

MARCH 2026

Report to the Congress

Medicare Payment Policy

MECPAC



The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare’s traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

The Commission’s 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the Comptroller General and serve part time. Appointments are staggered; the terms of five or six Commissioners expire each year. The Commission is supported by an executive director and a staff of analysts, who typically have backgrounds in economics, health policy, and public health.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress. In the course of these meetings, Commissioners consider the results of staff research, presentations by policy experts, and comments from interested parties. (Meeting transcripts are available at www.medpac.gov.) Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the Centers for Medicare & Medicaid Services (CMS), health care researchers, health care providers, and beneficiary advocates.

Two reports—issued in March and June each year—are the primary outlets for Commission recommendations. In addition to annual reports and occasional reports on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

REPORT TO THE CONGRESS

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*Medicare Payment
Advisory Commission*

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March 12, 2026

The Honorable JD Vance
President of the Senate
U.S. Capitol
Washington, DC 20510

The Honorable Mike Johnson
Speaker of the House
U.S. House of Representatives
U.S. Capitol
Room H-232
Washington, DC 20515

Dear Mister President and Mister Speaker:

I am pleased to submit the Medicare Payment Advisory Commission's March 2026 *Report to the Congress: Medicare Payment Policy*. This report fulfills the Commission's legislative mandate to evaluate Medicare payment issues and make recommendations to the Congress. This report also satisfies additional legislative mandates to report on the impact of changes to the home health payment system and describe special-needs plans for beneficiaries who are dually eligible for Medicare and Medicaid.

The report contains 15 chapters:

- a chapter that provides a broad context for the report, including Medicare's overall financial situation and factors contributing to Medicare spending growth;
- a chapter that describes the Commission's analytic framework for assessing fee-for-service (FFS) Medicare payment adequacy;
- seven chapters that describe the Commission's recommendations on FFS Medicare payment-rate updates and related issues to ensure that beneficiaries have access to high-quality care and the program achieves good value for taxpayers and beneficiaries;
- a chapter that describes the trends and key issues in post-acute care;
- a chapter that describes use of and spending for services provided to FFS Medicare beneficiaries in ambulatory surgical centers;
- a chapter that describes the Medicare Advantage (MA) program, including recent trends in enrollment, plan availability, and Medicare's payments to plans, and discusses issues such as MA coding intensity, favorable selection, and Medicare payments and MA plan costs for MA enrollees with end-stage renal disease;

- a chapter about Medicare's pharmacy benefit, Part D, that updates trends in enrollment and plan offerings and includes information about the effects of major changes that have taken place since 2025, as implementation of the Inflation Reduction Act of 2022 continues; and
- two chapters containing the congressionally mandated reports on the impact of recent changes to the home health prospective payment system and the performance of dual-eligible special-needs plans (D-SNPs), a type of MA plan for people enrolled in both Medicare and Medicaid.

Our statutory charge is to evaluate available data to assess whether FFS Medicare payments, in aggregate, are sufficient to support the efficient delivery of care and ensure access to care for Medicare's beneficiaries. In this report, we make recommendations aimed at supporting access to high-quality care for Medicare beneficiaries while giving providers incentives to constrain their cost growth and thus help control program spending. For 2027, we recommend FFS payment updates above current law for physician and other health professional services; the payment update specified in current law for acute care hospitals; no payment update for outpatient dialysis providers and hospice providers; and payment reductions for skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities. We also recommend targeting additional resources to Medicare safety-net hospitals (as well as redistributing current disproportionate-share and uncompensated-care payments).

I hope you find this report useful as the Congress continues its work on the difficult task of supporting Medicare beneficiaries' access to high-quality care while obtaining good value for the program's expenditures.

Sincerely,

A handwritten signature in dark ink, appearing to read 'm. chernew', with a stylized horizontal line extending to the right.

Michael E. Chernew, Ph.D.
Chair

Enclosure

Acknowledgments

This report was prepared with the assistance of many people. Their support was key as the Commission considered policy issues and worked toward consensus on its recommendations.

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Executive summary

Executive summary

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. ■

C H A P T E R

1

Context for Medicare payment policy

Context for Medicare payment policy

Chapter summary

Every March, the Commission reports to the Congress on Medicare's various fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare Part D prescription drug program. To provide context for the information presented in our report, this chapter 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 usually grows faster than GDP

National health care spending grew rapidly in 2023 and 2024, by 7 percent in each of these years. This growth was driven by a number of factors, including postpandemic rebounding growth in the volume and intensity of services and items furnished to patients, the share of the U.S. population with health insurance reaching an all-time high (of 92 percent in 2022 through 2024), population growth, and growth in medical prices (due to economy-wide price growth, as opposed to excess medical inflation). 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.

In this chapter

- National health care spending usually grows faster than GDP
- Drivers of Medicare's spending growth
- Provider consolidation has been increasing
- Medicare draws on an increasing share of the country's tax revenues
- When Medicare spending increases, beneficiaries' costs also increase
- The health care workforce plays an important role
- The Commission aims to improve value for taxpayers and beneficiaries

Drivers of Medicare's spending growth

Medicare spending grew rapidly 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 reach Medicare's eligibility age.

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. (Spending on Part B drugs has been growing rapidly in recent years—by an average of 9 percent per year between 2009 and 2023.)

Provider consolidation has been increasing

A key contextual factor in the health care sector is the ongoing consolidation of health care providers. Historically, health care market consolidation has primarily involved like types of provider organizations (e.g., hospitals merging with other hospitals) or different types of providers that had referral relationships between them (e.g., hospitals acquiring physician practices). In recent years, however, consolidation has expanded beyond hospital mergers and vertically integrated arrangements between providers, with nonprovider organizations such as private insurers, corporate entities, and private equity (PE) firms now also acquiring provider organizations.

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—namely, when a hospital acquires a clinician practice, the hospital can sometimes bill a “facility” fee (in addition to the physician's fee) each time a Medicare beneficiary is seen or receives services in the hospital-owned practice. Employing clinicians also may 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.

Obtaining higher payment rates is not the only reason providers consolidate. When hospitals vertically integrate with other types of providers, they can encourage patient referrals within their integrated system. When insurers consolidate with providers, they may be able to better coordinate care and gain provider cooperation in cost-control efforts such as prescribing generic drugs and improving care coordination that is tied to quality bonuses, such as through MA star ratings. In the case of consolidation between insurers and pharmacy benefit managers (PBMs), PBMs may be able to steer some patients to their affiliated pharmacies, especially in commercial markets. From a clinician's perspective, more predictable and stable income and the greater ability to maintain patient volume and referral privileges may lead to vertical integration. Clinicians also report selling practices to hospitals or health systems to gain access to costly resources and to get help navigating regulatory and administrative requirements. Conceptually, provider consolidation may also 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 payer-PBM consolidation on spending. Literature assessing the effect of PE-provider consolidation on spending is emerging but generally shows higher payments. 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 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, this shift 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). Medicare's Trustees report that in 2024, an amount equivalent to 16 percent of federal income taxes was used to pay for Medicare Part B and Part D. As the amount of general revenues needed to finance Medicare increases, less revenue is available for other priorities, such as 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.

In CMS's survey, some groups of beneficiaries reported affordability issues at higher rates than others—such as partial-benefit dually eligible beneficiaries (who do not qualify for the Medicaid benefits that full-benefit dually eligible beneficiaries do), beneficiaries under age 65 (most of whom are disabled), beneficiaries with low enough incomes to qualify for the Part D low-income subsidy, and beneficiaries enrolled in FFS Medicare without any supplemental coverage (e.g., without a Medigap plan or Medicaid). 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 a sufficient supply of nurses, nursing assistants, and other types of health care staff, this year's chapter explores that workforce, which comprises 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, the occupation of nearly 4 million people in 2024, followed by registered nurse (RN) (3.3 million) and health technologist or technician (2.5 million). One trend in the workforce is the lack of growth in certain roles requiring minimal training. From 2003 to 2024, the number of physical therapist assistants (who usually have an associate's degree and a license or certification) grew rapidly, while the number of physical therapist aides (who usually have only a high school diploma and on-the-job training) remained flat and then began to decline. Similar trends have been observed among occupational therapist assistants and aides, pharmacy technicians and pharmacy aides, and RNs and licensed practical nurses (LPNs).

The Bureau of Labor Statistics projects that what it calls the “healthcare support” occupational group (a set of occupations similar to 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. For example, over the next five years, the Department of Health & Human Services projects shortages of pharmacists, physical therapists, and diagnostic medical sonographers but surpluses of pharmacy technicians, physical therapy assistants, occupational therapists and occupational therapy assistants, speech-language pathologists, radiation therapists, and health care social workers. 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. In particular, nursing homes experience high staff turnover. 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.

The Commission aims to improve value for taxpayers and beneficiaries

The Commission regularly makes 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. A list of the Commission's recommendations, with links to relevant report chapters, is available at www.medpac.gov/recommendation. The evidence-based recommendations we formulate are intended to obtain good value for beneficiaries' and taxpayers' expenditures, which means maintaining or improving access to high-quality services while encouraging efficient use of resources. ■

Every March, the Commission reports to the Congress on Medicare’s various fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare Part D prescription drug program. To provide context for the information presented in our report, this chapter describes Medicare’s overall financial situation and describes some ways that Medicare affects, and is affected by, the broader health care sector.

National health care spending usually grows faster than GDP

In 2024, the U.S. spent \$5.3 trillion on health care, constituting 18 percent of the country’s gross domestic product (GDP) (Hartman et al. 2026). Since national health care spending usually grows faster than GDP, health care spending has made up an increasing share of GDP over time (Figure 1-1, p. 10).

National health care spending temporarily diverged from this historical trend during the recent coronavirus pandemic, sharply increasing as a share of GDP in 2020 due to new pandemic-related spending that occurred while the economy was shrinking. In 2021 and 2022, national health care spending as a share of GDP then sharply fell as health care spending increased modestly in the latter years of the pandemic while the economy grew rapidly (Hartman et al. 2024, Martin et al. 2025).

In 2023 and 2024, national health care spending rebounded strongly—growing by 7 percent per year—as growth in the volume and intensity of the services and items furnished to patients increased while GDP growth slowed to rates more consistent with prepandemic years. This reversal caused national health care spending as a share of GDP to again rise. One of the reasons health care spending has grown so rapidly in recent years is that the share of the population with health insurance reached an all-time high of 92 percent in 2022 through 2024. Population growth and growth in medical prices (due to economy-wide price growth, as opposed to excess medical inflation) also drove spending in these years (Hartman et al. 2026).

In 2025, CMS expects that national health care spending continued to experience robust growth

(increasing by another 7 percent) because of continued high rates of insurance coverage that year and the rebound in service use continuing in 2025 after the somewhat suppressed growth observed during the pandemic (Keehan et al. 2025).

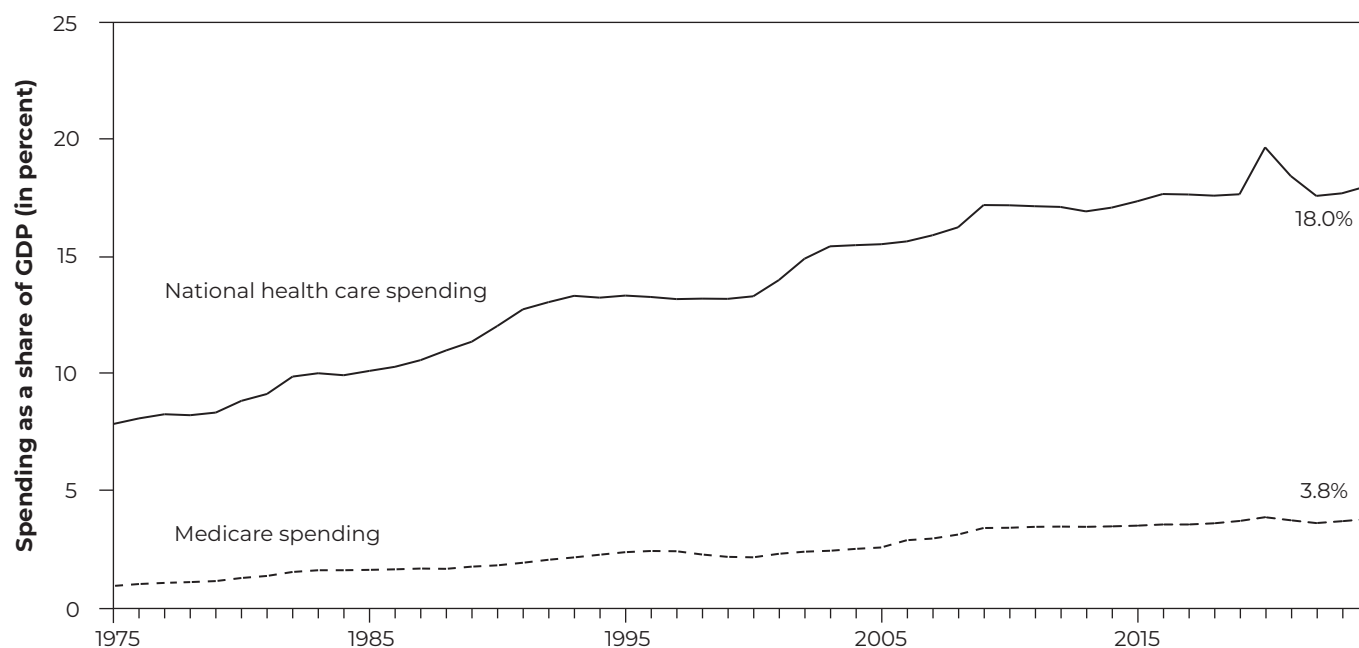
Drivers of Medicare’s spending growth

Medicare spending totaled \$1.1 trillion in 2024, equivalent to 21 percent of national health care spending and 3.8 percent of GDP (Figure 1-2, p. 11). 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 (Figure 1-2).

Medicare spending grew rapidly in 2023 and 2024 (by 9 percent and 8 percent, respectively), in part due to changes mandated by the Inflation Reduction Act of 2022 (IRA) that shifted more of the cost of Part D prescription drug coverage from beneficiaries to the federal government (Hartman et al. 2026).

Another driver of Medicare’s projected spending growth is continued elevated enrollment in the program as the baby-boom generation continues to reach Medicare’s eligibility age. By 2029, all members of the baby-boom generation will have reached age 65 and Medicare enrollment will reach 75 million, up from 49 million in 2011, when this generation first began to reach Medicare’s eligibility age (Figure 1-3, p. 12). In 2024, 67 million beneficiaries were enrolled in Medicare.

When the Medicare Trustees decompose the drivers of Medicare spending growth, they find that factors other than enrollment growth, changing beneficiary demographics, and changes in the price of medical services are projected to be the main drivers of spending growth from 2025 to 2034 (shown in the “Other” column of Table 1-1, p. 12). As discussed below, examples of these “other” spending drivers include growth over time in the volume and intensity of services and items that clinicians prescribe and growth in the average price Medicare pays for Part B drugs and biologics. These other spending drivers are currently projected to increase by 3 percent per year over the next 10 years.

**FIGURE
1-1****National health care spending has grown as a share of U.S. GDP**

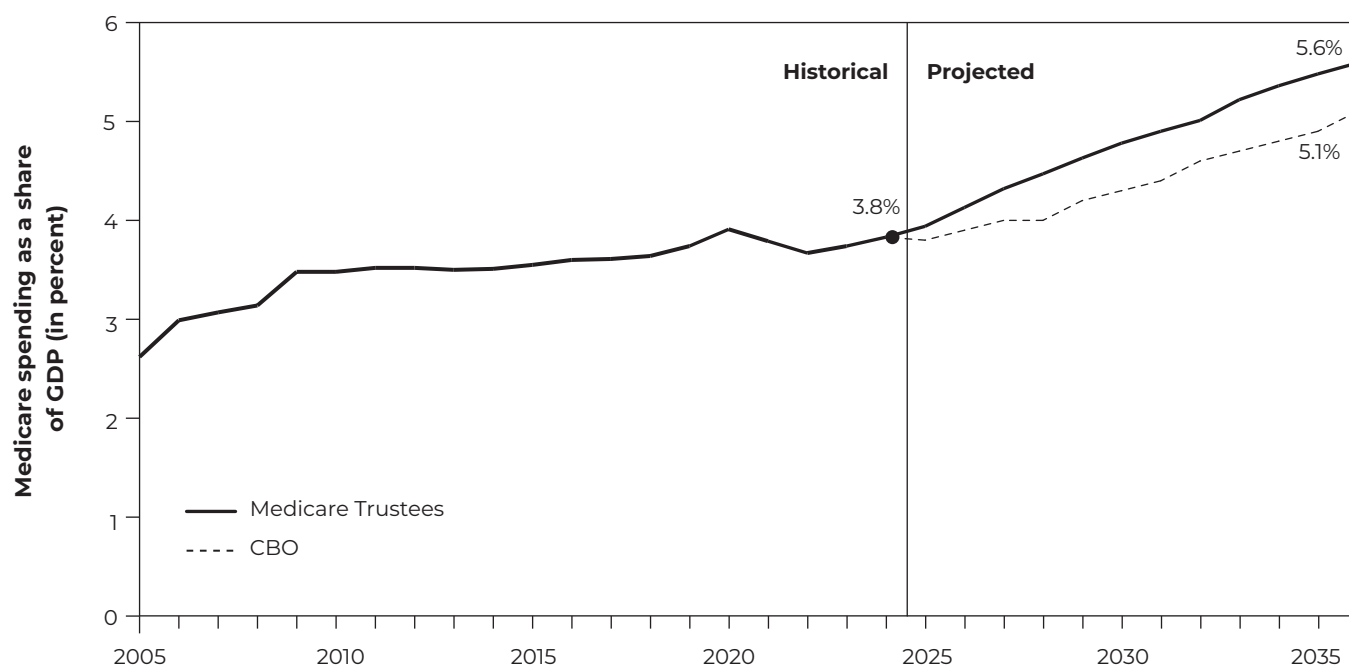
Note: GDP (gross domestic product). Pandemic relief funds are counted as national health care spending rather than Medicare spending because they were meant to offset pandemic-related revenue losses from all payers, not just Medicare. Medicare spending excludes COVID-19 Accelerated and Advance Payments (short-term loans paid to providers in 2020 that were subsequently repaid) since this graph shows expenditures on an incurred basis rather than a cash basis. Medicare spending includes spending for beneficiaries in both Medicare fee-for-service and Medicare Advantage.

Source: MedPAC analysis of CMS's national health expenditure data (projected data released in June 2025 and historical data released in January 2026), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html>.

The volume and intensity of services used by Medicare beneficiaries has varied over time and across settings. “Increasing volume” refers to an increase in the number of services furnished to beneficiaries. In recent years, the volume of services furnished per beneficiary has grown for some types of services (e.g., clinician encounters) and declined for others (e.g., inpatient hospital stays and skilled nursing facility care postdischarge) (Medicare Payment Advisory Commission 2025c). “Increasing intensity” refers to a change in the mix of services or items furnished as clinicians prescribe more complex services in place of less complex ones (e.g., nuclear medicine stress tests instead of electrocardiogram stress tests). Studies

that have tried to understand whether higher service volume and intensity (as measured by Medicare spending) improve patient outcomes have produced mixed findings, sometimes finding improved outcomes and sometimes finding no relationship (Kaestner and Silber 2010, Likosky et al. 2018, Romley et al. 2013, Tsugawa et al. 2017).

Increased spending on drugs has also contributed to Medicare’s overall spending growth. In 2023 and 2024, CMS observed rapid increases in the demand for glucagon-like peptide-1 receptor agonist (GLP-1) drugs, which are available under Medicare Part D to treat conditions like diabetes (Hartman et al. 2026).

**FIGURE
1-2****Medicare spending is projected to constitute 5 percent of GDP by 2035**

Note: GDP (gross domestic product), CBO (Congressional Budget Office). The CBO line reflects fiscal years, while the Medicare Trustees line reflects calendar years. The first projected year is 2025. Medicare spending includes program spending and spending financed by premiums and other offsetting receipts for beneficiaries in both fee-for-service Medicare and Medicare Advantage but does not include beneficiary cost sharing. The sharp increase in spending in 2020 includes \$104 billion in Medicare Accelerated and Advance Payments paid to providers that were then recouped by the Medicare program in 2021, 2022, and 2023.

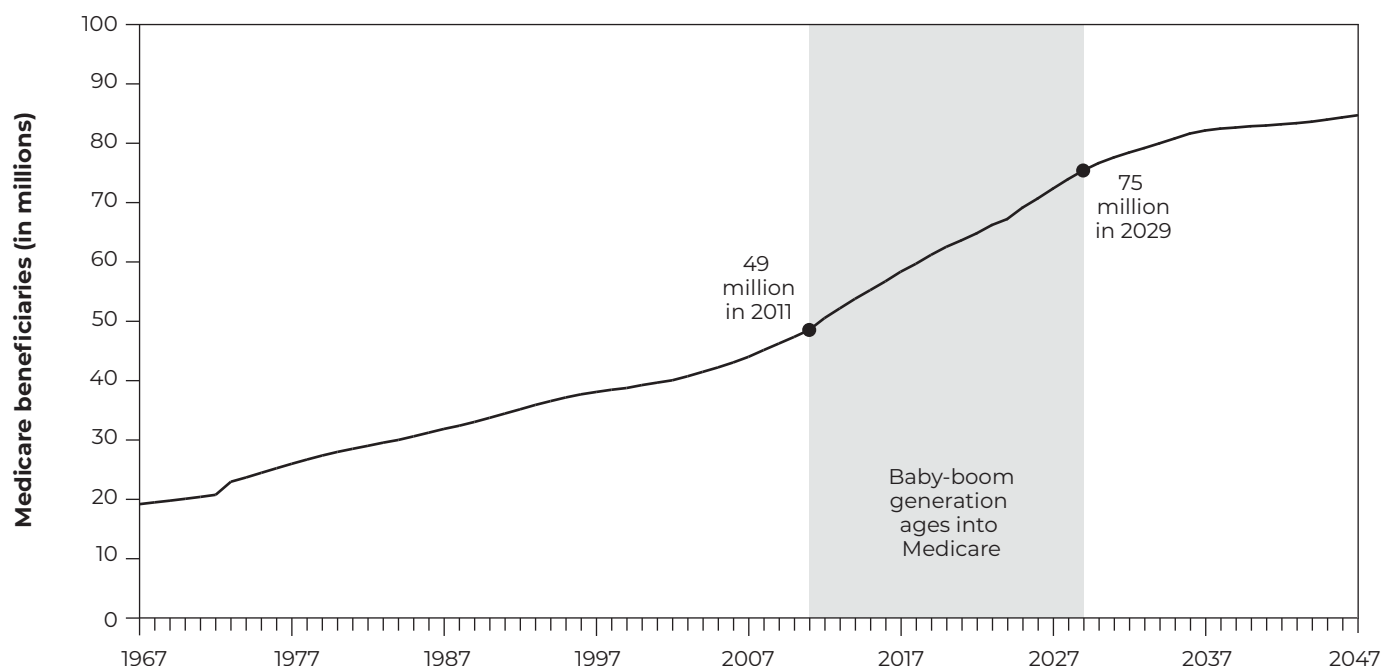
Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds, Figure II.D1; CBO's long-term budget projections released in March 2025.

Over the longer term, there has also been rapid growth in spending on drugs covered under Part B, which are typically administered in physician offices or hospital outpatient departments (as opposed to obtained by patients from retail pharmacies) and include drugs and biologics like cancer drugs and skin substitutes. Between 2009 and 2023, FFS Medicare spending on Part B drugs grew by an average of 9 percent per year, rising from \$15 billion to \$54 billion (Medicare Payment Advisory Commission 2025a). (By comparison, FFS Medicare's overall Part B spending grew by 7 percent per year over this period (Boards of Trustees 2025).) Part B drug spending growth was driven by a rise in the average price paid by Medicare for these products, due to the introduction of new, higher-priced drugs,

increased prices for existing products, and shifts in the mix of drugs furnished to beneficiaries (Medicare Payment Advisory Commission 2025a). (Projections of continued growth in Part B drug prices are captured in the "Other" column of Table 1-1 (p. 12), along with projected growth in the volume and intensity of services and items that are furnished to beneficiaries, as well as other factors.) The Commission has expressed concern about the lack of price competition and high launch prices for some products under the current average sales price (ASP) payment system and has recommended improvements to Medicare's payment approach for Part B drugs (Medicare Payment Advisory Commission 2023a).¹

**FIGURE
1-3**

Medicare enrollment has accelerated as the baby-boom generation ages into Medicare



Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries enrolled in Medicare Advantage plans). More beneficiaries have Part A Hospital Insurance than Part B Supplementary Medical Insurance because Part A is usually available to beneficiaries at no cost. The first projected year is 2025. Part A services are financed by Medicare's Hospital Insurance Trust Fund and beneficiary cost sharing.

Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds.

**TABLE
1-1**

Medicare Trustees' projections of the influence of different drivers of Medicare's projected spending growth (after accounting for inflation), 2025-2034

Average annual percent change in:

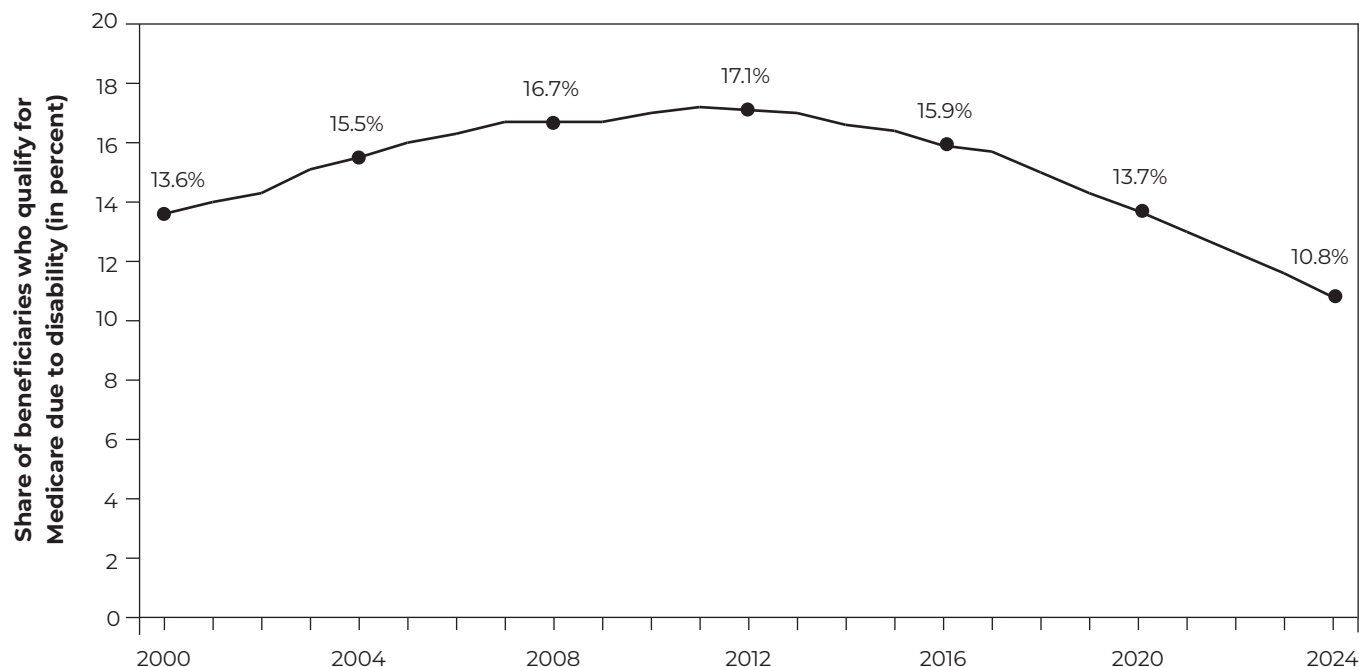
Medicare Part	Medicare prices for services (minus inflation)	Number of beneficiaries	Beneficiary demographic mix	Other	Medicare's projected spending (minus inflation)
Part A	-0.3%	1.8%	0.4%	1.8%	3.6%
Part B	-1.0	1.9	0.1	4.5	5.5
Part D	-1.3	2.0	-0.2	1.0	1.6
Total	-0.8	1.9	0.2	3.0	4.3

Note: Includes fee-for-service and Medicare Advantage enrollees. "Medicare prices for services (minus inflation)" reflects Medicare's annual updates to payment rates (not including inflation, as measured by the Consumer Price Index), total-factor productivity reductions, and any other reductions required by law or regulation. "Beneficiary demographic mix" adjusts for age, sex, and time to death. "Other" refers to the residual after the other three factors shown in the table (Medicare prices for services, number of beneficiaries, and beneficiary demographic mix) are removed. "Medicare's projected spending" is the product of the other columns in the table, but components may not produce totals in this column due to rounding. The "total" row is the sum of the other rows of the table, each weighted by its part's share of total Medicare spending in 2024.

Source: MedPAC analysis of data from the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

**FIGURE
1-4**

In recent years, a declining share of Medicare beneficiaries have qualified for the program due to disability



Note: The figure reflects beneficiaries enrolled in Part A and/or Part B, including beneficiaries enrolled in Medicare Advantage plans (who have both Part A and Part B). Beneficiaries who qualify for Medicare due to disability are under the age of 65.

Source: MedPAC analysis of data from annual reports of the Boards of Trustees of the Medicare trust funds and unpublished data from CMS's Office of the Actuary.

Medicare prices for services (captured in the first column of Table 1-1) are not expected to be a key driver of program spending growth in the next decade because these prices are generally set administratively by the program and are expected to grow at or below inflation. Medicare's constraint of most types of prices could be one reason why spending per enrollee for Medicare beneficiaries usually grows more slowly than for the privately insured—whose plans have less ability to set prices and instead must negotiate with providers (Martin et al. 2025, Martin et al. 2018).

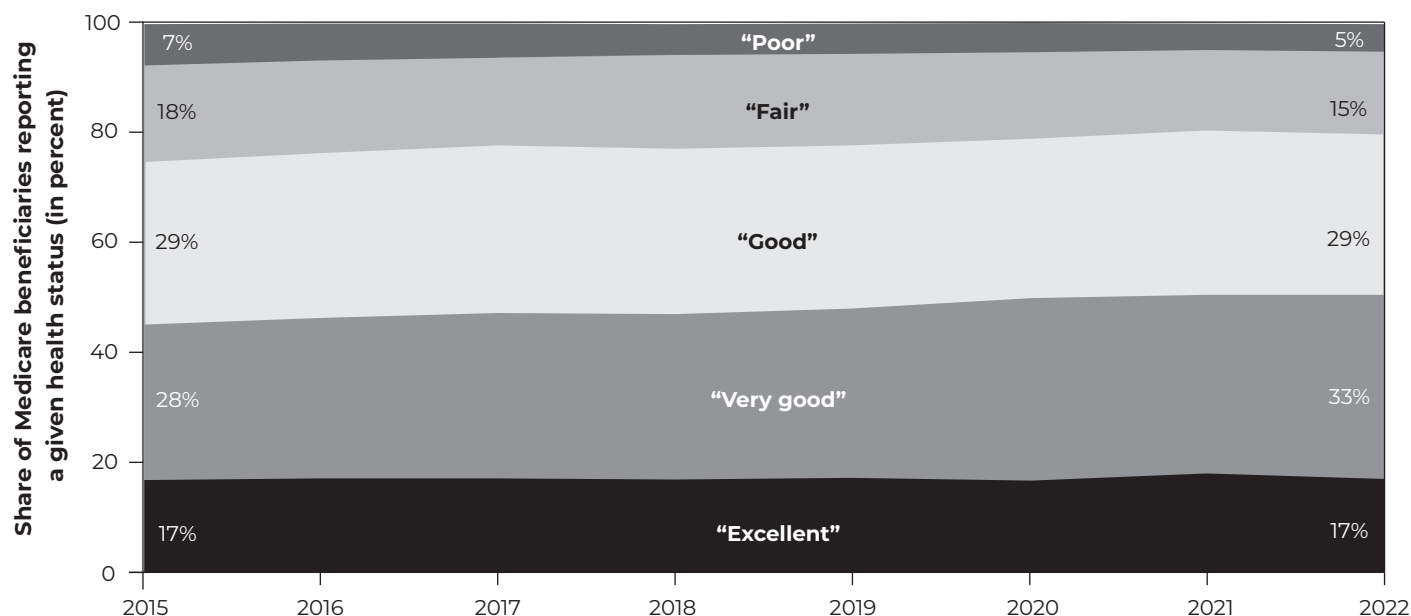
The demographic mix of beneficiaries in the program (shown in the third column of Table 1-1) is also not expected to cause a significant increase in spending over the next 10 years. To the contrary, the average Medicare beneficiary has been getting younger and

healthier in recent years as the baby-boom generation ages into Medicare (Boards of Trustees 2025). In addition, the Medicare beneficiaries who survived the recent coronavirus pandemic are now healthier, on average, than beneficiaries were before the pandemic began, which has reduced the Medicare Trustees' projections of Medicare's per capita spending through 2029 (Boards of Trustees 2025).

The health of the average beneficiary has also improved in recent years because a declining share of Medicare beneficiaries have been qualifying for the program due to disability (Figure 1-4). (Beneficiaries who qualify due to disability tend to be in worse health and generate more spending than those who qualify due to age (Medicare Payment Advisory Commission 2025a, Medicare Payment

FIGURE
1-5

An increasing share of Medicare beneficiaries report being in “very good” health, 2015-2022



Note: CMS's Medicare Current Beneficiary Survey asked respondents to characterize their health compared to other people their age. The health status of beneficiaries residing in facilities was reported by a proxy respondent (e.g., a nurse). Includes beneficiaries in traditional fee-for-service Medicare and Medicare Advantage enrollees. Respondents who did not know their health status or refused to answer are not shown above but were included in the denominator of these percentages.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2015–2022.

Advisory Commission 2023b).) A declining share of applications to the Social Security Administration (SSA) for disability payments have been approved since 1998, and a declining number of applications have been submitted to the SSA since 2010 (Social Security Administration 2025). These declines in turn are believed to be driven by factors like low unemployment rates, greater availability of health care because of the Affordable Care Act of 2010 (ACA), and employers increasingly offering job flexibility and accommodations to workers with impairments (Social Security Administration 2024).

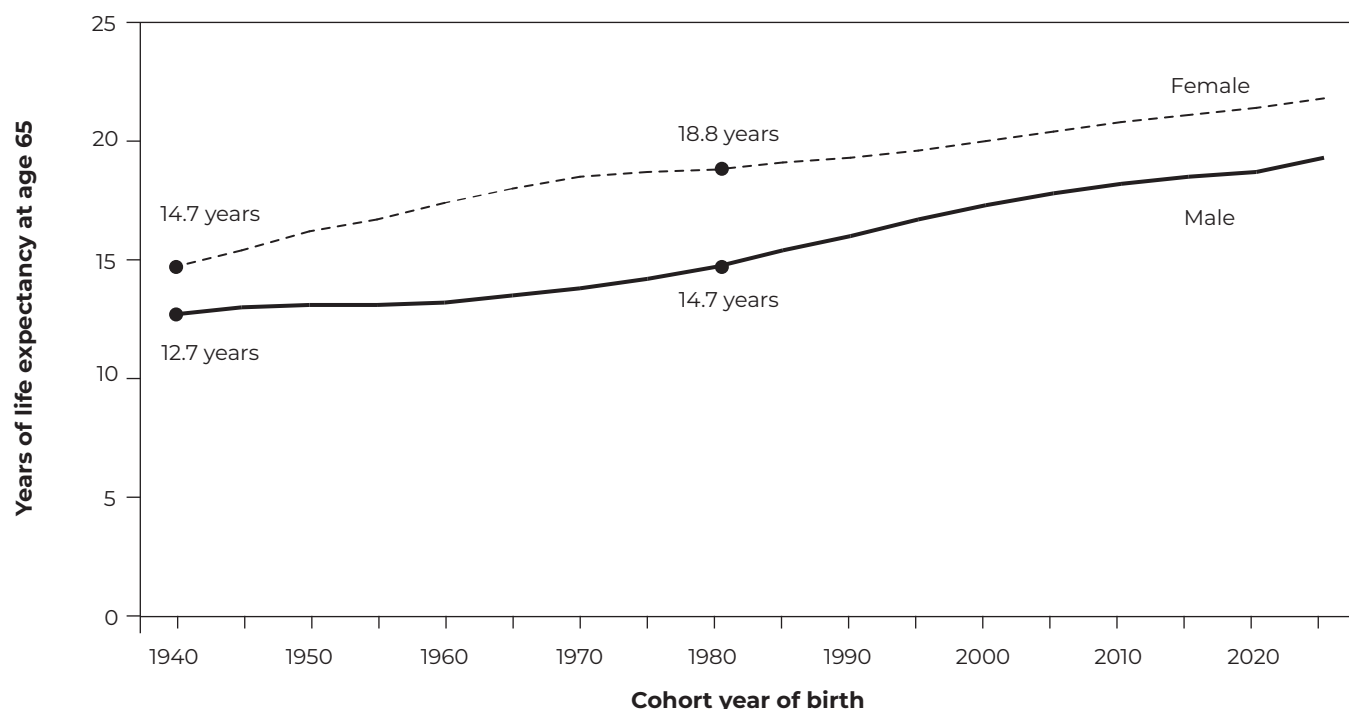
As a result of these trends, the overall share of Medicare beneficiaries who report being in “very good” health in CMS's Medicare Current Beneficiary Survey has been increasing in recent years (Figure 1-5).

(Studies have found that self-reported health status is a good predictor of health care spending (Cunningham 2017, DeSalvo et al. 2009).)

Looking to the more distant future, Medicare's Trustees predict the aging of the baby-boom generation to eventually increase spending growth per person through 2045 since older seniors tend to generate more health care spending than younger seniors (Boards of Trustees 2025). That said, the Trustees also predict a reduction in the share of Medicare beneficiaries who are closer to death at any given age thanks to improving mortality rates, which will partially offset increases in spending stemming from people living longer (Boards of Trustees 2025). (People who are closer to death have higher health spending, regardless of their age (Office of the Actuary 2025).) As shown in

**FIGURE
1-6**

People born in 1980 are projected to have several more years of life expectancy at age 65 than people born in 1940



Source: The 2025 annual report of the Boards of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds.

Figure 1-6, among the cohort of people born in 1940 (who are currently Medicare beneficiaries), women who reach the age of 65 are projected to have nearly 15 years of additional life expectancy (living until age 80) and men are projected to have nearly 13 years of life expectancy (living until age 78). In contrast, among those born in 1980 (future Medicare beneficiaries), women who reach 65 are projected to have nearly 19 years of life expectancy (living until nearly 84) and men are projected to have nearly 15 years of life expectancy (living until nearly 80).

Provider consolidation has been increasing

A key contextual factor in the health care sector is the ongoing consolidation of health care providers. Over the last several decades, health care providers have

pursued horizontal mergers and vertical acquisitions, in part to obtain higher payments both from Medicare and private payers. Historically, consolidation primarily involved like types of provider organizations (e.g., hospitals merging with other hospitals) or different types of providers that had referral relationships between them (e.g., hospitals acquiring physician practices). As a result of this consolidation, the share of hospital markets with a single dominant health system that accounted for a majority of hospital discharges rose from 47 percent in 2003 to 57 percent in 2017 (Medicare Payment Advisory Commission 2020). A more recent estimate from KFF suggests that nearly all (97 percent) markets of inpatient hospital care are highly concentrated (Godwin et al. 2024).² As local hospital markets have grown more concentrated, hospitals have shifted to consolidating across geographically separate areas (cross-market mergers). Moreover, the integration of physician practices with

hospitals has also increased. By 2024, only 42 percent of practices were owned solely by physicians (Kane 2025).

In recent years, consolidation has expanded beyond hospital mergers and vertically integrated arrangements between providers: Nonprovider organizations, such as private insurers, corporate entities, and private equity (PE) firms, have also acquired provider organizations. Private insurers, operating in both commercial and MA markets, have acquired or financially contracted with hospitals, physician groups, ambulatory surgical centers, and urgent care facilities (Herman 2022, Zhao et al. 2024). UnitedHealth Group's Optum Health is now reported to be the largest employer of clinicians in the U.S. and controls more than 2.7 percent of the Medicare primary care market by service volume (Adler et al. 2025, Emerson 2023, UnitedHealth Group 2023). Payer-operated practices in 2023 accounted for more than 4 percent of the national primary care market volume (albeit with considerable geographic variability), up from about 0.8 percent in 2016. Payers are especially likely to integrate with primary care practices in counties with high MA penetration (Adler et al. 2025).

Private insurers are also increasingly consolidating with pharmacies and with pharmacy benefit managers (PBMs) (which develop drug formularies, establish pharmacy networks, and negotiate rebates with pharmaceutical manufacturers) (Medicare Payment Advisory Commission 2023a). The largest insurers, including UnitedHealth, Humana, and CVS Health, are vertically integrated with PBMs and typically operate their own mail-order, specialty, and sometimes retail pharmacies (Medicare Payment Advisory Commission 2023a). As a result, PBMs now exercise significant influence over drug availability and prices for an increasing share of Medicare beneficiaries enrolled in a stand-alone prescription drug plan or Medicare Advantage Prescription Drug plan (Medicare Payment Advisory Commission 2025c).

Companies that have not traditionally participated in health care, such as Amazon, have also begun acquiring primary care practices, building pharmacy capabilities, and providing telehealth visits, although some, including Walmart, have stopped due to profitability concerns (Landi 2022, McMillon 2024).

Although not the dominant consolidation trend, the growth of PE investment in provider organizations is

also notable. An American Medical Association (AMA) survey found that roughly 6.5 percent of physician practices were characterized as PE owned in 2024, up from 4.5 percent in 2022 (Kane 2025). While PE-owned physician practices remain a relatively small, albeit growing, share nationally, PE-provider consolidation may be more pronounced at the local level and within certain geographic markets. PE firms appear to be targeting high-revenue specialty practices (e.g., dermatology, gastroenterology, ophthalmology, cardiology, emergency medicine, and anesthesiology) in specific geographic markets (Abdelhadi et al. 2024, Adler et al. 2023, Bartlett et al. 2024, Torabzadeh and Singh 2025). One recent study found that 807 dermatology, ophthalmology, and gastroenterology practices were acquired by PE firms between 2016 and 2020—more than half of which were subsequently sold to larger PE firms within three years of acquisition. That same study found a 600 percent average increase in the number of physician practices affiliated with PE firms over this period, suggesting rapid consolidation (Singh et al. 2024). In addition to physician practices, a recent study evaluating trends in PE investment in home health agencies from 2006 to 2024 found substantial investment growth after 2017 (Zhu et al. 2025).

Motivations for consolidation

There are several economic motivations for health care provider consolidation. In commercial markets, consolidated providers are often in a stronger bargaining position when negotiating payment rates with private insurers, even in markets with a relatively high concentration of insurers (Chernew et al. 2020, Congressional Budget Office 2022, KFF 2020, Li et al. 2025, Whaley et al. 2024, Whaley et al. 2022). In fact, a 2024 AMA physician survey found that “the need to better negotiate higher payment rates with payers” was the most commonly cited driver of consolidation among physicians in consolidated practices (Kane 2025). When PE firms invest in providers, they often use a so-called roll-up strategy, which consists of acquiring a number of small practices in specific high-revenue specialties to form a larger group. This larger group establishes greater market power and is likely to negotiate higher payment rates with insurers.

Certain types of consolidation can also lead to higher Medicare payment rates through exploitation of site-based payment differentials—namely, when a

hospital acquires a clinician practice, the hospital can sometimes bill a “facility” fee (in addition to the physician’s fee) each time a Medicare beneficiary is seen or receives services in the hospital-owned practice if it is located on the hospital campus or in an excepted off-campus facility (an off-campus facility that is excepted from the site-neutral payments required under Section 603 of the Bipartisan Budget Act of 2015). The combination of the facility fee and the physician’s fee results in hospitals’ on-campus and excepted off-campus physician practices receiving higher Medicare payment rates than independent physician practices. The Commission has recommended eliminating this payment differential by applying “site-neutral” payment rates for certain services provided in hospital outpatient practices (including on-campus and excepted off-campus practices). This change in payment policy would reduce incentives to shift the billing of Medicare services from low-cost settings to high-cost settings and would result in lower Medicare program spending and lower beneficiary cost sharing. A recent study showed that from 2017 to 2020, 87 percent of Medicare spending at hospital-owned practices was generated in on-campus practices and therefore exempted from current site-neutral policies (Post et al. 2025b).

