attractive to investors. Price per bed has been stable since 2024, and investors are optimistic about the Department of Housing and Urban Development loan environment. The all-payer total margin—the percentage of revenue from all payers and all lines of business that is left after accounting for all costs—improved from 0.4 percent in 2023 to 2.1 percent in 2024. Total margins may be understated, given the complex arrangements many nursing homes have with third parties.

FFS Medicare payments and providers' costs—From 2023 through 2024, FFS Medicare payments per day to freestanding SNFs increased 4.9 percent, while growth in costs per day increased 2.3 percent. The FFS Medicare margin for freestanding SNFs was 24 percent in 2024, an increase from 22 percent in 2023. Margins varied greatly across facilities, reflecting differences in costs per day, economies of scale, and cost growth.

Recommendation—Based on our assessment of the payment-adequacy indicators above, Medicare's FFS payment rates need to be reduced to align aggregate payments more closely with aggregate costs. The Commission therefore recommends that, for FY 2027, the Congress reduce the 2026 base payment rates for SNFs by 4 percent.

Alternative approaches to calculating 5-star ratings—Since 2009, CMS has publicly reported a star rating for each nursing home (NH). The goal of these ratings is to provide consumers and hospital discharge planners with easy-to-understand information when selecting a facility for post-acute or long-term care. We examined alternative ways to weight the three domain ratings (performance on the annual inspection, staffing, and quality measures) that comprise the overall star rating of each NH. Currently, performance on the annual inspection is weighted most heavily in the calculation of an NH's overall rating. Because research has shown that staffing plays a key role in shaping the quality of care in SNFs, we considered options that would raise the importance of the staffing domain while continuing to consider all domain ratings in calculating the overall rating. In our illustrative approaches, we found that weighting the domains equally (which would increase the weighting of staffing relative to current policy) or weighting the staffing domain more heavily than the other domains would raise or lower the ratings by one star for the majority of NHs. The revised weightings could provide beneficiaries and their families with a more comprehensive gauge of the quality of an NH.

Medicaid trends—As required by law, we report each year on Medicaid use and spending and non–FFS Medicare margins in NHs. Almost all SNFs are also long-term care nursing facilities, and Medicaid finances most long-term care services provided in SNFs. Some state programs also cover the SNF copayments for beneficiaries who are dually eligible for Medicare and Medicaid and who stay more than 20 days in a SNF. Between December 2024 and July 2025, the number of Medicaid-certified facilities declined 0.7 percent, to 14,232. In 2024, FFS Medicaid spending (federal and state) was $46.3 billion, 9.0 percent more than in 2023. The average non–FFS Medicare margin (which includes all other payers and all lines of business except FFS Medicare SNF services) was –2.3 percent, an improvement from 2023.

Home health care services

HHAs provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2024, about 2.7 million Medicare FFS beneficiaries received care, and the program and its beneficiaries spent $16.0 billion on home health care services.

In that year, over 12,000 HHAs were certified to participate in Medicare. As described in Chapter 8, the indicators of Medicare payment adequacy for home health care were positive.

Beneficiaries' access to care—Supply and volume indicators show that FFS beneficiaries have good access to home health care. In 2024, over 97 percent of FFS Medicare beneficiaries lived in a ZIP code served by at least two HHAs, and 86 percent lived in a ZIP code served by five or more HHAs. The share of general acute care hospital discharges that were followed by at least one 30-day home health period jumped to 20.1 percent in the first year of the coronavirus pandemic and then declined, reaching 18.0 percent in the first 10 months of 2024, but the share remains higher than the rate for 2019 (15.8 percent). The number of HHAs participating in the Medicare program increased by 1.5 percent in 2024. However, this increase was due almost entirely to growth in the number of HHAs in California, with the highest growth in HHAs in Los Angeles County. Many stakeholders, including the California state auditor, have suggested that the aberrant patterns of HHA supply and utilization in Los Angeles County raise program-integrity concerns. Excluding California, the number of participating HHAs declined by 1.0 percent in 2024. The number of 30-day periods per 100 FFS Medicare beneficiaries increased slightly in 2024, by 2.6 percent, and the number of full 30-day periods per FFS user of home health was stable at 3.1. The average number of in-person visits per 30-day period was steady at 8.3 in 2024.

Quality of care—During the two-year period from January 1, 2022, to December 31, 2023, the median risk-adjusted rate of discharge to the community from HHAs was 80.6 percent, an increase (improvement) of 1.3 percentage points relative to the median from January 1, 2021, to December 31, 2022. The median rate of potentially preventable readmissions after discharge was 3.8 percent from January 1, 2021, to December 31, 2023.

Providers' access to capital—Home health care agencies are generally not as capital intensive as many other provider types because they do not require extensive physical infrastructure. In 2024, the all-payer margin for freestanding HHAs was 5.0 percent, indicating that many HHAs yielded positive financial results that should appeal to capital markets. According to industry reports, investor interest in home health care services has slowed since 2023, but the slowdown comes after a peak period for HHA mergers and acquisitions.

FFS Medicare payments and providers' costs—FFS Medicare margins for freestanding HHAs averaged 21.2 percent in 2024. These margins indicate that FFS Medicare payments in 2024 far exceeded costs, as they have for more than 20 years; the FFS Medicare margin for freestanding agencies averaged 17.2 percent from 2001 to 2023. The average payment per full 30-day period increased 1.6 percent in 2024. Cost per 30-day period was relatively stable in 2024, rising just 0.2 percent because growth in costs per visit were offset by a reduction in the number of in-person visits per 30-day period. We project a FFS Medicare margin of 19 percent for freestanding HHAs in 2026.

Recommendation—Our review indicates that FFS Medicare payments for home health care are substantially in excess of costs. Home health care can be a high-value benefit when it is appropriately and efficiently delivered, but payments need to be reduced to align aggregate payments more closely with aggregate costs. The Commission recommends that, for calendar year 2027, the Congress reduce the 2026 Medicare base payment rate for HHAs by 7 percent.

Inpatient rehabilitation facility services

IRFs are freestanding hospitals or hospital-based units that provide intensive rehabilitation services to patients after illness, injury, or surgery. Care provided in IRFs is supervised by rehabilitation physicians and includes services such as physical and occupational therapy, rehabilitation nursing, and speech–language pathology. In FY 2024, the FFS Medicare program and its beneficiaries spent $11.0 billion on about 435,000 IRF stays in about 1,170 IRFs nationwide. As described in Chapter 9, indicators of FFS Medicare payment adequacy for IRFs were generally positive.

Beneficiaries' access to care—Between FY 2023 and FY 2024, IRFs' available capacity and the supply of IRFs remained relatively stable. IRFs' occupancy rate remained below capacity (71 percent), indicating capacity was more than adequate to meet demand. The number of IRFs increased slightly, driven by growth in freestanding and for-profit IRFs. From 2023 to 2024, the number of FFS Medicare stays in IRFs increased

by about 8 percent, and stays per FFS beneficiary increased by about 10 percent.

Quality of care—Quality of care was relatively stable. For the two-year period of FY 2023 through FY 2024, the median facility risk-adjusted rate of discharge to the community from IRFs was relatively stable at 67.5 percent. The median facility risk-adjusted rate of potentially preventable readmissions was 9.2 percent, 0.4 percentage points more than in the prior period of FY 2022 through FY 2023.

Providers' access to capital—In FY 2024, freestanding IRFs' all-payer total margin increased 2 percentage points to 12 percent. For-profit corporations continued to open new IRFs and enter into joint ventures with other organizations, suggesting strong access to capital. Hospital-based IRFs access capital through their parent hospitals, and these hospitals' access to capital also improved.

FFS Medicare payments and providers' costs—In FY 2024, IRFs' FFS Medicare margin rose to 17.1 percent, up from 14.8 percent in 2023, as the average payment per stay increased by 3.4 percent, while average cost per stay increased by 0.6 percent. IRFs' FFS Medicare margin continued to vary substantially across IRF categories, including a much higher margin for freestanding IRFs (25.0 percent) than for hospital-based IRFs (4.1 percent). For 2026, we project that IRFs' FFS Medicare margin will increase to about 18 percent.

Recommendation—Given the positive payment-adequacy indicators, the Commission recommends that, for FY 2027, the Congress reduce the 2026 IRF base payment rate by 7 percent. This recommendation would continue to provide IRFs with sufficient revenue to maintain FFS Medicare beneficiaries' access to IRF care while bringing IRF PPS payment rates closer to the cost of efficiently delivering high-quality care.

Hospice services

The Medicare hospice benefit covers palliative and supportive services for beneficiaries who are terminally ill with a life expectancy of six months or less if the illness runs its normal course. When a beneficiary elects hospice, they agree to receive palliative care for their terminal illness and related conditions under the hospice benefit and forgo care related to the terminal illness outside of hospice. FFS Medicare pays for hospice care for beneficiaries enrolled in either traditional FFS Medicare or MA. In 2024, more than 1.8 million Medicare beneficiaries (including more than half of decedents) received hospice services from about 6,700 providers, and Medicare hospice expenditures totaled $28.3 billion. As described in Chapter 10, the indicators of Medicare payment adequacy for hospice services were positive.

Beneficiaries' access to care—In 2024, indicators of beneficiaries' access to hospice were positive. The number of hospice providers increased by 2.6 percent as more for-profit hospices entered the market, a trend that has continued for more than a decade. The share of decedents using hospice increased to 52.9 percent in 2024, up from 51.7 percent in 2023, reaching a new high. The number of hospice users and total days of hospice care also increased in 2024. For decedents, average lifetime length of stay increased by about 3 days in 2023 to 99.6 days, and median length of stay increased by 1 day to 19 days in 2024. For hospice patients receiving routine home care, the frequency and length of in-person hospice visits by hospice staff was stable in 2024, an average of 3.9 visits per week, each just under an hour long on average.

Quality of care—Measures of patient experience from the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) were stable in the most recent period. Performance on a measure of processes of care at admission—reflecting a composite score calculated by CMS using data on seven processes of care submitted by hospices—improved slightly but was very high and topped out for most providers (i.e., scores were so high and unvarying that one can no longer make meaningful distinctions among providers or gauge improvement in performance). A measure of in-person nurse and social worker visits in the last three days of life improved in the most recent period.

Providers' access to capital—Hospices are generally not as capital intensive as many other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (an increase of about 5 percent in 2024) and reports of continued investor interest in the sector suggest that capital is available to these providers. Less is known about access to capital for nonprofit freestanding providers. Hospital-based and home health–based hospices have access to capital through their parent providers.