When insurers consolidate with providers, they may be able to better coordinate care and gain provider cooperation in cost-control efforts including prescribing generic drugs and improving care coordination that is tied to quality bonuses, such as through MA star ratings. Improved quality may in turn attract new MA plan enrollees, leading to greater market share (Johnson et al. 2017). Employing providers also may enable plans to generate more extensive diagnosis coding in claims, which can yield higher payments to both insurers and providers in some capitated payment models. In addition, acquiring providers could allow insurers operating in commercial and MA markets to shift profits to their own providers, to avoid the constraints of medical-loss-ratio regulations that limit the share of premiums that insurers are allowed to keep as profit (Frank and Milhaupt 2023).

Obtaining higher payments is not the only reason providers consolidate. When hospitals vertically integrate with other types of providers, they can

encourage patient referrals within their integrated system. These referrals can make it more difficult for new or competing providers to retain enough patient volume to be financially stable (Cooper et al. 2025, Harris et al. 2025, Richards et al. 2022). Moreover, more predictable and stable income and the greater ability to maintain patient volume and referral privileges may also lead certain physicians to vertically integrate (Alinezhad et al. 2024, Berenson 2017). Physicians also report selling practices to hospitals or health systems to gain access to costly resources and to get help navigating regulatory and administrative requirements (Berenson 2017, Kane 2025). Conceptually, provider consolidation, including payer-provider consolidation, may also increase access to intellectual and economic capital and improve care coordination and efficient care delivery through economies of scale, streamlined operations, electronic health record interoperability, improved adherence to clinical guidelines, and alignment with value-based payment programs (Berenson 2017, Harris et al. 2025). Finally, provider consolidation is occurring in a complex legal environment of federal, state, and local laws and regulations (e.g., the federal Physician Self-Referral Law (also known as the Stark law), state certificate-of-need laws), which can also influence health care providers’ decisions about whether and how to consolidate with other entities.

In the case of payer-PBM consolidation, vertical integration of payers and PBMs (and in some cases, pharmacies) potentially creates conflicting incentives. Integrated payer-PBMs may improve efficiency by reducing transaction costs between upstream and downstream entities (Medicare Payment Advisory Commission 2023a). For example, PBMs may help payers negotiate rebates and discounts with pharmaceutical manufacturers, potentially reducing costs for payers and lowering premiums for beneficiaries. However, the degree to which integrated PBMs pass through these rebates and discounts to their integrated payers (and to nonintegrated payers they contract with) can be opaque (Gray et al. 2023). For example, specialty pharmacies that are owned by PBMs may receive discounts or fees that lower the cost of prescriptions. However, since these transactions are not visible to Medicare, payer-PBM integration diminishes price transparency and can increase costs to Medicare and its beneficiaries (Martin 2025,

Medicare Payment Advisory Commission 2025c).³ Since integrated PBMs may also contract with nonintegrated payers, payer-PBM integration may create incentives to raise costs for those nonintegrated payers (and their beneficiaries) (Gray et al. 2023). Notably, the IRA is expected to affect the broader pharmaceutical industry, which may have implications for consolidation among pharmaceutical supply-chain participants (see Chapter 13 of this report).

Providers consolidating with PBMs may also designate preferred network pharmacies, which can steer patients to their affiliated pharmacies and away from nonaffiliated pharmacies (Federal Trade Commission 2024). Though there are regulations in place to prevent payer-PBMs from leaving pharmacies out of network and payers cannot require beneficiaries to fill their prescriptions at specific pharmacies, payer-PBMs can sometimes incentivize use of preferred network pharmacies by offering lower cost sharing at those pharmacies (Medicare Payment Advisory Commission 2025c).⁴ As a result, if nonaffiliated pharmacies experience higher costs and/or lower drug volume, it may result in pharmacy closures and restrict pharmacy access for beneficiaries (Martin 2025). PBMs also help payers develop and maintain formularies, which directly affects beneficiaries' access to, and out-of-pocket spending on, drugs (Mattingly et al. 2023).

With respect to PE-provider consolidation, potential benefits include modernizing infrastructure and technology and improving operational efficiencies; however, PE firms' focus on short-term financial gain may hinder providers' ability to benefit from these efficiencies (Singh et al. 2022).

Consolidation leads to higher payment rates and spending

Research has shown that consolidation between providers leads to higher payments in both commercial and Medicare markets (Baker et al. 2014, Beaulieu et al. 2023, Beaulieu et al. 2020, Cooper et al. 2015, Gaynor and Town 2012, Government Accountability Office 2025a, Harris et al. 2025, Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2017, Whaley et al. 2022). For example, this trend has been observed with Part B drug spending: Two studies using Medicare FFS claims have found that vertical integration shifted utilization of physician-administered drug spending from physician offices to

hospital outpatient departments, which resulted in higher physician-administered drug spending (Jung et al. 2019, Levin et al. 2025). In commercial markets, cross-market mergers have also resulted in expanded market power with common customers and higher prices (Arnold et al. 2025b, Dafny et al. 2019, Fulton et al. 2022).

No published empirical evidence exists that evaluates the effect of payer-provider consolidation on insurers' spending to date. However, there is evidence that provider-owned MA plans are associated with greater coding intensity, which may lead to higher payments to insurers and providers (Curto et al. 2025, Geruso and Layton 2020). In part due to a lack of transparency and data, there is limited empirical evidence to date that assesses the effect of payer-PBM integration on Medicare spending. However, a recent report by the Federal Trade Commission (FTC) found that for Medicare Part D beneficiaries, there was substantial markup of, and higher payment rates for, specialty generic drugs at PBM-affiliated pharmacies (Federal Trade Commission 2025). Literature that assesses the effect of PE-provider consolidation on spending is emerging. Two studies using national commercial claims data to evaluate PE acquisitions of gastroenterology and primary care practices showed a 4.5 percent and 7.8 percent increase in commercial prices, respectively (Arnold et al. 2025a, Singh et al. 2025b). Another study using national claims data found that commercial prices increased \$92 per gastroenterology claim after PE acquisition, driven by a 78 percent increase in professional fees (Singh et al. 2025c). Early results from PE acquisitions of ambulatory surgical centers have also shown a substantial increase in average charges per case (Lin et al. 2023).

Effect of consolidation on access to care appears minimal

There is mixed, albeit limited, evidence about the effects of consolidation on access to care. A recent study using FFS Medicare claims data found that physicians who became hospital integrated were more likely to treat medically complex beneficiaries and those who were more socioeconomically disadvantaged (Alinezhad et al. 2024), while another found no difference in FFS patient case mix after primary care physicians became hospital employed (Post et al. 2025a). Although clinicians' willingness to

accept Medicare patients remains high, the effect of payer-provider consolidation on access to care for Medicare beneficiaries is not well understood. Moreover, the effect of payer-PBM consolidation on access to care for Medicare beneficiaries is also not clear, though some evidence suggests that payer-PBM consolidation does lead to steerage of patients to the payer-PBM's own affiliated pharmacies—in part through manufacturers' use of limited distribution networks, which may constrain beneficiaries' pharmacy access (Kakani et al. 2025).

With respect to PE-provider consolidation, early research suggests that after such acquisitions, there is an increase in the provision of profitable service lines (e.g., robotic surgery, hemodialysis, cardiac catheterization, physician-administered drugs) and a reduction in the provision of some unprofitable, yet essential, services (e.g., outpatient psychiatric care, retinal detachment surgery) (Braun et al. 2024, Cerullo et al. 2021, Singh et al. 2025a).

Effect of consolidation on quality remains ambiguous

While some providers may be able to improve quality after integration, the overall effect of horizontal consolidation and vertical integration on quality remains ambiguous. Some have posited that the lack of clear quality improvement across different types of provider consolidation may be because financial integration does not necessarily translate into clinical integration (such as information sharing, care coordination, and efficient transitions of care) (Ridgely et al. 2020).

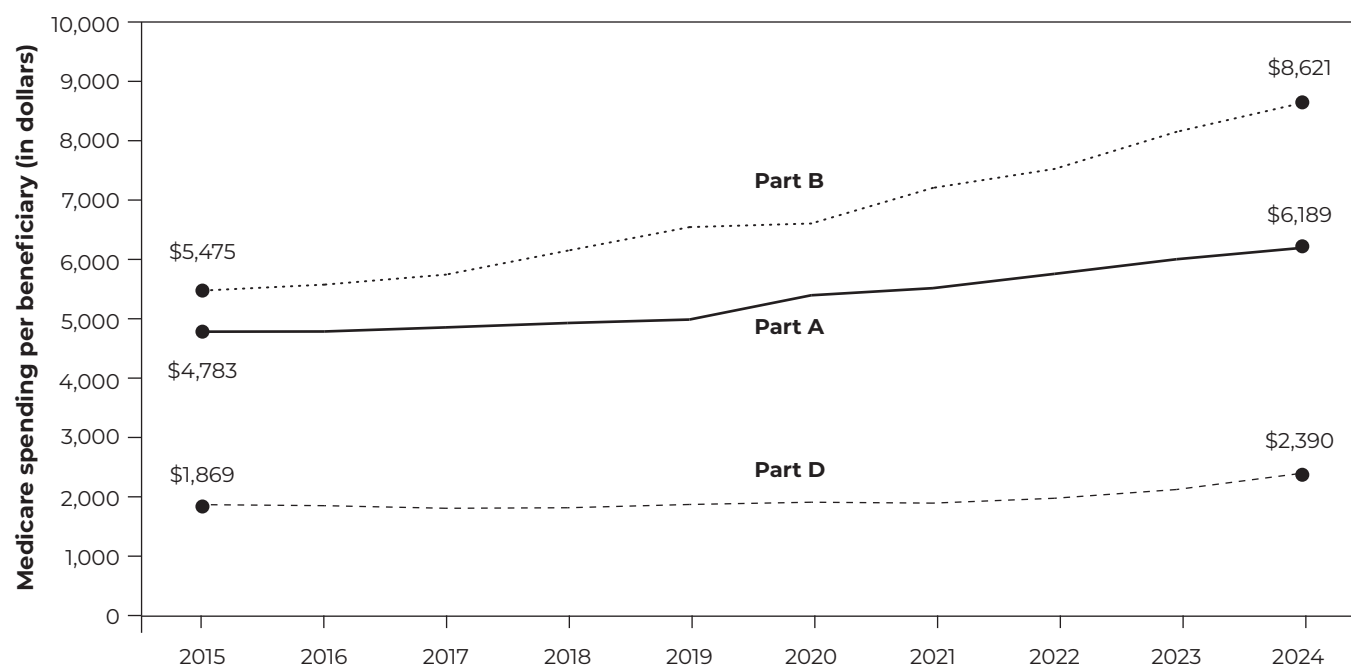
The effect of hospital mergers on quality outcomes is mixed. One study found hospital mergers resulted in higher mortality and lower patient-experience scores (Setzler 2025), while another study that examined the longitudinal effects of hospital mergers on quality found that “hospital acquisitions were associated with modestly worse patient experiences but had little to no effect on readmission rates, mortality rates, or other process measures” (Beaulieu et al. 2020). Results from studies of mergers involving rural hospitals are also ambiguous: One study found lower inpatient mortality and lower postoperative complications for elective surgeries in rural hospitals postmerger (Jiang et al. 2021), while another study found no difference in rural hospital mortality or patient satisfaction but

modestly higher readmission rates postmerger (Tsai et al. 2025). With respect to vertical integration, a recent systematic review found some evidence that hospital-physician and hospital-post-acute care consolidation were associated with modest improvements in some condition-specific process measures but little to no effect on mortality, readmission, or emergency department visit rates (Harris et al. 2025). Another recent study found that while hospital employment of cardiologists nearly tripled from 2008 to 2019, there was minimal evidence to suggest commensurate quality improvements among heart-failure and acute myocardial infarction patients (Moghtaderi et al. 2025).

The effect of payer-provider and PE-provider consolidation on quality is also not clear. Recent literature has shown hospital-MA integrated plans to be associated with modest improvements in patient-experience measures; however, these improvements were generally limited to integrated plans offered by well-established managed care organizations, such as Kaiser Permanente (Bejarano et al. 2024). One older study also found hospital-MA integrated plans were associated with higher unadjusted quality ratings, primarily driven by better enrollee satisfaction; however, the magnitude of this effect diminished over the five-year study period (Johnson et al. 2017). Meanwhile, PE-hospital consolidation has been shown to result in declining patient experience, especially in the first three years following acquisition (Bhatla et al. 2025). For other specialty-specific quality outcomes, such as complications after a colonoscopy, evidence suggests no discernible change in quality after PE acquisition of physician practices (Arnold et al. 2025a).

Gaps remain in data about ownership of Medicare providers

To better understand the extent to which different types of provider consolidation are occurring and the impact on outcomes important to Medicare beneficiaries and taxpayers, better data on ownership and affiliation relationships are needed. Existing data sources, particularly those used to identify PE ownership of providers, are often incomplete or inaccurate and often do not capture the nuances of ownership (Government Accountability Office 2023). Greater ownership transparency may also be useful to beneficiaries when they choose where to seek care.

**FIGURE
1-7****Medicare spending per beneficiary has grown faster for Part B than for Part A and Part D, 2015–2024**

Note: Amounts were calculated as total nominal spending (not adjusted for inflation) on a Medicare part, divided by the number of beneficiaries enrolled in that part. Part B mainly covers physician-administered drugs, hospital outpatient fees, and clinician services in all settings. Figure includes enrollees in Medicare Advantage (MA) and fee-for-service (FFS) Medicare. The share of funds transferred from Part A and Part B to pay for MA enrollees' coverage is based on the shares of total FFS Medicare spending on Part A and Part B.

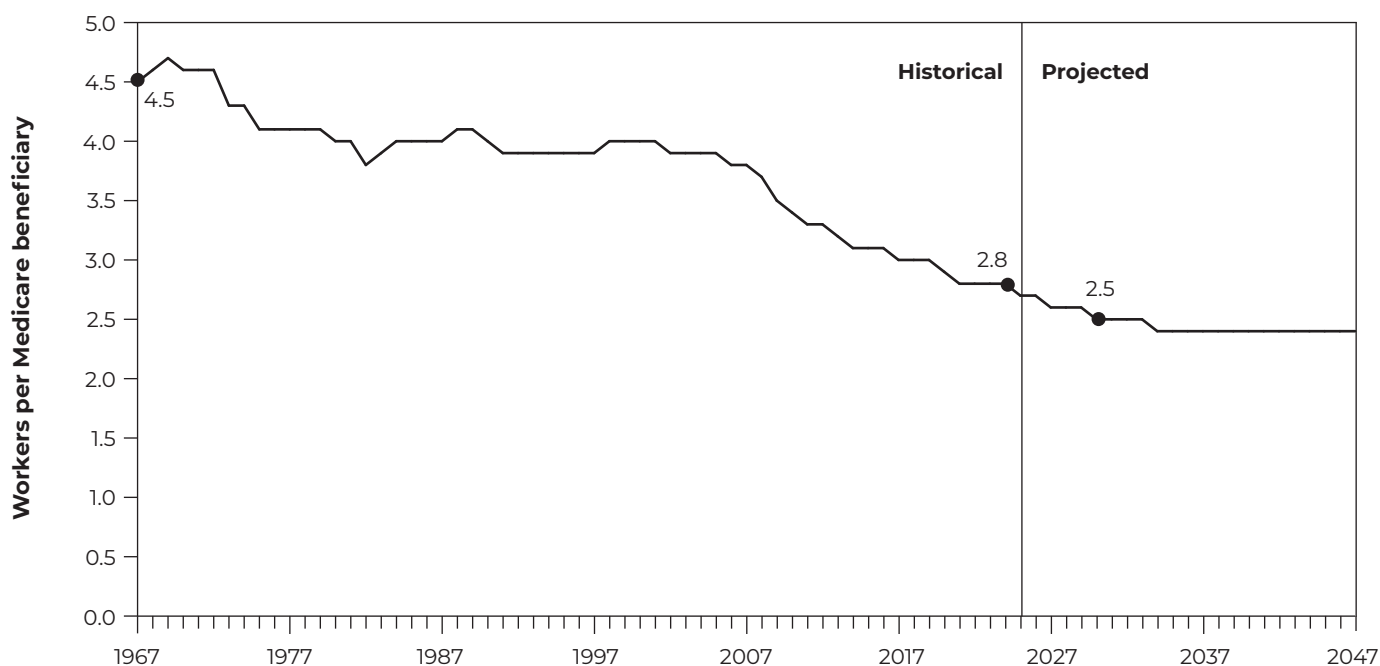
Source: MedPAC analysis of data from the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

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 Part B than Part A or Part D (Figure 1-7). In addition to the rapid growth in spending on Part B drugs noted earlier (p. 11), there has been an increase in the number of clinician encounters per beneficiary (paid for under Part B) (see Chapter 4). In contrast, there has been a decline in the number of inpatient hospital stays and skilled nursing facility stays per beneficiary (paid for under Part A) (Chapters 3 and 7), and researchers have observed a shift from prescription to over-the-counter drugs in several categories and an increase in the prescribing of generic, rather than brand-name, drugs (paid for under Part D) in recent years (Glied and Lui 2026).

Observers have offered competing theories to explain recent changes in the mix of services and items used by Medicare beneficiaries, but alternative payment models are generally not thought to have driven these changes. Instead, observers tend to cite factors like a younger and healthier beneficiary pool and changes in the rate at which new technologies were adopted over this period (Glied and Lui 2026). (The ACA also reduced payment rates in a number of Medicare payment systems, which is widely credited for slowing growth in Medicare spending but is not believed to have changed the mix of services and items used (Glied and Lui 2026).)

As a result of the shift in the mix of items and services being used by beneficiaries, Medicare Part A (which mainly pays for inpatient hospital stays and post-acute care afterward) has constituted a declining share of

**FIGURE
1-8****The number of workers per Medicare beneficiary is declining**

Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries enrolled in Medicare Advantage plans). More beneficiaries have Part A Hospital Insurance than Part B Supplementary Medical Insurance because Part A is usually available to beneficiaries at no cost. First projected year is 2025. Part A services are financed primarily by Medicare payroll taxes (deposited into Medicare's Hospital Insurance Trust Fund) and beneficiary cost sharing.

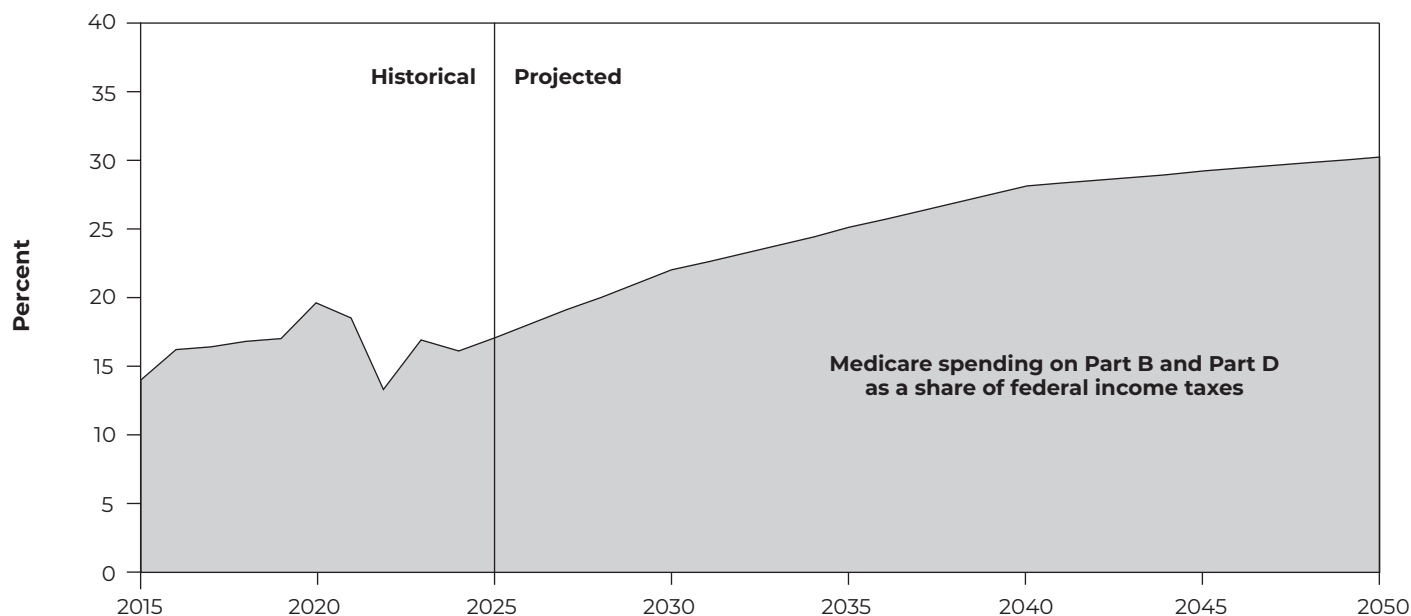
Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds.

Medicare spending over time, while Part B (which mainly pays for physician fee schedule services in all settings, physician-administered drugs in outpatient settings, and outpatient facility fees) 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) (Boards of Trustees 2025).

The shift in the mix of items and services furnished to beneficiaries has reduced pressure on Medicare payroll tax revenues, which are deposited into Medicare's Hospital Insurance Trust fund and pay for Medicare Part A.⁵ In their most recent report, Medicare's Trustees estimated that the trust fund would remain solvent until 2033 (Boards of Trustees 2025, Office of

the Actuary 2025).⁶ (Some researchers have estimated that the subsequent passage of the One Big Beautiful Bill Act may have shortened this timeline by a year (Committee for a Responsible Federal Budget 2025).)

The relative slowdown in spending on Part A has somewhat eased a growing financing challenge for Medicare's Hospital Insurance Trust Fund: Revenue from workers' Medicare payroll taxes has not been growing as fast as overall Medicare spending for decades now (shown in Figure 1-10 (p. 23)).⁷ The main driver of this trend is the continual decline in the ratio of workers relative to Medicare beneficiaries. As shown in Figure 1-8, around the time of Medicare's creation in 1967, there were 4.5 workers for each Medicare beneficiary, but by 2024 there were only 2.8 workers per beneficiary, and by 2030 there are expected to be only 2.5 workers per beneficiary.

**FIGURE
1-9****Medicare spending on Part B and Part D is equivalent to a sizable share of federal income taxes**

Note: Includes both personal and corporate income tax revenues. First projected year is 2025.

Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds, Table II.F3.

Meanwhile, the faster growth in spending on Part B is increasing pressure on the country's general revenues (e.g., income taxes) and beneficiary premiums, which pay for Part B (and for Part D drug coverage).⁸ Medicare's Trustees report that in 2024, an amount equivalent to 16 percent of all personal and corporate income taxes collected by the federal government was used to pay for Part B and Part D (Boards of Trustees 2025). By 2028, 20 percent will be needed for this purpose (Figure 1-9). (See next section for a discussion of the impact of rising Medicare spending on beneficiaries' out-of-pocket spending.)

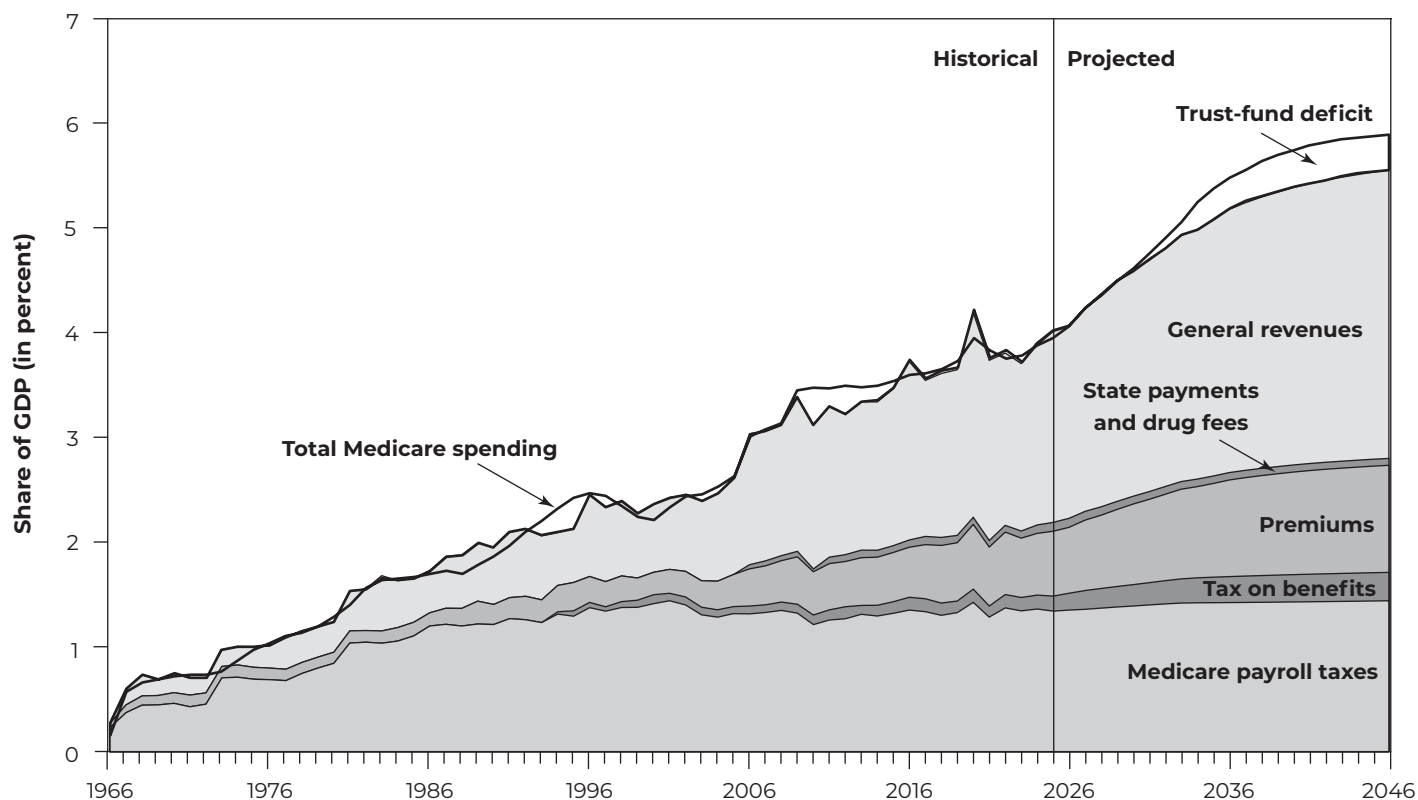
As the amount of general revenues needed to finance Medicare increases, less revenue is available for other priorities, such as deficit reduction or investments in other priorities.

The increasing amount of general revenues spent on the Medicare program (shown in Figure 1-10) is also a

problem because the overall amount that the federal government spends per year (about \$7 trillion in 2024) exceeds the amount it collects in revenues (about \$5 trillion) (Department of Treasury 2025a, Department of Treasury 2025b). Whenever the U.S. spends more than it collects in revenues, it increases the size of the country's national debt. Given the amount of money the U.S. has borrowed to cover its debt (\$30 trillion as of 2025), CBO estimates that the U.S. now spends \$1 trillion per year on annual interest payments—about the same amount as is spent on the Medicare program (Congressional Budget Office 2025). CBO has noted that from 2027 on, interest costs as a share of GDP are expected to be higher than they have been since that statistic first began to be tracked in 1940 (Congressional Budget Office 2025). The Government Accountability Office has warned that the federal government is on an unsustainable fiscal path that poses serious economic, security, and social challenges (Government Accountability Office 2025b).

**FIGURE
1-10**

Medicare's largest funding source has shifted from Medicare payroll taxes to the U.S.'s general revenues



Note: GDP (gross domestic product). First projected year is 2025. Projections are based on the Trustees' intermediate set of assumptions. "Tax on benefits" refers to the portion of income taxes that higher-income individuals pay on Social Security benefits, which is designated for Medicare. "State payments" refers to payments from the states to Medicare, required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), for assuming primary responsibility for prescription drug spending. "Drug fees" refers to the fee imposed by the Affordable Care Act of 2010 (ACA) on manufacturers and importers of brand-name prescription drugs; these fees are deposited in the Part B account of the Supplementary Medical Insurance Trust Fund. "Trust-fund deficit" refers to the shortfall when Medicare Part A spending exceeds the amount collected through Medicare payroll taxes and other trust-fund revenue sources. Graph does not include interest earned on trust-fund investments.

Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds.

When Medicare spending increases, beneficiaries' costs also increase

When Medicare spending grows, it affects beneficiaries' ability to afford health care by raising their premiums and cost-sharing obligations.

Medicare beneficiaries typically do not pay premiums for Part A coverage, but the annual cost of Part B

premiums was \$2,220 in 2025 (Centers for Medicare & Medicaid Services 2024a).⁹ The average annual cost of premiums for Part D prescription drug plans that year was \$468 for stand-alone drug plans and \$84 for drug coverage through an MA plan (since MA plans can use Part C rebates to "buy down" enrollees' Part D premiums) (Medicare Payment Advisory Commission 2025a).¹⁰

Cost-sharing liabilities for beneficiaries in FFS Medicare averaged \$396 for Part A services and \$1,621 for Part B services in 2021 (the most recent year of information available) (Medicare Payment Advisory Commission 2025a). (The amount of cost sharing that beneficiaries actually pay is lower when they have supplemental coverage such as through Medicaid or a Medigap plan.) Average annual cost sharing for prescription drugs was \$492 for beneficiaries with stand-alone Part D plans and \$264 for those with drug coverage through an MA plan in 2023, but these amounts are expected to be lower in coming years (Medicare Payment Advisory Commission 2025a).¹¹ (Starting in 2024, beneficiaries are no longer required to pay cost sharing when they reach the catastrophic phase of the Part D benefit; in 2025, out-of-pocket costs in Part D were capped at \$2,000.)

The typical Medicare beneficiary has relatively modest resources to draw on when paying these various premiums and cost-sharing obligations. 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 (including nearly half of those under 65) were food insecure—meaning they reported that in the past year, food did not last and they had no money to buy more, they cut the size of meals or skipped meals, they ate less because they did not have enough money for food, they did not eat because they did not have enough money for food, and/or they could not afford balanced meals (Centers for Medicare & Medicaid Services 2025a).

Another way of assessing the affordability of Medicare's premiums and cost sharing is by comparing them with the average Social Security benefit received by people ages 65 and over. Medicare's Trustees estimate that beneficiary spending on the standard Medicare Part B premium, the average basic Part D premium, plus average cost sharing for Part B and Part D consumed 24 percent of the average Social Security benefit in 2025—up from 19 percent 20 years earlier (Boards of Trustees 2025). Although most people ages 65 and over supplement their Social Security benefits with income from pensions, withdrawals from individual retirement accounts, or other assets, a sizable minority rely on Social Security benefits as their primary source of income. For one in five people ages 65 and over, Social

Security benefits make up three-quarters or more of their family income, and for one in seven, Social Security benefits make up 90 percent or more of their family income (Dushi and Trenkamp 2021).

Most beneficiaries try to reduce their total out-of-pocket spending by obtaining supplemental insurance coverage or opting out of FFS Medicare and into an MA plan, which is required to apply a cap on beneficiaries' out-of-pocket spending. In 2022, 43 percent of noninstitutionalized beneficiaries had FFS Medicare plus some type of supplemental coverage (obtained through Medicaid, a former employer, or a Medigap plan they purchased themselves). Another 51 percent were enrolled in an MA plan or other managed care plan (including some beneficiaries who were dually eligible for Medicare and Medicaid). The remaining 6 percent of beneficiaries had FFS Medicare without any supplemental coverage to reduce their cost sharing (Figure 1-11).¹² (Among the subset of beneficiaries with FFS Medicare, 11 percent of FFS Medicare beneficiaries have no supplemental coverage (data not shown).) For more information on Medicare beneficiaries' insurance enrollment options, see text box (pp. 26–28).

In 2024, 18 percent of Medicare beneficiaries received help paying their Part B premium (and, in some cases, their cost sharing) through their state's Medicaid program, and 21 percent received help with their drug costs through the Part D low-income subsidy (Centers for Medicare & Medicaid Services 2025g). When beneficiaries are covered through both Medicare and Medicaid at the same time, their out-of-pocket cost are reduced, but interactions between these two programs' payment policies can sometimes produce unintended incentives (see text box on interactions between Medicare and Medicaid payment policies, p. 30).

Only 7 percent of Medicare beneficiaries reported having problems paying a medical bill in CMS's 2023 Medicare Current Beneficiary Survey, but some beneficiary subpopulations experienced affordability issues at notably higher rates. For example:

- Among partial-benefit dual-eligible beneficiaries, 25 percent reported a problem paying a medical bill. (These beneficiaries receive Medicaid assistance with premiums and, in some cases, cost sharing, but they do not qualify for additional

Medicaid benefits that full-benefit dually eligible beneficiaries receive, such as dental care and nonemergency medical transportation.)

- Among Medicare beneficiaries under the age of 65 (who are disabled or have end-stage renal disease), 17 percent reported a problem paying a medical bill. (Beneficiaries under 65 tend to require more health care services, have lower incomes, and face higher Medigap premiums than beneficiaries who have reached Medicare’s eligibility age of 65 (Cottrill et al. 2024, Cubanski et al. 2016, Medicare Payment Advisory Commission 2025a).)
- Among beneficiaries who qualify for the Part D low-income subsidy, 13 percent reported a problem paying a medical bill. (Beneficiaries qualify for this extra help with their drug costs if they receive full or partial Medicaid benefits or Supplemental Security Income payments and/or, in 2026, have income below \$23,940 (or \$32,460 if married) and liquid assets below \$16,590 (or \$33,100 if married) (Centers for Medicare & Medicaid Services 2025h).)
- Among beneficiaries enrolled in FFS Medicare with no supplemental coverage, 11 percent reported a problem paying a medical bill.

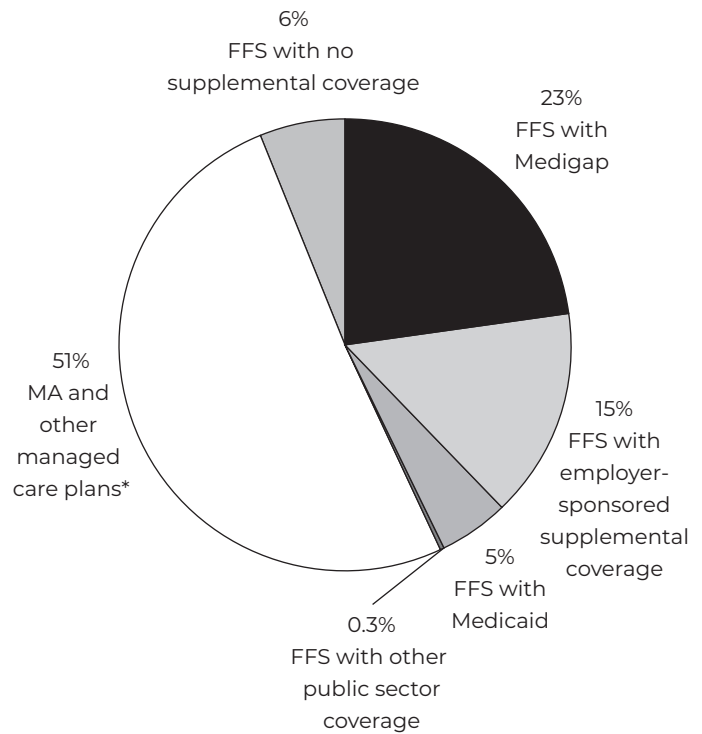
Given these findings, it is important to keep in mind that when Medicare payment rates for providers increase, premiums and cost sharing also increase for Medicare beneficiaries, some of whom already have a hard time affording health care. Restraining the annual growth in Medicare spending can help beneficiaries better afford their health care, free up tax revenues for other purposes, and preserve the Medicare program for future generations.

The health care workforce plays an important role

Ensuring that beneficiaries have access to high-quality care remains an important focus of the Commission. Since numerous studies have found a clear relationship between care quality and having a sufficient supply of nurses and other health care staff, we explore that workforce in this section (Aiken et al. 2010, Cimiotti et al. 2022, Dall’Ora et al. 2022, Harrison et al. 2019, Hyer

FIGURE 1-11

Most Medicare beneficiaries tried to reduce their cost sharing through supplemental coverage or enrollment in a Medicare Advantage plan, 2022



Note: FFS (fee-for-service), MA (Medicare Advantage). Our analysis assigned beneficiaries to the coverage category in which they spent the most time in 2022; beneficiaries could have had coverage in other categories during 2022. The analysis is restricted to community-dwelling beneficiaries (not living in institutions such as nursing homes) who were enrolled in both Part A and Part B throughout their Medicare enrollment in 2022. It excludes beneficiaries who had Medicare as a secondary payer. The number of beneficiaries represented in this chart is 53.5 million.

* Includes plans for beneficiaries who are also eligible for Medicaid and plans sponsored by employers.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Survey file, 2022.

et al. 2011, Kane et al. 2007, Kutney-Lee et al. 2009, Lasater et al. 2021a, Lasater et al. 2021b, McHugh et al. 2013, Mukamel et al. 2023, Park et al. 2014, Rosenbaum et al. 2024, Shen et al. 2023, Wiltse Nicely et al. 2013).

Almost 2 million physicians, nurse practitioners, physician assistants, psychologists, audiologists, chiropractors, optometrists, dietitians, and other types

Medicare beneficiaries have numerous enrollment options

Once an individual becomes eligible for Medicare, a number of enrollment options become available to them. (Individuals gain eligibility for Medicare either because they have turned 65, they are disabled and have received Social Security Disability Insurance payments for two years, they have just begun to receive disability payments and have a diagnosis of amyotrophic lateral sclerosis, or they have been diagnosed with end-stage renal disease.) As described below, initial decisions related to Medicare enrollment may have lifetime consequences since some choices can lead to late-enrollment penalties. Because of the complexity and multitude of plan choices, beneficiaries often rely on resources like family and friends, insurance agents and brokers, Medicare's hotline and website, and counselors from State Health Insurance Assistance Programs to help them make coverage decisions. (Additional information regarding the complexity of enrollment decisions and available information sources to assist beneficiaries will be included in our June report.)

Initially enrolling in coverage

People who reach Medicare's eligibility age and are already receiving Social Security benefits are automatically enrolled in Medicare Part A, which helps pay for inpatient hospital stays, post-acute care, and hospice care. Part A is available to 99 percent of Medicare beneficiaries without a monthly premium because they or their spouse paid Medicare payroll taxes for at least 10 years (Centers for Medicare & Medicaid Services 2024a).¹³

Individuals can also enroll in Medicare Part B, which helps pay for clinician services in all settings, outpatient facility fees, and physician-administered drugs. For most beneficiaries (including those in a Medicare Advantage (MA) plan), the Part B premium is deducted from their monthly Social Security checks.¹⁴ In 2026, the standard Part B premium is \$203 per month for beneficiaries with a modified adjusted gross annual income of up to \$109,000 (or \$218,000 for a married couple); beneficiaries with higher incomes pay higher Part B premiums (Centers for Medicare & Medicaid Services 2025b).¹⁵

Prescription drug coverage is available through Part D, either through stand-alone prescription drug plans or MA plans that include drug coverage. Part D enrollees with higher incomes are also required to pay higher premiums, based on the same thresholds used for Part B premiums. The average premium for a stand-alone Part D plan in 2025 was \$39 per month, while the average cost of the Part D portion of an MA premium was \$7 per month (Medicare Payment Advisory Commission 2025a).

Individuals who are under 65 and had a kidney transplant more than three years prior (and therefore no longer qualify for Medicare due to end-stage renal disease) can qualify for Medicare coverage of their immunosuppressive drugs under the Part B Immunosuppressive Drug Benefit (Part B-ID), which started in 2023 (Centers for Medicare & Medicaid Services 2023). Enrollees in Part B-ID who have higher incomes are required to pay higher premiums, based on the same thresholds used for Part B premiums. In 2026, the standard monthly Part B-ID premium is \$122 (Centers for Medicare & Medicaid Services 2025b).

Late-enrollment penalties. Individuals who do not enroll in Part B or Part D when they reach Medicare's eligibility age will usually owe late-enrollment penalties if they eventually do enroll in coverage.¹⁶ Late Part B enrollees have a life-long surcharge added to their Part B premiums that adds 10 percent for each year that they could have signed up but did not (Centers for Medicare & Medicaid Services 2024b). Late Part D enrollees have a life-long surcharge added to their Part D premiums that adds 1 percent of the Part D national base beneficiary premium for each uncovered month (Centers for Medicare & Medicaid Services 2024b).

Annual enrollment options

Beyond the initial decision of whether to enroll in Medicare, beneficiaries also make an annual decision about how to receive their benefits.

(continued next page)

Medicare beneficiaries have numerous enrollment options (cont.)

Fee-for-service Medicare. Unless they opt into an MA plan (described below), Medicare beneficiaries are covered through fee-for-service (FFS) Medicare, which allows them to obtain care from any health care provider who accepts Medicare. Beneficiaries in FFS Medicare owe 20 percent cost sharing for clinician services after they meet their annual Part B deductible (which is \$283 in 2026); they also owe \$1,736 for the first 60 days of each hospital admission, plus additional daily coinsurance amounts if they require a longer hospital stay. For beneficiaries with a skilled nursing facility stay that exceeds 20 days, the daily coinsurance after the first 20 days is \$217 (Centers for Medicare & Medicaid Services 2025b).

Beneficiaries in FFS Medicare can obtain subsidized prescription drug coverage by purchasing a stand-alone Medicare Part D plan (see Chapter 13 for more on Part D).

Medigap. Beneficiaries who want to reduce their cost-sharing liability while maintaining broad access to providers can obtain a Medigap plan that wraps around FFS Medicare coverage. Medigap plans can be purchased by employers for their retired workers or by individuals for themselves. There are a number of standardized Medigap plans (e.g., Plan A, Plan B) that private insurers can offer, which must include the same benefits but can vary in price. The average monthly premium among Medigap policyholders was \$217 in 2023 (Freed et al. 2024). (Subsidized supplemental coverage is available to low-income FFS beneficiaries through Medicaid, described below.) Beneficiaries who purchase a Medigap plan when they first reach age 65 are guaranteed the right to purchase any Medigap plan an insurer offers and the insurer cannot factor in the beneficiary's health status when setting the premium; beneficiaries who enroll in a Medigap plan when they first turn 65 can renew that plan indefinitely (Centers for Medicare & Medicaid Services 2025c).¹⁷ In general, beneficiaries who are under the age of 65 or are over 65 and missed the six-month guaranteed-issue period are subject to medical

underwriting in most states, which means they can face higher Medigap premiums or be denied a policy due to their health conditions.

Medicare Advantage. As an alternative to FFS Medicare, beneficiaries can opt to receive their Medicare benefits through an MA plan, which allows beneficiaries to lower their cost-sharing liability and receive additional benefits while often paying a relatively low, or no, additional monthly premium. (Aside from MA plan premiums, MA enrollees also pay the Part B premium mentioned earlier.) MA plans typically offer lower cost sharing if a beneficiary seeks care from a provider in a plan's provider network and higher cost sharing or no coverage if the beneficiary seeks care from a provider outside the plan's network.¹⁸ MA plans also have an annual out-of-pocket limit on cost sharing for Part A and Part B services (and, as of 2024, for Part D). To manage costs, MA plans commonly engage in utilization-management strategies such as requiring beneficiaries to obtain a referral from a primary care clinician before seeing a specialist, requiring clinicians to obtain prior authorization from an insurer before furnishing certain services, and denying payment for some claims. MA plans often also offer beneficiaries prescription drug coverage as well as supplemental benefits not available in FFS Medicare (such as vision, dental, and hearing benefits and non-health care benefits such as gym memberships) (Medicare Payment Advisory Commission 2025b).

Medicare beneficiaries who wish to switch from an MA plan to FFS Medicare during Medicare's annual open enrollment period can do so but may face higher Medigap premiums and fewer Medigap plan options than individuals who enroll in a Medigap plan when they first reach age 65.¹⁹ Most states' insurance regulations allow Medigap insurers to deny coverage or vary premiums based on a beneficiary's health status if the beneficiary is buying a Medigap plan after age 65 (Centers for Medicare & Medicaid Services 2025c).²⁰

(continued next page)

Medicare beneficiaries have numerous enrollment options (cont.)

Employers can subsidize coverage for Medicare beneficiaries. Some employers help pay for their retired employees' health insurance by paying for Medigap plans, sponsoring their own Medigap-like coverage that wraps around the FFS Medicare benefit package, sponsoring their own prescription drug plans, or sponsoring their own MA plans (which can include or exclude prescription drug coverage). Medicare beneficiaries who served in the military can receive health care services subsidized by the Department of Veterans Affairs (VA) or the Department of Defense (TRICARE 2025). Depending on the circumstances of the retiree coverage, individuals with retiree coverage from a previous employer may be subject to late-enrollment penalties if they do not enroll in Part B or Part D when they first turn 65.

Additional assistance for low-income beneficiaries. Medicare beneficiaries with very low incomes and liquid assets can apply for Medicaid coverage that will pay their Medicare premiums (and, in some cases, their cost sharing).²¹ Most individuals dually enrolled in Medicare and Medicaid qualify for additional benefits that are not available under FFS Medicare, such as long-term services and supports (e.g., nursing home care), vision and dental care, and nonemergency medical transportation to appointments. Dually eligible beneficiaries can obtain their Medicare benefits through FFS Medicare or an MA plan and can receive their Medicaid benefits through a FFS Medicaid program or a Medicaid managed care plan (depending on which option(s) their state offers). Some dual enrollees receive coordinated Medicare and Medicaid benefits through a single plan, although such plans are not widely available (Peña et al. 2024).

Low-income beneficiaries can also get financial assistance paying for their prescription drugs through Medicare's Part D low-income subsidy (LIS), which pays for a beneficiary's Part D premium and deductible and reduces their cost sharing for drugs.²² Medicare beneficiaries are automatically enrolled in this program if they are enrolled in Medicaid or another state program that pays their Medicare Part B premium and/or if they receive Supplemental

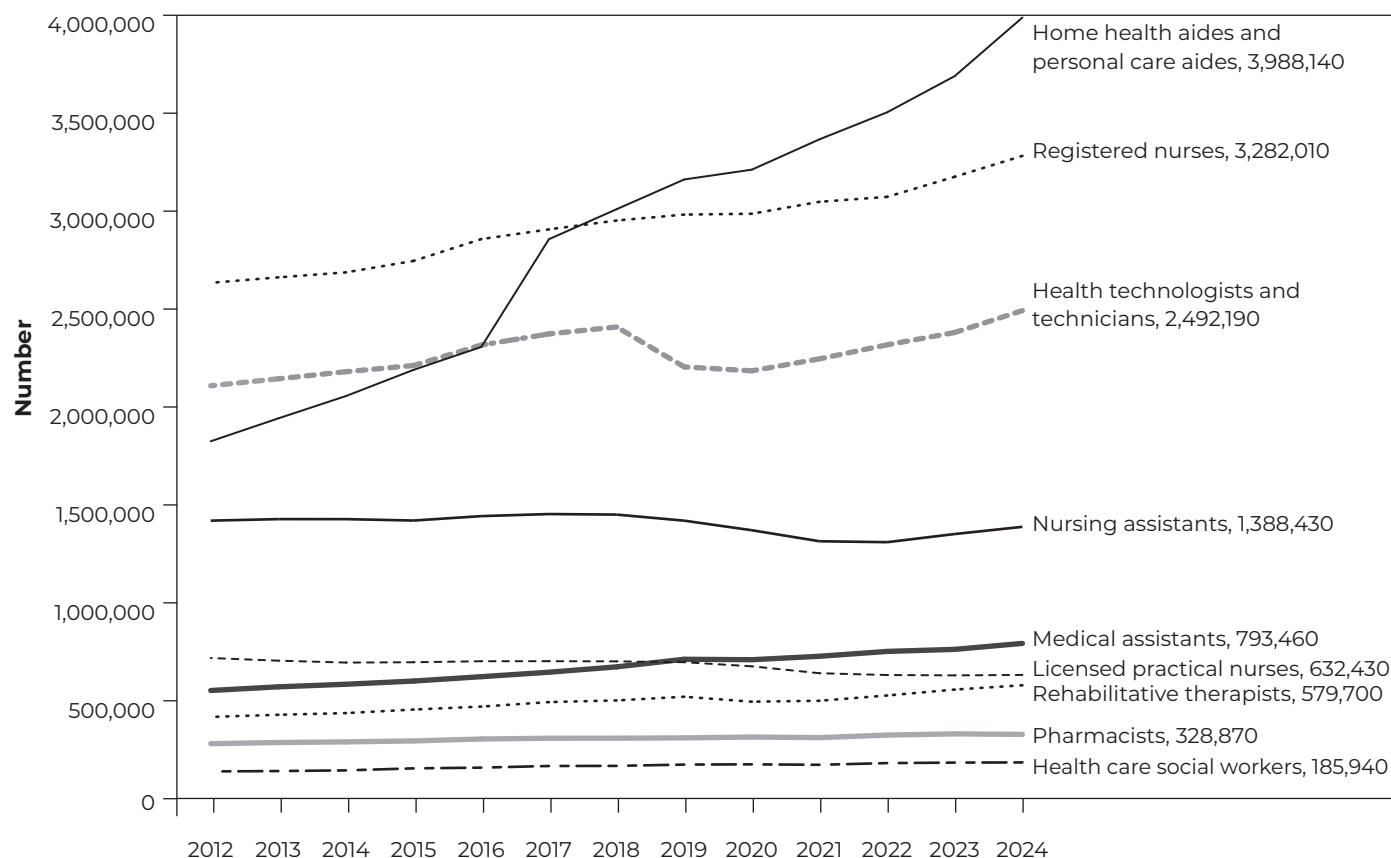
Security Income benefits due to low income. If they are not automatically enrolled in the Part D LIS, Medicare beneficiaries can apply for it if they have an income below \$23,940 (or \$32,460 for a married couple) and liquid assets below \$16,590 (or \$33,100 if married) in 2026 (Centers for Medicare & Medicaid Services 2025h).

Beneficiaries' enrollment decisions vary by income and race/ethnicity. According to our analysis of CMS's 2023 Medicare Current Beneficiary Survey, higher-income beneficiaries are more likely to enroll in FFS Medicare while lower-income beneficiaries tend to prefer MA plans. Among beneficiaries with household incomes of \$80,000 or more, 61 percent were enrolled in FFS Medicare in 2023; the vast majority of these beneficiaries had private supplemental insurance (e.g., Medigap). Among those with household incomes under \$50,000, MA was the more popular option, with 61 percent of these lower-income beneficiaries enrolled in such plans.

Since CMS's survey finds that White beneficiaries' incomes are twice as high as Black and Hispanic beneficiaries' incomes, we also see major differences in coverage selections by race and ethnicity. In CMS's 2023 survey, 51 percent of White beneficiaries had FFS Medicare compared with 25 percent of Black beneficiaries and 28 percent of Hispanic beneficiaries. White beneficiaries were also more likely to have FFS Medicare with some type of supplemental private insurance (obtained through an employer or purchased individually, such as a Medigap plan): 41 percent of White beneficiaries had this coverage combination compared with 11 percent of Black beneficiaries and 14 percent of Hispanic beneficiaries. Enrollment in MA plans was more common among Black and Hispanic beneficiaries: 70 percent of Black and Hispanic beneficiaries were in MA plans compared with 46 percent of White beneficiaries. Black and Hispanic beneficiaries were also more likely to be dually enrolled in Medicare and Medicaid and/or receiving the Part D LIS; for example, nearly half of Black and Hispanic beneficiaries received the LIS compared with 12 percent of White beneficiaries.²³ ■

**FIGURE
1-12**

Some health care staff occupations have grown faster than others, 2012–2024



Note: The Bureau of Labor Statistics includes licensed practical nurses (LPNs) in its “health technologists and technicians” group of occupations, but we have subtracted them from this group and show LPNs separately in this graph; “LPNs” includes licensed vocational nurses. “Nursing assistants” provide basic care (e.g., monitoring vital signs and reporting changes to a nurse) and assist with activities of daily living; “home health aides and personal care aides” help with these tasks as well as other tasks such as scheduling appointments, doing dishes and laundry, and shopping for groceries and preparing meals. We have grouped together physical therapists, occupational therapists, and speech-language pathologists into a “rehabilitative therapists” group in this graph.

Source: U.S. Bureau of Labor Statistics’ Occupational Employment and Wage Statistics Tables for 2012–2024, <https://www.bls.gov/oes/tables.htm>.

of practitioners bill Medicare directly for the health care services they provide (Centers for Medicare & Medicaid Services 2025f). This workforce is supported by over 14 million people who work with these practitioners to deliver care to Medicare beneficiaries (shown in Figure 1-12). This latter workforce (which we refer to as “health care staff”) includes nurses (registered nurses (RNs) and licensed practical nurses (LPNs)), direct care workers (nursing assistants, home health aides, personal care aides), pharmacists, certain types of therapists (including physical therapists,

occupational therapists, and speech-language pathologists) when they provide care in certain clinical settings, and other types of allied health professionals (including numerous types of health technicians and technologists).^{24,25,26} The training required for health care staff occupations ranges from a few weeks of on-the-job training to graduate degrees after college, and their roles and responsibilities vary (and can overlap) (Medicare Payment Advisory Commission 2025c).

Interactions between Medicare and Medicaid payment policies

Both Medicare and Medicaid help pay for the cost of some low-income individuals' health care. For services covered by both programs (e.g., physician services), Medicare is the primary payer, while Medicaid may pay some of the cost sharing for dually eligible enrollees. For services covered only by Medicaid (e.g., long-term custodial care in a nursing home), Medicaid is the primary payer and Medicare does not contribute toward the cost of these services. Although these payment rules may appear clear cut, there are times when the interaction of Medicare's and Medicaid's payment policies produces unintended incentives for providers or state Medicaid programs.

One interaction exists in nursing homes that provide skilled nursing facility (SNF) care. Medicaid pays for long-term custodial care in nursing homes, but their payment rates are relatively low. Nursing homes receive higher payment rates if they are providing Medicare-covered skilled nursing care to a beneficiary, which often requires the beneficiary to have just returned from an inpatient hospital stay that lasted at least three days (Centers for Medicare & Medicaid Services 2025i). Nursing homes that qualify as SNFs therefore have an incentive to hospitalize their dually enrolled long-stay residents to requalify those with Medicare coverage for a higher-paying Medicare-covered stay once they return to the nursing home—even if the resident has a clinical condition that typically would not require hospitalization (Grabowski 2007).

Interactions between Medicare and Medicaid payment policies also affect payments to providers due to limits on Medicaid's coverage of Medicare cost sharing. For most dually eligible enrollees, Medicaid can cover a beneficiary's Medicare cost-

sharing liability (e.g., 20 percent coinsurance for a physician visit), but states have the flexibility to pay only the cost sharing that would be owed if the provider received the Medicaid payment rate for that service, and most states use this approach (Roberts et al. 2020). Since states usually set Medicaid payment rates well below Medicare rates and providers are prohibited from billing dually eligible enrollees for unpaid cost sharing, the result is that providers may not receive the full amount allowed by Medicare (Roberts et al. 2020). (States have a particularly strong incentive to use this approach for services provided in facilities since Medicare reimburses facilities for 65 percent of any unpaid cost sharing as "bad debt.") The lower revenue that health care providers receive from dually eligible enrollees creates a disincentive for them to treat these enrollees compared with other Medicare beneficiaries (Hayford et al. 2025). (To help improve access to clinician services, MedPAC has recommended an add-on payment when a clinician provides services to dually eligible beneficiaries or other very-low-income beneficiaries (Medicare Payment Advisory Commission 2023b).)

A third interaction affects payments to hospitals and (unlike the prior two examples) potentially improves, rather than impedes, dually eligible enrollees' access to care. Although Medicaid pays hospitals relatively low payment rates, these low payment rates are offset by Medicare disproportionate-share-hospital payments—which increase in size when very poor or disabled Medicare beneficiaries make up a greater share of a hospital's Medicare inpatient days (Centers for Medicare & Medicaid Services 2025d). This policy gives hospitals an incentive to treat such beneficiaries. ■

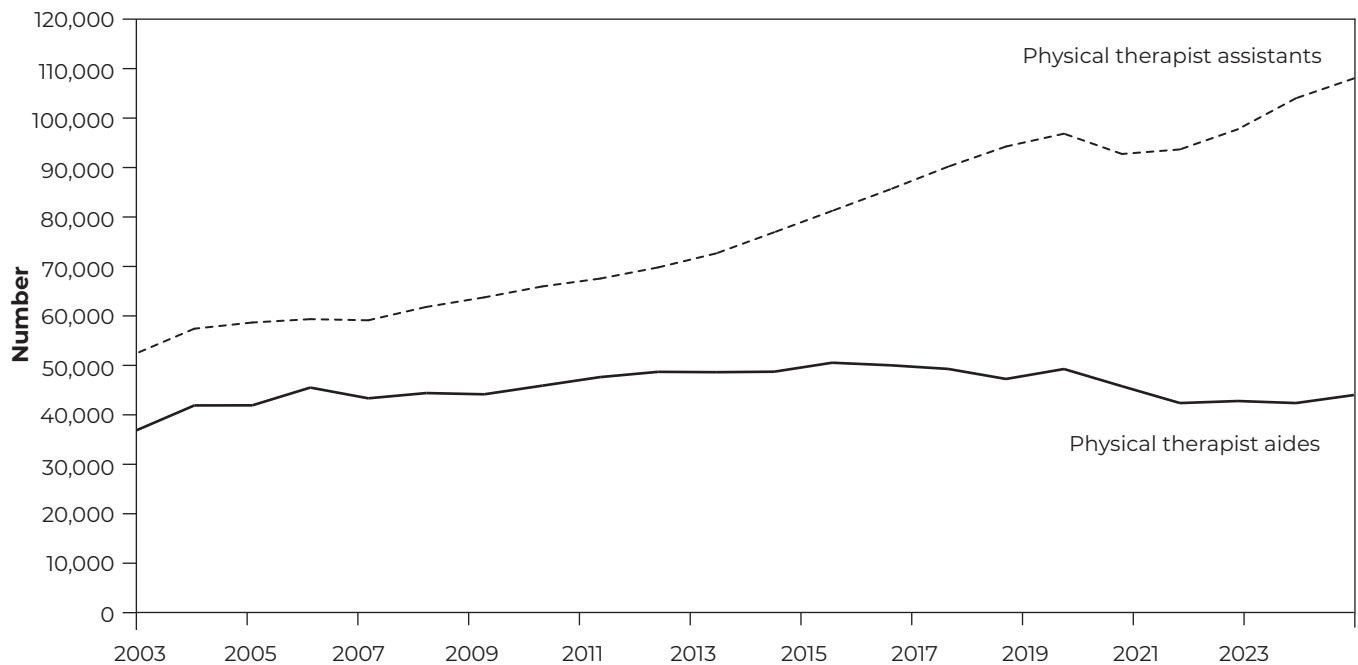
The health care staff workforce changes over time

The most common and fastest-growing health care staff occupation is home health or personal care aide, which was the occupation of nearly 4 million

people in 2024 (Figure 1-12, p. 29).²⁷ These workers are primarily employed by individuals and families, but about 1 million are employed by home health agencies (Bureau of Labor Statistics 2025b). This occupation requires the least amount of training of the health

**FIGURE
1-13**

The number of physical therapist assistants has grown, while the number of physical therapy aides (who have less training) has remained flat



Note: Physical therapist assistants usually have an associate's degree and a license or certification, while physical therapist aides usually have only a high school diploma and on-the-job training. Similar trends have been observed for occupational therapist assistants and aides, pharmacy technicians and aides, and registered nurses and licensed practical nurses.

Source: U.S. Bureau of Labor Statistics' Occupational Employment and Wage Statistics Tables for 2012–2024, <https://www.bls.gov/oes/tables.htm>.

care staff occupations, with some aide positions not requiring a high school diploma and relying on on-the-job training (e.g., in housekeeping, cooking, what to do in an emergency, patients' personal hygiene, taking patients' vital signs, infection control, and basic nutrition) (Bureau of Labor Statistics 2025b). The growth in the number of home health and personal care aides coincides with Medicaid shifting to primarily paying for long-term services and supports in the home rather than in institutional settings (Medicaid and CHIP Payment and Access Commission 2024). (Medicaid is the main funder of home health aide services; Medicare's home health benefit covers home health aide services, but as discussed in Chapter 8, they are infrequently provided (averaging less than 0.5 home health aide visits per 30-day period).)

The next two most common health care staff occupations are RNs (3.3 million people's occupation in

2024) and health technologists or technicians (which is an umbrella term for a variety of occupations held by 2.5 million people).²⁸ The number of people working as RNs and health technologists or technicians has grown more quickly than most other health care staff occupations in recent years (Figure 1-12, p. 29).

One workforce trend is the lack of growth in certain low-training roles. From 2003 to 2024, the number of physical therapist assistants (who usually have an associate's degree and a license or certification) grew rapidly, while the number of physical therapist aides (who usually have only a high school diploma and on-the-job training) remained flat and then began to decline (Figure 1-13) (Bureau of Labor Statistics 2025e). Similar trends are seen among occupational therapist assistants and aides (Bureau of Labor Statistics 2025b). Over this period, we have also seen an increasing number of pharmacy technicians (who must usually

pass an exam or complete a formal education or training program) and a declining number of pharmacy aides (who have only on-the-job training and do not perform tasks related to medications) (Bureau of Labor Statistics 2025b, Bureau of Labor Statistics 2025d, Pharmacy Technician Education & Career Guide 2025). And in the nursing workforce, there has been strong growth in the number of RNs (who must complete a multiyear nursing education program before passing a national exam), while there has been a decline in the number of LPNs (who complete a one-year educational program before passing an exam) (shown earlier in Figure 1-12 (p. 29)).

The health care sector is sometimes referred to as “recession proof” since the number of health care workers tends to increase, even during recessions when other sectors’ workforces are shrinking (Buerhaus et al. 2009, Dillender et al. 2021, Wood 2011). The unemployment rate in the health care sector is also consistently much lower than the unemployment rate in the broader U.S. economy (Woodward et al. 2025).

Researchers have also found a “countercyclical” relationship between the share of health care staff who leave their jobs for another industry and the national unemployment rate. During economic downturns, when the unemployment rate is high and it is difficult to find a job, the share of health care workers without a graduate or professional degree who leave the health care sector for a job in another industry is low. Conversely, during times of economic growth, when the unemployment rate is low and it is easier to find a job, the share of these health care workers who leave the health care sector for another industry (e.g., retail) increases (Woodward et al. 2025).

Wages vary by training requirements, geography, and clinical setting

In general, health care staff wages are higher for occupations that require more training (Figure 1-14). For example, in 2024, the highest-paid health care staff occupation was pharmacist (with an annual median wage of about \$137,000); pharmacists must complete at least two years of prerequisite undergraduate coursework, a four-year doctor of pharmacy degree, and then pass two exams to become licensed (Bureau of Labor Statistics 2025c). In contrast, the lowest-paid occupation was home health or personal care aide, with annual median wages of about \$35,000.

The wages of health care staff can vary based on geographic location and clinical setting. Wages for a given health care staff occupation tend to be higher in areas with higher costs of living (e.g., California).²⁹ This finding is in contrast to the wages of physicians, which are often higher in areas of the country with lower costs of living. For example, one recent analysis found the highest physician earnings in places like Indiana, Nebraska, North Dakota, and South Dakota (Gottlieb et al. 2025). Provider organizations in such areas may subsidize physician salaries as part of their recruitment efforts.

Some types of provider organizations pay particular types of health care staff higher wages than others, which may reflect in part how important certain occupations are in certain clinical settings. According to the U.S. Bureau of Labor Statistics (BLS), hospitals tend to pay more than other settings for RNs, direct care workers (home health aides, personal care aides, nursing assistants), pharmacists, and health care social workers. Skilled nursing facilities (SNFs) and home health agencies tend to pay more than other settings for physical therapists and physical therapy assistants, occupational therapists and occupational therapy assistants, speech–language pathologists, and LPNs. Physicians’ offices, in contrast, tend to pay lower wages to their health care staff relative to providers in these other clinical settings.³⁰

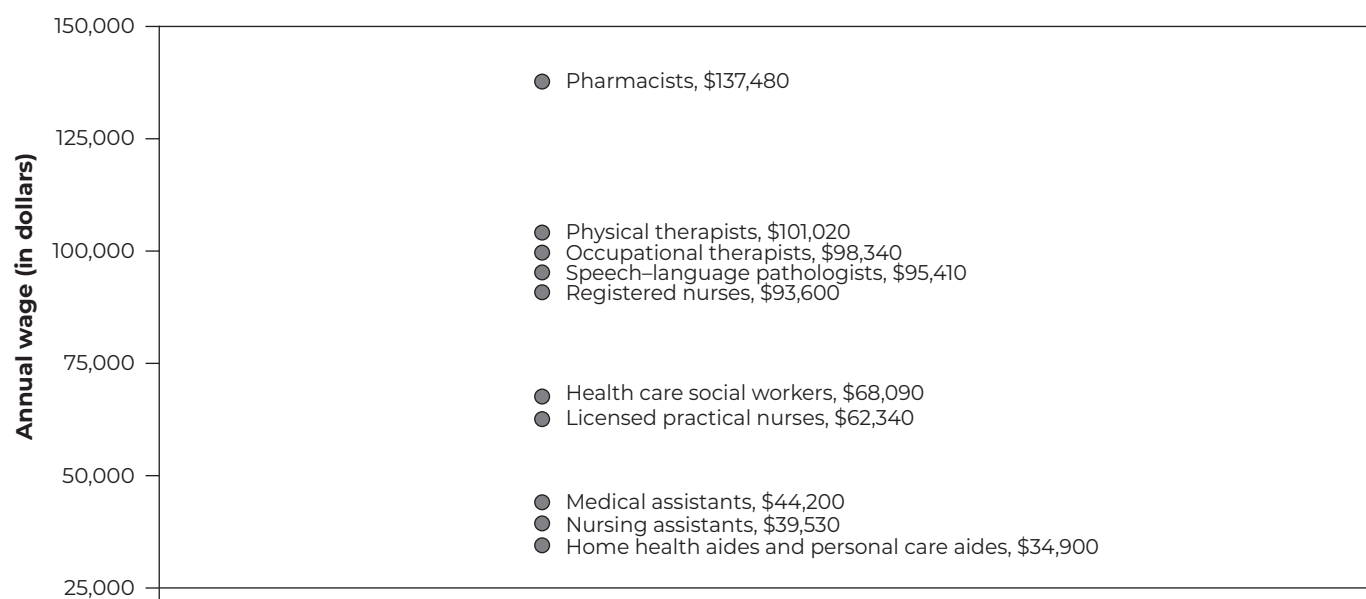
Assessing the size and stability of the health care staff workforce

It is difficult to project whether the supply of health care staff will be sufficient to meet demand. For one, demand for different health care staff roles can change over time, as described earlier. The supply of workers willing to fill low-wage health care jobs can also change when immigration laws or policies change (Azaroff et al. 2025, Chidambaram and Pillai 2025). In 2024, about one in four direct care workers (e.g., nursing assistants, home health aides) in the U.S. were foreign born (Azaroff et al. 2025, Bureau of Labor Statistics 2024a, Jun and Grabowski 2024, Zallman et al. 2019).

Overall, the BLS projects that what it calls the “healthcare support” occupational group (a similar set of occupations as the ones we focus on here) 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 (Bureau

**FIGURE
1-14**

Annual wages are generally higher for occupations that require more training, 2024



Note: Figure shows median annual wages. "Licensed practical nurses" includes licensed vocational nurses.

Source: U.S. Bureau of Labor Statistics' Occupational Employment and Wage Statistics Tables for 2024, <https://www.bls.gov/oes/tables.htm>.

of Labor Statistics 2024b).³¹ BLS projects home health aides and personal care aides, specifically, to be among the fastest-growing occupations in the U.S., accounting for one in eight new jobs between 2023 and 2033 (Bureau of Labor Statistics 2024b).

That said, the Department of Health & Human Services has projected that the U.S. will have shortages of some types of health care staff and surpluses of others. For example, over the next five years, the agency projects shortages of pharmacists, physical therapists, and diagnostic medical sonographers but surpluses of pharmacy technicians, physical therapy assistants, occupational therapists and occupational therapy assistants, speech-language pathologists, radiation therapists, and health care social workers (Health Resources & Services Administration 2024). RNs and LPNs are projected to be in shortage nationally, but this will vary by state, with some states projected to have an oversupply of nurses (National Center for Health Workforce Analysis 2024). The largest union of

nurses has argued that there is not in fact a shortage of nurses—just a shortage of nurses willing to accept current working conditions (National Nurses United 2025). They note that over 1 million individuals currently have active RN licenses but are not working as RNs due to retirements, burnout, family obligations, and concerns about employers using insufficient staffing levels (Muir et al. 2024, National Council of State Boards of Nursing 2025, National Nurses United 2025).

Ensuring adequate care quality for Medicare beneficiaries not only requires having an adequately sized workforce; it also requires having a sufficiently stable workforce. According to Medicare's Care Compare website, nearly half of nursing homes' nursing staff (which primarily consists of nursing assistants) leave their jobs in a given year (Centers for Medicare & Medicaid Services 2025e). This finding is concerning since researchers have found that nursing homes with higher staff turnover provide lower-quality care (Gandhi et al. 2021, Mukamel et al. 2023, Shen et al. 2023).

A number of studies have tried to understand why turnover rates are so high among nursing assistants. One study asked both nursing assistants and nursing home leaders to identify the workplace factors that they viewed as most important for retaining nursing assistants. Both groups agreed that competitive pay, positive supervisor relationships, adequate staffing levels, and a sense of teamwork were important. Nursing assistants also prioritized some factors that management did not: the ability to safely perform their job, the nursing home's reputation for care quality, and access to continuing education (Lauver et al. 2024). Nursing assistants experience musculoskeletal disorders (which can be caused by physical strain) at one of the highest rates in the U.S. (Bureau of Labor Statistics 2025a). A national survey found that more than half of nursing assistants in nursing homes reported having at least one work-related injury in the past year (Squillace et al. 2009). (For more detailed analyses of staffing levels in nursing homes, see Chapter 7.)

How Medicare pays for health care staff labor

Medicare pays for the labor of health care staff differently than it pays for the labor of physicians and other billable practitioners. FFS Medicare pays most practitioners through the physician fee schedule, and generally pays more if a practitioner spends more time or effort delivering a service (e.g., if more minutes are spent delivering a visit or more services are provided during an encounter). In contrast, under FFS Medicare, payment for the labor of nurses and other types of health care staff is bundled into the payments made to clinicians through the physician fee schedule (for office-based services) or into the payments made to facilities through prospective payment systems (PPSs) (for services provided by hospitals, SNFs, home health agencies, and other providers).^{32,33,34}

Medicare sometimes specifies what types of health care staff must be on duty in a given type of facility but usually does not specify how many of such staff must be on duty, thus giving facilities flexibility in how they structure their care teams. For example, hospitals are required to provide round-the-clock nursing services to patients using “adequate numbers” of RNs, LPNs, and other personnel “to provide nursing care to all patients as needed” (42 CFR Sec. 482.23). Home health agencies are required to employ an RN, a physical or

occupational therapist, and a social worker, but there is no particular number of such staff that must be employed, and patient services can be delivered by other types of workers as long as they are supervised by these key staff (42 CFR Part 484). Hospices are required to have an interdisciplinary team that includes a doctor, an RN, a social worker or marriage and family therapist or mental health counselor, and a pastoral or other counselor, but they can also include other types of workers on their teams (42 CFR Sec. 418.56). (SNFs have more stringent staffing rules.)

The packaged nature of Medicare payments for health care staff, noted earlier, incentivizes facilities and clinician offices to maximize profit by using a less expensive mix of staff. Other aspects of Medicare's payment systems attempt to counter this incentive by tying a portion of payments to performance on measures of care quality, thereby encouraging providers to employ enough staff to deliver high-quality care. For example, many Medicare payment systems have pay-for-performance programs that provide additional payments to facilities or clinicians that meet or exceed certain quality-measure targets and penalize those that miss these targets. Providers also have an incentive to prevent adverse events from happening since such events can lengthen a beneficiary's stay (and a provider's associated costs) without increasing the size of the Medicare payment they receive.

Medicare also promotes adequate staffing by publicly reporting staffing levels in nursing homes that qualify as SNFs. CMS posts 5-star ratings of SNFs on the Medicare Care Compare website (<https://www.medicare.gov/care-compare/>), including an overall 5-star assessment of each SNF's staffing levels. This website also shows more specific staffing information for each SNF (e.g., the amounts of RN, LPN, and nursing-assistant care hours provided per resident per day and how these amounts compare to state and national averages). The Commission has reported on variation in RN staffing levels in SNFs and expressed interest in elevating the role of RN staffing in these facilities' overall quality ratings, given the link between staffing levels and health care quality outcomes in the research literature (Medicare Payment Advisory Commission 2025b, Medicare Payment Advisory Commission 2025c). In Chapter 7 of this report, we explore different weighting mechanisms for the staffing component of the SNF

5-star rating formula; these illustrative scenarios better align overall star ratings with staffing levels.

In 2026, when it changes the quality measures used in the Medicare SNF value-based purchasing (VBP) program, Medicare will begin tying SNF payments to facilities' performance on staffing measures. Under the SNF VBP program, Medicare withholds 2 percent of SNFs' FFS Medicare Part A payments; 40 percent of these payments are retained for Medicare as savings and the remaining 60 percent are redistributed to SNFs based on their performance on quality measures. In 2026, two of the SNF VBP program's measures directly measure staffing, and two others may be indirectly influenced by staffing levels. The direct staffing measures will assess the number of RN, LPNs, and nursing assistants that SNFs employ by measuring (1) the average number of case-mix-adjusted nursing staff hours provided per resident day and (2) the annual turnover rate among SNF staff. The other measures will assess a SNF's annual risk-standardized rates of (1) health care-associated infections requiring hospitalization and (2) unplanned all-cause hospital readmissions (Centers for Medicare & Medicaid Services 2025j).

State laws can affect staffing levels and wages

States can also give health care providers incentives to use an adequately trained and sized health care staff workforce. California passed a law in 1999 that established minimum nurse-to-patient staffing ratios for hospitals, and researchers have found that it resulted in an extra half-hour of nursing care being provided per patient per day (McHugh et al. 2011). A 2024 study found that six other states had adopted such laws (while one state, Idaho, had banned minimum nurse-to-patient ratios) (Krishnamurthy et al. 2024).

States have also passed laws intended to increase facilities' investments in health care staff, particularly direct care workers. (Research has found that higher minimum wages in the nursing home sector increase retention among low-wage employees and decrease inspection violations, adverse preventable health conditions, and resident mortality (Ruffini 2024).) A 2024 study found that 22 states have enacted "wage pass-through" laws, which can require a certain share of Medicaid payments to be used to compensate direct care workers, for example. That study counted another

seven states that have passed laws requiring wages for direct care workers to be a certain amount above the minimum wage. Another five states have passed laws requiring direct care workers to be paid more if they complete various certifications or training programs (Assistant Secretary for Planning and Evaluation 2024). After implementation of these policies, the wages of direct care workers increased more quickly than the wages of other entry-level workers in many states, but the hourly wages of direct care workers remained several dollars lower than the wages of other entry-level workers in most states (Assistant Secretary for Planning and Evaluation 2024).

States may also influence the health care labor market via bans on noncompete agreements in employment contracts. Noncompete agreements prohibit departing staff from working for competitors, thereby curtailing employees' mobility and ability to negotiate better wages and employment terms. Almost all states have passed laws partially restricting the use of such agreements, and some states have gone further and completely banned them (e.g., Minnesota, Montana, Oklahoma) (Paycor 2025).

The Commission aims to improve value for taxpayers and beneficiaries

The Commission regularly makes recommendations to promote program efficiencies and beneficiaries' access to care in our annual March and June reports. Each year we recommend 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. We also continue to explore how Medicare affects, and is affected by, the broader health care sector. A list of the Commission's recommendations, with links to relevant report chapters, is available at <http://www.medpac.gov/recommendation>. The evidence-based recommendations we formulate are intended to obtain good value for beneficiaries' and taxpayers' expenditures, which means maintaining or improving access to high-quality services while encouraging efficient use of resources. ■

Endnotes

- 1 The recently enacted Inflation Reduction Act of 2022 (IRA) gave Medicare certain tools to influence the price that the program and beneficiaries pay for certain Part B-covered drugs. Beginning in 2028, the Secretary will have the authority to negotiate the price of certain high-expenditure single-source products that lack generic or biosimilar competitors and that have been on the market for at least 9 years for drugs or at least 13 years for biologics. In addition, effective January 2023, Part B drug manufacturers are required to pay Medicare a rebate if the price of their product increases faster than inflation. The legislation includes additional provisions that affect Part B drugs, such as limiting beneficiary cost sharing for Part B-covered insulin and certain changes to payment for biosimilars. However, some challenges remain. The program continues to lack tools to influence launch prices of new drugs, including those with limited clinical evidence. In addition, because Medicare pays for single-source drugs and biologics according to separate billing codes based on their own average sales price, concerns remain about a lack of price competition among products with similar health effects during the period before they are eligible for negotiation. With respect to Medicare's payment to providers, concerns remain that paying the average sales price plus a percentage add-on can create financial incentives that favor prescribing higher-priced drugs in some circumstances.
- 2 Market concentration is defined based on the Herfindahl-Hirschman Index (HHI) measure thresholds in the merger guidelines from the Federal Trade Commission and Department of Justice: not concentrated (HHI < 1,000), moderately concentrated (1,000–1,800), and highly concentrated (HHI > 1,800); <https://www.justice.gov/atr/herfindahl-hirschman-index>.
- 3 Currently, in commercial markets, pharmacy benefit managers (PBMs) are not required to disclose the drug rebates they negotiate with pharmaceutical manufacturers or the price difference between what insurers pay them to fill a prescription and how much the PBM actually pays the pharmacy to fill the prescription.
- 4 In Medicare Part D, the “any willing pharmacy” requirement prevents plans from leaving pharmacies out of network if they meet the plan's standard contracting terms and conditions, which must be “reasonable and relevant.” See <https://www.cms.gov/files/document/chapter-5-benefits-and-beneficiary-protection-v92011.pdf> (Sec. 50.8.1)
- 5 Part A services are also funded by income from the taxation of higher-income individuals' Social Security benefits, interest earned on investments, premiums collected from voluntary participants, and other sources (Boards of Trustees 2025).
- 6 Once the Hospital Insurance Trust Fund's balance is depleted, the trust fund would be able to cover only 89 percent of the cost of scheduled Part A benefits (Boards of Trustees 2025).
- 7 Workers and their employers split the cost of the Medicare payroll tax (workers pay 1.45 percent and employers pay 1.45 percent). Meanwhile, self-employed people pay both the worker's and the employer's share of this tax, totaling 2.9 percent of their net earnings. High-income workers pay an additional 0.9 percent of their earnings above \$200,000 for single workers or \$250,000 for married couples (Boards of Trustees 2025).
- 8 General revenues primarily consist of individual and corporate taxes but also include customs duties, leases of government-owned land and buildings, the sale of natural resources, usage and licensing fees, and payments to agencies (Department of Treasury 2026).
- 9 Individuals with higher incomes pay a higher Part B premium. See Endnote 15.
- 10 The annual cost of premiums for stand-alone Part D drug plans mentioned in the text (\$468 in 2025) was the average for all stand-alone Part D drug plans, including both basic and enhanced plans. The annual cost of drug coverage through a Medicare Advantage (MA) plan mentioned in the text (\$84 in 2025) was the average cost for conventional MA plans with prescription drug coverage, excluding MA special-needs plans (which are for individuals who are institutionalized, dually enrolled in Medicare and Medicaid, or who have a severe or disabling chronic condition).
- 11 These amounts do not include cost-sharing liability paid by Medicare on behalf of Part D enrollees who receive the low-income subsidy.
- 12 The share of community-dwelling Medicare beneficiaries who report having FFS coverage with public or private supplemental coverage has declined from nearly three-quarters of beneficiaries in 2000 to nearly half of beneficiaries in 2022, according to our analysis of CMS's Medicare Current Beneficiary Survey data (Medicare Payment Advisory Commission 2025a, Medicare Payment Advisory Commission 2003).

- 13 Individuals paid the full Part A premium of \$565 per month in 2026 if they were eligible for Medicare but they or their spouse did not pay Medicare payroll taxes for at least 7.5 years. Individuals paid a discounted Part A premium of \$311 per month if they or their spouse paid Medicare payroll taxes for at least 7.5 years but less than 10 years (Centers for Medicare & Medicaid Services 2025b).
- 14 MA plans can reduce the amount deducted from enrollees' checks by "buying down" some or all of the standard Part B premium amount. In 2026, 29 percent of the beneficiaries enrolled in conventional MA plans are estimated to be in premium-reduction plans, with a median premium reduction of \$61 per month. (See Chapter 12 for more on Medicare Advantage.)
- 15 In 2026, beneficiaries with an annual modified adjusted gross annual income (MAGI) of greater than \$109,000 and less than or equal to \$137,000 (or greater than \$218,000 and less than or equal to \$274,000 for a married couple) pay a monthly premium of \$284. Beneficiaries with a MAGI of greater than \$137,000 and less than or equal to \$171,000 (or greater than \$274,000 and less than or equal to \$342,000 for a married couple) pay \$406. Beneficiaries with a MAGI of greater than \$171,000 and less than or equal to \$205,000 (or greater than \$342,000 and less than or equal to \$410,000 for a married couple) pay \$528. Beneficiaries with a MAGI of greater than \$205,000 and less than \$500,000 (or greater than \$410,000 and less than \$750,000, for a married couple) pay \$649. Beneficiaries with a MAGI of \$500,000 or more (or \$750,000 or more for a married couple) pay \$690 (Centers for Medicare & Medicaid Services 2025b).
- 16 Individuals who do not qualify for premium-free Part A are also subject to a late-enrollment penalty if the individual does not buy Part A when the individual is first eligible for Medicare. Medicare beneficiaries are exempt from Part A, Part B, and Part D late-enrollment penalties if they delayed enrolling in Medicare because they had comparable coverage through another source (e.g., an employer, TRICARE) or they missed a chance to sign up because they were impacted by a natural disaster or declared emergency, they were given inaccurate or misleading information from their health plan or employer, they were incarcerated, or they experienced other exceptional conditions (Centers for Medicare & Medicaid Services 2024c).
- 17 The initial six-month open enrollment period for Medigap starts the first month that a beneficiary is age 65 and has Medicare Part B.
- 18 MA enrollees in preferred provider organization plans or HMO point-of-service plans generally have some out-of-network coverage with up to 50 percent coinsurance, but out-of-network care is generally not covered in HMO plans except for emergency and urgently needed services. In cases where medically necessary care is not obtainable in network, all MA plans must allow enrollees to go out of network and pay in-network cost sharing. See Chapter 12 of this report for more information on MA plan types.
- 19 Medicare gives nursing home residents more flexibility than other beneficiaries: They can switch from FFS Medicare to an MA plan, from MA to FFS, or change their MA or stand-alone Part D plan on a monthly, rather than annual, basis. But, as with other types of beneficiaries, they may encounter higher Medigap premiums and fewer Medigap plan options if they switch from MA to FFS and try to buy a Medigap plan after their first year of Medicare eligibility.
- 20 However, we note that in the MA initial trial period, Medicare beneficiaries who were initially enrolled in a Medigap plan and switched to MA for the first time may return to FFS Medicare and their Medigap plan before the end of their first year of MA coverage without being subject to medical underwriting. In addition, beneficiaries who join MA for the first time when first eligible at age 65 may disenroll during the first 12 months for FFS Medicare and may obtain a Medigap plan.
- 21 In 2025, in general, beneficiaries with less than \$15,900 in annual income and \$9,660 in liquid assets (or \$21,396 in income and \$14,470 in assets if married) were able to sign up to have Medicaid pay their Medicare Part A (if needed) and Part B premiums and cost sharing; however, some states have set higher income and/or asset thresholds. Slightly higher-income beneficiaries can sign up to have Medicaid pay their Medicare Part A or Part B premiums.
- 22 Medicare will cover the premium for LIS beneficiaries up to the low-income premium subsidy amount (LIPSA) for the region in which the beneficiary resides. See Chapter 13 for more information regarding LIPSA.
- 23 The statistics in this paragraph are calculated using a different, simpler approach compared with the statistics shown earlier in Figure 1-11 (p. 25). The enrollment statistics in this paragraph are based on our analysis of the 2023 Medicare Current Beneficiary Survey's Survey file for noninstitutionalized beneficiaries enrolled in both Part A and Part B.
- 24 We use "licensed practical nurses" as a shorthand for licensed practical nurses and licensed vocational nurses.
- 25 We use "nursing assistants" as a shorthand for nursing assistants, certified nursing assistants, and nurse aides.

- 26 Physical therapists, occupational therapists, and speech-language pathologists are types of allied health professionals. They are identified separately here since they are used heavily in certain clinical settings.
- 27 Another fast-growing segment of the health care workforce is advanced practice registered nurses (APRNs) and physician assistants (PAs). Although many APRNs and PAs hold salaried positions within provider organizations, we consider them to be practitioners as opposed to health care staff. For more information on APRNs and PAs, see Chapter 4 of this report.
- 28 The Bureau of Labor Statistics' "health technologist and technician" category includes licensed practical nurses (LPNs), but we have subtracted LPNs from this category in this sentence and track them separately in Figure 1-12 (p. 29).
- 29 MedPAC analysis of Bureau of Labor Statistics data on annual median wages for various types of health care support staff in different geographic areas of the U.S. (Bureau of Labor Statistics 2025a).
- 30 MedPAC analysis of BLS data on annual median wages for various types of health care support staff in general medical and surgical hospitals, nursing care facilities (SNFs), home health care services, and offices of physicians (Bureau of Labor Statistics 2025a).
- 31 For example, in contrast with our definition of "health care staff," the BLS's "healthcare support" occupational group includes dental and veterinary assistants and excludes nurses, rehabilitative therapists, and pharmacists (Bureau of Labor Statistics 2023)
- 32 Payment for administrative staff, medical equipment and supplies, rent, health information technology, and other expenses is also bundled into FFS Medicare's base payment rates under the physician fee schedule and under Medicare's various PPSs.
- 33 PPS payments to facilities are adjusted for certain facility characteristics, relative area wages, and for differences in patients' expected costliness.
- 34 Although Medicare's general approach is to pay for health care staff labor through flat PPS payments to facilities, there are a number of exceptions to this general approach. Some types of clinicians are paid through Medicare's physician fee schedule in some settings but through a PPS in other settings: For example, physical therapists are paid directly through the physician fee schedule when they provide services in a hospital outpatient department, but when they provide services in a SNF, they are paid by the SNF, which receives a flat PPS payment intended to cover the cost of the physical therapy services provided in that setting. Some types of clinicians are paid through Medicare's physician fee schedule for some types of services and through a PPS for other types of services. For example, pharmacists can bill the physician fee schedule directly when they administer vaccines but not when they perform medication reconciliation (which is sometimes paid for through some other Medicare PPSs). And finally, some types of health care staff's services can be billed by a physician or other billable practitioner when they are provided "incident to" services provided by that practitioner, while other services cannot. For example, Medicare's physician fee schedule pays nurses to furnish the lowest-level evaluation and management office visit when it is billed by a physician under "incident to" rules but does not make separate payment to nurses when they take a patient's vitals as part of a more advanced evaluation and management visit.

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C H A P T E R

2

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

Assessing payment adequacy and updating payments in fee-for-service Medicare

Chapter summary

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional fee-for-service (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. To determine an update recommendation, we assess 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. This year, we consider the adequacy of payments in FFS payment systems for the following sectors: acute care hospitals, physician and other health professional services, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and hospice.

Our goal is to make a payment-update recommendation for each sector that balances beneficiary access to high-quality care with good stewardship of taxpayer and beneficiary resources. We use the

In this chapter

- Important context for payment-adequacy analysis
- The Commission's principles for assessing payment adequacy
- Payment-adequacy analytic framework
- Anticipated payment and cost changes in 2026
- Recommendations for FFS Medicare payment in 2027

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.

This chapter reviews our approach to analyzing payment adequacy and making payment-update recommendations in FFS Medicare. The Commission also assesses Medicare payment systems for Part C (Medicare Advantage), Part D (outpatient prescription drug coverage), and ambulatory surgical center services in the March report each year and makes recommendations as appropriate. Those sectors, however, are outside the scope of this chapter. ■

The Commission's goal for Medicare payment policy is to support beneficiary access to high-quality care while obtaining good value for the program's expenditures, which entails encouraging the efficient use of resources funded through taxes and Medicare beneficiary premiums. Appropriate payment begins with base payment rates that reflect the costs of efficiently delivering care to the average beneficiary, followed by adequate adjustments for differences in cost due to market-, service-, and patient-level variations. Payment policy can also be a mechanism for encouraging improvements in quality of care, ensuring access for beneficiaries, and pursuing other policy objectives such as ensuring program integrity.