FFS Medicare payments and providers' costs— Hospice FFS margins are presented through 2023 because of the standard data lag required to calculate cap-overpayment amounts. Between 2022 and 2023, average cost per day increased by 3.0 percent. The aggregate FFS Medicare margin for 2023 was 8.0 percent, down from 9.8 percent in 2022. In 2024, cost growth slowed, with hospices' average cost per day increasing by 1.1 percent. The projected 2026 FFS Medicare margin is 9 percent.

Recommendation—Under current law, the FFS Medicare base payment rate for hospice services is projected to increase by 2.3 percent in 2027. Based on the positive indicators of payment adequacy and the strong FFS Medicare margins, current payment rates appear sufficient to support the provision of high-quality care without an increase to the payment rates in 2027. The Commission recommends that the Congress eliminate the update to the hospice base payment rates for fiscal year 2027.

Ambulatory surgical center services: Status report

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay. As described in Chapter 11, in 2024, about 6,400 ASCs treated 3.4 million FFS Medicare beneficiaries. FFS Medicare program spending and beneficiary cost sharing on ASC services was about $7.5 billion in 2024. Signs point to a robust industry: The number of ASCs nationwide grew over 2 percent per year, on average, between 2019 and 2024, and the volume of ASC surgical procedures per FFS beneficiary increased by 3.5 percent in 2024 and at an annual average rate of 1.3 percent from 2019 to 2023. Numerous factors have contributed to this sector's growth over the past few decades, including changes in clinical practice and health care technology that have expanded the provision of surgical procedures in ambulatory settings. For patients, ASCs can offer more convenient locations, shorter waiting times, lower cost sharing, and easier scheduling relative to hospital outpatient departments (HOPDs). ASCs can also offer physicians more specialized staff and control over their work environment.

Over 95 percent of ASCs are for profit, and 94 percent are located in urban areas. The concentration of ASCs varies widely across states, ranging from more than 36 ASCs per 100,000 Part B beneficiaries (FFS and MA combined) in Maryland to 3 or fewer ASCs per 100,000 Part B beneficiaries in the District of Columbia, West Virginia, and Vermont. Relative to HOPDs, ASCs are less likely to provide surgical procedures to FFS Medicare beneficiaries who are disabled, have Medicaid coverage, or are age 85 or older. About 68 percent of ASCs that billed FFS Medicare in 2024 specialized in a single clinical area, of which gastroenterology and ophthalmology were the most common. The remainder were multispecialty facilities, providing services in more than one clinical specialty, of which pain management and orthopedics were the most common. From 2023 to 2024, the ASC specialties that grew most rapidly were pain management and cardiology. The most common FFS Medicare procedure in ASCs in 2024 was extracapsular cataract removal with intraocular lens insertion, accounting for 18 percent of FFS Medicare volume. The 20 most common surgical procedures performed in ASCs made up about 68 percent of ASCs' FFS Medicare volume in 2024.

Medicare spending per FFS beneficiary on ASC services rose at an average annual rate of 9.4 percent from 2019 through 2023 and by 15.9 percent from 2023 to 2024. Because FFS Medicare payment rates are lower in ASCs than in HOPDs for all services that are covered in both settings, the cost to Medicare (and the taxpayers who fund the program) is lower if a surgical procedure is provided in an ASC rather than an HOPD. Beneficiaries' cost-sharing obligation is lower as well. However, it is possible that additional services provided in ASCs could increase the overall volume of surgical procedures, which would partially offset the reduction in total FFS Medicare spending associated with a shift in the site of care. A greater volume of services furnished is especially likely if FFS Medicare's payments for ASC services are substantially higher than the costs of providing them. But policymakers know little about the costs that ASCs incur in treating beneficiaries because Medicare does not require ASCs to submit cost data, unlike its requirements for other types of facilities.

The Commission contends that ASCs could feasibly provide cost data and for many years has recommended that the Congress require ASCs to submit such data. In addition, we encourage CMS to synchronize measures in the ASC Quality Reporting Program with measures included in the Hospital

Outpatient Quality Reporting Program to facilitate comparisons between ASCs and HOPDs. More expansive ASC quality data would also inform and facilitate FFS beneficiaries' decision-making about where they choose to receive care.

The Medicare Advantage program: Status report

Each year, the Commission provides a status report on the MA program, which gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional FFS Medicare program. As described in Chapter 12, the MA program is quite robust, with growth in enrollment, considerable plan offerings, and a record-high level of supplemental benefits. In 2025, 55 percent of eligible Medicare beneficiaries enrolled in MA, up from 54 percent in 2024 and 37 percent in 2018. In 2025, the MA program included 5,492 plan options offered by 164 organizations, enrolled about 34.9 million beneficiaries, and paid MA plans an estimated $537 billion (not including payments for drug coverage offered by MA plans). In 2026, on average, a Medicare beneficiary can choose from 39 plans offered by an average of eight organizations.