Per statute, the Commission annually undertakes a systematic assessment of payment in sectors that provide services to Medicare beneficiaries.¹ We consider recommendations in seven fee-for-service (FFS) payment systems: acute care hospitals, physician and other health professional services, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and hospice. Our annual analysis leads to recommendations for updates to FFS Medicare payments in the upcoming year (this year, for 2027). For each sector, we analyze the most recently available data (2024 in most cases) on beneficiary access and quality of care, provider margins and access to capital, and other contextual factors to determine the adequacy of FFS Medicare payment rates. We then consider forthcoming policy and anticipated cost changes to project FFS Medicare payments and provider costs for 2026. Finally, we recommend how overall FFS Medicare payments for a given sector should change in aggregate for 2027, including whether payments should increase, decrease, or remain the same. We update our payment recommendations annually based on the most recent information and assuming current law remains in place. We avoid speculating on whether and how changes in external circumstances might lead to different recommendations.

Within each of the seven payment systems, we also examine how payment rates may affect providers' ability to serve Medicare beneficiaries, taking into consideration geographic, demographic, and other characteristics. We contemplate whether payment adjustments are necessary to address differences in

access, incentivize quality of care, or otherwise fairly distribute FFS payments across providers in a sector. We also identify program-integrity concerns and potential remedies. However, often the Commission's work to address those types of concerns falls outside of the annual payment-update exercise.

We compare our update and other policy recommendations for 2027 with the base FFS Medicare payment rates specified in law to understand the implications for beneficiaries, providers, and the Medicare program. This chapter details our analytic framework for assessing payment adequacy, as well as our principles underlying that framework.

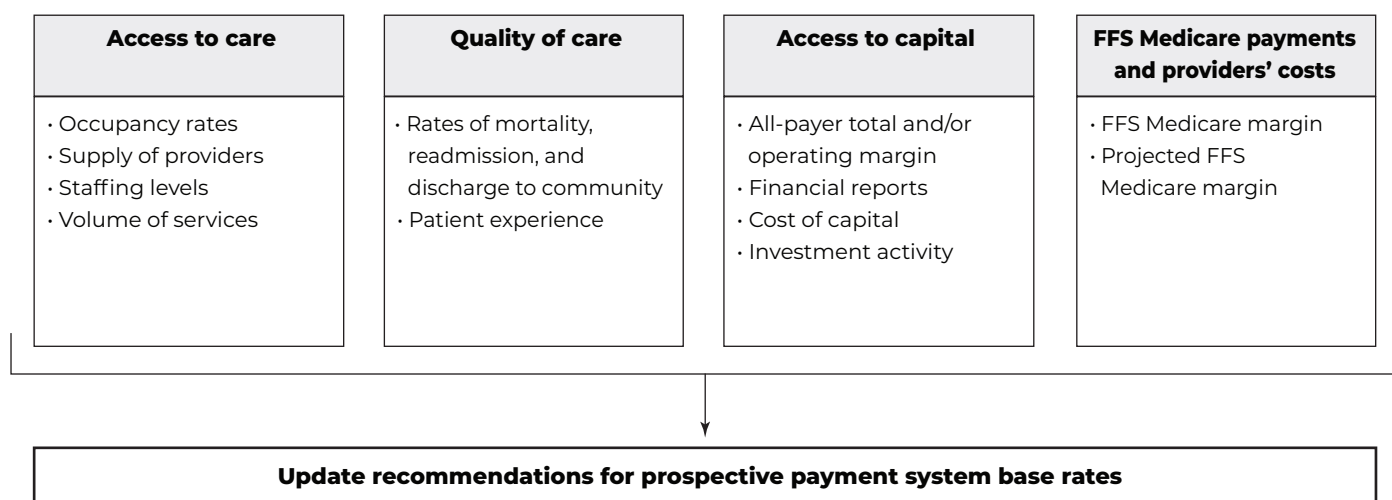
Notably, our update work and related recommendations are setting specific. That said, in our broader work, the Commission has maintained that, for services that are safe and appropriate to apply across settings, payment for the same services should be comparable regardless of where the services are provided. Such "site neutrality" helps to ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions. For example, the Commission recommended in 2023 that the Congress more closely align payment rates across ambulatory settings (e.g., hospital outpatient departments, ambulatory surgery centers, and physicians' offices) for selected services that are safe and appropriate to provide in all ambulatory settings and when doing so does not pose a risk to access (Medicare Payment Advisory Commission 2023a). Because the analytic issues related to cross-setting analysis are more complex, this work is generally outside the scope of our sector-specific payment-adequacy analyses and recommendations and thus is not discussed in this chapter.

Important context for payment-adequacy analysis

In any year, factors unrelated to the adequacy of FFS Medicare's payment rates can affect indicators of access to care, quality of care, access to capital, and FFS Medicare payments and providers' costs in the settings where Medicare beneficiaries seek care. The previous chapter discussed the wider health care landscape and policy context. Here, we discuss how that context shapes our payment-adequacy analysis.

**FIGURE
2-1**

The Commission's framework for assessing FFS Medicare payment adequacy



Note: FFS (fee-for-service). Payment-adequacy indicators are used as available and applicable. We use multiple measures of margins for different purposes in our payment-adequacy analysis (see text box, p. 55). The “all-payer total margin,” defined as ((payments from all payers and sources – costs of providing services) / payments from all payers and sources), is a measure of a sector’s access to capital. For the hospital sector, we also evaluate the “all-payer operating margin,” which is defined as ((payments from all payers and sources except investments and donations – costs of providing services) / payments from all payers and sources except investments and donations). “FFS Medicare margin,” defined as ((FFS Medicare payments for services – allowable costs of providing services) / FFS Medicare payments for services), is a sector-wide measure of the relationship between FFS Medicare’s payments and providers’ costs for services.

Source: MedPAC.

Lingering effects of the public health emergency and coronavirus pandemic

The public health emergency (PHE) related to the coronavirus pandemic officially expired on May 11, 2023. The Commission recognizes that the coronavirus pandemic has had tragic effects on beneficiaries, as well as damaging impacts on the nation’s health care workforce. While the direct and indirect effects of the pandemic on beneficiaries, PHE-related policy changes, and emergency funding for providers have made it challenging to interpret some of our indicators of the adequacy of Medicare’s payment rates in the past, our most recent measures of payment adequacy (using data from 2023 and 2024) indicate that the most pronounced effects of the pandemic have passed. Nonetheless, certain changes in practice patterns in response to the pandemic may persist. For instance, many of the temporary telehealth policies intended as an alternative to some in-person appointments

during the pandemic were still in effect at the end of 2025. In our 2025 survey of Medicare beneficiaries ages 65 and over, 35 percent of beneficiaries reported using telehealth in the past year; among those who had a telehealth visit, more than 90 percent of beneficiaries expressed satisfaction.² We will continue to monitor the impacts of the telehealth expansions as beneficiaries continue to access care via telehealth outside the context of the PHE.

Growth of Medicare Advantage

Enrollment in Medicare Advantage (MA) plans continued to increase in 2025, with more than half of eligible Medicare beneficiaries enrolled in an MA plan. The extent to which the growth in MA might affect the provision of care to FFS Medicare beneficiaries is not yet clear, nor is the appropriate relationship between MA and FFS payment rates. Generally, we do not adjust our update recommendations based on payment rates

or policies of other health insurers, including MA plans. Instead, in Chapter 12 of this report, we present our current assessment of the MA program. Additionally, the Commission is continuing to analyze how growth in MA may or may not affect providers' operations and the health care landscape more broadly.

The Commission's principles for assessing payment adequacy

For each respective payment system, the overarching goal of our payment-update recommendation is to determine the aggregate level of payments that balances competing objectives. Payment rates should be sufficient to support efficient delivery of high-quality care for beneficiaries. Payment rates should also maintain fiscal pressure on providers to constrain their costs and to ensure value for taxpayers. Of course, in many sectors there is widespread heterogeneity among providers, with some performing much better on our indicators than others. However, because we are focused on making recommendations to ensure that there are sufficient resources in a payment system overall to support beneficiary access to care, we aim to make recommendations that are appropriate for the sector on average. When different performance from providers creates challenges for beneficiary access to care, we develop targeted policies outside of the payment update to address them.

That said, the Commission is also committed to the accuracy of payments, which might lead us to make additional recommendations that redistribute FFS Medicare payments within a sector to better target them. For instance, in 2018, the Commission recommended that the payment weights in the skilled nursing facility (SNF) prospective payment system (PPS) be adjusted to increase payments for medically complex patients and decrease payments for patients receiving rehabilitation therapy unrelated to their care needs (Medicare Payment Advisory Commission 2018). In 2020, we recommended that CMS replace existing adjustments in the end-stage renal disease PPS for low-volume and rural facilities with a single payment adjustment that would direct additional payments to dialysis facilities that are isolated and have low volume (Medicare Payment Advisory Commission 2020). In 2023, we recommended that current disproportionate-

share-hospital and uncompensated-care payments be redistributed using the Commission-developed Medicare Safety-Net Index (MSNI) and that additional funding for Medicare safety-net payments be authorized to support hospitals that are key sources of care for low-income Medicare beneficiaries (Medicare Payment Advisory Commission 2023b). Such recommendations are generally developed outside of our update work and, to the extent feasible, integrated into our update recommendations.

Finally, we note that our primary concern is the appropriateness of FFS Medicare payments to support FFS beneficiaries' access to care, not the adequacy of payments across all payers. We do not seek to set FFS Medicare payments based on over- or underpayments by other payers.

Payment-adequacy analytic framework

The Commission bases its payment-update recommendations on an assessment of the adequacy of current FFS Medicare payments. For each sector, we make an assessment by examining indicators of beneficiaries' access to care, quality of care, providers' access to capital, and FFS Medicare payments and providers' costs. The direct relevance, availability, and quality of each type of information vary among sectors, and no single measure provides all the information needed for the Commission to judge payment adequacy. We use a combination of administrative data, surveys, and other sources to inform our assessments, aiming to incorporate as many high-quality data sources as possible. Figure 2-1 illustrates our payment-adequacy framework, including examples of the types of indicators used for each sector (as available and applicable).

Beneficiaries' access to care

Access to care is an important signal of providers' willingness to serve Medicare beneficiaries and the adequacy of FFS Medicare payments. Poor access could indicate that Medicare payments are too low, either in aggregate or for certain types of cases. The measures we use to assess beneficiaries' access to care depend on the availability and relevance of information in each sector. Broadly speaking, we consider provider capacity

and supply, as well as FFS Medicare service volume (and changes in volume) as measures of access. Much of our analysis uses claims and other administrative data, but we also use results from several surveys to assess the willingness of physicians and other health professionals to serve FFS Medicare beneficiaries and FFS beneficiaries' ability to access physician and other health professional services when needed. However, factors unrelated to FFS Medicare's payment policies may also affect access to care, such as Medicare's coverage policies, changes in the delivery of health care services, local market conditions and barriers to access, and supplemental insurance, so we exercise judgment when interpreting how information for this domain should influence recommendations.

Provider capacity and supply

FFS Medicare beneficiaries' access to care depends in part on providers' ability to meet demand. Low provider capacity, long wait times, and difficulty maintaining staffing levels can indicate inadequate payment rates. By contrast, rapid provider entry into a sector may indicate that payments are too high. Technological changes are a factor in that they can, in many cases, increase capacity in ways that reduce costs. For example, as a surgical procedure becomes less invasive, it might be more frequently performed in lower-cost outpatient settings, freeing up some inpatient hospital capacity. Likewise, as the prices of new technologies fall, providers can more easily purchase them, increasing the capacity to provide certain services.

We have observed that providers have modulated excess capacity in response to payment-policy changes. But provider capacity is not always a clear indicator of payment adequacy. For instance, if FFS Medicare is not the dominant payer for a given provider type (e.g., ambulatory surgical centers), changes in the number of providers may be influenced more by other payers and their enrollees' demand for services and be less indicative of the adequacy of FFS Medicare payments.

Volume of services

The Commission analyzes the volume of services provided to FFS beneficiaries as an indirect indicator of access. A stable or increasing volume of services relative to the number of FFS beneficiaries can

indicate adequate access to services and, by extension, payment. However, it does not necessarily demonstrate that those services are necessary or appropriate. A more rapid increase in volume relative to the number of FFS beneficiaries could suggest that FFS Medicare's payment rates are too high. By contrast, reductions in the volume of services per capita can sometimes be a signal that revenues are inadequate for providers to continue operating or to provide the same level of service. In sectors whose services can be substituted for one another, changes in volume by site of service may suggest distortions in payment and raise questions about payment equity.

It is important to note that changes in the volume of services are not direct indicators of access; increases and decreases can be explained by factors such as population changes, changes in disease prevalence among beneficiaries, dissemination of new and improved medical knowledge and technology, deliberate policy interventions, and beneficiaries' preferences. A change in aggregate volume, for instance, could be attributable either to a change in services per beneficiary or a change in the number of beneficiaries. We analyze per beneficiary service use as well as the total volume of services to isolate these effects.

Quality of care

The quality of care provided to FFS Medicare beneficiaries is an indirect indicator of the adequacy of FFS Medicare payments. Increasing payments through an update for all providers in a sector is unlikely to influence the overall quality of care that beneficiaries receive because there is no incentive for providers to devote the additional revenue to actions that are known to improve quality. Thus, within our framework, we consider whether changes in FFS Medicare's rates would meaningfully affect the quality of care that beneficiaries receive in a particular sector. Indeed, historically, FFS Medicare payment systems created little or no incentive for providers to spend additional resources on improving quality. Over the past two decades, the Medicare program has implemented FFS quality-reporting programs for almost all major provider types and several pay-for-performance programs that tie FFS payment to a provider's performance on quality standards. Throughout the years, measures developed and used in public and

MedPAC uses several definitions of “margin” when assessing FFS Medicare payment adequacy

Margins are a measure of profitability and are calculated as the difference between revenue and cost, divided by revenue $((\text{revenue} - \text{costs}) / \text{revenue})$. A positive margin indicates that a line of business is profitable, while a negative margin indicates a financial loss on a line of business. Unless otherwise indicated, all margins reported by the Commission are calculated in aggregate across all included providers. We use several definitions of “margin” when assessing fee-for-service (FFS) Medicare payment adequacy:

Fee-for-service Medicare margin

The percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable costs of providing services to FFS Medicare patients.

All-payer total margin

The percentage of revenue from all payers and sources that is left as profit after accounting for all costs.

All-payer operating margin

The percentage of revenue from all payers and sources exclusive of investments and donations that is left as profit after accounting for all costs. ■

private quality programs have proliferated, which has created confusion and increased reporting burden. The Commission is concerned that many of these measures focus on processes that are not associated with meaningful outcomes for beneficiaries.

Providers’ access to capital

Providers must have access to capital to maintain and modernize their facilities and to improve patient-care delivery. One indicator of a sector’s access to capital is its all-payer profitability, reflecting income from all sources. We refer to this amount as the sector’s all-payer margin, which is calculated as aggregate income, minus costs, divided by income. A sector’s all-payer margin can inform our assessment of a sector’s overall financial condition and hence its access to capital. Other indicators, such as bond rating and investment in the sector, may also be relevant.

Widespread ability to access capital throughout a sector may reflect the adequacy of FFS Medicare payments, but it is more indicative in some sectors than others. For instance, hospitals require large capital investments, and the ability to finance those investments can indicate the adequacy of FFS Medicare payments in hospitals for which the plurality of patients

are FFS Medicare patients. Other sectors, such as home health care, are not as capital intensive, so access to capital is a more limited indicator. Similarly, when FFS Medicare represents a relatively small share of a sector’s volume, access to capital is a weak indicator of FFS Medicare payment adequacy. Access to capital may be more reflective of conditions in credit markets or other macroeconomic phenomena.

FFS Medicare payments and providers’ costs

While we do consider all-payer margins as an indicator of providers’ financial health, our primary financial analysis assesses the adequacy of FFS Medicare payments relative to the costs of treating FFS beneficiaries, and the Commission’s recommendations address a sector’s FFS Medicare payments, not total payments. For providers that we analyze and that submit cost reports to CMS—acute care hospitals, SNFs, home health agencies, outpatient dialysis facilities, inpatient rehabilitation facilities, and hospices—we estimate total Medicare-allowable costs and assess the relationship between FFS Medicare’s payments and those costs for FFS beneficiaries. This report uses cost-report data from 2024 (2023 for hospices), due to standard data lags.

The coronavirus pandemic and PHE-related policy changes primarily affected FFS Medicare payments and providers' costs from 2020 until the expiration of the PHE in May 2023.³ Supplemental payments or policies to waive Medicare's payment rules during the PHE may have subsidized providers that would have otherwise exited the market. In the hospital sector, where coronavirus relief-fund revenue was substantial, we calculate a FFS Medicare margin exclusive of PHE relief funds (assuming all else equal), as well as a FFS Medicare margin inclusive of relief funds. To make this latter calculation, we allocated to FFS Medicare payments a portion of relief funds received by a provider, using measures of Medicare's market share in 2019 (such as the ratio of FFS Medicare to all-payer revenue).

FFS Medicare margins

We typically express the relationship between payments and costs as a FFS Medicare margin, which is calculated as aggregate FFS Medicare payments for a sector, minus the allowable costs of providing services to FFS Medicare patients, divided by FFS Medicare payments.⁴ Margins for individual providers will always be distributed around that aggregate, and a judgment of payment adequacy does not mean that every provider has a positive FFS Medicare margin. To assess the distribution of payments and any need for targeted support, we calculate FFS Medicare margins for certain subgroups of providers that have unique roles in the health care system or that receive special payments.

Multiple factors can contribute to changes in the FFS Medicare margin, including changes in providers' efficiency and changes in providers' coding practices that may influence payments (but not their costs). Knowing whether these factors have contributed to margin changes may inform decisions about whether and how much to recommend changes to a sector's base payment rate.

In sectors where the data are available, the Commission makes a judgment when assessing the adequacy of FFS Medicare payments relative to costs. No single standard governs this relationship for all sectors, and margins are only one indicator for determining payment adequacy. Moreover, although payments can be ascertained with some accuracy,

there may be no "true" value for the portion of reported costs that are attributed to providing care for FFS Medicare patients. Attributing reported costs to FFS Medicare patients is challenging and reflects in part the accounting choices made by providers (such as allocations of costs to different services) and the relationship of service volume to capacity in a given year. Further, even if costs are accurately reported, they reflect strategic investment decisions of individual providers, and FFS Medicare—as a prudent payer—may choose not to recognize some of these costs or may exert financial pressure on providers to encourage them to reduce their costs.

Ascertaining whether payments are adequate to cover the costs of efficiently providing high-quality care for Medicare beneficiaries is challenging. Assessing payments relative to costs is complicated because costs can change in response to financial pressure and strategic decisions made by providers. Analyses by MedPAC and other researchers have found that providers that face financial pressure to constrain costs generally have lower costs than those who face less pressure (Medicare Payment Advisory Commission 2011, Robinson 2011, Stensland et al. 2010, White and Wu 2014). Providers might also strategically make costly investments in an effort to appeal to higher-paying privately insured patients. Studies have shown that hospitals with more revenue, or more potential revenue, from private patients tend to have higher costs (Garthwaite et al. 2022, Wang and Anderson 2022). As a result, providers with higher revenues can have higher cost structures and, all other things being equal, lower margins on FFS Medicare patients.⁵ Those providers with high revenues and high costs often have lower margins on their FFS Medicare patients (because of their higher costs) but higher all-payer margins (because their higher revenues from non-Medicare patients more than offset those higher costs) (Medicare Payment Advisory Commission 2021). That view stands in contrast to arguments that costs are largely outside the control of providers and that providers (for example, hospitals) shift costs onto private insurers to offset FFS Medicare losses.

Lack of fiscal pressure is more common in markets where a few providers dominate and have negotiating leverage over payers. This situation is

becoming more common as health care providers continue to consolidate in order to bolster their negotiating power. The Commission generally does not recommend lowering FFS Medicare payments because payments from private plans are higher or raising them if other payers (e.g., Medicaid) pay less. Moreover, we recognize that in some sectors, FFS Medicare itself can, and should, exert greater pressure on providers to reduce costs. We rely on our other indicators of payment adequacy, especially beneficiary access to and quality of care, to ensure that FFS beneficiaries are not adversely affected by policy responses aimed at constraining costs.

Anticipated payment and cost changes in 2026

For most payment sectors, we estimate a FFS Medicare margin for 2026 to inform our update recommendations for 2027. In general, to estimate payments, we first apply the annual payment updates specified in law for 2025 and 2026 to our base data (2024 for most sectors). We then incorporate the effects of other policy changes that will affect the level of FFS Medicare payments in 2026. To estimate 2026 costs, we first consider the rate of input price inflation or historical cost growth, and, as appropriate, we adjust for other changes that might affect providers' expected costs, including forthcoming policy changes. When considering the change in input price inflation, we refer to the price index that CMS uses for that sector.⁶ For each sector of facility providers (e.g., hospitals, SNFs), we use the forecasted increase in a sector-specific index of national input prices, called a "market basket index." Forecasts of these indexes approximate how much providers' costs are projected to change in the coming year if the quality and mix of inputs they use to furnish care remains constant—that is, if there were no change in efficiency. Other factors considered may include the trends in actual cost growth, as well as anticipated effects of policy changes. For clinician services, we consider a CMS-derived weighted average of price changes for inputs used to provide clinician services (the Medicare Economic Index), inclusive of productivity changes, but are unable to estimate margins because clinicians do not submit cost reports.

Recommendations for FFS Medicare payment in 2027

The Commission's assessments about payment adequacy, policy changes in the intervening years, and expected cost changes result in an update recommendation for each FFS payment system. The Commission does not start with any presumption that an update is needed or that any increase in costs should automatically be offset by a payment update. An update recommendation is the amount (usually expressed as a percentage change) by which the base payment for all providers in a FFS payment system is changed. Sometimes, these recommendations are expressed relative to the level in the prior year. For example, if the statutory base payment for a sector was \$100 in 2026, an update recommendation of a 1 percent increase to the 2026 base payment rate for a sector means that we are recommending that the base payment in 2027 for that sector be 1 percent greater, or \$101. Alternatively, they may be expressed relative to current law. For example, if the statutory payment update under current law were 2 percent for 2027 and our recommendation called for an update of 0.5 percent above the current-law amount, that would result in a payment update of 2.5 percent in 2027.

If adopted, the Commission's recommendations may result in an increase, decrease, or no change in payment levels relative to current law. When indicators of payment adequacy are positive and Medicare's payments are substantially above costs, the Commission often recommends a reduction in payment levels relative to current law to promote greater value for Medicare program resources. Alternatively, if indicators of payment adequacy are mixed or negative, the Commission may recommend increased payments to ensure beneficiary access to high-quality care. These recommendations inherently involve judgment and weighing many factors.

When our recommendations differ from current law or regulation, as they often do, the Congress or the Secretary of Health and Human Services must actively change law or regulation to implement them. The Congress and the Secretary are under no obligation to adopt the Commission's recommendations; in the absence of other action from the Congress and/or the Secretary, current law continues to apply.

Budgetary consequences

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Commission to consider the budgetary consequences of our recommendations. Therefore, this report includes information about how spending for each recommendation would compare with expected spending under current law. The Commission contends

that FFS Medicare payment rates should achieve access to high-quality care for FFS beneficiaries by efficiently allocating the resources funded by taxpayers and beneficiary premiums. Our recommendations are not driven by any specific budget target but instead reflect our assessment of the level of payment needed to ensure that FFS beneficiaries have access to high-quality, appropriate care delivered efficiently. ■

Endnotes

- 1

The Medicare Payment Advisory Commission is authorized under Title XVIII of the Social Security Act.
- 2

The results of this survey are described in more detail in Chapter 4 of this report.
- 3

Some policies have been extended beyond the expiration of the PHE.
- 4

In most cases, we assess FFS Medicare margins for the services furnished in a single sector (e.g., SNF or home health care services) and covered by a specific payment system. However, in the case of hospitals, we include in our FFS Medicare margin all services paid under either the inpatient or outpatient prospective payment systems (see Chapter 3 for more detail). The hospital update recommendation in Chapter 3 applies to hospital inpatient and outpatient payments; the updates for other distinct units of the hospital, such as SNFs, are covered in separate chapters.
- 5

For-profit providers may prefer to keep costs low to maximize returns to stockholders and, indeed, often have higher FFS Medicare margins than similar nonprofit providers.
- 6

These indexes are estimated quarterly; we use the most recent estimate available when we conduct our analyses.

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C H A P T E R

3

Hospital inpatient and outpatient services

R E C O M M E N D A T I O N

- 3** The Congress should:
- for 2027, update the 2026 Medicare base payment rates for general acute care hospitals by the amount specified in current law; and
 - implement the Medicare Safety-Net Index (MSNI) described in our March 2023 report, with \$1 billion added to the MSNI pool.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 2 • ABSENT 0

Hospital inpatient and outpatient services

Chapter summary

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, fee-for-service (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.

Assessment of payment adequacy

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.

In this chapter

- Are FFS Medicare payments adequate in 2026?
- How should FFS Medicare payments change in 2027?
- Mandated report: Rural emergency hospitals
- Medicare should move toward more site-neutral payments

Beneficiaries' access to care—Indicators of beneficiaries' access to hospital inpatient and outpatient services suggest that FFS Medicare beneficiaries maintained good access.

- **Capacity and supply of providers**—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. The supply of hospitals was relatively steady, though eight more hospitals closed than opened in each of 2024 and 2025.
- **Volume of services**—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 Medicare Advantage 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.)

How should FFS Medicare payments change in 2027?

Because some of our payment indicators are intertwined between the IPPS and OPPS 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 summer 2026, but CMS’s current forecasts and other required updates are currently 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.

Mandated report: 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 to cover REHs' standby costs.

Medicare should move toward 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 payment rates for services across hospital outpatient departments, ambulatory surgical centers, and/or freestanding offices when safe and appropriate and when doing so does not pose a risk to access. ■

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare’s traditional fee-for-service (FFS) payment systems. Such providers include general acute care hospitals, which 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.¹

Background

FFS Medicare makes two payments for hospital inpatient and outpatient services: one to the facility, generally through the inpatient prospective payment systems (IPPS) and the outpatient prospective payment system (OPPS), and the other to the clinicians for their professional services.² As with all FFS Medicare payment rates, IPPS and OPPS payment rates have important implications beyond FFS Medicare because Medicare Advantage (MA) and other payers rely upon FFS payment rates in setting their rates (see Chapter 2).

In setting these prospective rates per inpatient stay or primary outpatient service, CMS adjusts IPPS and OPPS national base payment rates for factors generally outside of hospitals’ control, such as regional wage rates and patient characteristics. Both the IPPS and OPPS also include other payments not tied to the base payment rates: The IPPS includes uncompensated-care payments (based in part on each hospital’s share of uncompensated-care costs), and the OPPS sets payment rates for separately payable drugs and other inputs (based on manufacturers’ average sales price for drugs and on hospitals’ costs for most other separately payable inputs). (FFS Medicare payments for all drugs and other inputs provided in the inpatient setting and for some drugs and other inputs provided in outpatient settings are bundled with the payment for the inpatient stay or primary outpatient service.³)

In 2024, the FFS Medicare program and its beneficiaries spent \$185 billion on IPPS and OPPS services at general acute care hospitals (Table 3-1). Over \$110 billion of this spending was on 6.5 million inpatient stays, including nearly \$6 billion in uncompensated-care payments under the IPPS. The other nearly \$75 billion

TABLE 3-1 In 2024, FFS Medicare and its beneficiaries spent \$185 billion on IPPS and OPPS services at general acute care hospitals

	Medicare payment system	
	IPPS	OPPS
Number of hospitals	3,095	3,060
Number of users (in millions)	4.2	15.8
Volume of services (in millions)	6.5	70.8
Total Medicare payments (in billions)	\$110.5	\$74.8
Payments for base-rate-covered services (in billions)	\$104.6	\$52.7
Other payments (in billions)	\$5.9	\$22.0
Beneficiary cost-sharing liability as share of total Medicare payments	7%	17%

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), OPPS (outpatient prospective payment system). “General acute care hospitals” refers to hospitals paid under the IPPS (in the case of the IPPS) or Subsection (d) hospitals paid under the OPPS (in the case of the OPPS). “Number of hospitals” is the count of unique provider numbers that provided at least one IPPS or OPPS service; the number of IPPS hospitals is higher than the number of OPPS hospitals primarily because Indian Health Service hospitals are paid under the IPPS but not OPPS. “Volume of services” refers to inpatient stays (in the case of the IPPS) and hospital outpatient encounters (in the case of the OPPS) where Medicare was the primary payer. “Total Medicare payments” includes the program amount and beneficiary cost-sharing liability (which may be paid by the beneficiary or the beneficiary’s supplemental insurance, or it may become hospital bad debt). “Other payments” refers to uncompensated-care payments (in the case of the IPPS) and to payments for separately payable drugs, devices, blood products, and brachytherapy sources (in the case of the OPPS). The given year (2024) refers to fiscal year for inpatient services and calendar year for outpatient services, consistent with when CMS updates these payment systems.

Source: MedPAC analysis of Medicare Provider Analysis and Review, outpatient claims, and IPPS and OPPS final-rule data.

was for 70.8 million hospital outpatient encounters, including \$22 billion for separately payable drugs and other separately payable inputs under the OPPI. FFS beneficiaries' cost-sharing liability totaled 7 percent of IPPS payments and 17 percent of OPPI payments. Over 20 percent of all acute inpatient stays (and days) at hospitals were FFS Medicare stays paid under the IPPS, and 17 percent of all hospital outpatient services (as measured by charges) were FFS Medicare services paid under the OPPI. Together, IPPS and OPPI payments accounted for about 13 percent of hospitals' operating revenue across all service lines (data not shown).⁴

Are FFS Medicare payments adequate in 2026?

Based on the most recently available data, indicators of the adequacy of IPPS and OPPI payments have been mixed. FFS Medicare beneficiaries maintained good access to hospital inpatient and outpatient services: Hospitals continued to have available capacity in aggregate, the supply of hospitals was relatively steady in both fiscal year (FY) 2024 and FY 2025, and FFS Medicare beneficiaries' inpatient stays and hospital outpatient encounters per beneficiary increased. In addition, hospitals' access to capital improved: Hospitals' all-payer operating margin increased to 6.5 percent in 2024, and preliminary data suggest a continued increase in 2025. However, the quality of hospital care was mixed: FFS Medicare beneficiaries' risk-adjusted mortality rate improved in 2024, but their readmission rate worsened, and most patient-experience measures remained stable. Hospitals' FFS Medicare margin remained negative but increased to -12.1 percent in aggregate and to -1 percent for the median relatively efficient hospital. For 2026, we project hospitals' FFS Medicare margin to increase to about -10 percent in aggregate and to 1 percent for the median relatively efficient hospital.

Beneficiaries maintained good access to hospital inpatient and outpatient services in 2024

Indicators of hospital capacity and supply and FFS Medicare beneficiaries' use of services suggest that FFS Medicare beneficiaries maintained good access to hospital inpatient and outpatient services. In FY

2024, hospitals continued to have available capacity in aggregate. The supply of hospitals was also relatively steady in both FY 2024 and FY 2025. Looking more specifically at FFS Medicare beneficiaries, the number of inpatient stays per beneficiary and hospital outpatient encounters per beneficiary both increased.

Hospitals continued to have available capacity

In FY 2024 hospitals continued to have available inpatient capacity in aggregate (Table 3-2). The number of inpatient beds remained relatively stable at about 674,000 in FY 2024. Similarly, hospitals' occupancy rate remained relatively stable at about 71 percent, indicating available inpatient capacity in aggregate. However, as in past years, there was significant variation within these aggregates, with some hospitals having substantially higher available capacity while others faced capacity constraints. For example, in FY 2024, 5 percent of hospitals had an occupancy rate under 13 percent while another 5 percent had an occupancy rate over 90 percent; this variation was similar to FY 2023 (data not shown).

Hospital outpatient capacity is harder to measure, but two measures of timely and effective care suggest hospitals continued to have available emergency department (ED) capacity (Table 3-2). The median time from patients' ED arrival to departure remained stable at about 150 minutes in FY 2024. While the median time is 15 minutes higher than in 2019, it still suggests available ED capacity, especially as the median share of patients who left the ED without being seen has remained steady at 1 percent to 2 percent from calendar year (CY) 2019 through CY 2023 (the most recent year of data currently available for that measure).

Overall hospital employment also continued to increase, reaching 4.8 million full-time-equivalent staff in FY 2024 (Table 3-2).

Supply of hospitals held relatively stable, though slightly more hospitals closed than opened

Since 2021 the supply of hospitals has been relatively stable, with about 4,530 unique provider numbers in FY 2024 (Table 3-3, p. 70). Most hospitals continued to be short-term acute care hospitals, virtually all of which were paid by FFS Medicare under the IPPS and OPPI.⁵ However, FFS Medicare beneficiaries also received care at 1,370 critical access hospitals, which are hospitals

**TABLE
3-2****In FY 2024, hospitals continued to have available capacity in aggregate**

	2019	2020	2021	2022	2023	2024
Beds (in thousands)	675	674	677	675	671	674
Occupancy rate	67%	64%	68%	70%	70%	71%
Median time from ED arrival to departure (in minutes)	135	137	147	153	152	150
Median share of patients that left ED without being seen	1%	1%	2%	2%	1%	N/A
Employment (in millions)	4.5	4.5	4.5	4.6	4.6	4.8

Note: FY (fiscal year), ED (emergency department), N/A (not available). "Hospitals" refers to Subsection (d) hospitals as well as critical access hospitals and short-term acute care hospitals in territories. "Beds" refers to inpatient beds, regardless of what share of the time the bed was used for observation or swing-bed services or the share of time the bed was staffed. "Occupancy rate" refers to the share of bed days that were occupied by a patient. "Median time from ED arrival to departure" refers to the median across hospitals' reported median time that patients spent from ED arrival to ED departure for patients who were discharged from the ED. "Median share of patients that left the ED without being seen" is the median across hospitals' reported median share of patients who left the ED without being seen by qualified medical personnel (physician, physician's assistant, or advanced practice nurse) and is reported on a calendar year basis; 2024 data for this measure were not available at the time of our analysis. "Employment" refers to the average number of paid full-time-equivalent employees over hospitals' cost-reporting periods. To account for hospitals that had not yet submitted 2024 cost reports as of the time of our analysis, missing 2024 data were imputed for employment and beds. Data for ED measures include hospitals with a complete cost report in a prior year.

Source: MedPAC analysis of hospital cost-report and CMS timely and effective care data.

with 25 or fewer beds that are generally located in rural areas and paid based on their costs. Additionally, since 2023, FFS Medicare beneficiaries also receive care at a new type of hospital called a "rural emergency hospital" (REH). REHs are required to provide 24/7 ED services but are prohibited from furnishing acute inpatient care (see section at the end of this chapter on REHs, pp. 87–88). The majority of hospitals continued to be located in urban areas and be nonprofit, and the number of nonprofit hospitals has continued to increase.

However, changes in the count of hospital provider numbers that provided FFS Medicare inpatient and outpatient services is an imperfect measure of changes in beneficiary access. For example, decreases in provider numbers can also reflect mergers and acquisitions without any change in the locations where beneficiaries can receive hospital services. On the other hand, hospitals opening new campuses can result in an increase in access without any change in the count of hospital provider numbers.

We therefore also look at changes in unique hospital locations where beneficiaries can receive hospital inpatient and emergency and other outpatient care; by this metric, eight more hospitals closed than opened in

both FY 2024 and FY 2025 (Table 3-4, p. 71). In FY 2024, 5 hospitals opened at some point in the year while 13 closed. Of the five hospitals that opened, four were in metropolitan areas and three were for-profit facilities. Of the 13 hospitals that closed, 7 were in metropolitan areas and 8 were nonprofit facilities. In FY 2025, an additional 10 hospitals opened and 18 closed. Of the 10 hospitals that opened, 9 were in metropolitan areas, none were critical access hospitals, and the distance to the nearest hospital ranged from 1 mile to about 32 miles (some data not shown). Of the 18 hospitals that closed, 14 were located in metropolitan areas, 5 had fewer than 50 beds, and none were critical access hospitals. In addition, 13 of the closures were in 12 hospital systems. The average distance to the next-nearest hospital was 11 miles; three rural closures were at least 25 miles from the next hospital. The ability of hospitals to transition to REHs has likely prevented a number of rural hospital closures since 2023. Among the three rural nonmetropolitan hospitals that closed in FY 2025 (all of which were at least 25 miles from the next hospital), one is working to reopen as an REH, and the other two were not eligible to become an REH because they were not open in December 2020 (a condition for REH eligibility).

TABLE
3-3

In FY 2024, the supply of hospitals held relatively stable

Hospital category	Unique provider numbers (rounded to nearest 10)						Average annual percent change	
	2019	2020	2021	2022	2023	2024	2019–2023	2023–2024
All	4,620	4,590	4,550	4,550	4,550	4,530	–0.4%	–0.6%
Type								
Short-term acute care	3,280	3,230	3,210	3,200	3,170	3,120	–0.8	–1.7
Critical access	1,350	1,350	1,350	1,350	1,360	1,370	0.2	0.7
Rural emergency	0	0	0	0	20*	40*	N/A	100*
Geography								
Metropolitan	2,780	2,750	2,740	2,730	2,720	2,710	–0.5	–0.4
Micropolitan	820	810	800	800	800	790	–0.5	–0.9
Other rural	1,030	1,020	1,020	1,020	1,040	1,020	0.1	–1.0
Ownership								
For profit	890	860	840	820	800	760	–2.7	–4.6
Nonprofit	2,720	2,710	2,720	2,740	2,750	2,770	0.3	0.7
Government	1,020	1,010	1,000	990	1,000	990	–0.3	–1.1

Note: FY (fiscal year), N/A (not applicable). “Supply of hospitals” refers to the count of provider numbers for hospitals (Subsection(d) hospitals, critical access hospitals, rural emergency hospitals, and short-term acute care hospitals in territories) that provided both at least one inpatient service to a fee-for-service (FFS) Medicare beneficiary in that fiscal year (or was a rural emergency hospital) and at least one outpatient service to a FFS Medicare beneficiary in that calendar year. “Metropolitan” (urban) counties contain an urban cluster of 50,000 or more people; “micropolitan” rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as “other rural.” Components may not sum to totals due to rounding. Percentage changes were calculated on unrounded data.

* For unrounded count of REHs on a calendar year basis, see p. 88.

Source: MedPAC analysis of Medicare Provider Analysis and Review, hospital outpatient claims, hospital cost-report, Provider of Services, and census geographic data.

According to hospital press releases and news reports, FFS Medicare payment rates did not appear to be the main contributor to the financial difficulties of the hospitals that closed in 2024 or 2025. Rather, many hospitals that closed cited other financial reasons; low patient volume was the most common.⁶

FFS Medicare beneficiaries’ inpatient services per capita increased

In FY 2024, FFS Medicare beneficiaries had 208.3 inpatient stays per 1,000 beneficiaries, an increase of 1.5 percent from 2023 (Table 3-5). (In contrast,

the number of inpatient stays by FFS Medicare beneficiaries declined 0.4 percent in FY 2024 because the number of FFS Medicare beneficiaries decreased by more than the number stays per beneficiary increased.) Despite the increase in 2024, the number of inpatient stays per capita remained nearly 15 percent below the level in 2019. About one-quarter of the decline in inpatient stays per capita since 2019 was from the shift of knee and hip replacements from inpatient to outpatient settings after these services were removed from the inpatient-only list in 2018 and 2020, respectively (data not shown).

**TABLE
3-4****In both FY 2024 and FY 2025, slightly more hospitals closed than opened**

	2019	2020	2021	2022	2023	2024	2025
Net openings	-31	-8	1	2	-9	-8	-8
Openings	12	16	11	17	7	5	10
Metropolitan	12	14	10	13	5	4	9
Rural micropolitan	0	1	0	2	0	1	0
Other rural	0	1	1	2	2	0	1
Closures	43	24	10	15	16	13	18
Metropolitan	25	13	7	10	9	7	14
Rural micropolitan	4	6	1	5	4	1	1
Other rural	14	5	2	0	3	5	3

Note: FY (fiscal year). "Hospital" refers to a Subsection (d), critical access, or rural emergency hospital. "Openings" refers to a new location that provided inpatient and outpatient services, while "closures" refers to a hospital location that ceased inpatient services and did not convert to a rural emergency hospital. "Metropolitan" (urban) counties contain an urban cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." The counts of openings and closures do not include the conversion of a short-term acute care hospital to or from a critical access hospital or rural emergency hospital, the relocation of inpatient services from one hospital to another under common ownership within 10 miles, or hospitals that both opened and closed within a five-year period. The number of hospital openings and closures in a given year can change from prior publications as hospitals reopen and newer data become available.

Source: MedPAC analysis of Provider of Services and census geographic data and internet searches.

The majority of the growth in FFS Medicare inpatient stays per capita in FY 2024 was from stays for infectious and parasitic diseases and for diseases of the kidney and urinary tracts (data not shown). In particular, stays for blood poisoning (septicemia) continued to be the most common type of inpatient patient stay and disproportionately increased relative to other types of stays. Inpatient stays for diseases

of the circulatory system continued to be the most common major diagnostic category, but its share of volume declined in 2024, led by a decline in inpatient stays for heart failure. The decrease in the average length of stay in 2024 was driven by a decline in the share of inpatient stays longer than one week (from 18.8 percent of stays in 2023 down to 18.2 percent of stays in 2024).

**TABLE
3-5****FFS Medicare beneficiaries' hospital inpatient stays per capita increased in FY 2024**

	2019	2020	2021	2022	2023	2024	Average annual percent change	
							2019–2023	2023–2024
Inpatient stays (millions)	9.2	7.9	7.4	7.0	6.9	6.9	-6.9%	-0.4%
Inpatient stays per 1,000 beneficiaries	244.5	213.6	207.7	202.2	205.2	208.3	-4.3	1.5
Average length of stay (days)	4.9	5.1	5.5	5.6	5.3	5.2	1.9	-2.1

Note: FFS (fee-for-service), FY (fiscal year). "Hospital" refers to Subsection (d) hospitals as well as critical access hospitals and short-term acute care hospitals in territories. "Inpatient stays per 1,000 beneficiaries" refers to FFS Medicare inpatient stays divided by all FFS Medicare beneficiaries who resided in the U.S. and had Part A. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of Medicare Provider Analysis and Review and Common Medicare Environment data.

**TABLE
3-6**

FFS Medicare beneficiaries' hospital outpatient encounters increased in CY 2024

							Average annual percent change	
	2019	2020	2021	2022	2023	2024	2019–2023	2023–2024
Outpatient encounters (millions)	93.7	75.7	91.5	82.1	81.0	82.2	–3.6%	1.5%
Outpatient encounters per beneficiary	2.9	2.4	3.0	2.8	2.9	3.0	0.1	4.0

Note: FFS (fee-for-service), CY (calendar year). "Hospital" refers to Subsection (d) hospitals as well as critical access hospitals and short-term acute care hospitals in territories. "Outpatient encounters" are unique combinations of claims, beneficiaries, and providers, where the claim included at least one outpatient-prospective-payment-system (OPPS)-equivalent service. "Outpatient encounters per beneficiary" refers to FFS Medicare outpatient encounters divided by all FFS Medicare beneficiaries who resided in the U.S. and had Part B. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of hospital outpatient claims, OPPS final rule, and Common Medicare Environment data.

FFS Medicare inpatient stays continued to be predominantly provided by urban hospitals and nonprofit hospitals, and the share of volume provided by these hospitals continued to slowly increase. In FY 2024, nearly 90 percent of FFS Medicare inpatient stays were provided by hospitals located in urban areas (up from 88 percent in 2019). Similarly, in FY 2024, nearly 75 percent of FFS Medicare inpatient stays were provided by nonprofit hospitals (up from 72 percent in 2019).

FFS Medicare beneficiaries' hospital outpatient encounters per capita increased

In CY 2024, FFS Medicare beneficiaries had 3.0 hospital outpatient encounters per beneficiary, an increase of 4.0 percent from 2023 (Table 3-6). (The number of outpatient encounters by FFS Medicare beneficiaries increased by a smaller amount, 1.5 percent because the number of FFS Medicare beneficiaries declined.) In contrast to inpatient stays, the number of outpatient encounters per capita quickly rebounded from the decline in 2020 and in each of 2021 through 2024 was in line with the 2019 level (within 0.1 encounters per beneficiary).