The Commission strongly supports the inclusion of private plans in the Medicare program. We hold the goal of meaningful and transparent competition in MA to create incentives for plans to improve quality and reduce costs for beneficiaries and taxpayers. Beneficiaries should be able to choose among Medicare coverage options since some may prefer to avoid the constraints of provider networks and utilization management by enrolling in FFS Medicare, while others may prefer features of MA, like reduced premiums and cost-sharing liability. MA plans are required by statute to offer an out-of-pocket spending limit—which is not included in FFS Medicare—and plans can reduce cost-sharing liability, offer integrated Part D benefits, and provide supplemental benefits that generally are not available to beneficiaries in FFS unless they purchase additional health insurance coverage or pay for the services out of pocket. Medicare's capitated payments to MA plans (which are expected to average $16,242 per beneficiary per year in 2026, including rebate payments) provide plans with incentives to reduce unnecessary services and increase the use of preventive services.

In 2026, the Medicare program will pay MA plans, on average, $2,660 per beneficiary per year in rebate payments, which plans use to provide supplemental benefits for their enrollees. These rebates have more than doubled since 2018 and now account for a projected 15 percent of Medicare's total payments to MA plans. The benefits that rebates finance reduce out-of-pocket costs for MA enrollees and have the potential to address health challenges that many seniors face as they age (such as vision and hearing issues) and for which there is limited coverage under FFS Medicare. On average, plans project using about 26 percent of the rebate funds to reduce cost sharing for MA enrollees, 38 percent for non-Medicare services, 19 percent to enhance plans' Part D benefit through lower premiums or reduced cost sharing, 7 percent to reduce MA enrollees' Part B premiums, and 10 percent for administrative expenses and profit. New data from CMS show that in 2023, MA organizations spent roughly $24 billion on non-Medicare services; however, available data do not provide information about the extent to which beneficiaries use these benefits, making it difficult for policymakers to weigh the cost of rebate payments against the unknown value of the added benefits.

In 2026, we estimate that Medicare will spend 14 percent—a projected $76 billion—more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare. The higher payments that we estimate relative to FFS vary significantly across MA parent organizations and are not an estimate of plan profits and administrative expenses. These increased payments to MA plans contribute to funding for the supplemental benefits plans provide. However, the relatively higher payments to MA plans are financed by the taxpayers and beneficiaries who fund the Medicare program. Higher MA spending increases Part B premiums for all beneficiaries, including those in FFS Medicare who do not enjoy subsidized supplemental benefits. The Commission estimates that Part B premium payments will be about $11 billion higher in 2026 because of higher Medicare payments to MA plans (equivalent to roughly $175 per beneficiary per year, or $14.61 per beneficiary per month). In total, private plans have never been paid less than FFS Medicare because of policies that increase payments to MA above FFS payments and distort the nature of plan competition in MA.

The two largest factors responsible for higher payments to plans in recent years are favorable selection and coding intensity. "Favorable selection" into MA occurs when beneficiaries with risk scores (which are used to set MA payments) that overpredict their spending tend to enroll in MA more often than beneficiaries whose risk scores underpredict their spending. Favorable selection is the extent to which, without any management or other intervention from MA plans, the risk-standardized spending of MA enrollees is lower than what Medicare would spend if they were in FFS. This selection may stem from a variety of factors, including beneficiaries' propensities to use care for reasons unrelated to their health, differences in health status that are not accounted for by risk scores, or plan benefit designs that are less attractive to beneficiaries whose spending is underpredicted by their risk scores, among other reasons. "Coding intensity" refers to the tendency for more diagnosis codes to be recorded for MA enrollees, which causes risk scores—and payments—for the same beneficiaries to be higher when they are enrolled in MA than they would be in FFS Medicare. MA coding intensity is driven by several factors, including MA plans' documenting diagnoses more comprehensively than providers in FFS Medicare (who may not report all possible diagnosis codes), submitting fraudulent diagnostic data, and other reasons. Separately identifying all of the factors causing favorable selection and coding intensity is challenging and, in many cases, not possible given available data. However, regardless of the causes, favorable selection of enrollees into MA and higher MA coding intensity lead to pricing errors that cause CMS's risk-adjustment system to set payment rates too high for MA enrollees, thereby increasing Medicare's payments to plans.

The Commission contends that important reforms are needed to improve Medicare's policies of paying and overseeing MA plans. First, reforms are needed to reduce the overall level of Medicare payments to MA plans. As noted above, relatively higher levels of payment stem largely from coding intensity and favorable selection. Those effects vary across plans and distort the nature of competition in the program. Past experience with reductions in MA payments has demonstrated that plans can adjust their bidding behavior, which lessens the effects on plan participation, supplemental benefits offered to enrollees, and beneficiary enrollment while achieving program savings. Second, reforms are needed to the quality-bonus program because it is administratively burdensome, adds significantly to program costs, and does not provide meaningful information about quality of care to beneficiaries choosing among MA plans. Third, reforms to the MA benchmark system would be valuable because current benchmarks generate a number of inequities, including "cliff" effects due to grouping counties into quartiles, caps on benchmarks, and benchmarks that are skewed by the inclusion of FFS-spending data for beneficiaries with only Part A coverage. Fourth, it is important for Medicare to carefully monitor and respond to the challenges, burdens, and care disruptions that beneficiaries experience when choosing among plans and navigating changes to provider networks. Finally, the Commission has found that plan-submitted data about beneficiaries' health care encounters are incomplete, and we lack information about the use of many MA supplemental benefits. Without these data, policymakers cannot fully understand enrollees' use of services, which limits policymakers' ability to oversee the program and assess the value that enrollees get from supplemental benefits.