The majority of the growth in FFS Medicare hospital outpatient encounters per capita in CY 2024 was from an increase in evaluation and management services. In particular, clinic services continued to be the most common primary service, and they disproportionately increased relative to other outpatient services.

However, all other categories of hospital outpatient services also increased in CY 2024, led by imaging and tests. There was also continued growth in outpatient services per encounter, driven by growth in ancillary services that are always packaged under the OPPS, such as X-rays.

FFS Medicare hospital outpatient encounters continued to be predominantly provided by urban hospitals and nonprofit hospitals, and the share of volume provided at these hospitals continued to slowly increase. In CY 2024, 83 percent of FFS Medicare hospital outpatient encounters were provided by hospitals located in urban areas (up from 82 percent in 2019). Similarly, in CY 2024, 77 percent of FFS Medicare hospital outpatient encounters were provided by nonprofit hospitals (up from 73 percent in 2019).

A growing share of FFS Medicare hospital outpatient encounters occur in off-campus provider-based departments or off-campus emergency rooms—defined as locations not on or within 250 yards of a hospital campus or remote location of a hospital. In CY 2024, nearly 20 percent of FFS Medicare hospital outpatient encounters were provided at off-campus locations (up from 17 percent in 2019).

Quality of hospital care in 2024 was mixed

In FY 2024, the quality of hospital care was mixed relative to 2023. FFS Medicare beneficiaries' risk-

**TABLE
3-7**

FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved in FY 2024 and relative to prepandemic level

	2019	2020	2021	2022	2023	2024	Percentage point change	
							2019–2023	2023–2024
Risk adjusted	7.9%	8.4%	8.4%	7.9%	7.6%	7.4%	–0.3	–0.2
Unadjusted	8.2	9.8	11.3	10.6	9.4	9.1	1.2	–0.3

Note: FFS (fee-for-service) FY (fiscal year). "Hospital" refers to hospitals paid under the inpatient prospective payment systems. "Mortality rate" refers to the share of inpatient stays that result in death during or within 30 days after the inpatient stay.

Source: MedPAC analysis of Medicare Provider Analysis and Review data.

adjusted hospital mortality rate improved, while their risk-adjusted readmission rate worsened. Most patient-experience scores remained the same.

Hospital mortality rate improved

Mortality during or soon after a hospital stay (e.g., within 30 days) is an outcome measure that provides information about important aspects of hospital care, such as prevention of and response to complications, emphasis on patient safety, and the timeliness of care. It also encourages hospitals to effectively discharge plan and coordinate with post-acute care providers. Risk-adjusted mortality can be determined with a high degree of accuracy through claims, reducing administrative burden on providers.

In FY 2024, FFS Medicare beneficiaries' risk-adjusted hospital mortality rate—defined as the share of inpatient stays that result in death during or within 30 days after the inpatient stay—improved to 7.4 percent, 0.2 percentage points lower than the level in 2023 and 0.5 percentage points lower than in 2019 (Table 3-7). Both unadjusted and risk-adjusted hospital mortality rates for FFS Medicare beneficiaries have improved since 2021.

FFS Medicare beneficiaries' mortality rate continued to vary across hospital categories. In FY 2024, hospitals in rural nonmicropolitan areas continued to have a higher risk-adjusted mortality rate (9.2 percent) compared

with hospitals in rural micropolitan (8.1 percent) and hospitals in urban areas (7.3 percent) (data not shown). When stratifying results by bed size, smaller hospitals (those with fewer than 100 beds) also continued to have the highest risk-adjusted mortality rate (7.8 percent), while larger hospitals (those with more than 250 beds) had the lowest risk-adjusted mortality rate (7.3 percent) in 2024. In 2024, for-profit hospitals continued to have higher risk-adjusted mortality rates (7.6 percent) than nonprofit hospitals (7.3 percent), and major teaching hospitals continued to have higher risk-adjusted mortality rates (7.5 percent) than nonteaching hospitals (7.1 percent).

Hospital-readmission rate worsened

Acute, unplanned hospital readmissions are disruptive to patients and caregivers, costly to the health care system, and put patients at additional risk of health care-associated infections and complications. Such readmissions can also be a major source of patient and family stress and may contribute substantially to loss of functional ability, particularly in older adults. Measuring hospitals' readmission rates holds hospitals accountable for ensuring that beneficiaries have the discharge information they need and encourages hospitals to coordinate with other providers. Like the mortality measure, the readmission measure is important to and understandable by beneficiaries and can be calculated through claims data, reducing administrative burden on providers.

**TABLE
3-8**

FFS Medicare beneficiaries' risk-adjusted hospital readmission rate worsened in FY 2024 but remained better than prepandemic level

	2019	2020	2021	2022	2023	2024	Percentage point change	
							2019–2023	2023–2024
Risk adjusted	15.5%	15.0%	14.7%	14.6%	15.1%	15.4%	–0.4	0.3
Unadjusted	15.7	15.5	15.8	15.6	15.7	15.9	0.0	0.2

Note: FFS (fee-for-service), FY (fiscal year). "Hospital" refers to hospitals paid under the inpatient prospective payment systems. "Readmission rate" refers to the share of inpatient stays that result in a readmission for any condition within 30 days after the initial inpatient stay. Results differ from those published in prior years because of minor methodological updates.

Source: MedPAC analysis of Medicare Provider Analysis and Review data.

In FY 2024, FFS Medicare beneficiaries' risk-adjusted hospital-readmission rate worsened (increased) by 0.3 percentage points to 15.4 percent; however, it remained 0.1 percentage points lower than in 2019 (Table 3-8). (For information on our risk-adjustment methodology, see Chapter 1 of MedPAC's June 2018 report to the Congress.) The unadjusted readmission rate increased by 0.2 percentage points from 2023 to 2024.

FFS Medicare beneficiaries' readmission rate continued to vary across hospital categories. In 2024, hospitals in urban areas continued to have a higher risk-adjusted readmission rate (15.5 percent) compared with hospitals in rural micropolitan and nonmicropolitan areas (14.7 percent) (data not shown). When stratifying results by bed size, larger hospitals continued to have the highest risk-adjusted readmission rates (15.6 percent), while small hospitals had the lowest risk-adjusted readmission rate (14.4 percent). In 2024, for-profit hospitals continued to have higher risk-adjusted readmission rates (16.1 percent) than nonprofit hospitals (15.3 percent), and nonteaching hospitals continued to have higher risk-adjusted readmission rates (16.0 percent) than major teaching hospitals (15.1 percent).

Most patient-experience measures remained stable

Hospitals collect Hospital Consumer Assessment of Healthcare Providers and Systems (H-CAHPS) surveys

from a sample of admitted patients, which CMS uses to calculate results for 10 measures of patient experience included in hospitals' overall ratings. The H-CAHPS measures key components of quality by assessing whether something that should happen during a hospital stay (such as clear communication) actually happened or how often it happened.

Almost all hospital patient-experience measures remained stable from FY 2023 to FY 2024, but performance remained at least 1 percentage point below prepandemic levels for almost all measures (Table 3-9). In FY 2024, 72 percent of surveyed patients rated their overall hospital experience a 9 or 10 on a 10-point scale, consistent with FY 2023 but still a percentage point below 2019.⁷ Receipt of discharge information had the highest score: 86 percent of surveyed patients answered with the most positive response. The care-transition measure continued to get the lowest score, with only 52 percent of surveyed patients "strongly agreeing" that they understood their care plan when they left the hospital.

Hospitals' patient-experience performance continued to vary across hospital categories. Hospitals in rural areas have better (higher) H-CAHPS results than hospitals in urban areas (HCAHPS Online 2025). For example, 75 percent of surveyed patients who received care in a rural hospital rated their overall hospital experience a 9 or 10, while 70 percent of surveyed patients who received care in an urban

**TABLE
3–9**

Most hospital patient-experience measures remained the same in FY 2024 but below prepandemic levels

H–CAHPS measure	2019	2020	2021	2022	2023	2024	Percentage point change	
							2019–2023	2023–2024
Share of patients rating the hospital a 9 or 10 out of 10	73%	72%	72%	70%	72%	72%	–1	0
Share of patients who would definitely recommend the hospital	72	71	71	69	70	70	–2	0
Share of patients giving top ratings for:								
Communication with nurses	81	80	80	79	80	80	–1	0
Communication with doctors	82	81	80	79	80	80	–2	0
Responsiveness of hospital staff	70	67	67	65	66	66	–4	0
Communication about medicines	66	63	63	61	62	62	–4	0
Cleanliness of hospital environment	76	73	73	72	73	74	–3	1
Quietness of hospital environment	62	63	63	62	62	62	0	0
Understanding their care when they left the hospital (care transitions)	54	52	52	51	52	52	–2	0
Share of patients who received discharge information	87	86	86	86	86	86	–1	0

Note: FY (fiscal year). “Patient-experience measures” refers to measures in the Hospital Consumer Assessment of Healthcare Providers and Systems (H–CAHPS) survey, a standardized 29-item survey of patients’ evaluations of hospital care. The survey items are combined to calculate measures of patient experience for each hospital. The H–CAHPS measures included in the table are “top box,” or the most positive, response to H–CAHPS survey items. Each year’s results are based on a sample of surveys of hospitals’ patients from October to September. Results in 2020 include surveys only from patients discharged July to December 2020 rather than the customary full year. These results encompass H–CAHPS survey responses from inpatient prospective payment systems hospitals (that are penalized if they do not participate) as well as critical access hospitals, cancer hospitals, and Veterans Affairs or Department of Defense hospitals that voluntarily participate. National H–CAHPS response rates from 2019 to 2024 ranged from 23 percent to 26 percent.

Source: CMS summary of H–CAHPS survey-results tables.

hospital rated their overall hospital experience highly (data not shown). Nonprofit hospitals have modestly higher H–CAHPS results than for-profit hospitals on most measures, other than the respective measures of cleanliness and quietness in the hospital. In FY 2024, smaller hospitals (based on number of beds) consistently had better H–CAHPS results than larger hospitals, as did nonteaching hospitals (compared with major teaching hospitals).

While H–CAHPS surveys a sample of all hospital patients, not just Medicare patients, the patient-experience metrics have tended to be inversely correlated with FFS Medicare beneficiaries’ risk-

adjusted mortality and readmission rates (data not shown). This relationship suggests that the quality measures are consistent: Hospitals with higher patient-experience ratings tended to have better (that is, lower) FFS Medicare mortality and readmission rates.

Medicare should move toward a single value-based incentive payment program

In March 2019, the Commission recommended that the Congress replace Medicare’s current hospital quality programs (including the penalty-only programs) with a single, outcome-focused quality-based payment program for hospitals—that is, the hospital value

**TABLE
3-10****Hospitals' all-payer operating margin increased across all hospital categories in FY 2024, though substantial variation persisted**

Margin type and hospital category	2019	2020	2021	2022	2023	2024
Excluding relief funds						
All	6.7%	2.0%	7.4%	1.9%	4.9%	6.4%
Ownership						
For profit	12.3	10.7	14.3	12.4	13.3	14.5
Nonprofit	6.2	1.2	6.9	0.1	4.1	5.8
Geography						
Metropolitan	6.8	2.1	7.5	2.1	5.1	6.5
Micropolitan	5.0	1.2	6.4	-0.7	2.5	5.1
Other rural	1.3	-1.8	2.9	-2.5	-1.3	1.3
Including relief funds						
All	6.7%	5.5%	8.8%	2.7%	5.2%	6.5%
Ownership						
For profit	12.3	13.0	15.4	12.8	13.5	14.5
Nonprofit	6.2	4.8	8.3	0.9	4.4	5.9
Geography						
Metropolitan	6.8	5.5	8.8	2.8	5.4	6.6
Micropolitan	5.0	5.7	8.8	1.2	2.9	5.3
Other rural	1.3	3.9	7.8	0.9	-0.7	1.5

Note: FY (fiscal year). "Hospitals" refers to hospitals paid under the inpatient prospective payment systems. "All-payer operating margin" excludes reported investment and donation income. "Relief funds" refers to federal or other coronavirus relief funds. "Metropolitan" (urban) counties contain an urban cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Government-owned hospitals operate in a different financial context from other hospitals, so their margin is not necessarily comparable; therefore, data for government-owned hospitals are not reported separately or included in the ownership rows (but are included in other rows). Results differ from those published last year in part because of newer data.

Source: MedPAC analysis of hospital cost-report and census geographic data.

incentive program (HVIP)—which balances rewards and penalties and has the potential to drive further improvement in hospital quality (Medicare Payment Advisory Commission 2019). A single HVIP would also reduce complexity and overlap between existing Medicare hospital quality programs and would reduce the reporting burden for providers.

Hospitals' access to capital improved in 2024

Hospitals access to capital—which can be used to maintain, modernize, and expand their facilities—improved in FY 2024, and preliminary data suggest continued improvement in 2025. Other measures of

hospitals' access to capital also improved or remained positive in both FY 2024 and FY 2025.

Hospitals' all-payer margin increased

Hospitals' all-payer operating margin (including coronavirus relief funds) increased 1.3 percentage points in FY 2024, to 6.5 percent, indicating that hospitals had net operating profits that could be used for hospital capital projects (Table 3-10).⁸ (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) The 6.5 percent operating margin in 2024 was near the level in the immediate prepandemic period (6.7 percent in 2019). As in prior years, there was significant variation within this aggregate. In FY 2024, a quarter of hospitals

had an all-payer operating margin below -2 percent, while another quarter had a margin above 12 percent; both of these levels were about 2 percentage points higher than in 2023 (data not shown).

Several factors contributed to the 1.3 percentage point increase in hospitals' all-payer operating margin in FY 2024, including a one-time increase in revenue and slower growth in hospitals' labor costs. A subset of hospitals received \$9 billion in 340B remedy payments from Medicare in 2024 to offset lower Medicare payment rates for drugs obtained through the 340B Drug Pricing Program from CY 2018 to CY 2021; we estimate that about half of the increase in hospitals' operating margin in 2024 was from these one-time remedy payments. (The payment reduction to offset higher Medicare payments for nondrug services in CY 2018 through CY 2022 began in CY 2026 and so is not reflected in hospitals' 2024 margin.) Another contributing factor to the increase in margin was slower growth in hospitals' labor costs in 2024 (less than 2 percent growth in 2024 vs. about 9 percent growth in 2023); this slower growth was driven by an \$8 billion decrease in hospitals' spending on direct patient-care contract labor (a decline of about 25 percent from 2023). One partially offsetting factor putting downward pressure on hospitals' all-payer operating margin was a \$0.8 billion decrease in coronavirus relief funds (from \$3 billion in 2023 to \$2.2 billion in 2024).

Hospitals' all-payer operating margin continued to vary across hospital categories (Table 3-10). For-profit hospitals' all-payer operating margin continued to be much higher than nonprofit hospitals' margin (14.5 percent vs. 5.9 percent, including relief funds). One factor contributing to for-profit hospitals' higher all-payer operating margin is their lower average hourly wage. The all-payer operating margin also continued to be higher at urban hospitals than at hospitals in rural nonmicropolitan areas (6.6 percent vs. 1.5 percent, respectively).

While cost reports were complete only through FY 2024, financial statements from large hospital systems suggest that hospitals' all-payer operating margin continued to gradually increase in FY 2025. The all-payer operating margin among three for-profit and five nonprofit hospital systems—which together represented over 20 percent of hospitals—increased

by about 1 percentage point in 2025. Among the three largest for-profit health systems, the increase in all-payer operating margin varied from a 0.5 percentage point increase to a 2.5 percentage point increase (Community Health Systems 2025, HCA Healthcare 2025, Tenet Health 2025). The weighted average operating margins for these three for-profit systems was 12.8 percent during the first nine months of 2025. To explain what drove their improved margin, these for-profit systems cited reasons such as higher patient volume, increased payment rates, higher supplemental revenues, and lower contract-labor costs. Among the five selected large nonprofit hospital systems, the all-payer operating margin increased by about 1 percentage point in aggregate from July 30, 2024, to July 30, 2025 (the most recent period available), though again the experience of the individual systems varied (ranging from a 2.0 percentage point decrease to a 3.3 percentage point increase) (Advocate Health Care 2025, Ascension 2025, CommonSpirit 2025, Providence 2025, Trinity Health 2025). On a weighted average basis, these nonprofit systems had an operating profit margin of 0.3 percent during the period ending June 30, 2025. To explain what improved their margin, these systems primarily cited higher patient volume. To explain downward pressures on their margin, they cited inflation and the absence of the previous year's 340B settlement.

Other indicators of access to capital improved or remained positive

A second way hospitals access capital is through income from investments and donations, and such income increased in FY 2024. In FY 2024, hospitals reported over \$18 billion in investment income on their cost reports, an increase of nearly 40 percent, consistent with the U.S. stock market surging to record highs. Hospitals also reported \$2 billion in donation income, an increase of 3 percent. Together these components led hospitals' all-payer total margin to increase 1.5 percentage points (more than their operating margin), up to 7.9 percent. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) Moreover, despite some volatility, in FY 2025, the U.S. stock market rose to even higher levels, suggesting hospitals' investment income further increased in 2025.

A third way hospitals access capital is by issuing bonds, and hospitals' borrowing costs held stable in FY 2024

and FY 2025 while investors' risk premium on hospitals decreased, suggesting that investors see little risk of hospital defaults on their bonds (relative to the U.S. government). In FY 2024, hospitals' borrowing costs held stable: The yield on hospital municipal bonds remained about 4.4 percent on average in each of FY 2023, FY 2024, and FY 2025 (S&P Global 2025). Over this same period, the spread between hospitals' borrowing costs and borrowing costs in the general market declined slightly—falling from an average of 0.6 percentage points above the yield of 10-year treasury bonds in 2023 to about 0.2 percentage points in 2024 and 0.1 percentage points in 2025.

Hospital mergers and acquisitions also continued in FY 2024 and FY 2025, indicating that investors—including hospital systems—continue to be willing to put capital into acquiring hospitals. About 50 hospital deals were announced in FY 2024 and 35 in FY 2025 (Irving Levin Associates LLC 2025).

FFS Medicare payments to hospitals were lower than hospitals' costs in aggregate but near hospitals' costs for the median relatively efficient hospital

In FY 2024, FFS Medicare payments for inpatient and outpatient services continued to be well below hospitals' costs in aggregate: Hospitals' FFS Medicare margin was -12.1 percent. However, among a group of hospitals that historically achieved relatively low costs while maintaining relatively high quality (a group we refer to as “relatively efficient” hospitals), the median FFS Medicare margin increased to -1 percent. For 2026, we project hospitals' FFS Medicare margin to increase to about -10 percent in aggregate and to 1 percent for the median relatively efficient hospital.

Hospitals' FFS Medicare margin increased but remained negative

In FY 2024, hospitals' FFS Medicare margin increased to -12.1 percent (Table 3-11). (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) Consistent with the methodological updates implemented last year (see March 2025 Chapter 3, pp. 79–80), hospitals' FFS Medicare margin is limited to a comparison of their payments and costs for services paid under the IPPS and OPps.⁹ We focus our discussion on hospitals' FFS Medicare margin exclusive of coronavirus relief funds; however, we also report a version including

the FFS Medicare share of coronavirus relief funds because these funds were intended to cover lost revenue and higher costs—including those related to FFS Medicare patients. The 2024 FFS Medicare margin does not reflect the \$9 billion in one-time payments that Medicare paid hospitals in 2024 to offset lower payments for drugs acquired through the 340B Drug Pricing Program from 2018 to 2021. If we had included this \$9 billion, we estimate hospitals' 2024 FFS Medicare margin would have been -6.5 percent, or 5.4 percentage points higher. (The payment reduction to offset higher Medicare payments for nondrug services in CY 2018 through CY 2022 began in CY 2026 and so is not reflected in hospitals' 2024 margin.) As in prior years, there was significant variation within this aggregate. In FY 2024, a quarter of hospitals had a FFS Medicare margin below -21 percent, while another quarter had a margin above 3 percent (data not shown); both of these levels were slightly higher than in 2023. A higher FFS Medicare margin can reflect higher FFS Medicare payments and/or lower costs.

The 0.5 percentage point increase in hospitals' FFS Medicare margin in FY 2024 reflects several partially offsetting factors. Factors that put upward pressure on hospitals' FFS Medicare margin include growth in the share of FFS Medicare revenue from profitable separately payable drugs and the slower growth in hospitals' labor costs. These upward pressures on hospitals' FFS Medicare margin were partially offset by an about \$1 billion decline in uncompensated-care payments. While there are analytic challenges to calculating FFS Medicare margins separately for services paid under the IPPS and OPps, we approximate that, after excluding uncompensated-care payments, hospitals' FFS Medicare margin in 2024 was roughly similar for FFS Medicare patients across inpatient and outpatient settings.¹⁰

Hospitals' FFS Medicare margin continued to vary across hospital categories (Table 3-11). For-profit hospitals' FFS Medicare margin remained slightly positive and substantially higher than nonprofit hospitals' margin (1.1 percent vs. -13.4 percent, respectively), primarily because they have been able to constrain their labor and other costs (including having a lower average hourly wage). Rural hospitals' FFS Medicare margin also continued to exceed urban hospitals' margin, especially for rural hospitals in nonmetropolitan areas (-3.4 percent vs. -12.6 percent, respectively), primarily

**TABLE
3-11**

Hospitals' FFS Medicare margin increased in FY 2024 but remained substantially negative, and substantial variation across hospitals persisted

Margin type and hospital category	2019	2020	2021	2022	2023	2024
Excluding relief funds						
All	-7.9%	-12.2%	-8.2%	-12.8%	-12.6%	-12.1%
Ownership						
For profit	1.3	1.9	4.2	0.3	0.4	1.1
Nonprofit	-9.4	-14.6	-10.1	-14.6	-14.2	-13.4
Geography						
Metropolitan	-8.3	-12.7	-8.6	-13.0	-12.9	-12.6
Micropolitan	-4.5	-7.6	-4.6	-10.7	-10.4	-7.3
Other rural	0.3	-0.6	2.6	-3.6	-4.7	-3.4
Fiscal pressure						
Low pressure	-10.9	-14.7	-10.5	-14.7	-14.5	-13.9
Medium pressure	-4.5	-8.9	-4.9	-9.3	-9.6	-9.1
High pressure	3.7	0.9	2.4	-4.8	-5.6	-6.6
Including relief funds						
All	-7.9	-8.1	-6.2	-11.7	-12.2	-11.9
Ownership						
For profit	1.3	4.6	5.7	0.8	0.7	1.6
Nonprofit	-9.4	-10.1	-8.1	-13.4	-13.7	-13.2
Geography						
Metropolitan	-8.3	-8.7	-6.8	-12.1	-12.5	-12.3
Micropolitan	-4.5	-2.5	-1.4	-8.1	-9.8	-7.1
Other rural	0.3	5.4	8.0	0.6	-3.8	-3.1
Fiscal pressure						
Low pressure	-10.9	-11.1	-8.8	-13.8	-14.2	-13.7
Medium pressure	-4.5	-4.4	-2.7	-8.0	-9.1	-8.8
High pressure	3.7	6.9	5.8	-3.2	-4.8	-6.2

Note: FFS (fee-for-service), FY (fiscal year). "Hospitals" refers to hospitals paid under the inpatient prospective payment systems. "FFS Medicare margin" is limited to revenue and costs for services included under the inpatient or outpatient prospective payment systems, including uncompensated-care payments and revenue and costs of separately payable drugs, including any reported discounts to drug costs under the 340B Drug Pricing Program. The FFS Medicare margin does not include remedy payments hospitals received in 2024 to offset lower payments for 340B drugs acquired in 2018 through 2021; but it does include the higher payments for drugs on reprocessed claims in 2022. "Relief funds" refers to FFS Medicare's share of federal and other coronavirus relief funds (with the share based on FFS Medicare's share of 2019 all-payer operating revenue). "Metropolitan" (urban) counties contain an urban cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural". "Low [fiscal] pressure" hospitals are defined as those with a median non-FFS Medicare margin greater than 5 percent over five years and a net worth that would have grown by more than 1 percent per year over that period if the hospital's FFS Medicare profits had been zero. "High [fiscal] pressure" hospitals are defined as those with a median non-FFS Medicare margin of 1 percent or less over five years and a net worth that would have grown by less than 1 percent per year. All other hospitals with complete data are classified as "medium pressure." Government-owned hospitals operate in a different financial context from other hospitals, so their margin is not necessarily comparable; therefore, data for government-owned hospitals are not reported separately or included in the ownership rows (but are included in other rows). Results differ from those published last year in part because of newer data.

Source: MedPAC analysis of hospital cost-report and census geographic data.

because most rural hospitals benefit from one or more special designations that provide additional FFS Medicare payments above standard IPPS and/or OPDS payments.¹¹ In addition, hospitals under higher

fiscal pressure, and therefore under more pressure to constrain their costs, continued to have an FFS Medicare margin over 7 percentage points higher than hospitals under low pressure.¹²

Relatively efficient hospitals, which historically have had higher quality and lower costs, continued to have higher margins

As part of our assessment of payment adequacy, the Commission calculates a median FFS Medicare margin in a performance year for a group of hospitals that has historically performed relatively well on a set of quality metrics (measures of mortality and readmissions) while keeping unit costs relatively low. We refer to the group of hospitals identified by our method as “relatively efficient” because these hospitals historically performed better than other hospitals on selected measures of quality and cost for inclusion. Under this concept, “efficiency” refers to the level of resources needed to provide a certain quality and quantity of services. While our method is one way of identifying relatively efficient hospitals, it does not seek to identify all hospitals that efficiently deliver hospital care. For example, we exclude from our analysis hospitals that have few Medicare or Medicaid patients or do not have sufficient baseline or performance-year data, even though these hospitals may be relatively efficient. In addition, our method does not seek to identify hospitals that performed relatively well in all possible quality and cost metrics. For example, the use of other quality and cost measures (e.g., hospital-acquired conditions, transition to post-acute care, or spending per episode) to identify relative efficiency likely would yield a different set of hospitals. Still, the median margin for our group of relatively efficient hospitals provides one source of information about whether FFS Medicare payments are adequate to cover the costs of providing hospital care efficiently.

We first published a “relatively efficient hospital” analysis as a way to identify lower-cost hospitals that maintained quality in 2009 (Medicare Payment Advisory Commission 2009). Since then, as we annually review our methods and results, we have refined our analysis and updated data sources. For example, we have (1) incorporated hospital outpatient costs to obtain a more complete picture of hospitals’ costs, (2) refined quality measure thresholds, and (3) explored incorporating additional hospital factors that drive costs (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2011). In each year since 2009, the group of hospitals that we identified as relatively efficient in a historical baseline period had higher quality and lower standardized costs than other hospitals in the performance year.

This year, we continued to refine our method for identifying relatively efficient hospitals (see text box on our refined methods, pp. 82–83). In past years, we identified relatively efficient hospitals as those that consistently met performance criteria in all three historical years before the performance year. This year, to allow for the possibility of some year-to-year variation in performance measurement, we relaxed our requirements such that relatively efficient hospitals must meet criteria in at least three of the four years (2020, 2021, 2022, and 2023) before our 2024 performance year. About 13 percent of eligible hospitals met these criteria for costs and quality; in contrast, we had identified only 6 percent of hospitals as relatively efficient using the prior criteria last year.¹³

Among the 13 percent of hospitals that we identified as relatively efficient, the median hospital continued to have higher quality and lower costs in FY 2024 than the comparison group (Table 3-12). In terms of quality, the relatively efficient hospitals had lower median mortality and readmission rates (90 percent of the national median and 95 percent, respectively) and slightly higher median shares of patients highly rating the hospital. They also had lower standardized FFS Medicare costs per unit, at 89 percent of the national median. These lower standardized costs resulted in a higher FFS Medicare margin than the comparison group. The median relatively efficient hospital in 2024 had a FFS Medicare margin of –1 percent, an increase from –2 percent last year (latter data not shown). The median relatively efficient hospital also had a higher all-payer operating margin than the median other hospital, though the spread was narrower than the FFS Medicare margin.¹⁴

As in past years, relatively efficient hospitals were spread across the country and included various categories of hospitals. Relatively efficient hospitals were more likely to be in urban areas and were slightly larger in terms of bed size compared with other hospitals (data not shown). Among teaching and nonteaching hospitals, the shares of hospitals categorized as relatively efficient were similar. The share of relatively efficient hospitals was slightly higher among hospitals under low fiscal pressure than those under high fiscal pressure. Finally, the share of relatively efficient hospitals was slightly higher among for-profit hospitals than nonprofit hospitals; generally, for-profit hospitals tend to have lower standardized

**TABLE
3-12**

Relatively efficient hospitals performed better than other hospitals but still had a slightly negative median FFS Medicare margin in FY 2024

	Relatively efficient hospitals	Other hospitals
Number of hospitals	270	1,875
Share of hospitals in our study sample	13%	87%
Historical performance, average over 2020–2023 (median)		
FFS Medicare mortality rate (relative to national)	89%	102%
FFS Medicare readmission rate (relative to national)	93	102
Standardized FFS Medicare costs per unit (relative to national)	91	102
Current year performance, 2024 (median)		
FFS Medicare mortality rate (relative to national)	90%	101%
FFS Medicare readmission rate (relative to national)	95	101
Share of patients rating the hospital a 9 or 10 (out of 10) (relative to national)	101	100
Standardized FFS Medicare costs per unit (relative to national)	89	102
FFS Medicare margin	–1	–10
All-payer operating margin	9	4

Note: FFS (fee-for-service), FY (fiscal year). “Relatively efficient” and “other” hospitals were identified based on their performance during 2020 to 2023. (For more details, see text box on our identification methodology, pp. 82–83.) “Hospitals” refers to hospitals paid under the inpatient prospective payment systems. The “all-payer operating margin” excludes reported investment and donation income. The “FFS Medicare margin” is limited to revenue and costs for services included under the inpatient or outpatient prospective payment systems, including uncompensated-care payments and revenue and costs of separately payable drugs (and any reported discounts to drug costs under the 340B Drug Pricing Program) and is reported without FFS Medicare’s share of federal or other coronavirus relief funds (which were small in 2024).

Source: MedPAC analysis of hospital cost-report, claims, inpatient and outpatient prospective payment system final rules, and Common Medicare Environment data and CMS’s summary of H–CAHPS survey-results tables.

costs and nonprofit hospitals tend to have higher quality metrics (see quality section, pp. 72–76).

FFS Medicare margin is projected to increase in 2026

We project that hospitals’ FFS Medicare margin in FY 2026 will be about –10 percent, about 2 percentage points higher than the level in 2024 exclusive of coronavirus relief payments. Similarly, we project the median FFS Medicare margin among relatively efficient hospitals to increase to 1 percent. These projections are based on actual payments and costs in the most recent year of complete data (2024), FFS Medicare payment policies for 2025 and 2026, and environmental changes that took place in 2025 and are anticipated in 2026.

Our projected increase in hospitals’ FFS Medicare margin in 2026 reflects several partially offsetting pressures. One key factor that will put upward pressure on hospitals’ FFS Medicare margin is the \$1.8 billion dollar increase in FFS Medicare’s uncompensated-care payments (from \$5.9 billion in 2024 to \$7.7 billion in 2026), driven by CMS’s estimated increase in the percentage of individuals without insurance and in FFS Medicare inpatient volume. Another key factor that we project will put upward pressure on hospitals’ FFS Medicare margin is the projected continued growth in the share of hospitals’ FFS Medicare revenue from separately payable drugs, for which FFS Medicare payments are above hospitals’ average acquisition costs. We project these upward pressures will be

Identifying relatively efficient hospitals

The Commission follows two principles when identifying a set of relatively efficient hospitals:

- hospitals must perform relatively well on both quality and cost metrics, and
- the performance must be generally consistent and not due to random variation.

Our assessment of efficiency is not in absolute terms but, rather, relative to a comparison group of other hospitals.

Updates to the method for categorizing hospitals as relatively efficient

Due to concerns about the increasingly small share of hospitals identified as relatively efficient in our analysis, this year we relaxed our consistency requirement such that relatively efficient hospitals must meet quality and cost criteria in three of four baseline years (instead of three out of three). Under this updated requirement, a hospital could have lower quality or higher costs in one of the four baseline years and still be identified as a relatively efficient hospital. This update balances our

principles of consistently meeting relatively higher performance thresholds with acknowledging that in any particular year a relatively high-performance hospital may experience a negative shock. Indeed, recent years were likely a more difficult time for hospitals to perform consistently well because of the coronavirus pandemic and its impacts. Our quality and cost criteria that relatively efficient hospitals had to meet—now in three of four baseline years—remained the same.¹⁵

- Either fee-for-service (FFS) Medicare risk-adjusted mortality rates or standardized inpatient and outpatient cost per unit was among the best one-third of hospitals and
- FFS Medicare risk-adjusted mortality rates, risk-adjusted readmission rates, and standardized costs per unit were not in the bottom third of all hospitals.¹⁶

We also made other methodological refinements, such as improving the data sources used for standardizing hospitals' FFS Medicare costs per unit and using more current wage indexes to standardize for labor costs.¹⁷

(continued next page)

partially offset by other factors. One of these is the temporary 0.5 percentage point decrease in the update to the OPPI base rate, which CMS is implementing to offset the increased Medicare payments for nondrug items and services made in CY 2018 through CY 2022.

Like all projections, ours are subject to uncertainty. For example, actual inflation in FY 2026 is unknown. In addition, it is uncertain how hospitals will respond to legislative changes passed in 2025 and policy changes in 2026, such as expanded site-neutral payment policies and the phase-out of the inpatient-only list.

Looking forward to 2027, there are additional uncertainties. Most notably, we do not yet know what

the uncompensated-care pool will be in 2027. However, while there is more uncertainty, we expect hospitals' 2027 FFS Medicare margin to be slightly higher than in 2026. We will update data on actual experience in our next recommendation cycle.

The Commission-developed Medicare Safety-Net Index should be used to target hospitals most in need of Medicare funds

In the Commission's March 2023, 2024, and 2025 reports, we recommended transitioning existing hospital payments to payments based on this new metric—the Medicare Safety-Net Index (MSNI)—to improve targeting Medicare safety-net payments toward hospitals that

Identifying relatively efficient hospitals (cont.)

The collective effect of these method changes increased the share of hospitals we identify as relatively efficient. In 2024, the updated method resulted in approximately double the share of hospitals identified as relatively efficient compared with last year. Not surprisingly, among this larger group, the median relatively efficient hospital had slightly lower quality and higher costs than if we had continued with our stricter criteria. Had we continued to require that relatively efficient hospitals meet quality and cost criteria in three out of three baseline years, the median FFS Medicare margin in 2024 would have been slightly higher, at 0 percent. We also found that requiring three of four baseline years last year would have yielded a similar FY 2023 median FFS Medicare margin among hospitals identified as relatively efficient as was reported last year. Overall, our findings indicate an improvement in 2024 in the median FFS Medicare margin among relatively efficient hospitals.

Implications

There is no single way to identify hospitals that are operating efficiently, and we do not seek to identify all efficient hospitals, nor do we conclude that all hospitals that did not meet our criteria are inefficient. For example, lower-volume hospitals have more variation in their costs, volume, and mix of patients and therefore may be more likely to experience a shock and have inconsistent performance during the baseline years. It is also important to note that there is substantial variation in performance among both the relatively efficient hospitals and the other hospitals. Still, the median FFS Medicare margin among the set of hospitals we identified as relatively efficient provides some insight about whether FFS Medicare payments to hospitals are adequate to cover the cost of providing inpatient and outpatient hospital care efficiently. This analysis is one of many metrics we use to assess the adequacy of FFS payments. ■

provide care to large shares of low-income Medicare beneficiaries (Medicare Payment Advisory Commission 2025, Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2022). The MSNI was developed with the Commission's principle that Medicare safety-net payments should be used primarily to support hospitals that provide care to large shares of Medicare beneficiaries, and in particular low-income Medicare beneficiaries, and are therefore hospitals particularly vulnerable to unforeseen circumstances (such as misestimates of input price inflation). (The calculation of each hospital's MSNI value is described in the text box on p. 85.) This measure of "safety-net" status is Medicare-centric by design; safety-net definitions used by Medicaid and other payers would likely differ. Currently, Medicare payments to support safety-net hospitals are composed of disproportionate-share (DSH) and uncompensated-care payments.¹⁸ However, unlike those funds, payments based on the Commission's MSNI would be:

- targeted to hospitals with higher Medicare dependency, measured on a sliding scale;
- calculated as a percentage add-on for both Medicare inpatient and outpatient services; and
- made to hospitals for both their FFS and MA beneficiaries and carved out of MA benchmarks.

We have found that the MSNI was an important predictor of hospitals' all-payer margins and risk of closure—and a better predictor than the metric used in determining current DSH payments. This finding continued to be true in 2024: Hospitals with higher values on the MSNI had lower all-payer operating margins (Table 3-13, p. 84). Hospitals in the highest MSNI quartile had an all-payer operating margin of 4.3 percent compared with 8.6 percent among hospitals in the lowest MSNI quartile. The spread in margin between hospitals in the highest and lowest MSNI quartiles is even larger when looking at the all-payer operating margin exclusive of payments from state

**TABLE
3-13**

Hospitals with higher MSNI values had lower all-payer operating margins in FY 2024

	MSNI quartile			
	Lowest	2nd	3rd	Highest
All-payer operating margin	8.6%	6.3%	6.6%	4.3%
FFS Medicare margin	-16.1	-14.6	-10.7	-4.8

Note: MSNI (Medicare Safety-Net Index), FY (fiscal year), FFS (fee-for-service). "Hospitals" refers to hospitals paid under the inpatient prospective payment systems. The "all-payer operating margin" excludes reported investment and donation income. The "FFS Medicare margin" is limited to revenue and costs for services included under the inpatient or outpatient prospective payment systems, including uncompensated-care payments and revenue and costs of separately payable drugs (and any reported discounts to drug costs under the 340B Drug Pricing Program) and is reported without FFS Medicare's share of federal or other coronavirus relief funds (which were small in 2024).

Source: MedPAC analysis of hospital cost-report, claims, Medicare Advantage encounters, and Common Medicare Environment data, and H-CAHPS survey results.

and local governments, as reported on Medicare cost reports (8.6 percent vs. 1.2 percent) (data not shown). We also found that the MSNI continued to be a better predictor of hospitals' all-payer operating margin than the current DSH metric. For example, in 2024 the spread in all-payer operating margin between the lowest and highest MSNI quartile (4.4 percentage points) was wider for the MSNI than the DSH metric (2.4 percentage points) (data not shown).¹⁹

Consistent with prior years, the FFS Medicare margin continued to be higher among hospitals with higher values on the Commission-developed MSNI (Table 3-13). This finding primarily reflects how, in aggregate, these hospitals disproportionately receive additional FFS Medicare payments from existing DSH and uncompensated-care payments. However, as we noted previously, the MSNI would better target scarce Medicare resources to hospitals that treat large shares of low-income Medicare beneficiaries. Additionally, our proposed mechanism for distributing MSNI safety-net payments would have other advantages, including direct payments to hospitals for both their FFS and MA patients (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2022).²⁰

In our simulations of replacing current DSH and uncompensated-care payments with payments based on the MSNI, some hospitals would receive higher payments and others would receive lower payments.

Rural hospitals would tend to receive more payments under the MSNI than under the current DSH and uncompensated-care payments (since they treat large shares of Medicare beneficiaries and receive a relatively small share of these existing payments) while government hospitals would tend to receive less (since they receive large amounts of current DSH and uncompensated-care funds). Phasing in changes would help ease the transition for hospitals that would receive lower safety-net payments under the MSNI.

How should FFS Medicare payments change in 2027?

Under current law, CMS sets the percentage update to IPPS and OPFS payment rates based on its forecasts of market basket increases less a forecasted increase in productivity, as well as any other statutory or policy updates. The final hospital updates for 2027 will not be set until the IPPS and OPFS final rules in summer and fall 2026, respectively. However, based on current CMS forecasts through the third quarter of 2025 and current CMS policies, the 2027 updates would include:

- a 2.3 percent increase in the IPPS operating rate (resulting from a 3.1 percent increase in the market basket less a 0.8 percentage point productivity adjustment);

Calculating each hospital's Medicare Safety-Net Index value

Each hospital's Medicare Safety-Net Index (MSNI) value is calculated as the sum of three components: low-income share of Medicare volume, uncompensated-care costs as a share of hospital revenues, and Medicare share of all-payer volume (divided by two). These components were selected for their importance in identifying hospitals that would be more in need of Medicare safety-net funds. For more details on development of the MSNI, see our March 2023 report to the Congress, Chapter 3, Table 3A-1 (p. 97) (Medicare Payment Advisory Commission 2023b).

This year, we continued to incorporate additional data sources so that the MSNI calculation is based on both inpatient and outpatient data and on fee-for-service (FFS) and Medicare Advantage (MA) beneficiaries. The MSNI is calculated using 2022 Medicare hospital cost-report, enrollment, FFS claims, and MA encounter data for inpatient and outpatient services as follows:

- Low-income share of Medicare volume: We identified the share of hospitals' inpatient stays and outpatient encounters that were for patients eligible for the Part D low-income subsidy or

dually eligible for Medicare and Medicaid during the year. We included both FFS and MA patients.²¹

- Uncompensated-care costs as share of all-payer revenue: We calculated uncompensated-care cost shares as non-Medicare bad debt and charity care divided by all-payer revenue as reported in hospitals' cost reports.
- Medicare share of all-payer volume: To measure Medicare share of volume, we calculated Medicare (FFS and MA) inpatient and outpatient charges as a share of total charges, as reported by hospital's cost reports.²² We divided this share by two so that it received a lower weight in the calculation of the MSNI than the other two components (per findings during the development of the MSNI that showed that Medicare share had lower importance compared with the other two components).

Higher values on the MSNI indicate higher financial need for Medicare safety-net payments. As discussed in the March 2023 report, we bounded MSNI payments so that hospitals in the lowest 10th percentile would not receive any safety-net funds and capped MSNI values at the 95th percentile value. ■

- a 3.1 percent increase in the IPPS capital base rate (resulting from a 2.8 percent increase in the capital input price index plus a 0.3 percentage point forecast-error adjustment for FY 2025); and
- a 2.3 percent increase in the OPPS base rate (resulting from the same market basket and productivity adjustment as used for the IPPS operating rate).

Since 2006, the Commission has made a single update recommendation for FFS Medicare's payment rates for services provided under the IPPS and OPPS. Primarily

we do so because we cannot adequately apply some of the Commission's payment-adequacy indicators separately for hospital inpatient and outpatient services since hospitals typically provide both types of services. Allocating costs to inpatient and outpatient services is conceptually challenging and subject to data limitations and variation in hospitals' accounting practices. Access to capital is also fundamentally a hospital-specific, not service line-specific, measure. Moreover, at this time we do not see evidence of significant differences between inpatient and outpatient settings in FFS Medicare beneficiaries' access to care or hospitals' FFS Medicare margins.²³

That said, the Commission has long recognized that Medicare's payments in any sector should reflect the potential to deliver the service in other settings, suggesting the importance of considering the relationship of prices across sectors. That work, such as the Commission's recommendation for site-neutral payments, raises complex issues beyond the scope of our update criteria. For that reason, we address such issues separately. (However, we provide an overview of existing site-neutral policies and potential expansions at the end of this chapter; see pp. 88–91.)

Our hospital payment-adequacy indicators were mixed and suggest that FFS Medicare payments for inpatient and outpatient services were well below costs in aggregate; however, the FFS Medicare margin for the median relatively efficient hospital was –1 percent in FY 2024, and we project it will increase to 1 percent in FY 2026.

In considering how hospital base payment rates should change in 2027, the Commission contends that scarce Medicare resources should be used efficiently. To meet this goal, Medicare should aim to balance several objectives:

- support hospitals with payments high enough to ensure beneficiaries' access to care,
- maintain payments close to hospitals' cost of providing high-quality care efficiently to ensure value for taxpayers and beneficiaries,
- maintain fiscal pressure on hospitals to constrain costs, and
- limit the need for large across-the-board payment-rate increases by better targeting Medicare funds to safety-net hospitals that treat large shares of vulnerable Medicare patients.

Balancing these objectives continues to be difficult.

RECOMMENDATION 3

The Congress should:

- **for 2027, update the 2026 Medicare base payment rates for general acute care hospitals by the amount specified in current law; and**
- **implement the Medicare Safety-Net Index (MSNI) described in our March 2023 report, with \$1 billion added to the MSNI pool.**

Our indicators of the adequacy of FFS Medicare payments to hospitals continued to be mixed, though several measures improved relative to last year, and we project further improvement. In 2024, beneficiaries maintained good access to hospital care, hospitals' access to capital improved, and the FFS Medicare margin for the median relatively efficient hospital increased to –1 percent. However, indicators of the quality of care experienced by patients continued to be mixed, and FFS Medicare payments continued to be well below hospitals' costs in aggregate. Looking forward, there continues to be uncertainty, including how hospitals will respond to legislative changes passed in 2025 and policy changes in 2026, each of which may have factors that could improve or worsen some of our FFS Medicare payment-adequacy indicators. However, preliminary data suggest hospitals' access to capital improved in 2025, and we project that hospitals' FFS Medicare margin will increase in 2026 and 2027 under current law. Therefore, for 2027, the Commission recommends increasing hospital inpatient and outpatient base rates by current law.

However, there continued to be substantial variation within the aggregates in each of our payment-adequacy indicators; in particular, hospitals that treat larger shares of low-income Medicare patients continue to face larger financial challenges. Therefore, for 2027, the Commission reiterates our recommendation from March 2023 that the Congress implement the MSNI, which 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. As specified in more detail in our March 2023 report, implementing the MSNI would involve:

- a transition from DSH and uncompensated-care payments to payments through the MSNI;
- scaling FFS–MSNI payments in proportion to each hospital's MSNI value and distributing the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems;²⁴
- paying commensurate MSNI amounts for services furnished to MA enrollees directly to hospitals and excluding them from MA benchmarks; and

- expanding the MSNI pool in future years—for example, the pool could be expanded by the same rate as Medicare’s base payment rates to hospitals.

As we previously noted, 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.

Given that current law has already increased uncompensated-care payments in 2026 by \$1.8 billion relative to 2024, this year’s recommendation would increase the MSNI pool by \$1 billion dollars (to be distributed across hospitals’ FFS and MA patients), less than our recommendation in prior years.

A current-law update to hospital base rates would affect all hospitals equally; however, implementing the MSNI and adding \$1 billion to the MSNI pool would have distributional impacts, with some hospitals receiving more than current law and others less than current law. We estimate that about half of the \$1 billion would be used for hospitals’ FFS Medicare patients and, compared with current law, would increase hospitals’ FFS Medicare margin by less than 1 percentage point, both in aggregate and for the median relatively efficient hospital.

There would also be variation in the impacts across categories of hospitals. We estimate that the recommendation would increase the FFS Medicare margin among hospitals in the highest MSNI quartile by about 3 percentage points. We also estimate the recommendation would increase rural hospitals’ FFS Medicare margin by about 3 percentage points over current law because they tend to have larger Medicare shares and larger shares of low-income Medicare patients. In contrast, we estimate that the recommendation would decrease government hospitals’ FFS Medicare margin by about 3 percentage points relative to current law because some large government hospitals have relatively few Medicare patients and, currently, very high uncompensated-care payments.²⁵ However, these are aggregate estimated impacts, and there would be substantial variation within categories of hospitals as well.

We anticipate that a 2027 update to hospital payment rates equal to current law and a transition to the MSNI would generally be adequate to maintain FFS beneficiaries’ access to hospital inpatient and outpatient care and to raise hospital payment rates close to the cost of delivering high-quality care efficiently.

IMPLICATIONS 3

Spending

- This recommendation would increase spending relative to current law by \$750 million to \$2 billion in one year and by \$5 billion to \$10 billion over five years.

Beneficiary and provider

- We expect that this recommendation will help ensure Medicare beneficiaries’ access to care by increasing hospitals’ willingness and ability to treat beneficiaries, especially those with low incomes.

Mandated report: Rural emergency hospitals

Since 1983, when Medicare moved from paying hospitals on the basis of their costs to paying prospectively determined rates, policymakers have sought ways to support rural beneficiaries’ access to hospital services. Historically, this support focused on making inpatient hospital services more profitable. However, inpatient volume has declined dramatically over the past 40 years, especially at rural hospitals, reducing the impact of Medicare’s inpatient-centric support of hospitals and contributing to an increase in rural hospital closures. This situation led the Commission, in 2018, to recommend that Medicare create a new category of hospital: a rural, outpatient-only facility with a 24/7 ED. Rather than being paid on a purely FFS basis, the new outpatient-only hospitals would receive fixed payments intended to help support the standby costs of maintaining an ED in addition to OPPS rates for each outpatient service. Consistent with the Commission’s recommendation, the Congress enacted the new REH designation in the Consolidated Appropriations Act (CAA), 2021. REHs:

- do not furnish inpatient care,
- have an emergency department that is staffed 24/7,

- receive fixed monthly payments from Medicare,
- are paid 105 percent of standard OPPS rates for emergency and outpatient services, and
- meet other criteria (e.g., have a transfer agreement with a Level I or II trauma center).

Becoming an REH is voluntary, meaning that hospitals can choose whether they want to transition to an REH. Hospitals eligible to transition to an REH are those that, as of December 27, 2020, were critical access hospitals or Subsection (d) hospitals with 50 or fewer beds in a rural county. Hospitals began to transition to REHs starting in 2023.

The CAA, 2021, requires the Commission to report annually on payments to REHs. In its March 2024 report to the Congress, the Commission described the historical context that led to the creation of REHs and the characteristics of the first cohort of REHs (Medicare Payment Advisory Commission 2024). In our March 2025 report, we provided updated information on the number of REHs, the fixed payments REHs received from Medicare, and FFS Medicare payments to REHs for outpatient services in the first full year that the designation was available.

In the first year of eligibility, CY 2023, 21 hospitals converted to REHs. In 2024, the number of REHs increased to 38, and the count further increased to 44 in 2025. These REHs were located in 18 states, including at least 4 in each of Arkansas, Mississippi, Oklahoma, and Texas.

In CY 2024, REHs received over \$100 million in enhanced Medicare payments, almost all of which were from fixed monthly payments. In CY 2024, fixed payments were about \$276,000 per month per REH, and we estimate that, in aggregate, the 38 REHs received about \$100 million in fixed payments. The other type of enhanced Medicare payment is the FFS Medicare program's payment of 105 percent of its share of the standard OPPS rates for services that a non-REH would be paid under the OPPS. In CY 2024, REHs received about \$24 million for OPPS-equivalent services, which was \$1.2 million higher than the amount would have been using standard OPPS rates. The OPPS-equivalent services that accounted for the highest share of spending at REHs were ED visits, observation visits, and partial-hospitalization mental health services.

The Commission continues to monitor the uptake of the REH designation and important policy issues surrounding it. For example, in our hospital site visits and interviews in the last few years, rural hospitals reported that MA plans tend to match FFS's claims-based payment rates for REHs but (as expected) do not pay REHs fixed monthly payments. However, Medicare's fixed monthly payments to REHs are included in MA benchmarks. In our March 2024 report to the Congress, we noted that excluding REH fixed payments from MA benchmarks would promote equity between FFS and MA because plans would not be paid (through higher benchmarks) for doing something they are not expected to do (i.e., match the fixed payments to REHs) (Medicare Payment Advisory Commission 2024).

Medicare should move toward more site-neutral payments

For over a decade, the Commission has observed that Medicare's payment rates often differ for the same service across different ambulatory settings (HOPDs, ambulatory surgical centers (ASCs), and freestanding physician offices). These payment differences encourage arrangements among providers—such as consolidation of physician practices with hospitals—that result in care being billed from settings with the highest payment rates, which increases total Medicare spending and beneficiary cost sharing without material improvements in patient outcomes. To address this issue, the Commission has twice recommended that Medicare should move toward more site-neutral payments. Specifically, we recommend 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 (Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2014).

Since the Commission's 2014 recommendation, Medicare has implemented some site-neutral payments for off-campus outpatient services. The Bipartisan Budget Act (BBA) of 2015 required CMS to implement site-neutral payment rates for services provided in certain off-campus outpatient departments beginning in 2017. In 2019, CMS extended site-neutral payment rates to clinic visits provided in almost all off-campus

outpatient departments, and, for 2026, expanded site-neutral payment rates to drug-administration services. However, there remain additional opportunities to expand site-neutral policies across ambulatory settings.

Starting in 2017, Medicare began site-neutral payments for outpatient services provided in some off-campus locations

In response to Section 603 of the BBA of 2015, Medicare began aligning FFS payment rates across ambulatory settings. Specifically, the Act stated that, starting January 1, 2017, applicable outpatient services provided to FFS Medicare beneficiaries in off-campus outpatient departments that are not excepted from site-neutral payments shall no longer be paid under the OPPS and instead under another FFS Medicare payment system.²⁶ Services provided at off-campus outpatient departments that were established before the Act were excepted from the payment changes.

To satisfy the requirements in the BBA of 2015, CMS reduced payment rates for most outpatient services provided in nonexcepted off-campus provider-based departments (PBDs) to levels that approximate those under the Medicare physician fee schedule (PFS). Specifically, CMS established a PFS relativity adjuster of 40 percent, which reflected the estimated overall difference between OPPS and PFS payments for most affected services.²⁷ CMS provided a two-year transition to this policy, paying 50 percent of standard OPPS rates in 2017 and then, starting in 2018, 40 percent of the standard OPPS payment rates, and did so in a non-budget-neutral manner.

In the years immediately following the implementation of site-neutral payments under the BBA of 2015, the number of nonexcepted off-campus PBDs, as well as the volume of affected services and site-neutral payments grew rapidly. More recently, the number of nonexcepted off-campus PBDs has been stable, though the volume of off-campus services and site-neutral payments have continued to climb. In CY 2024, about 1,100 hospitals had one or more nonexcepted off-campus PBDs that provided a service subject to site-neutral payments, similar to the number in 2023. The policy applied to 6.3 million FFS Medicare services, a nearly 30 percent increase from 2023. FFS Medicare and its beneficiaries paid about \$465 million for these services, and we estimate that this policy reduced FFS Medicare payments by about \$700 million in CY 2024.

Starting in 2019, CMS began site-neutral payments for clinic visits in excepted off-campus locations

In 2019, CMS phased in an expansion of the site-neutral payment rates (i.e., 40 percent of OPPS rates) to clinic visits provided in off-campus PBDs that were excepted from the BBA of 2015 (referred to as “excepted” off-campus PBDs).²⁸

As the implementation of this policy was phased in, the number of clinic services provided to FFS Medicare beneficiaries in these settings declined. Since then, the volume has been more stable. In CY 2024, about 1,000 hospitals had one or more excepted off-campus PBDs that provided a clinic service subject to this site-neutral policy, and the policy applied to 6.8 million clinic visits by FFS Medicare beneficiaries, both slightly below the levels in 2023. FFS Medicare and its beneficiaries paid about \$350 million for these visits, and we estimate that this policy reduced FFS Medicare payments by about \$520 million in 2024.

Starting in 2026, CMS expanded site-neutral payments to drug-administration services in excepted off-campus locations

In the CY 2026 OPPS/ASC rule, CMS asserted that the effect of hospital-physician vertical integration and increased volume of outpatient services extends beyond clinic visits and includes drug-administration services. In particular, CMS stated that the high volume of drug-administration services and the magnitude of the FFS Medicare payment differential between settings creates an incentive for these services to migrate to the higher-paying HOPD setting. Both MedPAC and CMS have found increases in both the volume of drug-administration services billed under the OPPS and the volume of services provided per beneficiary, as well as significant volume growth for some individual codes within the drug-administration ambulatory-payment classifications (Centers for Medicare & Medicaid Services 2025, Medicare Payment Advisory Commission 2023a). As a result, starting in 2026, CMS expanded site-neutral payments (i.e., 40 percent of OPPS rates) to drug-administration services provided at excepted off-campus PBDs.²⁹

In CY 2024, about 740 hospitals had one or more excepted off-campus PBDs that provided 3.1 million separately payable drug-administration services. FFS Medicare and its beneficiaries paid about \$410 million

for these services, and we estimate that, if the 2026 site-neutral policy had been in place in 2024, FFS Medicare payments would have been reduced by about \$250 million. Looking forward to the proposed first year of implementation, CMS estimates slightly larger reductions: about \$290 million in CY 2026 (Centers for Medicare & Medicaid Services 2025).

Additional possible site-neutral expansions

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 outpatient services in off-campus locations. Another possible direction for site-neutral policies is our June 2023 recommendation.

Expanding site-neutral payments to clinic visits provided in on-campus locations

On-campus HOPDs are the most common outpatient setting where FFS Medicare beneficiaries receive clinic visits: In CY 2024, FFS Medicare beneficiaries received 15.6 million clinic visits in on-campus HOPDs (or off-campus EDs), with payments of \$1.8 billion.³⁰ We estimate that expanding site-neutral payments (i.e., 40 percent of OPPS rates) to these 15.6 million clinic visits would have decreased FFS Medicare payments by about \$1.1 billion in CY 2024. Consistent with the volume of these services, the vast majority of the savings would be from clinic visits provided at urban metropolitan hospitals and nonprofit hospitals. As a percentage of hospitals' total FFS Medicare revenue for hospital outpatient OPPS and site-neutral services (including separately payable drugs and other inputs), the impacts would be slightly larger for hospitals designated as Medicare-dependent hospitals (2.4 percent), rural micropolitan hospitals (2.1 percent), and government hospitals (2.1 percent).

Expanding site-neutral payments to outpatient services provided in excepted off-campus locations

As noted above, CMS has implemented site-neutral payment rates for two types of outpatient services provided in excepted off-campus locations: clinic visits and drug-administration services. Policymakers could

also consider expanding site-neutral payments to other outpatient services provided in excepted off-campus locations.

In CY 2024, FFS Medicare beneficiaries received 13.2 million OPPS services in excepted off-campus PBDs (inclusive of the drug-administration services), with payments of \$3.5 billion.³¹ We estimate that expanding site-neutral payments (i.e., 40 percent of OPPS rates) to these 13.2 million services would have decreased FFS Medicare payments by about \$2.1 billion in CY 2024. This \$2.1 billion reduction would have been equivalent to a 4.2 percent reduction in payments for remaining OPPS services; therefore, applying a budget-neutral adjustment would require a uniform increase of 4.2 percent to the payment rates for all remaining OPPS services. After applying a budget-neutrality adjustment, there would be no change in aggregate FFS Medicare payments for hospital outpatient services if volume remained the same, but there would be distributional effects (Table 3-14). For example, urban and nonprofit hospitals would lose a small amount of revenue while rural hospitals and for-profit hospitals would gain a small amount.

Implementing site-neutral payments consistent with MedPAC's June 2023 recommendation

The Commission acknowledges that there are different approaches to implementing site-neutral payments across ambulatory settings.

In our June 2023 report to the Congress, we recommended aligning payment rates across ambulatory settings when safe and appropriate and when doing so does not pose a risk to access (Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2014). In general, the Commission maintains that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting. However, Medicare should be selective about which services should have payment rates aligned across settings, as many ambulatory services cannot be safely or appropriately provided in freestanding offices in the majority of circumstances.

We discussed a method to identify the services for which it might be appropriate to align payment rates across hospital outpatient departments, ASCs, and/or freestanding offices, aligning payment rates in higher-

**TABLE
3-14**

Expanding site-neutral payments to outpatient services in excepted off-campus PBDs would have had varying effects, CY 2024

Hospital category	After budget-neutrality adjustment	
	Dollar change in FFS Medicare payments (in millions)	Percent change
All	\$0	0.0%
Ownership		
For profit	140	2.0
Nonprofit	-110	-0.2
Government	-30	-0.2
Geography		
Metropolitan	-50	-0.1
Micropolitan	30	0.4
Other rural	20	2.4

Note: PBD (provider-based department), CY (calendar year), FFS (fee-for-service). "Site-neutral payments" estimated as 40 percent of outpatient prospective payment system (OPPS) rates. "Outpatient services" refers to services covered under the OPPS in 2024, inclusive of drug-administration services, but exclusive of separately payable drugs and other separately payable inputs. "Excepted off-campus PBDs" are those not affected by the Balanced Budget Act of 2015. "Percent change" refers to the dollar change in FFS Medicare payments divided by total OPPS and site-neutral payments (including for separately payable drugs and other separately payable inputs). "Metropolitan" (urban) counties contain an urban cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural."

Source: MedPAC analysis of hospital outpatient claims, outpatient provider-specific, OPPS final-rule, census geographic, and hospital cost-report data.

cost settings to the setting that had the highest volume. For example, if ASCs had the highest volume for a service, we aligned the OPPS payment rate (in both on- and off-campus settings) with the ASC payment rate and left the PFS payment rate unchanged.

We also noted the benefits of making budget-neutral adjustments for some OPPS services in conjunction with site-neutral payments. For example, applying a budget-neutral payment adjustment with a site-neutral

policy would increase OPPS payment rates for other services, including emergency department visits, which would support hospitals' emergency care and standby capacity. Further, CMS could augment the aligned payment rates when one of the aligned services is provided as part of a visit for emergency care. Finally, CMS should closely monitor the effect that payment rate alignment has on beneficiary access to the services that have aligned payment rates. ■

Endnotes

- 1 This chapter uses the term “general acute care hospital” or just “hospital” to refer to short-term acute care hospitals paid under the inpatient prospective payment systems and/or outpatient prospective payment system, and the term “inpatient services” and “outpatient services” to refer to services paid under these systems. However, in some instances we use these terms to refer to a broader set of hospitals that provide similar services (but that fee-for-service Medicare pays for under alternative methodologies); the precise definition used in each table is specified in the table note.
- 2 Clinicians who provide inpatient and outpatient services at hospitals are paid separately under the Medicare physician fee schedule. FFS Medicare uses other payment systems for certain types of hospitals, such as critical access hospitals, hospitals participating in demonstrations, and hospitals that provide care to a specific population (e.g., children’s hospitals) or, for inpatient services, a limited set of diagnoses (e.g., psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals). An assessment of the adequacy of these payment systems is beyond the scope of this chapter.
- 3 A more detailed description of the IPPS and OPPS can be found in our *Payment Basics* series at <https://www.medpac.gov/document-type/payment-basic/>.
- 4 The share of hospitals’ operating revenue from FFS Medicare across all service lines, such as physician services, is higher.
- 5 Examples of short-term acute care hospitals not paid by FFS Medicare under the IPPS and OPPS include hospitals in Maryland, which are paid under a state total cost of care waiver, and Indian Health Service hospitals, which are paid under the IPPS for inpatient services but receive an all-inclusive rate for outpatient services.
- 6 We reviewed the press releases, websites, and regulatory documents of closing hospitals to identify the factors that facilities listed as contributing to their decision to close. When those sources were not available or did not provide sufficient detail, we considered popular-press coverage that included quotations from hospital representatives. We did not independently verify all the factors cited by each facility.
- 7 The H-CAHPS national response rate for 2024 was 23 percent. The response rate for other provider-focused CAHPS surveys is similar (e.g., the Home Health CAHPS response rate was 23 percent, and the Hospice CAHPS response rate was 28 percent).
- 8 The all-payer operating margin excludes investment and donation income reported on the indicated cost report lines for these values. However, some hospitals appear to report investment and/or donation income on nonstandard lines; therefore, our calculated operating margin still includes the subset of investment and/or donation income that is reported outside of the indicated cost-report lines.
- 9 The payments and costs for IPPS and OPPS services include those for services determined by IPPS and OPPS base rates as well as uncompensated-care payments made under the IPPS and payments and costs for separately payable drugs under the OPPS. The FFS Medicare margin does not include FFS Medicare payments and costs for hospital outpatient services provided in off-campus locations paid at site-neutral rates since these are not considered OPPS services and are not included on hospitals’ cost reports; for more information on site-neutral payments, see section at the end of this chapter, pp. 88–91.
- 10 The FFS Medicare margin on inpatient services is bolstered by inpatient-centric add-on payments for hospitals with certain characteristics (i.e., teaching hospitals, DSH hospitals, and certain rural hospitals). The FFS Medicare margin on outpatient services is bolstered by the inclusion of separately payable drugs, which are paid at the average sales price plus 6 percent but can be obtained at significantly reduced prices by hospitals participating in the 340B Drug Pricing Program. However, cost reports only measure drug-acquisition costs jointly across inpatient and outpatient services. Therefore, we cannot precisely differentiate between inpatient and outpatient margins.
- 11 A subset of rural hospitals can use inpatient beds as “swing beds” and provide skilled nursing services. If we had included swing-bed services in our FFS Medicare margin, rural nonmicropolitan hospitals’ margin would have been about 2 percentage points lower.
- 12 In 2024, about 13 percent of hospitals in our FFS Medicare margin analysis met the definition of “high fiscal pressure” (those with a median non-FFS Medicare margin of 1 percent or less over five years and a net worth that would have grown by less than 1 percent per year if the hospital’s FFS Medicare profits had been zero) and about 48 percent met the criteria of “low fiscal pressure” (those with a median non-FFS Medicare margin greater than 5 percent over five years and a net worth that would have grown by more than 1 percent per year over that period if the hospital’s FFS Medicare profits had been zero). That is, hospitals under high fiscal pressure generate lower profits from “other payers”

which include a mix of commercial, Medicaid, uninsured, and Medicare Advantage patients. This fiscal pressure gives them pressure to constrain costs. Lower non-FFS margins could be related to payer mix, possibly having fewer patients covered by commercial insurance plans (which tend to pay higher prices). We continue to find that hospitals under high pressure have higher FFS Medicare margins, stemming from lower costs.

- 13 Hospitals identified as relatively efficient constituted about 13 percent of inpatient beds in FY 2024.
- 14 The 2024 FFS Medicare and all-payer operating margins for relatively efficient hospitals were higher than those in 2023 even when applying the same methods in both years.
- 15 Our other eligibility criteria also remained the same. Relatively efficient hospitals must also have at least half of the hospitals' patients rating it a 9 or 10 on the 10-point scale in the previous year (per the Hospital Consumer Assessment of Healthcare Providers and Systems survey). We exclude from our analyses all hospitals in the lowest 1 percentile of FFS Medicare inpatient stays or outpatient services in the year (but do not adjust our costs per unit for economies of scale). We also exclude hospitals with low shares of Medicaid inpatient days (lower than 5 percent).
- 16 We risk adjust our mortality and readmission rates but do not adjust for patient income, consistent with the Commission's prior recommendations. We standardize inpatient and outpatient costs per unit by (1) average patient severity; (2) relative labor costs; (3) low-income status (as measured by the share of FFS Medicare patients who received the Part D low-income subsidy or were eligible for Medicaid); (4) teaching intensity; and (5) a portion of a hospital's outlier index (as measured by FFS Medicare outlier payments' share of total FFS base payments) since high outlier costs can indicate either unmeasured differences in illness severity or high cost structures. On the outpatient side, we calculate outpatient cost per encounter, excluding separately payable drugs. We exclude the costs for these drugs because factors besides hospital efficiency, such as participation in the 340B drug program and market power can substantially affect hospitals' drug costs, and we are unable to accurately standardize drug costs.
- 17 We previously used Medicare's annual outpatient Limited Data Set (LDS) to calculate standardized outpatient costs per service, which is based on cost reports and outpatient claims data that are necessarily lagged. This year, we did not use the outpatient LDS; instead, we directly aligned cost reports with corresponding outpatient claims, providing a more accurate calculation of standardized outpatient costs

per encounter each year. We also replaced the MedPAC wage index (calculated from 2019 data) with the annually updated CMS geographic wage index (before reclassifications and floors). Other minor improvements were made as a result of our regular methodology review.

- 18 Under current policy, hospitals whose Medicaid and Supplemental Security Income (SSI) patient shares are over a certain percentage receive DSH and uncompensated-care payments determined by CMS each year. CMS calculates a "traditional DSH" payment using a formula based on each hospital's share of Medicaid and SSI patients (i.e., the disproportionate patient percentage). Each hospital receives 25 percent of these "traditional DSH" payments (called the "empirically justified" Medicare DSH payment amount). Hospitals then receive uncompensated-care payments calculated as a share of the remaining 75 percent of the aggregated "traditional DSH payments" adjusted by the national uninsurance rate and each hospital's share of uncompensated costs across all DSH hospitals. For more information see <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/disproportionate-share-hospital-dsh>.
- 19 The 4.4 percentage point spread in the all-payer operating margin in 2024 between the lowest and highest MSNI quartile appears different than in Table 3-13 (8.6 percent – 4.3 percent) because the difference was calculated on unrounded components. The 2.4 percentage point spread the all-payer operating margin among the hospitals in the lowest and the highest DSH quartile reflects the spread from 7.9 percent in the lowest quartile to 5.5 percent in the highest. These results also indicate that hospitals in the highest MSNI quartile are more financially vulnerable than those in the highest DSH quartile.
- 20 Currently, interim uncompensated-care payments are incorporated into the IPPS Pricer software. Most MA plans use this software to pay for enrollees' inpatient stays; therefore, the payment that hospitals receive for most MA patients' inpatient stays include interim uncompensated-care payments (Berenson et al. 2015, Centers for Medicare & Medicaid Services 2013, Maeda and Nelson 2017). On our hospital site visits in recent years, we have also continued to hear that most MA plans payments to hospitals for inpatient services are similar to FFS rates inclusive of DSH and uncompensated-care payments. However, we have shown that this method may lead to inequities in payments depending on the hospitals' MA shares (Medicare Payment Advisory Commission 2023b). In addition, it is uncertain that MA plans will continue to use the IPPS Pricer. Direct payments would ensure that hospitals receive the intended amount of safety-net funds for both their FFS and MA patients.

- 21 Last year, we calculated hospitals' shares of services that were for low-income patients using FFS and MA inpatient stays and FFS outpatient services. This year, we have incorporated MA enrollees' outpatient encounters in determining each hospital's low-income shares.
- 22 Since cost reports do not separately report MA outpatient charges, we inflated FFS Medicare inpatient and outpatient charges by the MA-to-FFS inpatient-day ratio to approximate total Medicare inpatient and outpatient charges. We then divided this amount by each hospital's total all-payer charges.
- 23 The FFS Medicare margin on inpatient services is bolstered by inpatient-centric add-on payments for hospitals with certain characteristics (i.e., teaching hospitals, DSH hospitals, and certain rural hospitals). The FFS Medicare margin on outpatient services is bolstered by the inclusion of separately payable drugs, which are paid at the average sales price plus 6 percent but can be obtained at significantly reduced prices by hospitals participating in the 340B Drug Pricing Program. However, cost reports measure drug-acquisition costs jointly across inpatient and outpatient services. Therefore, we cannot precisely differentiate between inpatient and outpatient margins.
- 24 As we previously noted, separately payable Part B drugs would not be eligible for MSNI add-on payments. In addition, coinsurance would continue to be based on the pre-MSNI payment amount to ensure that beneficiaries using Medicare safety-net hospitals would not pay more than patients at hospitals with fewer low-income patients.
- 25 While government hospitals would see a decline in FFS payments in aggregate, it is possible that they could see an increase in MA revenues if MA plans are currently not fully paying uncompensated care payments or are taking hospitals with high uncompensated care add-on payments out of their network.
- 26 Under Sections 1833(t)(1)(B)(v) and 1833(t)(21) of the Social Security Act, the affected services are no longer considered HOPD services for the purpose of payment under the OPps. "Off-campus" was defined as a department of a provider that is not on within 250 yards of a hospital campus or a remote location of a hospital facility.
- 27 CMS did not apply the PFS relativity adjuster to separately payable drugs, which were already paid at the average sales price plus 6 percent in both hospital outpatient and physician office settings; other separately payable inputs (e.g., devices, blood, or brachytherapy), which continued to be paid based on costs; or partial-hospitalization program services, which were aligned with rates paid to community mental health centers (Centers for Medicare & Medicaid Services 2016). Starting in CY 2024, CMS also excepted inpatient cardiac rehabilitation services from the lower site-neutral rate (Centers for Medicare & Medicaid Services 2023).
- 28 "Clinic visits" refers to services billed using Healthcare Common Procedure Coding System code G0463, which is used for all clinic visits under the OPps and is assigned to ambulatory payment classification 5012. In 2023, CMS modified this policy to except off-campus PBDs of sole-community hospitals that are designated as rural for payment purposes.
- 29 Similar to the clinic visit policy, CMS excepts drug-administration services provided at sole-community hospitals that are designated as rural for payment purposes.
- 30 This amount excludes services provided at sole-community hospitals that are designated as rural for payment purposes.
- 31 This amount excludes separately payable OPps inputs, such as drugs, that CMS excepts from current site-neutral policies.

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C H A P T E R

4

Physician and other health professional services

R E C O M M E N D A T I O N

- 4** For calendar year 2027, the Congress should increase payment rates for physician and other health professional services by 0.5 percentage points more than current law.

COMMISSIONER VOTES: YES 15 • NO 2 • NOT VOTING 0 • ABSENT 0

Physician and other health professional services

Chapter summary

In 2024, traditional fee-for-service (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, accounting for just over 15 percent of spending in FFS Medicare. 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.

Assessment of payment adequacy

Based on our assessment of the latest available data, the Commission's indicators of the adequacy of clinician payments have remained positive

In this chapter

- Are FFS Medicare payments adequate in 2026?
- How payment rates are updated
- How should FFS Medicare payments change in 2027?
- Appendix: Key findings from the Commission's 2025 access-to-care survey

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 up to a limiting charge as “nonparticipating” providers. In addition, very few clinicians forgo all Medicare payments by electing to “opt out” of the program; these clinicians may collect the full amount 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 school 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 in 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 or to their full panel of patients. Instead, we rely on indirect measures of clinicians' payments and costs for 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 to help comply with payers’ regulatory and administrative requirements). Despite the growing divergence between Medicare and private insurers’ payment rates, Medicare beneficiaries continue to have similar (or better) access to care relative to the privately insured, and the volume of care beneficiaries receive continues to increase, which indicate that clinicians continue to have an incentive to treat Medicare beneficiaries.

How should payment rates change in 2027?

In 2027, current law calls for PFS payment rates to decline by 1.7 percent for qualifying 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 qualifying 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 qualifying 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 and maintain financial pressure on clinicians to constrain their costs. ■

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. Physicians and other health professionals who provide services to FFS beneficiaries are paid according to Medicare's physician fee schedule (PFS). In 2024, the PFS paid for about 9,000 types of medical services for FFS beneficiaries, including office visits, surgical procedures, imaging, and tests.¹ Just under 1.5 million clinicians—including physicians, advanced practice registered nurses (APRNs), physician assistants (PAs), chiropractors, physical therapists, psychologists, and other types of health professionals—billed the Medicare PFS for services in 2024, about 4.1 percent more than the previous year.

Background

To determine payment rates under the PFS, CMS establishes relative values for each service furnished by physicians and other health professionals. Services' relative values are multiplied by a conversion factor, which is a fixed dollar amount, to produce a total payment amount for each service.² Starting in 2026, payment rates will be updated by two conversion factors—one that applies to services furnished by qualifying participants in advanced alternative payment models (A-APMs) (\$33.57 in 2026) and a second, lower rate for services furnished by nonqualifying providers (\$33.40). When fee schedule services are delivered in certain facilities, such as hospitals or ambulatory surgical centers, CMS makes an additional payment through a separate facility payment system to pay for nonpractitioner costs such as nursing staff, medical supplies, equipment, and rooms. In such instances, the PFS payment rate is reduced, but it is normally more than offset by the additional fee Medicare pays through the applicable facility payment system (discussed in separate chapters of this report), resulting in higher program spending than if the service were delivered in a nonfacility setting.

In 2024, PFS spending constituted just over 15 percent of spending in FFS Medicare (Boards of Trustees 2025).³ That year, the FFS Medicare program and its beneficiaries paid \$93.8 billion for PFS services, up 1.5 percent (or \$1.4 billion) since 2023. This increase is

largely due to the 2.5 percent decrease in the number of beneficiaries enrolled in FFS Medicare and 4.1 percent growth in spending per FFS beneficiary.

In 2024, just under 1.5 million clinicians—including physicians, APRNs, PAs, chiropractors, physical therapists, psychologists, and other types of health professionals—billed the Medicare PFS for services. The total number of clinicians billing the fee schedule in 2024 was about 5 percent higher than the previous year.

Are FFS Medicare payments adequate in 2026?

To examine the adequacy of Medicare's FFS payments for clinician services, we analyze beneficiaries' access to care, the quality of their care, and clinicians' revenues and costs. Overall, our indicators of payment adequacy are positive or improved since last year, although input cost inflation remains slightly elevated.

Medicare beneficiaries generally report better access to care than the privately insured

Although directly measuring access to care is challenging, most of our indicators suggest that FFS Medicare beneficiaries have relatively good access to care. In the Commission's 2025 survey, Medicare beneficiaries reported access to care that was generally better than that of privately insured people. The share of clinicians accepting Medicare is also high and comparable with the share accepting private insurance.

Almost all clinicians who treat FFS Medicare beneficiaries accept the PFS's payment rates as payment in full, although they have the option, if they are a "nonparticipating" provider, to balance bill beneficiaries for higher amounts. If they elect to "opt out" of the program, clinicians treating FFS Medicare beneficiaries can also choose to forgo all FFS Medicare payments and may collect the full amount they charge patients. Very few clinicians choose to opt out of the program, and the number of clinicians choosing to do so has remained stable over time.

The overall number of clinicians billing FFS Medicare has grown in recent years. The composition of the clinician workforce billing the fee schedule continues to change, with the number of primary care physicians slowly

declining over time (although there was modest growth in 2024), the number of specialists growing steadily, and the number of APRNs and PAs growing rapidly.

Most beneficiaries report good access to clinician services in surveys and focus groups

One way we assess Medicare beneficiaries' access to care is by examining data from our survey of Medicare beneficiaries ages 65 and over and privately insured people ages 50 to 64. Our annual survey is completed by about 10,000 patients, and responses are weighted to produce nationally representative results that are available to us within one month of fielding—making it a more up-to-date data source for assessing beneficiaries' access to care than CMS's Medicare Current Beneficiary Survey.⁴ The Commission's survey includes both beneficiaries in FFS Medicare and those enrolled in Medicare Advantage (MA) plans, because in our focus groups we have found that many beneficiaries have difficulty accurately identifying the type of Medicare coverage they have in a questionnaire format. We consider this combined group to be representative of the experiences of FFS beneficiaries because FFS beneficiaries and MA enrollees tend to report comparable experiences accessing care in our analyses of CMS's survey (which is a much longer survey that is merged with administrative data and completed by nearly three times as many Medicare beneficiaries as our survey). For example, our analysis of CMS's 2023 survey found no statistically significant differences in the shares of FFS and MA beneficiaries who: saw their usual care provider in the past year, said their usual care provider usually or always spent enough time with them, were satisfied with the ease with which they could get to a doctor from where they live, reported having trouble getting health care in the past year, and reported foregoing care that they thought they should have gotten.

Consistent with our 2024 survey, our 2025 survey found that Medicare beneficiaries reported access to care that was generally better than that of privately insured people. (Throughout this section, the shares of Medicare beneficiaries and privately insured people who reported a given experience are statistically significantly different from each other at the 95 percent confidence level unless otherwise noted.) (See Table 4-A1, p. 141, in this chapter's appendix for some of our key survey findings for Medicare beneficiaries versus privately insured people.)

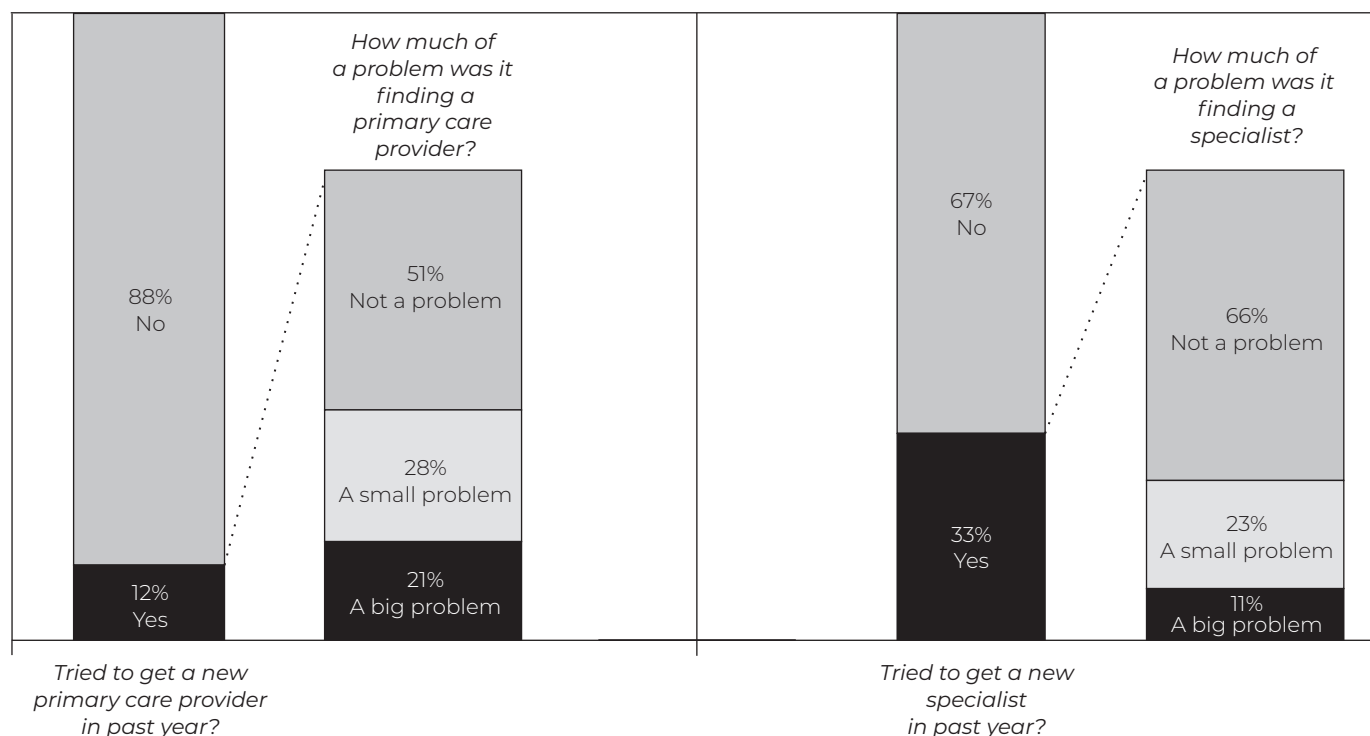
We also draw on findings from local focus groups that we conduct to ask beneficiaries and clinicians about their experiences with health care.⁵ We held separate groups with beneficiaries enrolled in traditional FFS Medicare and those enrolled in MA plans and, where relevant, we highlight similarities or differences in experiences.

Relatively high satisfaction with overall access to care Our 2025 survey found that the vast majority of Medicare beneficiaries ages 65 and over (94 percent) and privately insured people ages 50 to 64 (92 percent) had received some kind of health care in the past 12 months. Among these survey respondents, a higher share of Medicare beneficiaries was satisfied with their ability to find health care providers who accepted their insurance (97 percent) compared with privately insured people (93 percent). A higher share of Medicare beneficiaries was also satisfied with their ability to find health care providers that had appointments when they needed them (90 percent) compared with privately insured people (81 percent). In our focus groups, Medicare beneficiaries in both FFS Medicare and MA plans reported high satisfaction with their insurance coverage, with most participants rating their coverage as “excellent” or “good” (NORC at the University of Chicago 2025).

Nearly all Medicare beneficiaries reported having a primary care provider In our 2025 survey, 96 percent of Medicare beneficiaries reported having a primary care provider (PCP) compared with 92 percent of privately insured people. This finding is consistent with what we gathered from our focus groups, in which all beneficiaries we spoke with reported having a regular source of primary care.

Our survey found that Medicare beneficiaries were less likely to report receiving all or most of their primary care from a nurse practitioner (NP) or PA (19 percent) compared with privately insured people (24 percent). In our focus groups, some beneficiaries reported that they go to practices that employ a mix of clinician types and said that they alternate their appointments among different clinicians or see whoever is available.

Medicare beneficiaries reported having fewer problems finding a new clinician than the privately insured In our 2025 survey, 12 percent of Medicare beneficiaries and 14 percent of privately insured people reported

**FIGURE
4-1****Medicare beneficiaries had slightly more problems finding a new primary care provider than a new specialist, 2025**

Note: We received completed surveys from 4,788 Medicare beneficiaries ages 65 and over and 5,079 privately insured individuals ages 50 to 64. Sample sizes for individual questions varied. MedPAC's survey of Medicare beneficiaries included beneficiaries with fee-for-service Medicare and beneficiaries enrolled in Medicare Advantage plans because our analysis of the Medicare Current Beneficiary Survey found that these two groups of beneficiaries reported comparable experiences accessing care. Survey data are weighted to produce nationally representative results. In our survey, 12 percent of Medicare beneficiaries reported that they tried to get a new primary care provider in the past year; about one-third reported that they tried to get a new specialist.

Source: MedPAC's 2025 access-to-care survey, fielded by Gallup from July 18 to September 8, 2025.

looking for a new PCP. Among those respondents, 21 percent of Medicare respondents (equivalent to 2 percent of all Medicare beneficiaries) reported experiencing a “a big problem” finding a new one compared with 28 percent of privately insured respondents (equivalent to 4 percent of all privately insured people). Survey respondents most commonly looked for a new PCP because their old PCP had retired or stopped practicing.

A third of our survey respondents looked for a new specialist in the past 12 months, and among those looking, 11 percent of Medicare respondents (equivalent to 4 percent of all Medicare beneficiaries)

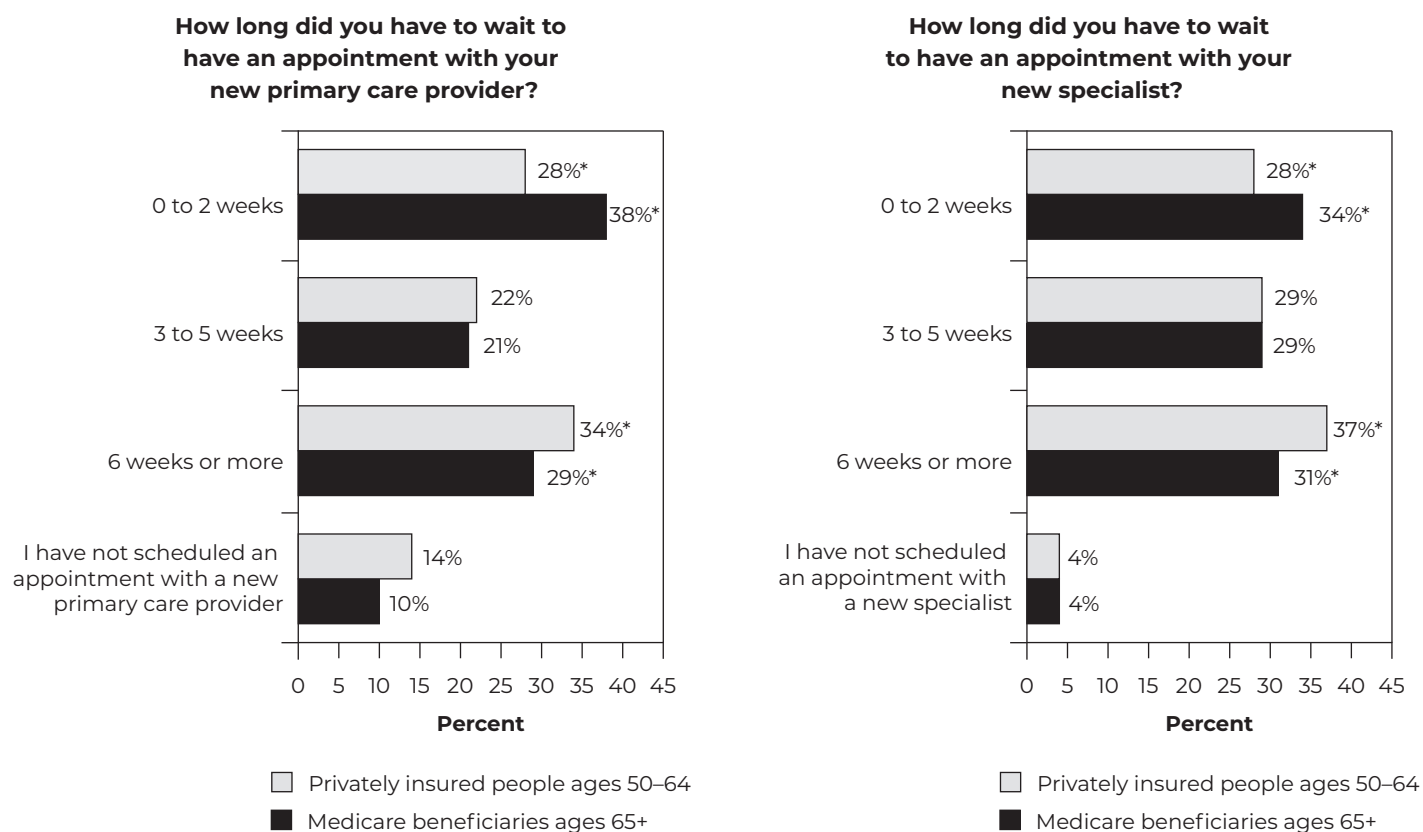
reported experiencing “a big problem” finding a new one compared with 17 percent of privately insured respondents (equivalent to 5 percent of all privately insured people).