Over the past few years, the Commission has made several recommendations to improve the program. These recommendations call for the Congress and CMS to address coding intensity, replace the quality-bonus program, establish more equitable benchmarks, and improve the completeness of encounter data. In addition, because of Medicare's fiscal situation, the growth in subsidization of supplemental benefits should be considered with attention to their value.

Medicare payments to plans—In 2026, Medicare's payments to MA plans are projected to be $615 billion. As noted above, we estimate that Medicare will spend 14 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, which translates to a projected $76 billion. In this year's report, we incorporate the ESRD population in our estimates of payments to MA plans relative to FFS, favorable selection, and coding intensity. The higher payments we estimate relative to FFS vary significantly across MA parent organizations and are not an estimate of plan profits and administrative expenses.

Last year, we projected that in 2025, Medicare would spend 20 percent more on MA enrollees than on similar enrollees in FFS Medicare. The lower projected payment difference for 2026 is primarily due to the completed phase-in of a new risk model (called Version 28, or V28) designed to reduce differences in coding and the availability of new risk-score data, which show slower growth in MA risk scores in recent years (described further below). The Commission has supported the change to the V28 risk model, and our lower estimated payment difference indicates that V28 is having the intended effect of reducing the impact of differences in MA and FFS diagnosis coding on payments. Altogether, our estimates suggest that plans were able to maintain their aggregate level of rebates ($222 per enrollee per month) in 2026 by adjusting their bids—and, in fact, rebates reached a record high, despite the complete phase-in of the V28 risk model.

Favorable selection—We project that in 2026, favorable selection will increase MA payments by roughly 11 percent above what the program would have paid under FFS Medicare, or $57 billion of the $76 billion in higher total payments to MA plans. The Commission's estimates of favorable selection are reasonably robust and in line with a growing body of research.

Risk adjustment and coding intensity—We estimate that MA risk scores in 2024 were about 14 percent higher than scores for similar FFS beneficiaries due to higher coding intensity. For 2026, we project that MA risk scores will be about 10 percent higher than scores for similar FFS beneficiaries. Declining differences in MA and FFS coding intensity is driven by the completed phase-in of the V28 risk model, which we estimate to reduce coding intensity by 2.9 percentage points in each year of the model's phase-in (2024 through 2026). By law, CMS reduces MA risk scores by a minimum amount to make them more consistent with FFS coding; CMS has the authority to impose a larger reduction than the minimum required by law but has never done so. In 2026, the adjustment will reduce MA risk scores by the minimum amount, 5.9 percent. We project that, after the adjustment, MA risk scores will remain about 4 percent higher than they would have been if MA enrollees were in FFS Medicare. We estimate that those higher scores will result in $22 billion of the $76 billion in higher total payments to MA plans. (We estimate that MA spending would have been about $3 billion lower than FFS spending for similar beneficiaries before accounting for the effects of favorable selection and coding intensity.)

Although the V28 risk model reduces the variation in coding intensity across MA plans, we continue to estimate meaningful heterogeneity in coding intensity: 16 percent of MA enrollees were in plans that had coding intensity in 2024 that fell below CMS's coding adjustment, and other plans coded far above that amount, including eight MA organizations with average coding intensity that was more than 20 percent higher than FFS levels in 2024. Eight of the 10 largest MA organizations had coding intensity that was 5 percentage points or more than CMS's coding adjustment. Higher coding intensity allows some plans to offer more supplemental benefits—and attract more enrollees—than other plans, thereby distorting both the nature of plan competition in MA and plan incentives to improve quality and reduce costs.

Quality in MA—The MA quality-bonus program will increase MA payments by about $16 billion in 2026. In 2026, 64 percent of MA enrollees are projected to be in a plan that receives a quality-bonus increase to its benchmark. Enrollees generally report satisfaction with their coverage—a trend that has held over time. The Commission continues to be concerned that the MA quality-bonus program and star-rating system are not adequate to assess the quality of care that MA enrollees can expect to receive and to evaluate alternatives for assessing beneficiary access to care, quality, and experience in MA.

Medicare payments and MA plan costs for enrollees with end-stage renal disease—Our analysis finds that, since the 21st Century Cures Act of 2016 allowed all beneficiaries with ESRD to sign up for MA plans beginning in 2021, overall finances appear to have improved for both MA plans and dialysis facilities with increasing MA enrollment. Between 2018 and 2023, Medicare payments to MA plans grew faster, on average, than plans' reported medical costs for enrollees with ESRD. While MA plans roughly broke even on medical costs for enrollees with ESRD, on average, in 2018, Medicare payments to plans were much higher relative to plans' medical costs for enrollees with ESRD in 2023, by 12 percent. We also find that a growing share of plans apply the maximum

allowable amount of cost sharing to dialysis services. In 2022, about 90 percent of enrollees with ESRD in conventional plans and special-needs plans for dually eligible beneficiaries were responsible for a 20 percent coinsurance for dialysis in 2022. Finally, most MA plans continue to pay more than FFS rates for dialysis services, but those prices have decreased over time. The average MA plan price for dialysis was 22 percent higher than the FFS Medicare rate in 2022, down from 28 percent higher in 2020.

The Medicare prescription drug program (Part D): Status report

As described in Chapter 13, in 2025, Part D paid for outpatient drug coverage on behalf of more than 55 million Medicare beneficiaries. Between 2023 and 2024, Medicare's Part D program spending increased nearly 18 percent, representing a sharp acceleration from growth of just over 10 percent in 2023. In 2024, payments to stand-alone prescription drug plans (PDPs) and Medicare Advantage Prescription Drug plans (MA–PDs), including premiums paid by enrollees, totaled $148.3 billion. Of that amount, Medicare paid $90.3 billion in subsidies for basic benefit costs and $41.3 billion in extra financial support for enrollees who receive the low-income subsidy (LIS), while Part D enrollees paid $16.7 billion in premiums for basic benefits. Not included in this total is an additional $17.7 billion in cost sharing paid by enrollees and $0.5 billion in retiree drug subsidies paid by Medicare to employers who provide drug coverage to their retirees.

Major changes taking place beginning in 2025— The IRA made the most significant changes to Part D since its inception, fundamentally altering the structure and financing of the Part D program. The redesign improves the affordability of medicines by reducing beneficiaries' cost-sharing liability and strengthens plan incentives to manage costs but also introduces new uncertainties and financial pressures for plans, Medicare, and the pharmaceutical supply chain. Key provisions include new cost-sharing protections, particularly for beneficiaries using high-cost drugs, and a shift from cost-based reinsurance to monthly capitated direct-subsidy payments as the primary mechanisms for subsidizing Part D premiums. Many of the IRA changes are directionally consistent with the Commission's 2020 recommendations to strengthen plan incentives to manage drug spending. However, the elimination of cost sharing above the annual out-of-pocket threshold and the lowering of that threshold, while improving affordability, likely created significant utilization uncertainties as plans lack cost-sharing tools to manage spending once beneficiaries reach the threshold. The Commission has consistently emphasized that when plan sponsors assume greater insurance risk, they should also have tools to manage spending.

By capping average growth in enrollees' share of benefit costs (premiums) at 6 percent, the IRA increased Medicare's share of program spending to more than 83 percent in 2025 (up from the 74.5 percent originally set in law). The IRA also included policies to address high drug prices (inflation rebates for manufacturers and the Medicare Drug Price Negotiation Program), areas where the Commission has not made recommendations.

Since the implementation of the redesign, the national average bid increased nearly 180 percent in 2025 and an additional 33 percent in 2026, likely driven, at least in part, by higher plan liability and uncertainty about the increase in utilization. For 2025, we estimate that most of the increase resulted from substantially shifting Part D's financing from cost-based reinsurance to capitated direct subsidies. In contrast, for 2026, our estimate suggests that nearly all of the increase reflects higher projected spending. While the Medicare Premium Stabilization Demonstration for PDPs helps limit premium increases that otherwise would have followed from higher bids for those plans, premiums for PDPs remain higher than for MA–PDs and continue to vary widely. The demonstration also increases program spending by adding costs beyond the subsidy amounts set by law. The Commission will continue to monitor the effects of the IRA and other drug-pricing policies, including the implementation of the Drug Price Negotiation Program.

Historical trends and long-term stability of the PDP market— Part D's market structure continues to evolve. With the ongoing enrollment shift from PDPs to MA–PDs, PDPs now account for less than 42 percent of all Part D enrollees, down from 53 percent in 2020. The number of PDPs has declined, especially among enhanced plans, while the number of SNPs—a type of MA plan—has grown. Despite the decline in PDP offerings, in 2026, beneficiary choices include an

average of 11 PDPs offered by five major insurers and 32 MA–PDs, offered by an average of eight insurers. The number of benchmark plans (premium-free options for FFS beneficiaries with the LIS) remained relatively stable in 2026, but there are ongoing concerns about the availability of benchmark plans in some regions. Trends through 2025 showed stable average premiums for beneficiaries, but significant differences remain between PDPs and MA–PDs. In 2026, monthly premiums are projected to average $44 for PDPs and $11 for MA–PDs (including SNPs).

Lower Part D premiums, along with more generous drug coverage—such as lower deductibles and cost sharing—and extra benefits offered under MA financed primarily by MA rebates, may be contributing to the broader shift in Medicare from FFS to MA. Recent work by the Commission has also found diverging trends in Part D risk scores and costs in the two markets. This divergence suggests a potential misalignment between Medicare's payments to plans and enrollees' drug costs that may be discouraging insurer participation in the PDP market and accelerating the shift to MA.

The risk-adjustment model is intended to align payments with expected costs, but analysis shows Part D's risk scores have tended to overpredict costs for MA–PDs and underpredict for PDPs. In response, CMS began applying separate normalization factors to MA–PD and PDP risk scores in 2025 to better reflect actual costs. However, further refinements may be needed for balanced competition and accurate payment adjustments to ensure the stability of the PDP market. The Commission will continue to monitor how recent changes to the separate normalizations of PDP and MA–PD risk scores may have affected the relationship between risk scores and costs.