Among survey respondents looking for a new clinician, a higher share of beneficiaries reported a problem finding a new PCP than a new specialist. This finding is true both for Medicare beneficiaries (shown in Figure 4-1) and the privately insured (not shown). (As discussed below, the number of primary care physicians treating more than 15 FFS Medicare beneficiaries has declined over time (see Table 4-1, p. 115).)

**FIGURE
4-2**

Medicare beneficiaries were more likely than privately insured people to get an appointment with a new clinician within two weeks, 2025

Among survey respondents who tried to get a new primary care provider/specialist in the past 12 months . . .



Note: We received completed surveys from 4,788 Medicare beneficiaries and 5,079 privately insured individuals. Sample sizes for individual questions varied. Medicare beneficiaries surveyed included beneficiaries with fee-for-service Medicare and beneficiaries enrolled in Medicare Advantage plans. Survey data are weighted to produce nationally representative results. Percentages do not sum to 100 percent because the response option “I don’t remember” is not included above.

* Statistically significant difference between Medicare beneficiaries and privately insured people (at a 95 percent confidence level).

Source: MedPAC’s 2025 access-to-care survey, fielded by Gallup from July 18 to September 8, 2025.

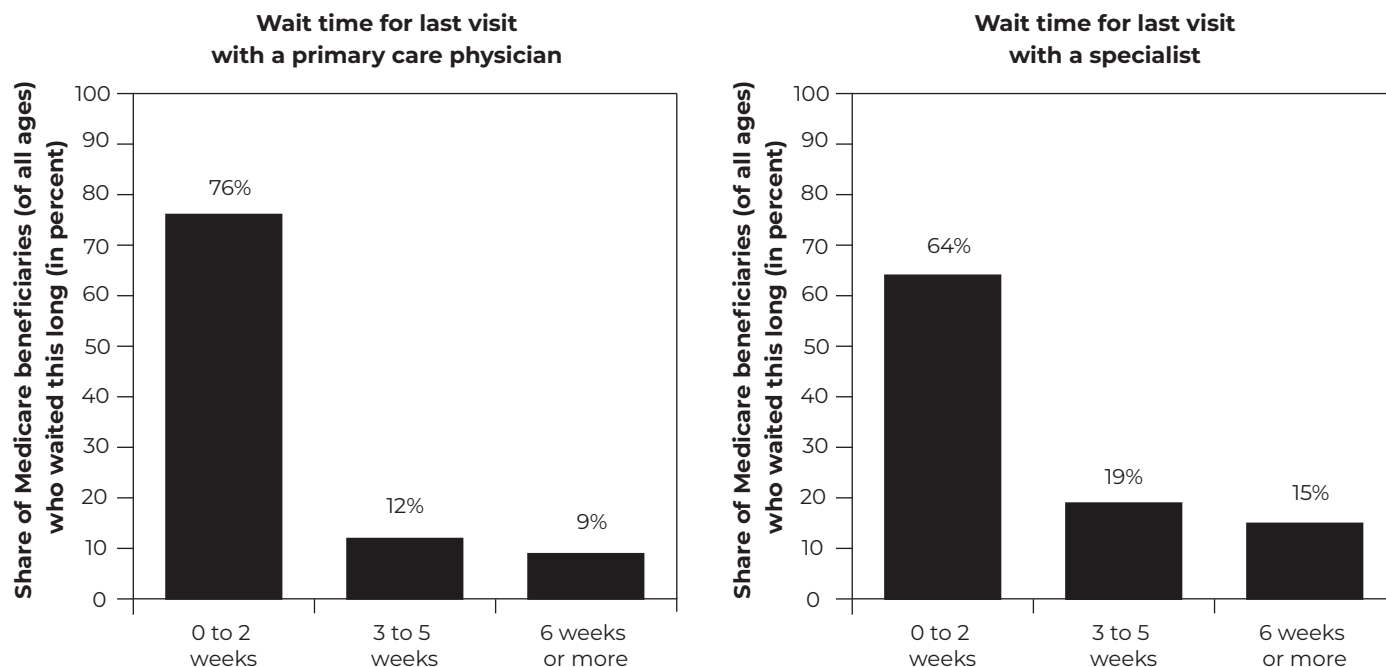
Medicare beneficiaries reported shorter waits for appointments than the privately insured Our 2025 survey found that among respondents looking for a new PCP, a higher share of Medicare beneficiaries reported being able to get their first appointment with a new PCP within two weeks or less compared with privately insured people (38 percent vs. 28 percent) (Figure 4-2). This was also true for respondents looking for a new specialist (34 percent vs. 28 percent). One possible reason Medicare beneficiaries reported

shorter wait times for new appointments could be that Medicare beneficiaries are more likely to be retired and thus may have more scheduling flexibility, which might allow them to be seen sooner than privately insured people who work full time.

Our survey also found that among those who tried to get a new clinician in the past 12 months, 10 percent of Medicare beneficiaries and 14 percent of privately insured people had yet to secure an appointment with a

FIGURE
4-3

Most Medicare beneficiaries waited two weeks or less for their last doctors' office visit (with either a new or existing clinician), 2023



Note: Bar chart reflects the experiences of beneficiaries who reported having a doctor's office visit that was scheduled after they contacted a doctor's office to set up an appointment. CMS collected responses to this segment of their survey from 11,350 Medicare beneficiaries of all ages (including those under the age of 65). Survey results are weighted to be nationally representative of continuously enrolled Medicare beneficiaries in 2023 (including those with fee-for-service Medicare and beneficiaries enrolled in Medicare Advantage plans).

Source: MedPAC analysis of CMS's 2023 Medicare Current Beneficiary Survey.

new PCP (not a statistically significant difference), and 4 percent of both Medicare beneficiaries and privately insured people had yet to secure an appointment with a new specialist (Figure 4-2).

Once Medicare beneficiaries establish a care relationship with a new clinician, subsequent appointments appear to be easier to schedule, according to CMS's Medicare Current Beneficiary Survey, which is a larger survey fielded among beneficiaries of all ages (including beneficiaries under age 65). CMS's survey asks about wait times for the most recent doctor's office visit that a beneficiary scheduled, and groups together appointments scheduled with new and existing clinicians. The survey finds that most beneficiaries were seen within two

weeks, with 76 percent of beneficiaries reporting waiting two weeks or less for their last visit with a primary care physician and 64 percent waiting two weeks or less for their last visit with a specialist (Figure 4-3). This difference may reflect primary care providers squeezing in existing patients for same- or next-day appointments when patients have an urgent health issue, since a core tenet of primary care is providing "first-contact" care to patients when they have a health issue (Starfield et al. 2005).

In our focus groups, beneficiaries also reported longer wait times for specialty care than primary care. Beneficiaries reported that the first visit can take months to a year to happen, but a few mentioned being able to see the specialist right away

if their primary care provider facilitated the referral. Many beneficiaries reported that wait times as a new patient tended to be much longer than as an established patient.

For routine care, beneficiaries in our focus groups reported no major issues with seeing their clinicians, with wait times ranging from a few days to a month. For more urgent care, beneficiaries described using a variety of resources to be seen in a timely manner, such as using a patient portal to contact their clinician.

Beneficiaries reported problems finding a new mental health professional, but access is improving In our 2025 survey, only a small share of people reported trying to get a new mental health professional in the past 12 months—3 percent of Medicare beneficiaries and 7 percent of privately insured people. Among those looking for a new mental health professional, 29 percent of Medicare beneficiaries and 36 percent of privately insured people reported “a big problem” finding one (not a statistically significant difference, given how few people looked for this type of clinician). (These shares are equivalent to 1 percent of Medicare beneficiaries and 3 percent of privately insured people overall.) The shares of respondents who reported problems finding a mental health professional has declined since we first started asking this question in 2023, which coincides with Medicare covering additional types of mental health services and mental health professionals in recent years.

Patients reported sometimes forgoing care but not necessarily due to difficulty accessing it In our 2025 survey, a smaller share of Medicare beneficiaries reported forgoing care that they thought they should have received in the past 12 months (17 percent) compared with privately insured people (27 percent). The most common reasons Medicare beneficiaries cited for not obtaining this care were that they did not think the problem was serious or they just put it off (cited by about half of those reporting forgoing care). Medicare beneficiaries were much less likely to report forgoing care because they thought it would cost too much (6 percent of those reporting forgoing care) compared with privately insured individuals (20 percent of those reporting forgoing care). Among people who reported forgoing care, comparable shares of Medicare beneficiaries and privately insured

people reported doing so because they could not get an appointment soon enough (23 percent of Medicare beneficiaries who reported forgoing care and 21 percent of privately insured people who reported forgoing care).

Other surveys also find that Medicare beneficiaries have relatively good access to care Our 2025 survey’s overall finding that Medicare beneficiaries reported access to care that was generally better than that of privately insured people is consistent with a 2023 KFF survey that compared the experiences of Medicare beneficiaries (of any age) with individuals who had employer-sponsored insurance, Marketplace plans, and other coverage. KFF’s survey found that, compared with privately insured people, Medicare beneficiaries were more likely to rate their insurance positively, less likely to report having a problem with their health insurance, and less likely to report issues affording medical bills (Pollitz et al. 2023).

Our survey findings are also consistent with several federally funded surveys that find that Medicare-aged people report better access to care than younger adults—which could mean that gaining Medicare coverage makes it easier for some people to access health care. For example, data from the Medical Expenditure Panel Survey (MEPS) and the National Health Interview Survey (NHIS) have been combined to find that around age 65, when most people gain eligibility for Medicare, there are fewer reports of being unable to get necessary care and of being unable to get necessary care specifically due to cost (Jacobs 2021). Another analysis of MEPS found that enrollment in Medicare at age 65 led to a 14 percent increase in visits to primary care providers and a 31 percent increase in visits to other providers (Lee and Li 2025). Another analysis of NHIS found that delaying or forgoing needed care due to cost was more common among adults under the age of 65 than adults over 65 (National Center for Health Statistics 2023). And analysis of the Behavioral Risk Factor Surveillance System survey has found that, compared with people with employer-sponsored or individually purchased private health insurance, Medicare beneficiaries are more likely to have a personal physician, less likely to have medical debt, and more likely to be very satisfied with their care (Wray et al. 2021).

Our analysis of CMS's 2023 Medicare Current Beneficiary Survey also found that Medicare beneficiaries reported good access to care. Because CMS's lengthy survey is fielded among a large sample of Medicare beneficiaries and merged with administrative data, this data source allows us to isolate the experiences of FFS beneficiaries, specifically (in contrast to our own survey, which does not differentiate between FFS beneficiaries and MA enrollees). In 2023, CMS's survey found that 92 percent of FFS beneficiaries (of all ages, not just those ages 65 and over) reported having a usual source of care that was not a hospital emergency department or an urgent care center, and 85 percent reported that their usual care provider was a primary care physician. CMS's survey found that 87 percent of FFS beneficiaries reported having seen their usual care provider in the past year, and 95 percent felt that this care provider usually or always spent enough time with them. In addition, 89 percent of FFS beneficiaries were satisfied with the availability of care by specialists. CMS's survey also found that a relatively small share of FFS beneficiaries (9 percent) reported experiencing trouble getting care in the past year—most often because the wait for an appointment was too long (cited by 3 percent of beneficiaries). A small share of FFS beneficiaries reported forgoing care that they thought they should have gotten in the past year (7 percent)—most often because they believed that it wasn't serious (cited by a third of this subset of beneficiaries). Most beneficiaries (87 percent) said they were satisfied with their out-of-pocket costs for medical services, but small shares had a problem paying a medical bill (4 percent) or reported delaying care due to cost in the past year (5 percent). Overall, 95 percent of FFS beneficiaries were satisfied with the ease with which they could get to a doctor from where they lived and 88 percent were satisfied with the availability of care on nights and weekends.

Beneficiaries under age 65 reported having more problems accessing care One group of Medicare beneficiaries that reported notably worse access to care than other beneficiary groups in CMS's 2023 survey is beneficiaries under age 65.⁶ For example, beneficiaries under age 65 were twice as likely as beneficiaries ages 65 and over to report having trouble getting health care (15 percent vs. 8 percent) and to report forgoing care that they thought they

should have received (13 percent vs. 6 percent). They were much more likely to report having a problem paying a medical bill (17 percent vs. 5 percent) and to report delaying care because of cost in the past year (13 percent vs. 5 percent). Part of the reason for these difficulties may be that beneficiaries under age 65 tend to report being in much worse health and require more health care services than beneficiaries ages 65 and over, yet they have much lower incomes and are less likely to have supplemental insurance (Medicare Payment Advisory Commission 2025b).

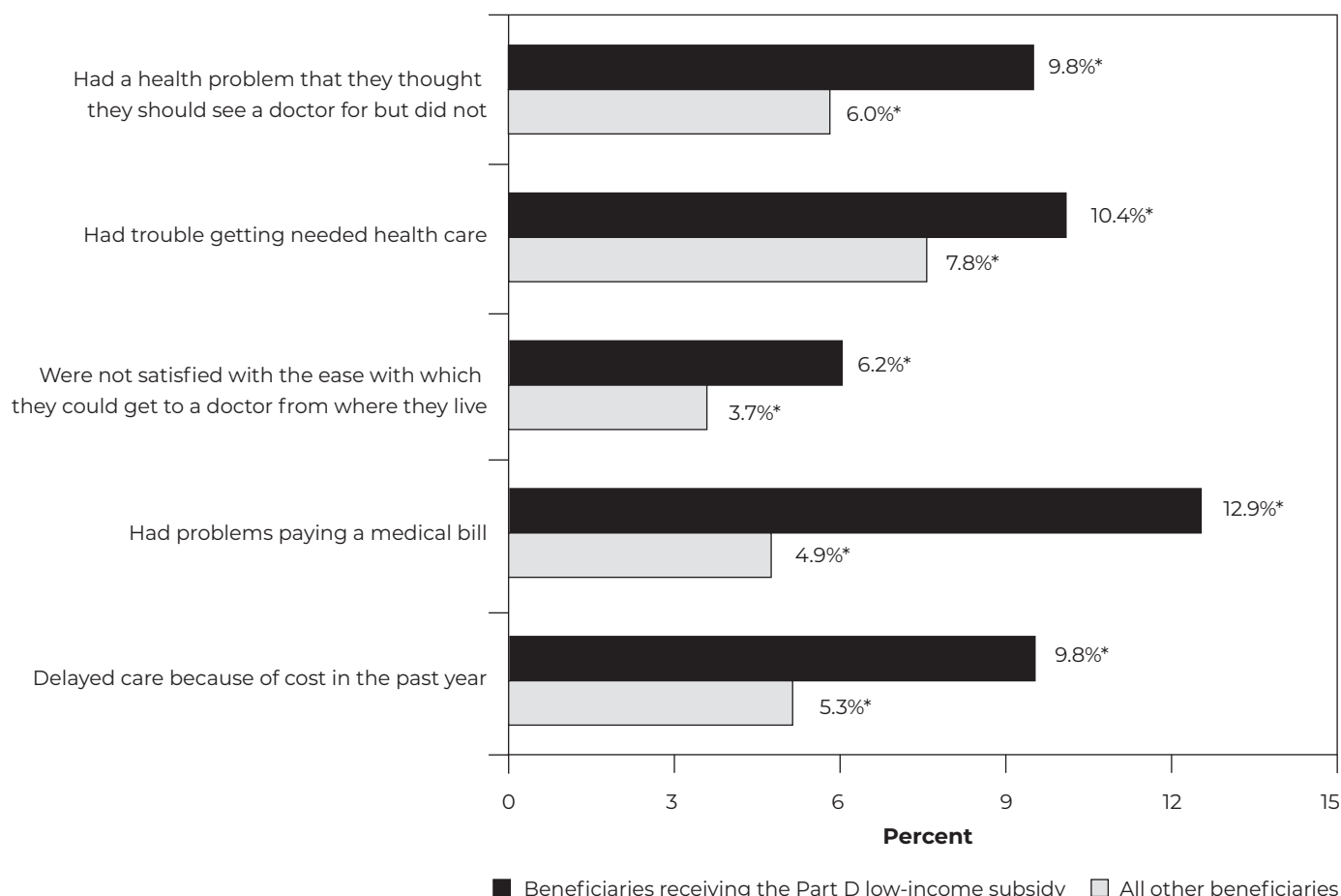
Beneficiaries with very low incomes reported more problems accessing care Beneficiaries with very low incomes also reported worse access to care compared with higher-income beneficiaries (Figure 4-4, p. 112) in our analysis of CMS's 2023 survey. For example, 9.8 percent of Medicare beneficiaries with incomes and assets low enough to qualify for the Part D low-income subsidy (LIS) reported forgoing care that they thought they should have received in the past year, compared with 6.0 percent of higher-income beneficiaries. LIS beneficiaries were more likely to report having trouble getting health care compared with higher-income beneficiaries (10.4 percent vs. 7.8 percent). And a greater share of LIS beneficiaries was dissatisfied with the ease with which they could get to a doctor from where they live (6.2 percent vs. 3.7 percent). (Our own survey, which uses higher income cut-offs, also found that lower-income beneficiaries were less likely to obtain health care than middle- and higher-income beneficiaries; see Table 4-A2, p. 142.)

One of the reasons some low-income Medicare beneficiaries may experience problems accessing health care is that clinicians often receive less payment for treating them. Beneficiaries who are dually enrolled in Medicare and Medicaid are not required to pay cost sharing for the services they receive, and some states' Medicaid programs do not pay this cost sharing either.

Concerns with low-income Medicare beneficiaries' access to care prompted the Commission to recommend in March 2023 that the Congress enact a safety-net add-on payment for fee schedule services delivered to beneficiaries who are dually enrolled in Medicare and Medicaid. Starting in 2025, CMS is now offering payment for advanced primary care management through codes (G0556, G0557, G0558)

**FIGURE
4-4**

Low-income Medicare beneficiaries reported worse access to care than higher-income beneficiaries, 2023



Note: Beneficiaries are eligible for the Part D low-income subsidy if (1) they have limited assets and incomes of 150 percent of the federal poverty level or less or (2) they are dually enrolled in Medicare and Medicaid. Survey results are weighted to be nationally representative of continuously enrolled Medicare beneficiaries in 2023 (including beneficiaries with fee-for-service Medicare and beneficiaries enrolled in Medicare Advantage plans).

* Statistically significant difference between beneficiaries eligible and automatically receiving the Part D low-income subsidy versus all other beneficiaries (at a 95 percent confidence level).

Source: MedPAC analysis of CMS's 2023 Medicare Current Beneficiary Survey.

that are billable each month and are much larger for qualified Medicare beneficiaries (QMBs), who generally have low incomes and limited resources.⁷ (In 2026, the codes pay \$117 per month for QMBs, compared with \$16 or \$54 per month for all other beneficiaries who have zero to one chronic condition or two or more chronic conditions, respectively.) These new codes are directionally consistent with the Commission's recommendation and should increase clinicians' incentives to treat low-income Medicare beneficiaries.

Rural beneficiaries reported having better access to primary care than urban beneficiaries Urban and rural Medicare beneficiaries reported similar experiences accessing care according to most questions in our survey and in CMS's survey. That said, there were some differences related to access to PCPs. As with past years, a higher share of rural beneficiaries in our 2025 survey reported receiving "all" or "most" of their primary care from an NP or PA (28 percent) compared with urban beneficiaries (16 percent). Interestingly,

among beneficiaries looking for a new PCP, more rural beneficiaries reported that it was “not a problem” to find a new one (65 percent) compared with urban beneficiaries (48 percent)—reflecting a steady improvement in rural beneficiaries’ ability to find PCPs in recent years. Wait times for an appointment with a new PCP were also shorter for rural beneficiaries than urban beneficiaries, with 57 percent of rural beneficiaries reporting being seen within two weeks versus 33 percent of urban beneficiaries (among those looking for a new PCP in our survey). In contrast, rural and urban beneficiaries reported more comparable experiences finding a new specialist (with nearly identical wait times for a first appointment with a new specialist in our survey, for example). (See Table 4-A3, p. 143, in this chapter’s appendix for additional results from our survey for rural and urban beneficiaries.) In CMS’s 2023 survey, rural beneficiaries were slightly less likely to have a usual care provider (91 percent vs. 93 percent), and among such beneficiaries, a smaller share of rural beneficiaries reported seeing a specialist in the past year (68 percent vs. 75 percent). Rural beneficiaries were more likely to be dissatisfied with the availability of specialists (13 percent vs. 9 percent).

A few differences in access to care by race/ethnicity

White, Black, and Hispanic Medicare beneficiaries reported similar experiences accessing care according to most questions in our survey. (See Table 4-A4, p. 144, for additional results from our survey for White, Black, and Hispanic beneficiaries.) In CMS’s lengthier survey, access was comparable on many key questions but a few differences did emerge; for example, we found that Black and Hispanic beneficiaries were more likely than White beneficiaries to report having a problem paying a medical bill (13 percent and 9 percent vs. 5 percent, respectively). Black and Hispanic beneficiaries were also less likely than White beneficiaries to have seen a specialist in the past year (61 percent and 64 percent vs. 77 percent), despite being twice as likely to report being in “fair” or “poor” health (28 percent and 34 percent vs. 17 percent).

Most clinicians accept Medicare

Several data sources suggest that the share of clinicians who accept Medicare is relatively high and comparable with the share who accept private health insurance, even though Medicare payment rates are usually lower than private insurers’ payment rates.

In a 2024 survey by the American Medical Association (AMA), among nonpediatric physicians accepting new patients, 85 percent reported accepting “all” new Medicare patients and another 10 percent reported accepting “some” new Medicare patients; only 3 percent said they only accepted new privately insured patients (American Medical Association 2025b). In our focus groups, the majority of clinicians reported accepting MA plans, but some reported that they do not accept all MA plans in their area and noted that such decisions are made at an organization level.

The AMA survey found that acceptance of Medicare varied by hospital ownership and medical specialty. Among those accepting new patients, larger shares of physicians in hospital-owned practices accepted “all” new Medicare patients (90 percent) compared with physicians in private practice (80 percent). And among those accepting new patients, larger shares of non-primary care physicians accepted “all” new Medicare patients (e.g., 93 percent of general surgeons, 96 percent of radiologists) compared with primary care physicians (e.g., 84 percent of internal medicine physicians, 79 percent of family medicine physicians). The one exception was psychiatry: Among psychiatrists taking new patients, only 55 percent accepted “all” new Medicare patients. Findings from our survey and other sources suggest that mental health professionals generally accept health insurance (of any kind) at lower rates than other medical specialties (American Psychological Association 2024, Ochieng et al. 2022). This observation suggests that psychiatrists’ low acceptance of Medicare may reflect a larger issue with health insurance more broadly rather than an issue confined to Medicare.

A survey that focused on the subset of physicians who work only in office-based settings (and not in facilities like hospitals) found that comparable shares of physicians accepted Medicare and private insurance. The 2021 National Ambulatory Medical Care Survey found that, among the 94 percent of nonpediatric office-based physicians who reported accepting new patients, 89 percent accepted new Medicare patients and 88 percent accepted new privately insured patients (Schappert and Santo 2023).

Our own survey has found that Medicare beneficiaries are less likely to encounter a doctor’s office that does not accept their insurance compared with privately

insured people. In 2025, among Medicare beneficiaries who had problems finding a new primary care provider in the past year, 17 percent reported encountering a doctor's office that did not accept their insurance (equivalent to 1 percent of all Medicare beneficiaries). In contrast, among privately insured people who had problems finding a primary care provider, 32 percent encountered a doctor's office that did not accept their insurance (equivalent to 3 percent of all privately insured people). A similar trend was observed for specialists: Among Medicare beneficiaries who had problems finding a new specialist, 14 percent reported encountering a doctor's office that did not accept their insurance (equivalent to 2 percent of all Medicare beneficiaries), while among privately insured people who experienced a problem finding a new specialist, 31 percent encountered a doctor's office that did not accept their insurance (equivalent to 4 percent of all privately insured people).

CMS administrative data also confirm that a high share of clinicians accept Medicare. In 2023, 98 percent of clinicians billing the PFS were participating providers, meaning they agreed to accept Medicare's fee schedule amount as payment in full. Clinicians who wish to collect somewhat higher payments (of up to 109.25 percent of Medicare's payment rates) can "balance bill" patients for additional cost sharing if they sign up as a nonparticipating provider and choose not to "take assignment" on a claim, but very few clinicians choose this option.⁸ In 2024, 99.7 percent of fee schedule claims were paid at Medicare's standard payment rate. If clinicians elect to opt out of the program entirely, they can choose the price they charge patients and bill beneficiaries directly for their services but receive no payment from Medicare. The number of clinicians who opted out of Medicare as of September 2025 (52,500) was extremely low compared with the 1.5 million clinicians who participated in the program in 2024, which is consistent with prior years (Centers for Medicare & Medicaid Services 2025b).⁹

There are many reasons why clinicians may choose to accept FFS Medicare despite payment rates that are usually lower than commercial rates. A sizable share of most clinicians' patients are covered by FFS Medicare, and if these clinicians opted to accept only commercially insured patients, they might not be able to fill their schedules. In addition, almost all hospitals accept FFS Medicare patients and may require their

employed physicians to also take FFS Medicare patients. And although commercial insurers' payment rates are typically higher than FFS Medicare's rates, commercial insurers do not pay all claims submitted to them. In contrast, FFS Medicare pays all "clean" claims within 30 days of receiving a claim (and owes providers interest on any late payments). Commercial insurers also often impose burdensome requirements on clinicians that take time to complete, such as requiring clinicians to complete prior-authorization paperwork. A 2024 survey by the AMA found that among physicians that indicated that they completed any prior authorizations in a typical week of practice, physicians reported completing an average of 39 such requests per week (requiring 13 hours per week) and 40 percent reported having dedicated staff who work exclusively on completing prior authorizations (American Medical Association 2025a). In contrast, FFS Medicare generally does not require prior authorization.¹⁰ The relative lack of utilization management and the administrative simplicity of billing FFS Medicare may help offset the program's lower payment rates.

The number of clinicians billing Medicare has increased, and the mix has changed

From 2019 to 2024, the total number of clinicians billing the fee schedule increased by an average of 2.2 percent per year, faster than FFS Medicare enrollment growth. The mix of clinicians has also changed over time.

We limit this part of our analysis to clinicians who billed for more than 15 FFS Medicare beneficiaries in a given year. This minimum threshold helps to (1) better measure clinicians who substantially participate in Medicare and therefore are likely critical to ensuring beneficiary access to care and (2) reduce year-to-year variability in clinician counts (i.e., because we exclude clinicians who billed for one or two beneficiaries in one year but may not have billed for any beneficiaries the following year).¹¹ As a point of reference, studies suggest that primary care physicians' patient panels range from 1,200 to 2,500 patients per physician (Dai et al. 2019, Raffoul et al. 2016).

Table 4-1 provides both the absolute number of clinicians who billed the fee schedule for more than 15 beneficiaries and the number of clinicians who met that threshold per 1,000 FFS Medicare beneficiaries.^{12,13} Although this measure has shortcomings (because by

**TABLE
4-1**

The number of clinicians billing Medicare's physician fee schedule increased, and the mix of clinicians changed, 2019–2024

Year	Number (in thousands)					Number per 1,000 FFS beneficiaries				
	Physicians					Physicians				
	Primary care specialty	Other specialties	APRNs and PAs	Other practitioners	Total	Primary care specialty	Other specialties	APRNs and PAs	Other practitioners	Total
2019	138	468	258	180	1,044	4.2	14.2	7.8	5.4	31.6
2020	135	468	268	172	1,043	4.2	14.5	8.3	5.3	32.3
2021	134	472	286	180	1,072	4.3	15.3	9.3	5.8	34.8
2022	133	477	308	184	1,102	4.5	16.1	10.4	6.2	37.2
2023	132	483	327	189	1,131	4.6	16.9	11.4	6.8	39.5
2024	133	491	348	193	1,165	4.8	17.6	12.5	6.9	41.7

Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). "Physicians" includes only clinicians who are licensed as a doctor of medicine (MD) or doctor of osteopathic medicine (DO). "Primary care specialty" includes family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists. Hospitalists are counted in "other specialties." "Other practitioners" includes clinicians such as physical therapists, psychologists, and social workers. This category also includes podiatrists, optometrists, dental surgeons, and chiropractors, which are defined as physicians in Section 1861 of the Social Security Act. This table includes only physicians with a caseload of more than 15 FFS beneficiaries in the year. Beneficiary counts used to calculate clinicians per 1,000 beneficiaries include those enrolled in FFS Medicare Part B. Numbers exclude nonperson providers, such as clinical laboratories and independent diagnostic-testing facilities. Components may not sum to totals due to rounding.

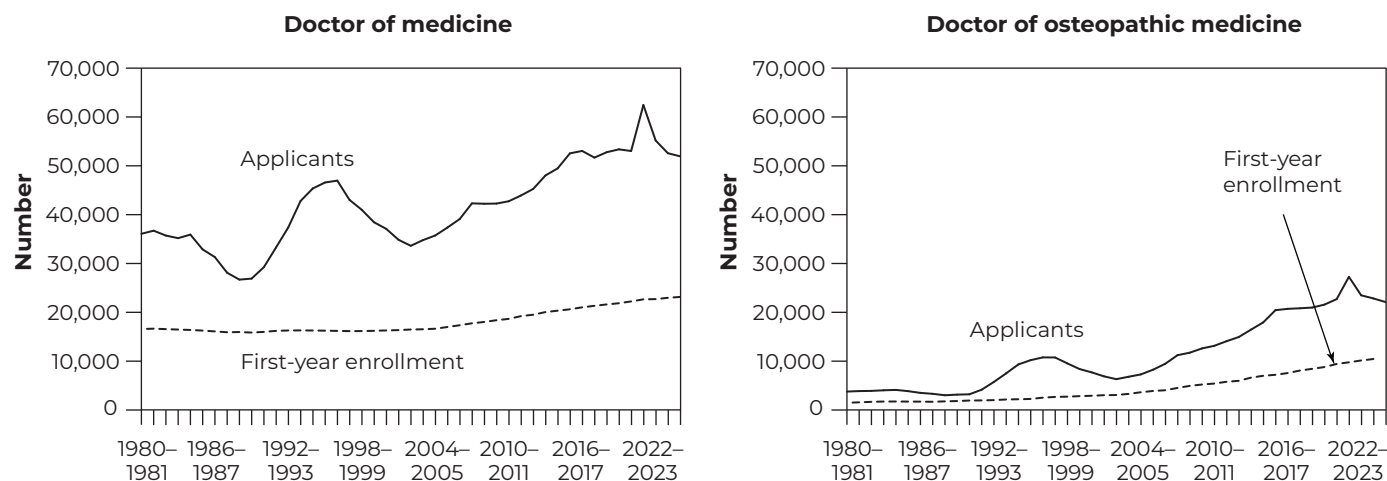
Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

excluding clinicians who treat only beneficiaries in MA it does not provide the broadest view of how many clinicians are caring for Medicare beneficiaries) a FFS-only approach is consistent with the way we calculate encounters, service units, and allowed charges per 1,000 beneficiaries. We plan to continue analyzing MA encounter data to identify MA-only clinicians and possibly include them in future analyses of access to care.

Using our threshold, we found that the total number of clinicians billing the fee schedule between 2019 and 2024 grew from about 1.0 million to almost 1.2 million. In addition to the absolute number of clinicians, we also calculate the number of clinicians billing the fee schedule per FFS Medicare beneficiary. This measure provides an indication of trends in access to clinician care among FFS beneficiaries. If the ratio of clinicians to beneficiaries is declining, it indicates that there are fewer clinicians available to care for FFS beneficiaries

and patients may have more difficulty accessing care; if the ratio is increasing, it is an indication that access to care is stable or increasing. Over the 2019 to 2024 period, the total number of clinicians per 1,000 FFS Medicare beneficiaries increased from 31.6 to 41.7.

While the total number of clinicians billing the fee schedule rose between 2019 and 2024, trends varied by type and specialty of clinician. Since 2019, the number of primary care physicians (which include physicians specializing in family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists) billing the fee schedule declined from 138,000 to 133,000—a net decrease of about 5,000 primary care physicians by 2024 (an average annual decline of 0.7 percent). Some of these clinicians may be continuing to see patients but no longer accepting insurance, instead billing patients directly for an all-inclusive monthly fee (in what are known as “direct primary care”

**FIGURE
4-5****First-year enrollment and the number of medical school applicants increased over the last two decades**

Note: For the “doctor of medicine” figure, matriculant data are used but referred to as “first-year enrollment” for comparability across figures. Matriculant and first-year enrollment data capture slightly different populations. For example, first-year enrollment data include students who repeat their first year of medical school, while matriculant data do not include such students. At the time this report was written, first-year enrollment data for doctors of osteopathic medicine were not available.

Source: Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine.

practices). One recent study estimated that a few thousand physicians and other types of clinicians now work in such practices (Zhu et al. 2025). (Another few thousand are estimated to work in “concierge” practices, which continue to accept insurance but charge patients an additional annual or monthly retainer fee.) That said, the number of beneficiaries enrolled in FFS Medicare also declined over time, as the share of beneficiaries enrolled in MA plans increased; as a result, the number of primary care physicians per 1,000 FFS Medicare beneficiaries increased from 2019 to 2024, from 4.2 to 4.8.

The total number of specialist physicians grew from 468,000 to 491,000 from 2019 to 2024, and the ratio of specialist physicians to every 1,000 FFS beneficiaries increased from 14.2 to 17.6 (an average annual increase of 4.4 percent). Over the same five-year period, the number of APRNs and PAs billing the fee schedule grew rapidly from about 258,000 to 348,000 (an average increase of 6.2 percent per year), or from 7.8 per 1,000 FFS beneficiaries to 12.5 per 1,000 FFS beneficiaries.¹⁴ Meanwhile, the number of other practitioners, such

as physical therapists and podiatrists, increased, as did the ratio of these practitioners per 1,000 FFS beneficiaries.

Interest in becoming a clinician remains high

In the long term, access to health care also depends on new physicians and other types of clinicians entering the workforce. While less immediately related to the adequacy of fee schedule payment rates than some of our other measures, we examine applications to medical school and first-year enrollment as proxies for students’ interest in and ability to become physicians. To supplement this analysis, we also examine the growth of other clinician specialties, such as NPs and PAs.

Physicians in the U.S. hold a degree as either a doctor of medicine (MD) or doctor of osteopathic medicine (DO). Despite year-to-year variations (e.g., an increase in medical school applications during the coronavirus pandemic), the long-term trend reflects an increasing number of applicants at both MD- and DO-granting educational institutions (Figure 4-5). From the 1980–

1981 academic year to the 2024–2025 academic year, the number of applicants to MD-granting institutions rose from about 36,000 to 52,000, an average increase of 0.8 percent per year, and the number of applicants to DO-granting institutions climbed from about 4,000 to 22,000, an average increase of 4.1 percent per year (Figure 4-5). First-year enrollment has grown as well, exceeding total U.S. population growth and accelerating in more recent years. From the 1980–1981 academic year to the 2023–2024 academic year, the combined first-year enrollment in MD or DO programs increased by an average of 1.4 percent per year compared with total U.S. population growth of 0.9 percent per year over the same period. In the most recent decade (from the 2013–2014 to the 2023–2024 academic years), first-year enrollment in MD or DO programs increased even faster (2.3 percent per year), while the total U.S. population grew more slowly (0.6 percent per year).¹⁵

In addition to physicians, APRNs and PAs represent an increasingly large share of the clinician workforce, and the number of these clinicians has grown rapidly, suggesting robust interest in becoming an APRN or PA. A record number of PAs—about 12,400—earned their board certification for the first time in 2024 (National Commission on Certification of Physician Assistants 2025b). As a result of the increased entry, the number of certified PAs in the U.S. has more than quadrupled from 2003 to 2024, increasing from about 43,500 to 189,900 (National Commission on Certification of Physician Assistants 2025a, National Commission on Certification of Physician Assistants 2014). Similarly, according to the Bureau of Labor Statistics, the estimated total employment for nurse practitioners roughly tripled from 2012 to 2024 (Bureau of Labor Statistics 2025). One estimate found that, in 2025, the number of licensed nurse practitioners reached about 461,000 (American Association of Nurse Practitioners 2025).

The total number of clinician encounters per FFS beneficiary grew from 2019 to 2024

We use the quantity of beneficiaries' encounters with clinicians as another measure of access to care. We use a claims-based definition of encounters.¹⁶ Clinicians submit a claim when they furnish one or more services to a beneficiary in FFS Medicare. For example, if a physician billed for an evaluation and management (E&M) visit and an X-ray on the same claim, we would

count that as one encounter. In 2024, about 98 percent of beneficiaries enrolled in FFS Medicare had at least one encounter.¹⁷

The total number of encounters per FFS Medicare beneficiary grew from 22.3 in 2019 to 24.3 in 2024 (Table 4-2, p. 118), with an average annual growth rate of 1.8 percent over that period.

Encounters with all types of clinicians declined by 11.2 percent in 2020 due to the effects of the pandemic. Total encounters then grew by an average of 5.6 percent over the 2020 to 2023 period as the effects of the pandemic subsided, and increased by 4.5 percent in 2024. The change in the number of encounters per FFS beneficiary varied by specialty and type of provider. For instance, the number of encounters furnished by primary care physicians declined by 10.2 percent during the first year of the pandemic, increased by an average of 0.1 percent from 2020 to 2023, and grew by 1.7 percent in 2024. Encounters furnished by specialist physicians decreased by 12.0 percent in 2020, increased by an average of 4.0 from 2020 to 2023, and grew by 2.8 percent in 2024.

Encounters with APRNs and PAs experienced a relatively small decrease in 2020 (-2.8 percent), and then grew by an average of 11.7 percent from 2020 to 2023, and by 11.8 percent in 2024. There was broad growth across different types of services in APRN and PA encounters: From 2023 to 2024, APRNs and PAs delivered 13.5 percent more encounters for E&M services, 14.7 percent more "other procedures," 9.2 percent more treatment services, 13.3 percent more imaging, and 14.9 percent more tests (APRNs and PAs furnish services in both primary care and non-primary care practices) (data not shown).

The number of encounters with APRNs and PAs has grown rapidly, yet we are likely undercounting the number of fee-schedule encounters provided by these clinicians due to "incident-to" billing. Medicare allows services furnished by APRNs and PAs to be indirectly billed as "incident-to" a physician visit, using the national provider identifier of a supervising physician if certain conditions are met. One study used Medicare claims data to estimate that about 40 percent of office visits provided by APRNs and PAs in 2018 were indirectly billed incident to a physician visit (Patel et al. 2022), which is consistent with the Commission's own research on this topic (Medicare Payment Advisory

**TABLE
4-2**

Total encounters per FFS beneficiary were higher in 2024 compared with 2019, and the mix of clinicians furnishing them changed

Specialty category	Encounters per FFS beneficiary						Percent change		
	2019	2020	2021	2022	2023	2024	2019–2020	Average annual 2020–2023	2023–2024
Total (all clinicians)	22.3	19.8	21.6	22.3	23.3	24.3	–11.2%	5.6%	4.5%
Primary care physicians	3.5	3.1	3.1	3.1	3.1	3.2	–10.2	0.1	1.7
Specialists	12.9	11.4	12.3	12.4	12.8	13.1	–12.0	4.0	2.8
APRNs/PAs	2.5	2.4	2.7	3.0	3.3	3.7	–2.8	11.5	11.8
Other practitioners	3.4	2.9	3.5	3.7	4.0	4.3	–15.2	11.4	6.1

Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). We define an “encounter” as a unique combination of beneficiary identification number, claim identification number (for paid claims), and the national provider identifier of the clinician who billed for the service. We use the number of FFS Medicare beneficiaries enrolled in Part B to define encounters per beneficiary. Numbers do not account for “incident to” billing—meaning, for example, that encounters with APRNs/PAs that are billed under Medicare’s “incident to” rules are included in the physician totals. Components may not sum to totals due to rounding, and percent-change columns were calculated on unrounded data.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

Commission 2019). The Commission has previously recommended that the Congress require APRNs and PAs to bill Medicare directly, eliminating incident-to billing for services they provide, which would allow a more accurate count of the number of beneficiary encounters with different types of clinicians (Medicare Payment Advisory Commission 2019). These changes would also enable policymakers to better understand whether services provided by APRNs and PAs are substituting for physician primary care visits or specialty care services.

We also measure changes in the number of encounters by type of service. From 2019 to 2023, the number of encounters per beneficiary increased for all types of services, but growth over that period was restrained by the effects of the pandemic (Table 4-3). From 2023 to 2024, encounters grew more rapidly, with some differences across broad service categories. For example, the number of E&M encounters per beneficiary (which includes E&M office visits, hospital outpatient visits, and services provided during an inpatient stay) provided by all clinicians rose 4.8

percent, from 13.1 to 14.1. In 2024, encounters for anesthesia declined (–0.8 percent), while encounters involving treatment (such as physical therapy, treatment for cancer, and dialysis)¹⁸ had the highest growth rate (5.5 percent).

Quality of clinician care is difficult to assess

The quality of clinician care is difficult to assess, but the indicators we track suggest it has remained relatively stable. The quality of care provided by individual clinicians is difficult to assess for a few reasons. First, Medicare does not collect clinical information (e.g., blood pressure, lab results) or patient-reported outcomes (e.g., improving or maintaining physical and mental health) at the FFS-beneficiary level. Second, CMS measures the performance of clinicians using the Merit-based Incentive Payment System (MIPS) that, in March 2018, the Commission recommended eliminating because it is fundamentally flawed (Medicare Payment Advisory Commission 2018b). For example, MIPS allows clinicians to choose what measures to report from a catalog of

**TABLE
4-3**

Encounters per FFS beneficiary across service types, 2019–2024

Type of service	Encounters per FFS beneficiary			Percent change	
	2019	2023	2024	Average annual 2019–2023	2023–2024
Total (all services)	22.3	23.3	24.3	1.1%	4.5%
Evaluation and management	13.1	13.5	14.1	0.7	4.8
Major procedures	0.2	0.2	0.2	0.2	2.5
Other procedures	2.4	2.4	2.5	0.5	3.0
Treatments	2.7	3.2	3.4	4.0	5.5
Imaging	4.1	4.2	4.3	0.6	3.1
Tests	2.2	2.3	2.4	0.8	4.1
Anesthesia	0.6	0.6	0.6	0.4	–0.8

Note: FFS (fee-for-service). We define an “encounter” as a unique combination of beneficiary identification number, claim identification number (for paid claims), and national provider identifier of the clinician who billed for the service. We use the number of FFS Medicare beneficiaries enrolled in Part B to define encounters per beneficiary. Values by type of service do not sum to totals because encounters with multiple service types are counted separately for each type of service but counted only once for the total. For example, if an imaging service and a test were billed in the same encounter, we count that as one encounter for imaging and one for tests (for a total of two encounters), but we count the services as one encounter for the total row. All numbers in the table are rounded, but calculations were made on unrounded data.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

hundreds of measures; this makes it harder to compare clinicians since only a few clinicians may report any given measure and allows clinicians to use measure-selection as a strategy to maximize their performance score. Also, many clinicians are exempt from reporting quality data for MIPS (e.g., if they see 200 or fewer Medicare Part B beneficiaries or bill less than \$90,000 for Part B–covered professional services), so there is a sizable share of clinicians for whom CMS has no quality information. Third, for claims-based measures, Medicare’s incident-to policies allow a substantial portion of services performed by APRNs and PAs to be billed by physicians, undermining efforts to assess clinician quality.

We report on the quality of the ambulatory care environment for beneficiaries in FFS Medicare using outcome measures that assess ambulatory care-sensitive (ACS) hospitalizations and emergency department (ED) visits, as well as patient-experience

measures (using the Consumer Assessment of Healthcare Providers and Systems (CAHPS)). This approach is consistent with the Commission’s principles for quality measurement (Medicare Payment Advisory Commission 2018a).