Part D prices and the Medicare Drug Price Negotiation Program—Brand-name drugs with very high prices are the primary driver of Part D spending. Brand-name drugs and biologics without a generic (or biosimilar) competitor now account for over 83 percent of gross Part D spending, despite constituting less than 10 percent of prescriptions. The first two rounds of drugs selected for the Medicare Drug Price Negotiation Program represent over $103 billion in gross spending—more than 36 percent of total gross Part D spending—and accounted for more than 60 percent of all manufacturer rebates in 2024. The shift from rebates to maximum fair prices (MFPs) under the negotiation program is expected to lower point-of-sale prices for beneficiaries but also affect plan operations in a way that places both downward and upward pressure on premiums and Medicare's subsidies. For example, reduced rebates tend to put upward pressure on benefit costs and premiums, though reduced prices at the point of sale would tend to lower costs for patients and Medicare's LIS. The net effect of those factors on program spending is uncertain. Pharmacies, especially independents, have raised concerns about how changes in reimbursement structures and the timing of payments may affect their operations.

Quality of Part D plans and beneficiary access to needed medicines—The quality of Part D plans and enrollee satisfaction is closely related to access to medicines and patient experience with the plan. Historically, the Part D program has generally enjoyed high levels of satisfaction. Part D plans use various tools to manage spending and design products that are attractive to beneficiaries. These tools can reduce benefit spending, program costs, and premiums. However, when used inappropriately, they can limit access to needed medications. Recent policy changes may also affect pharmacy finances and the contracting environment, potentially influencing decisions to remain open or exit markets. We plan to analyze trends in pharmacy networks to assess how evolving incentives affect pharmacy participation and beneficiaries' access.

The Medicare Plan Finder helps beneficiaries compare coverage and costs among plan options. However, CMS has raised concerns about the accuracy of drug prices displayed on Plan Finder during the annual enrollment period (AEP), which may affect plan choice and enrollee costs. Our analysis of Plan Finder data for 2024 found that prices displayed during the AEP generally aligned with those at the start of the benefit year and did not raise immediate concerns about price accuracy. However, more detailed analysis may reveal plan- or drug-level variation that affects beneficiaries who pay coinsurance. We encourage CMS to continue monitoring Plan Finder prices and consider implementing a measure to ensure accuracy of prices during the AEP.

Mandated report: The impact of recent changes to the home health prospective payment system

In Chapter 14, we report on the effects of recent changes to the home health PPS. The Bipartisan Budget Act (BBA) of 2018 required CMS to shift to a 30-day period for payment and eliminate therapy visits as a factor in payment. On January 1, 2020, CMS implemented these changes as part of a new case-mix model, the Patient-Driven Groupings Model (PDGM). The BBA of 2018 also mandated that the Commission assess the impact of the 30-day unit of payment in two reports: an interim report that we submitted in March 2022 and this final report due in March 2026.

For this report, the Commission assessed three domains: use of home health services, the quality of care received, and the payments and costs for home health stays. Our analysis uses an interrupted time series (ITS) methodology to produce two estimates: a "with PDGM" estimate, which reflects the observed postimplementation period, and a "without PDGM" estimate, which is a counterfactual of what would have happened in the absence of the policy changes. The difference between these two estimates, and its statistical significance, measures the estimated change associated with the PDGM. This analysis focuses on outcomes from 2023 to reduce the influence of the coronavirus pandemic on the results and to reflect the most recently available data on post-PDGM home health care trends. Our analysis examines outcomes for several categories of FFS Medicare beneficiaries, including demographic, socioeconomic, and other attributes.

The estimated effects presented in the analysis should be interpreted cautiously. While the ITS methodology attempts to isolate the PDGM's influence by comparing postimplementation outcomes with an estimate of what would have occurred under preexisting trends, it relies on the assumption that those trends would have continued unchanged if the PDGM had not been introduced. The model also assumes that our control variables have adequately adjusted for pandemic-related disruptions that persisted into 2023, but we cannot be certain of this assumption given the unprecedented scope of the event. Small changes are particularly difficult to interpret with confidence using this methodology. The estimates rely on the assumption that the adjusted trends before implementation of the PDGM would continue exactly, and small estimated effects may instead be related to other changes over time that are difficult to control for. Our report describes findings from this analysis as changes "associated with" the PDGM rather than "caused by" it, underscoring the need for cautious interpretation. Unless otherwise noted, the results we discuss are statistically significant at the 5 percent level.

For 2023, we found:

- No substantial difference associated with the PDGM in FFS Medicare beneficiaries' probability of home health use. Our analysis found that the probability of a FFS beneficiary using any home health care did not change substantially in 2023, with an 8.6 percent probability of any home care use with the PDGM and an 8.8 percent probability without the PDGM.
- No substantial difference associated with the PDGM in the number of 30-day periods per FFS home health user. The PDGM was also not associated with a substantial difference in the average number of 30-day periods received by home health users in 2023, with an average of 2.7 thirty-day periods per home health user with the PDGM compared with 2.6 thirty-day periods per home health user without the PDGM.
- Fewer home health visits per FFS stay associated with the PDGM. After adjusting for factors such as patient severity, the ITS models estimate an average of 15.9 visits under the PDGM compared with 18.8 visits without the PDGM—a difference of 2.9 visits, or about 15.3 percent fewer visits. That lower number of visits per stay in large part stemmed from a smaller number of therapy visits provided (2.4 fewer visits, on average). This finding was expected, given that the new payment system no longer includes the provision of therapy as a factor in payment. Indeed, prior to the implementation of the PDGM, the home health PPS was criticized for encouraging excessive therapy visits, and the PDGM's removal of therapy from the case-mix system was intended to correct this distortion. Importantly, Medicare's coverage rules for therapy services have remained unchanged,

and CMS has emphasized that therapy should still be provided based on patient needs. The decline in therapy visits therefore may reflect better alignment of home health care services with beneficiary needs. However, we note that, though the removal of therapy as a factor in payment may account for some of the decline in therapy associated with the PDGM, other factors—such as broader changes in the health care system or shifts in care-delivery practices—may have played a role.

- No substantial difference associated with the PDGM in outcomes for most quality measures we examined. For all FFS beneficiaries who received home health care, the rate of potentially preventable hospitalization during the home health stay with the PDGM was 2.1 percentage points lower relative to the 10.3 percent rate for potentially preventable hospitalizations without the PDGM; however, the limitations for our methods mentioned earlier require interpreting this finding with caution. The PDGM was associated with a slightly lower share of stays ending in discharge to the community. We found no substantial differences associated with the PDGM for self-care or mobility at discharge from home health, indicating that functional outcomes were similar after the implementation of the new system.
- No substantial difference associated with the PDGM in overall FFS Medicare margins. We found that the FFS Medicare margin for home health stays associated with the PDGM in 2023 was 0.6 percentage points lower than that for home health stays without the PDGM, a difference that was not statistically significant. As noted in Chapter 8 of this report, the FFS Medicare margin for freestanding HHAs was 21.2 percent in 2024. Given the many disruptions in the health care system during and after the pandemic, it is notable that FFS Medicare margins remained relatively high with no substantial difference associated with the PDGM in 2023.

The results for utilization, quality, and financial performance indicate that the implementation of the PDGM did not have an adverse impact on FFS Medicare beneficiaries and may have realigned therapy services to better reflect clinical need while maintaining quality of outcomes. Though the PDGM was associated with fewer visits per stay, and particularly therapy visits per stay, we did not observe worse quality of care. Looking ahead, the Commission plans to further analyze the PDGM's case-mix groups to assess their profitability under current utilization patterns and cost structures. Future studies may also explore factors such as agency size, geographic location, and ownership type to better understand variations in cost and payment outcomes across HHAs.

Mandated report: Dual-eligible special-needs plans

Dual-eligible special-needs plans (D–SNPs) are specialized MA plans that limit enrollment to beneficiaries who are dually eligible for both Medicare and Medicaid. The BBA of 2018 permanently authorized D–SNPs and, starting in 2021, required them to meet standards for integrating the delivery of Medicare and Medicaid services. The Commission is mandated by the BBA of 2018 to periodically compare the performance of different types of D–SNPs and other plans that serve dually eligible beneficiaries. Chapter 15 contains our third report under the mandate.

Dually eligible beneficiaries may receive care that is fragmented or poorly coordinated because of the challenges of navigating two distinct and complex programs. D–SNPs can address these challenges by providing both Medicare and Medicaid benefits, but their level of integration with Medicaid varies. Plans that are more highly integrated have incentives to better manage and coordinate care across the two programs and have the potential to improve the enrollee experience for dually eligible beneficiaries by integrating aspects of Medicare and Medicaid such as member materials, care planning, and the processes for handling appeals and grievances that would otherwise be separate.

To evaluate the performance of D–SNPs, we compared available quality measures that plans report as part of the Healthcare Effectiveness Data and Information Set (HEDIS) and patient-experience data that plans collect using the CAHPS beneficiary survey. Unfortunately, we find that these data sources provide limited insight into the relative performance of D–SNPs because most HEDIS measures are not tied to clinical outcomes and because HEDIS and CAHPS scores on many measures are fairly similar across plan types. The performance of MA plans and Medicare–Medicaid Plans (MMPs), which were part of a demonstration that recently ended, often

differed, but those differences could reflect structural differences between the two types of plans or differences in the types of beneficiaries enrolled. These findings are consistent with our earlier mandated reports and with other Commission analyses that have highlighted the difficulties of assessing the quality and performance of MA plans. External researchers who have studied integrated plans have found some evidence that they produce better outcomes, but their findings have been limited and inconsistent. For example, some studies have found positive effects on certain metrics, such as fewer long-term nursing home stays and greater use of outpatient care, but found inconclusive effects on other metrics, such as hospital admissions and emergency department visits. Better data and more research are needed on the effects of integrated plans on quality and outcomes.

One challenge to developing integrated plans has been "look-alike plans," which are MA plans that are not D–SNPs but target dually eligible beneficiaries. Look-alike plans have some of the same features as D–SNPs but are not subject to the additional requirements that apply to D–SNPs, such as having a state Medicaid contract. CMS has limited the ability of insurers to use conventional MA plans as look-alike plans, but insurers appear to be responding by using another type of MA plan, the chronic-condition special-needs plan (C–SNP), as a new type of look-alike plan. C–SNPs are specialized plans that target beneficiaries who have certain chronic conditions, but these plans do not integrate Medicaid benefits. The Commission has previously expressed concern that look-alike plans can undermine states' efforts to develop integrated care programs, and policymakers may want to consider applying the current limits on look-alike plans to C–SNPs. ■