Effectiveness and timeliness of care outside the hospital: Ambulatory care-sensitive hospitalizations and emergency department visits

The Commission worked with a contractor to specify two claims-based outcome measures—ACS hospitalizations and ED visits—to compare quality of care within and across different populations (e.g., FFS Medicare in different local-market areas), given the adverse impact on beneficiaries and high cost of these events (RTI International 2024). Two categories of ACS conditions are included in the measures: chronic (e.g., diabetes, asthma, hypertension, heart failure) and acute (e.g., bacterial pneumonia, cellulitis). Conceptually, an ACS hospitalization or ED visit entails hospital use that

**TABLE
4-4**

National risk-adjusted rates of ambulatory care-sensitive hospitalizations and emergency department visits per 1,000 FFS Medicare beneficiaries, 2019–2024

	Risk-adjusted rate per 1,000 FFS Medicare beneficiaries						Change 2019–2024
	2019	2020	2021	2022	2023	2024	
Ambulatory care-sensitive hospitalizations	43.9	30.8	29.9	30.2	31.6	31.6	–12.3
Ambulatory care-sensitive ED visits	68.3	46.9	47.0	51.3	53.6	55.0	–13.3

Note: FFS (fee-for-service), ED (emergency department). Lower rates are better. We calculated the risk-adjusted rates of admissions and ED visits tied to a set of acute and chronic conditions per 1,000 FFS Medicare beneficiaries.

Source: Analysis of 2019–2024 FFS Medicare claims data.

could have been prevented with timely, appropriate, high-quality care. For example, if a diabetic patient's primary care physician and overall care team work effectively to control the patient's condition, an ED visit for a diabetic crisis could be avoidable. However, measure results may also reflect differences in health care access, referral patterns, and specialist availability across market areas. The measures also may not pinpoint the exact areas in ambulatory care where improvements are needed.

The national risk-adjusted ACS-hospitalization rate remained relatively stable from 2021 to 2024 and below pre-pandemic rates, while the ACS-ED visit rate increased over this period (Table 4-4). For example, in 2019 the risk-adjusted ACS hospitalization rate was 43.9 per 1,000 FFS beneficiaries, which declined to 29.9 per 1,000 FFS beneficiaries in 2021 but rose in 2023 to 31.6 per 1,000 FFS beneficiaries where it remained in 2024. During the coronavirus pandemic, there was a significant drop in overall hospitalizations, so we would expect some accompanying decline in ACS hospitalizations. ACS hospitalization rates remain below pre-pandemic levels, and it is difficult to untangle whether and how much of the decline in these services is due to changes in hospital use or because of improved access to or quality of care.

Consistent with prior years, we have found differences in rates of ACS hospitalizations and ED visits across groups of Medicare beneficiaries, which could

indicate differential access to high-quality ambulatory care (Medicare Payment Advisory Commission 2023). In 2024, beneficiaries receiving the Part D low-income subsidy (a proxy for low income) had ACS hospitalization and ED visit rates that were 1.3 times higher than those of other beneficiaries. Black beneficiaries had a rate of ACS hospitalizations that was 1.6 times higher than that of Asian/Pacific Islander beneficiaries and a rate of ACS ED visits that was almost two times higher than that of Asian/Pacific Islander beneficiaries. Beneficiaries residing in rural areas had about the same ACS hospitalization rate as beneficiaries living in urban areas. However, beneficiaries in rural areas had ACS ED-visit rates that were 1.4 times higher than beneficiaries residing in urban areas.

Consistent with previous years, in 2024, the distribution of risk-adjusted rates of avoidable hospitalizations and ED visits per 1,000 FFS Medicare beneficiaries varied widely across Dartmouth Atlas Project-defined hospital service areas (HSAs) (data not shown).¹⁹ This variation signals opportunities to improve the quality of ambulatory care. The HSA at the 90th percentile of ACS hospitalizations had a rate that was almost twice the HSA at the 10th percentile. The HSA at the 90th percentile of ACS-ED visits had a rate that was 2.3 times the HSA in the 10th percentile. Relatively poor performance on a local market's ACS-hospitalization and ED-visit measures indicates opportunities for improvement in those ambulatory

**TABLE
4-5**

Medicare FFS-CAHPS performance scores, 2020-2024

CAHPS composite measure	2020	2021	2022	2023	2024	Score change, 2020-2024
Getting needed care and seeing specialists	83	81	80	80	81	-2
Getting appointments and care quickly	78	76	75	82	83	N/A*
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical record, helps with managing care)	85	85	85	86	87	2
Rating of health plan (FFS Medicare)	84	83	83	83	84	0
Rating of health care quality	86	85	85	85	86	0
Annual flu vaccine	77	77	77	73	69	-8

Note: FFS (fee-for-service), CAHPS (Consumer Assessment of Healthcare Providers and Systems), N/A (not applicable). Questions related to “getting needed care and seeing specialists,” “getting appointments and care quickly,” and “care coordination” have response options of “never,” “sometimes,” “usually,” and “always.” CMS converts these responses to linear mean scores on a 0 to 100 scale. Questions of “rating of health plan” and “rating of health care quality” have responses of 1 to 10, which CMS also converts to a linear mean score on a 0 to 100 scale. The “annual flu vaccine” question is a yes/no response converted to a percentage. CAHPS responses are case-mix adjusted for the predictable effects of the response tendencies of the people who complete them (e.g., age, sex, health status). FFS-CAHPS response rates from 2020 to 2024 range from 28 percent to 29 percent. Years represent experiences of care during the last six months from the survey. For example, 2024 scores are based on beneficiaries’ self-reported experience in the last six months from surveys collected in the spring of 2025.

* CMS revised which CAHPS survey items are scored in the “getting appointments and care quickly” composite measure, which may cause fluctuation in scores compared with prior years. Therefore, we do not report the change in scores over time.

Source: FFS-CAHPS mean scores reported by CMS.

care systems, while relatively good performance on the measures can indicate best practices for ambulatory care systems.

Patient-experience scores

The Agency for Healthcare Research and Quality’s CAHPS surveys generate standardized and validated measures of patient experience. CAHPS surveys measure a key component of quality of care because they assess whether something that should happen in a health care setting (such as clear communication with a provider) actually happened and how often it happened, from the patient’s perspective. When patients have a better experience, they are more likely to adhere to treatments, return for follow-up appointments, and engage with the health care system

by seeking appropriate care. CMS annually fields a CAHPS survey among a subset of FFS beneficiaries to measure beneficiaries’ experience of care with Medicare and their FFS providers. (In the text box, pp. 122-123, we also present Medicare Shared Savings Program (MSSP) accountable care organization (ACO) CAHPS results, as another measure of FFS Medicare beneficiaries’ experiences with care.²⁰)

Between 2020 and 2024, FFS-CAHPS scores were relatively stable. The 2024 FFS-CAHPS score for “getting needed care and seeing specialists” was 81 (score on a scale of 0 to 100), which was an increase of one from 2023, but the score has been trending downward over the past several years (Table 4-5). The score for “rating of health plan (FFS Medicare)” was 84, and the score for “rating of health care quality” was 86;

Medicare Shared Savings Program accountable care organizations' patient-experience scores

Medicare Shared Savings Program (MSSP) accountable care organization (ACO) patient-experience results serve as another indicator of fee-for-service (FFS) Medicare beneficiaries' experiences with access to and quality of care. About 40 percent of all FFS beneficiaries are assigned to an MSSP-ACO, a permanent part of the Medicare program established through the Affordable Care Act of 2010 (ACA) (Medicare Payment Advisory Commission 2025b). MSSP-ACOs are required to field Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Merit-based Incentive Payment System (MIPS) surveys to a subset of assigned beneficiaries to measure those beneficiaries' experiences with care across various domains, such as access to care, rating of providers, and care coordination. ACOs must meet a designated minimum attainment level on the CAHPS for MIPS measures, as well as other quality measures, in order to share in savings. National MSSP-CAHPS for MIPS measure results, although measuring experience for a subset of FFS beneficiaries, can also serve as an indicator of access and quality of care for Medicare FFS beneficiaries. Some of the MSSP-CAHPS for MIPS measures are conceptually the same as the FFS-CAHPS measures discussed above, such as measuring beneficiaries' experiences obtaining timely care. However, the

FFS-CAHPS measures and MSSP-CAHPS measures are not directly comparable because there are some differences in the survey items used to calculate the measures. For example, the MSSP-CAHPS for MIPS survey items focus on the beneficiaries' experiences with their provider or provider's offices that are part of the MSSP-ACO, while the FFS-CAHPS survey items ask more broadly about beneficiary experiences across their providers and the program.

Between 2019 and 2024, changes in MSSP-ACO-CAHPS for MIPS scores were mixed. The 2024 score for "getting timely care, appointments, and information" was 84 (score on a scale of 0 to 100), which was the same as the previous two years, but trending downward from 2019 (Table 4-6). The 2024 score for "access to specialists" was 76, which was the same as 2023, but a reduction of 6 from 2019. This decline may signal that beneficiaries are finding it harder to get appointments with specialists, which is consistent with some findings from the Medicare Current Beneficiary Survey analysis and our beneficiary focus groups (discussed on pp. 109–110). The MSSP-ACO-CAHPS for MIPS scores were relatively stable and high for "how well providers communicate" and "patient's rating of provider." The "care coordination" score was 86 in 2024 and has been relatively stable over the years. ■

(continued next page)

both scores have been stable over the past few years. In 2024, 69 percent of surveyed beneficiaries reported receiving an annual flu vaccine, which was a decline of 4 percentage points from 2023, and 8 percentage points from 2020. All 2023 FFS-CAHPS measure scores for urban residents were similar to the national average (Centers for Medicare & Medicaid Services 2024b). FFS-CAHPS scores for rural residents were similar to the national average, except for the annual flu vaccine rate, which was below the national average (data not shown).

Clinicians' revenues and compensation have increased, and inflation growth has moderated in the last few years

Clinicians do not submit annual cost reports to CMS, so we are unable to calculate their profit margins from delivering services to Medicare beneficiaries or to their full panel of patients more generally. Instead, we rely on indirect measures of clinicians' payments and their costs to provide services. We find that PFS spending per beneficiary has increased markedly over time—driven by substantial growth in the volume and

Medicare Shared Savings Program accountable care organizations' patient-experience scores (cont.)

**TABLE
4-6**

MSSP-ACO-CAHPS for MIPS performance scores, 2019–2024

CAHPS composite measure	2019	2020*	2021	2022	2023	2024	Score change, 2019–2024
Getting timely care, appointments, and information	86	—	85	84	84	84	–2
Access to specialists	82	—	79	77	76	76	–6
How well providers communicate (e.g., provider explains things in a way that is easy to understand)	94	—	94	93	94	94	0
Patient's rating of provider	92	—	92	92	92	93	1
Care coordination (e.g., provider has relevant medical record)	87	—	86	85	86	86	–1

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization), CAHPS (Consumer Assessment of Healthcare Providers and Systems), MIPS (Merit-based Incentive Payment System). A subset of the CAHPS for MIPS measures scored in the MSSP are presented in this table. Questions related to “getting timely care, appointments, and information,” “access to specialists,” “how well providers communicate,” and “care coordination” have response options of “never,” “sometimes,” “usually,” and “always.” CMS converts these responses to linear mean scores on a 0 to 100 scale. The question related to “patient's rating of provider” has a response of 1 to 10, which CMS also converts to a linear mean score on a 0 to 100 scale. CAHPS responses are case-mix adjusted for the predictable effects of the response tendencies of the people who complete them (e.g., age, sex, health status). Years represent the MSSP-ACO performance year. For example, 2024 scores are based on self-reported experience during the past six months from the survey collection period from October 2024 to January 2025. CMS does not publicly report response rates for the CAHPS for MIPS survey.

*CMS did not report 2020 performance year results because of the coronavirus pandemic.

Source: Analysis of CMS Medicare Shared Savings Program Performance Year Financial and Quality Results datasets.

intensity of services delivered per FFS beneficiary.²¹ Since peaking in 2022, growth in input costs has moderated but remains slightly elevated. Clinicians' annual compensation from all sources continues to rise.

Allowed charges per FFS beneficiary grew at a higher rate from 2023 to 2024 than during previous years

The total payments that clinicians received per FFS beneficiary grew from 2023 to 2024, in part because of increases in the volume and/or intensity of services

they deliver. We measure the total payments a clinician receives using allowed charges (which include Medicare payments and beneficiary cost-sharing liabilities) for services furnished to FFS beneficiaries that are paid under the PFS.²²

From 2023 to 2024, across all services, allowed charges per beneficiary rose by 4.1 percent (Table 4-7, p. 124). Among broad service categories, growth rates were 5.1 percent for E&M services, 4.0 percent for imaging services, 2.2 percent for other procedures

**TABLE
4-7**

Growth in allowed charges per FFS beneficiary varied by type of service, 2019–2024

Type of service	Change in units of service per FFS beneficiary		Change in allowed charges per FFS beneficiary		Share of allowed charges, 2024
	Annual average 2019–2023	2023–2024	Annual average 2019–2023	2023–2024	
All services	1.9%	7.1%	2.3%	4.1%	100%
Evaluation and management	0.8	10.9	3.2	5.1	52.1
Imaging	0.9	3.3	1.5	4.0	10.7
Major procedures	–0.2	3.1	–1.5	–0.3	6.7
Other procedures	1.4	3.6	1.2	2.2	12.5
Treatments	6.5	7.6	4.4	4.9	10.3
Tests	0.9	3.2	1.7	3.7	5.0
Anesthesia	–0.4	1.7	–1.4	–0.3	2.4

Note: FFS (fee-for-service). We use the number of FFS Medicare beneficiaries enrolled in Part B to define units of service and allowed charges per beneficiary. The Restructured BETOS Classification System (RBCS) is used to group clinically similar services into categories and subcategories. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare claims data for 100 percent of FFS beneficiaries and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

(i.e., procedures that are not considered major procedures), 4.9 percent for treatments, and 3.7 percent for tests. Allowed charges per FFS beneficiary for major procedures and anesthesia each fell by 0.3 percent. Growth in five of the seven service categories was higher in 2024 than the average annual growth rates during the 2019 to 2023 period (allowed charges declined for major procedures and anesthesia in 2024, but less than they declined from 2019 to 2023). The 2019 to 2023 period included slow or negative growth during the pandemic, but spending largely rebounded in 2021 and 2022. For most categories, the growth in allowed charges in 2024 was also higher than the average annual rate of growth in the years immediately prior to the pandemic, which averaged 2.0 percent from 2015 to 2019 (data not shown). The exceptions were major procedures and anesthesia, which declined or grew more slowly from 2023 to 2024 than they did over the 2015 to 2019 period.

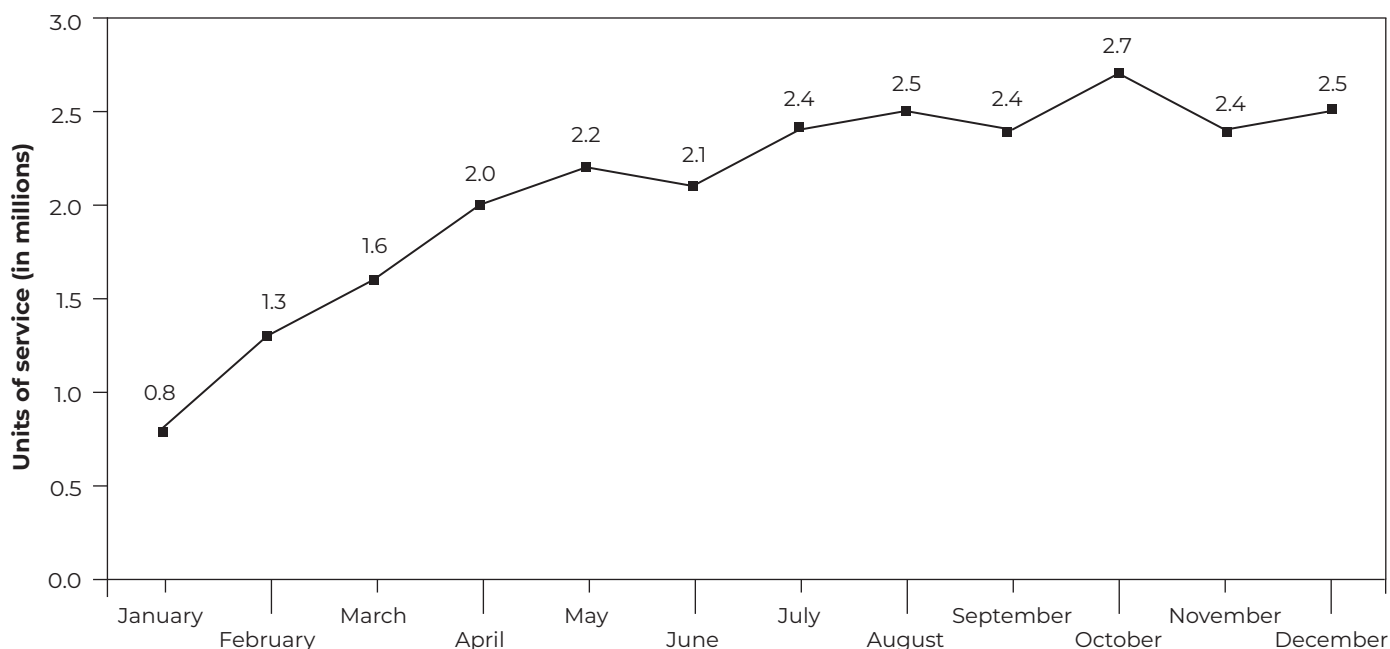
We also present data on changes in units of service per beneficiary. For most types of services, a unit

represents one individual service, such as an office visit, surgical procedure, or imaging scan. As measured by units of service per beneficiary, the volume of clinician services grew more quickly over the 2023 to 2024 period (7.1 percent) than it did from 2019 to 2023 (1.9 percent per year), which included the pandemic, during which volume for various types of services experienced relatively slow growth or declined (Table 4-7). Volume growth during both periods varied by type of service, but growth rates for all types of service were higher in 2024 than during the 2019 to 2023 period.

Overall volume grew more than spending growth in 2024, suggesting that much of the growth that year was driven by increased volume. Spending can also be affected by increased intensity of the services being delivered, which often does not result in changes in volume. For example, if providers substitute CT scans with contrast for CT scans without contrast (which results in an increase in relative value units (RVUs)), the allowed charges for imaging services would increase at a higher rate than would units of service for imaging.

FIGURE
4-6

Monthly utilization of the G2211 complexity add-on code increased during 2024



Note: G2211 is an add-on code that can be billed with certain office/outpatient evaluation and management (E&M) visit codes. It can be billed when a clinician is furnishing an eligible E&M visit to an existing patient for management of a serious or complex medical condition.

Source: MedPAC analysis of Medicare claims data for 100 percent of fee-for-service beneficiaries.

Differences in allowed charges from volume may also be partly attributable to increases or decreases in Medicare's payment rates for certain services, such as the recent increases in rates for E&M services. Decreases in allowed charges relative to service volume changes can also be related to the shift of services from freestanding offices to the outpatient hospital setting, where fee schedule payments are generally still made but payment rates under the PFS are lower.²³

Among the broad service categories shown in Table 4-7, E&M had the highest rate of growth in allowed charges and units of service in 2024. A substantial portion of the increase in E&M units and allowed charges is the result of clinicians billing for a new add-on code, which was introduced in 2024. G2211 is an add-on code that clinicians may use with traditional office/outpatient E&M visits but not with procedures or most other

codes. Code G2211 can be billed when the clinician is serving as the focal point for all of a patient's ongoing care or is treating a patient's single, serious condition—such as managing a complex illness over an extended period of time.²⁴ As long as all requirements for billing G2211 are met, there is no limit on how often it can be used and the code can be billed by multiple clinicians (e.g., both a primary care provider and a specialist) for the same patient.

In 2024, Medicare paid for the G2211 add-on code approximately 25 million times. As shown in Figure 4-6, monthly utilization of G2211 increased steadily during the first part of 2024 but stabilized toward the end of the year. Code G2211 is responsible for approximately half of the 10.9 percent volume growth that took place among all E&M codes in 2024 (data not shown). The add-on code accounted for about \$400 million in

allowed charges in 2024, which is responsible for about one-fifth of the overall 5.1 percent increase in spending on E&M services. The effect attributable to G2211 on E&M spending growth was not as large as its effect on volume because the payment rate for the add-on code is relatively small at about \$16.

Utilization and allowed charges in the treatment category of services also grew at a rapid rate (7.6 percent and 4.9 percent, respectively) in 2024. Treatment categories include services such as administration of dialysis and cancer treatments, physical therapy, and spinal manipulation. Among all treatments, increases in volume and spending among physical therapy services (which includes physical, occupational, and speech therapy (PT/OT/ST) services) were the primary drivers of growth. Spending per FFS beneficiary on these types of services rose by 8.0 percent from 2023 to 2024 and grew by a total of 54 percent over the 2019 to 2024 period (data not shown). Increases in allowed charges for PT/OT/ST were mirrored by utilization growth for these services.

Among all PT/OT/ST services, physical therapy represents more than 80 percent of spending and had the greatest impact on overall growth from 2019 to 2024. During that period, growth in physical therapy was driven by a combination of increases in the share of beneficiaries receiving physical therapy (26 percent), number of therapy services furnished to each beneficiary (54 percent), and number of clinicians who furnish these services (23 percent). The growth in volume of and spending on physical therapy services may be related to the elimination of previous annual caps on spending on physical therapy services for each beneficiary unless a medical exemption was granted. Providers who treat beneficiaries whose spending on physical therapy exceeds a specified spending threshold are now permitted to exceed those thresholds by including a modifier on claims to attest to medical necessity.

Growth in input costs is moderating from recent highs but remains slightly elevated

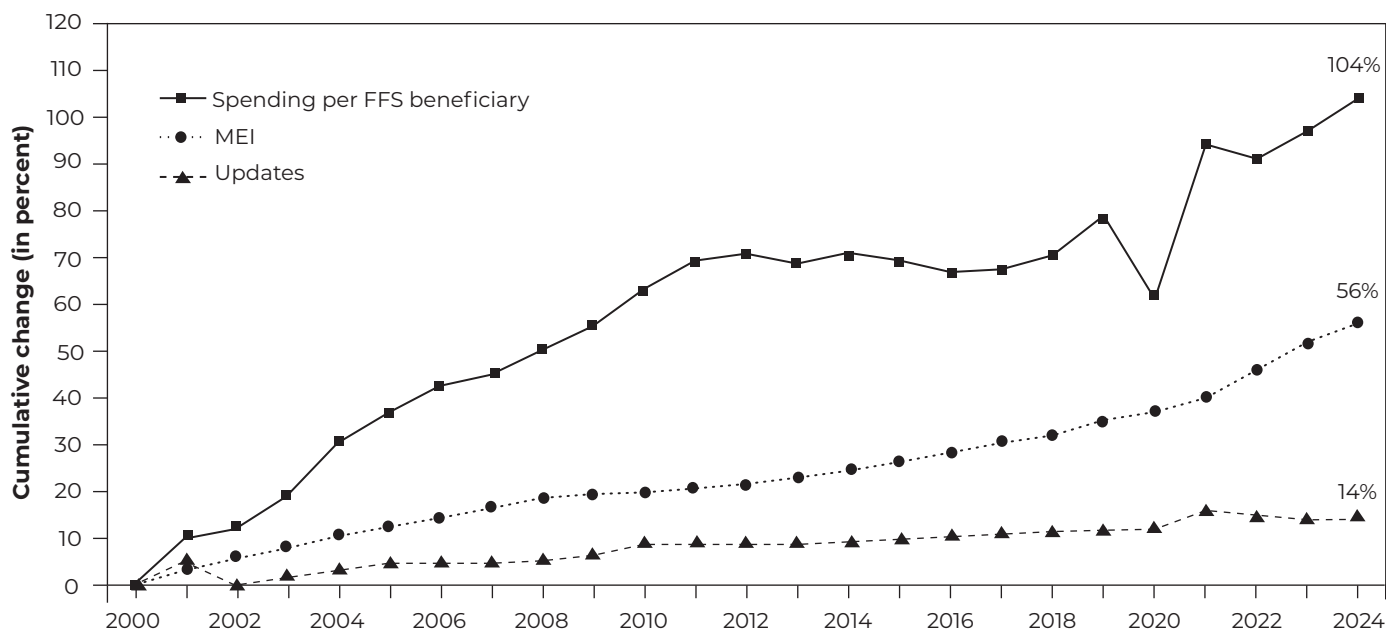
We report the growth in clinicians' input costs because it helps us understand the extent to which Medicare payment-rate updates and clinician revenues are keeping pace with increases in the costs associated with running a practice. The Medicare Economic

Index (MEI) measures the average annual price change for the market basket of inputs used by clinicians to furnish services. Unlike many other market baskets, the MEI has long been adjusted for a measure of productivity growth. Therefore, reported MEI growth figures include a built-in adjustment for total-factor productivity. The MEI consists of two main categories: (1) physicians' compensation and (2) physicians' practice expenses (e.g., compensation for nonphysician staff, rent, equipment, and professional liability insurance).

MEI growth was 1 percent to 2 percent per year for several years before the coronavirus pandemic and was 1.9 percent in 2020.²⁵ MEI growth then increased to 4.3 percent in 2022. MEI growth slowed to 3.0 percent in 2024 and is projected to moderate further in the coming years—to 2.7 percent in 2025, 2.2 percent in 2026, and 2.1 percent in 2027.²⁶

From 2000 to 2024, cumulative MEI growth has far exceeded updates to PFS payment rates (Figure 4-7). Over that period, the MEI increased cumulatively by 56 percent compared with 14 percent for fee schedule updates. However, the volume and intensity of clinician services delivered each year has increased, which has resulted in fee schedule spending per FFS beneficiary growing by 104 percent over the same time period.²⁷ The substantial growth in volume and intensity (and the Commission's broader finding that Medicare beneficiaries report relatively good access to care) suggests that below-MEI updates have not impeded access and that simply comparing changes in fee schedule updates with MEI growth is insufficient to capture changes over time in clinicians' ability to provide services to Medicare beneficiaries.

Some stakeholders have suggested that the large increases in volume and intensity over the last two decades represent clinicians' responses to fee schedule payment rates that declined (after adjusting for inflation) over that period, and some early studies finding a negative relationship between fee schedule payment rates and volume and intensity of fee schedule services supported this view (Congressional Budget Office 2007, Office of the Actuary 1998). However, some more recent research contradicts this theory, with multiple rigorous studies estimating a positive relationship between payment rates and volume and intensity (Hayford et al. 2025). That is, these studies find that volume and intensity *increase* as payment

**FIGURE
4-7****Physician fee schedule spending per FFS beneficiary grew substantially faster than the MEI or fee schedule payment updates, 2000–2024**

Note: FFS (fee-for-service), MEI (Medicare Economic Index). The MEI measures the change in clinician input prices. MEI data are from the new version of the MEI (based on data from 2017) and include updated total-factor productivity data. Spending per FFS beneficiary is based on incurred spending under the physician fee schedule. The graph shows updates to payment rates in nominal terms. Fee schedule updates do not include Merit-based Incentive Payment System adjustments or bonuses for participating in advanced alternative payment models. One-time payment increases of 3.75 percent in 2021, 3.0 percent in 2022, 2.5 percent in 2023, and a weighted average of 1.25 percent and 2.93 percent for 2024 are included.

Source: MedPAC analysis of Medicare regulations, CMS market basket data, and reports from the Boards of Trustees of the Medicare trust funds.

rates increase. For example, one study found that, among 40- to 55-year-old physicians, a 10 percent increase in payment rates was associated with physicians billing 4.4 percent more RVUs—3.9 percent more procedures (nearly all of which is driven by performing procedures on additional patients rather than doing procedures more frequently for the same number of patients) and additional shifts to relatively higher-paid procedures (Gottlieb et al. 2023).²⁸ That study also found that increasing Medicare payment rates decreases physicians' likelihood of retiring. Other research has found that the relationship between payment rates and the volume of care is greater for

elective procedures, such as cataract surgery, than it is for less discretionary services (Clemens and Gottlieb 2014). Yet not all studies have consistent results: in one specific clinical area, another recent study found that when a 10 percent bonus for primary care providers expired, clinicians responded by increasing the volume and intensity of the services they furnished by 4 percent (Brunt 2023). This evolving body of research suggests that the effects of changing PFS rates can vary depending on a number of factors, such as the type of service, but that in aggregate the slower growth in PFS rates relative to the MEI is unlikely to account for the growth in volume and intensity over the same period.

Clinician compensation growth has averaged 3 percent to 4 percent per year in recent years

Since the Commission lacks data that would allow us to calculate clinicians' all-payer profit margins from delivering services, we use clinician compensation data as a rough proxy for all-payer profitability. Clinician compensation levels suggest that clinicians' total all-payer revenues are greater than their costs and that providing clinician services is therefore profitable. These compensation levels also give some assurance that there is an incentive for individuals to pursue careers as clinicians. We note, however, that Medicare constitutes only a portion of the revenue clinicians receive since Medicare is only one of the insurers clinicians typically receive payments from. In addition, some health systems may choose to subsidize clinicians' compensation using profits from non-PFS sources (e.g., profits from payments through the hospital outpatient prospective payment system or from 340B drug discounts). Some clinicians' compensation arrangements may also not be directly tied to Medicare PFS payment rates (especially among employed clinicians paid a salary that reflects demand and supply in a local market). That said, academic research suggests that changes in Medicare fee schedule payment rates directly affect physician earnings. One study found that a 10 percent increase in Medicare payment rates was associated with a 2.4 percent increase in professional earnings of 40- to 55-year-old physicians (Gottlieb et al. 2023).

In SullivanCotter's latest physician compensation and productivity survey, median physician compensation grew by 6 percent from 2023 to 2024—twice as fast as inflation (which was 3 percent).^{29,30} And according to the U.S. Bureau of Labor Statistics, median PA compensation grew by 2.5 percent and median NP compensation grew by 2.3 percent over this period (Bureau of Labor Statistics 2025).

But compensation growth from one year to the next is somewhat erratic—with robust growth in some years and more modest growth in others—so it is useful to look at compensation growth over a multiyear period. From 2019 to 2024, median physician compensation grew by an average of 3.7 percent per year, median PA compensation grew by an average of 3.5 percent per year, and median NP compensation grew by an average of 3.3 percent. All of these growth rates are

somewhat slower than inflation from 2019 to 2024—which was higher than usual, at 4.2 percent per year.

From 2019 to 2024, compensation grew more quickly for some physician specialties than others. Higher growth was observed among a number of specialties that commonly furnish E&M office visits, such as family medicine (averaging 5.0 percent per year) and internal medicine (4.6 percent), neurology (4.8 percent), endocrinology (4.4 percent), rheumatology (4.8 percent), and oncology and hematology (5.4 percent). Higher growth was also observed for some surgical specialties: cardiovascular and cardiothoracic surgery (4.5 percent), general surgery (4.4 percent), and some other less-common surgical specialties (4.7 percent).³¹

By 2024, median compensation was \$369,000 for physicians, \$133,000 for PAs, and \$129,000 for NPs.³² As shown in Figure 4-8, physician compensation varied substantially by specialty, with much lower median compensation for primary care physicians (\$308,000) than for surgical specialties (\$525,000). Compensation differences by specialty for NPs and PAs tend to be much smaller.

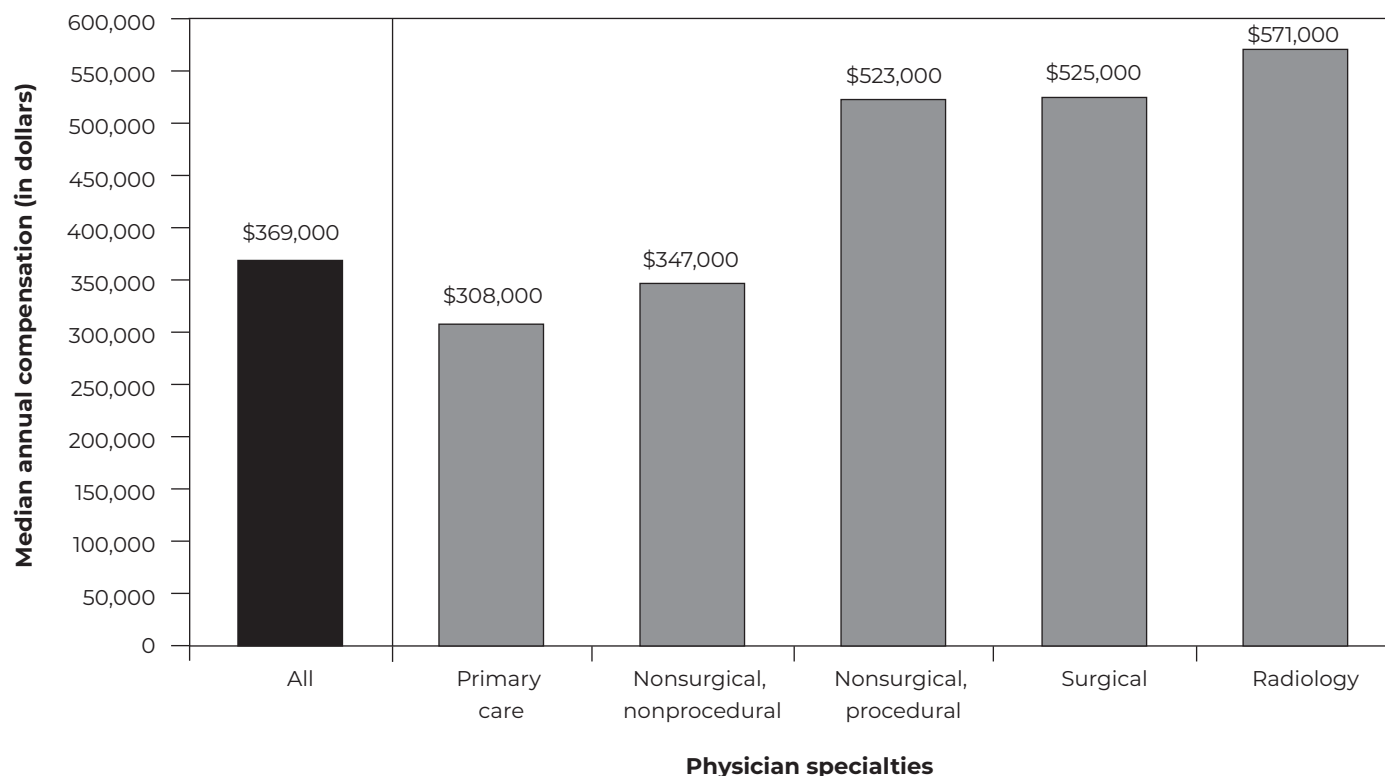
The large compensation gap between primary care physicians and most specialists may help explain why a declining share of physicians are pursuing careers in primary care. In recent years, CMS has pursued several payment policies that have the potential to disproportionately benefit primary care providers (see text box, pp. 130–133).

Average payment rates of private-insurance preferred provider organizations grew faster than, and remained higher than, Medicare payment rates for clinician services

Most clinicians see patients with a variety of types of insurance, and profitability varies by payer. We therefore compare trends in the rates paid by private-insurance plans with trends in Medicare rates for clinician services to gain insight into clinicians' revenues and incomes. We also examine these trends because extreme disparities in payment rates might create an incentive for clinicians to focus primarily on patients with private insurance and avoid those with FFS Medicare coverage. For this analysis, we used data on paid claims for enrollees of preferred provider

**FIGURE
4-8**

Compensation for primary care physicians is lower than for most specialists, 2024



Note: Figure reflects all physicians whose 2024 annual compensation was reported in the survey ($n = 124,193$). Numbers are rounded to the nearest thousand. "Compensation" refers to median total cash compensation adjusted to reflect full-time work and does not include employer retirement contributions or payments for benefits. The "primary care" group includes family medicine, internal medicine, and general pediatrics. The "nonsurgical nonprocedural" group includes psychiatry, emergency medicine, hospital medicine, endocrinology and metabolism, nephrology and hypertension, neurology, physical medicine and rehabilitation, rheumatology, and other internal medicine/pediatrics. The "nonsurgical procedural" group includes cardiology, dermatology, gastroenterology, pulmonology, and hematology/oncology. The "surgical" group includes general surgery, orthopedic surgery, cardiovascular and cardiothoracic surgery, neurological surgery, ophthalmology, otolaryngology, urology, obstetrics/gynecology, and other surgical specialties. Certain nonsurgical nonprocedural specialties (endocrinology, rheumatology, psychiatry) had lower median compensation than primary care physicians.

Source: SullivanCotter's 2025 Physician Compensation and Productivity Survey (reflecting 2024 compensation).

organization (PPO) health plans that are part of a large national insurer that covers a wide geographic area across the U.S.³³ In 2024, the average PPO payment rate for clinician services was 147 percent of FFS Medicare's average payment rate, up from 140 percent in 2023.

The ratio in 2024, as in prior years, varied by type of service. For example, private-insurance rates were 124 percent of Medicare rates for care-management and

coordination E&M visits but 213 percent of Medicare rates for CT scans.

The gap between private-insurance rates and Medicare rates has grown over time as Medicare rates have increased more modestly than private-insurance rates: In 2011, private-insurance rates were 122 percent of Medicare rates. However, as we noted earlier, clinicians accept Medicare at rates similar to those of private

Primary care providers may benefit from recent changes to Medicare's physician fee schedule

The Commission has called for increasing payment rates for certain services commonly provided by primary care providers and reducing payment rates for certain services commonly provided by specialists. Evidence suggests that many procedures are overvalued because Medicare's payment rates have not fully accounted for increases in efficiency in furnishing

these services. At the same time, services that cannot be performed more efficiently with practice and advances in technology, such as office visits, tend to become passively devalued over time (Medicare Payment Advisory Commission 2018a).

In recent years, CMS has adopted new payment policies that have the potential to increase

(continued next page)

**TABLE
4-8**

New codes disproportionately used by primary care providers

Year added	Billing code	Service description	Payment in 2026
Chronic care management (CCM)			
2015	99490	CCM, first 20 minutes of clinical staff time directed by a physician or other qualified health care professional (QHCP) (e.g., nurse practitioner) per month	\$66.13
2021	+99439	Each additional 20 minutes per month	+\$50.44
2017	99487	Complex CCM, first 60 minutes of clinical staff time directed by a physician/QHCP per month	\$144.29
2017	+99489	Each additional 30 minutes per month	+\$78.16
2019	99491	CCM, first 30 minutes provided personally by physician/QHCP per month	\$89.18
Transitional care management (TCM)			
2013	99495	TCM with patient contact within 2 business days of discharge, moderate medical decision-making, and a visit within 14 days of discharge	\$220.11
2013	99496	TCM with patient contact within 2 business days of discharge, high medical decision-making, and a visit within 7 days of discharge	\$298.60
Advanced primary care management (APCM) (can use instead of above codes)			
2025	G0556	APCM by clinical staff under direction of physician/QHCP of a patient with 0-1 chronic condition, per month	\$16.37
2025	G0557	APCM of a patient with 2+ chronic conditions, per month	\$53.78
2025	G0558	APCM of a QMB patient with 2+ chronic conditions, per month	\$117.24
Behavioral health integration			
2018	99484	Care management for behavioral health conditions, 20+ minutes of clinical staff time under direction of physician/QHCP per month	\$57.45
Social determinants of health (SDOH) assessment			
2024	G0136	Administration of a SDOH risk assessment by clinical staff/physician/QHCP, 5-15 minutes	\$20.04
2024	G0019	Community health integration services by clinical staff, 60 minutes per month	\$86.17
2024	+G0022	Each additional 30 minutes per month	+\$54.11

Primary care providers may benefit from recent changes to Medicare's physician fee schedule (cont.)

Medicare's total payments to primary care providers. Although Medicare does not specify which medical specialty a clinician must have to use a particular billing code, a number of codes added in the past decade are being used disproportionately by primary care providers (Table 4-8). (New codes for procedures, tests, and imaging disproportionately used by specialists are not shown.) Many of

these new codes pay for care management and coordination by clinical staff (e.g., nurses, medical assistants) working under the supervision of a physician or other qualified health care professional as part of a care team. Some of these codes have seen greater uptake than others (Figure 4-9, p. 132) and CMS has expanded and refined these code sets over the years.

(continued next page)

**TABLE
4-8**

New codes disproportionately used by primary care providers (cont.)

Year added	Billing code	Service description	Payment in 2026
Remote physiologic monitoring (RPM)			
2019	99453	Initial set-up and patient education on use of equipment	\$21.71
2026	99445	Device supply with daily recordings or programmed alerts transmission, 2–15 days in a 30-day period	\$52.11
2019	99454	Device supply with daily recordings or programmed alerts transmission, 16–30 days in a 30-day period	\$52.11
2026	99470	Patient-provider communication re: RPM data, first 10 minutes by clinical staff/physician/QHCP per month	\$26.05
2019	99457	Patient-provider communication re: RPM data, first 20 minutes by clinical staff/QHCP per month	\$51.77
2020	+99458	Each additional 20 minutes	+\$41.42
Advance care planning			
2016	99497	Advance care planning, first 30 minutes of physician/QHCP time	\$86.84
2016	+99498	Each additional 30 minutes	+\$78.16
Visit complexity add-on code			
2024	+G2211	Add-on code for office/outpatient E&M visit when clinician's care is continuing focal point for all needed care or part of ongoing care re: a patient's single serious or complex condition	+\$17.37

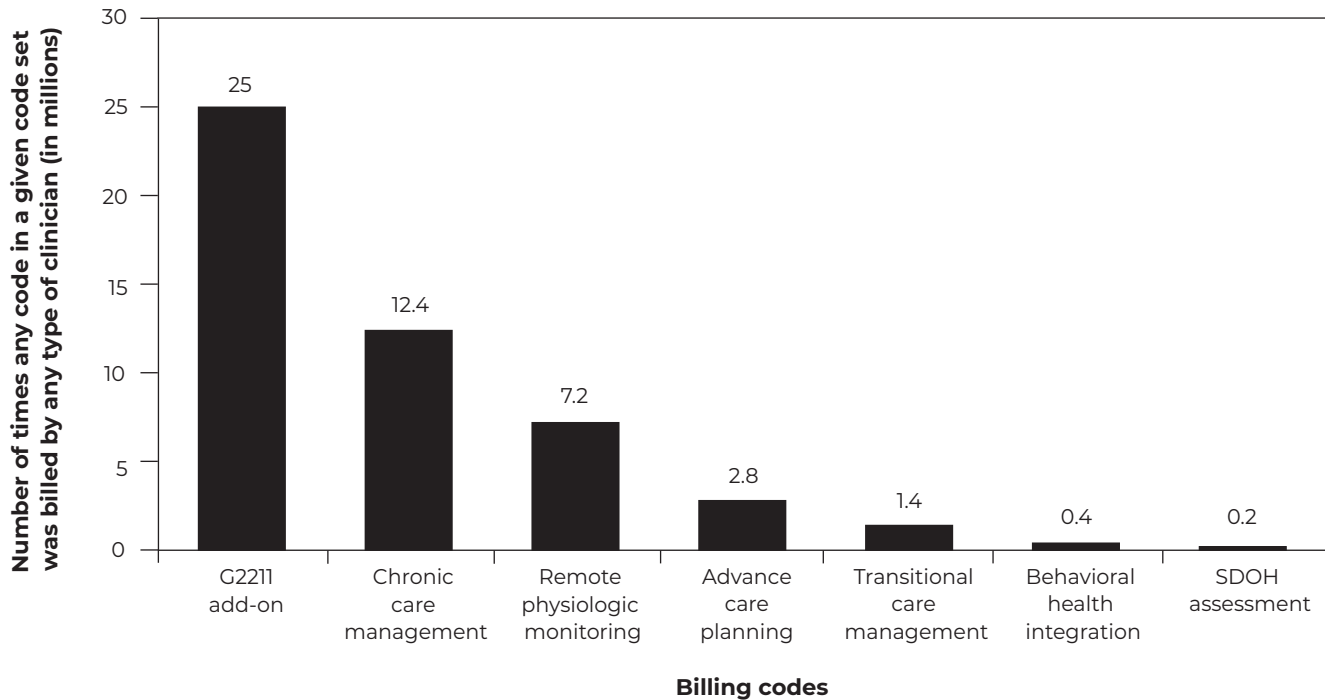
Note: QMB (Qualified Medicare Beneficiary), E&M (evaluation and management). "Year added" refers to the year that Medicare first started making payments for a given code. "Service description" presents our brief summaries of code descriptions. "Payment in 2026" reflects national payment amounts for a nonfacility setting (e.g., office); actual payment amounts vary based on geography and other factors. Some codes that are infrequently used are not shown (e.g., for e-visits, virtual check-ins). We include two billing codes that become payable in 2026 and are expected to be disproportionately used by primary care providers.

Source: American Medical Association RBRVS Data Manager.

Primary care providers may benefit from recent changes to Medicare's physician fee schedule (cont.)

FIGURE 4-9

Utilization of common primary care-focused codes, 2024



Note: SDOH (social determinants of health). Figure shows the number of times a code in a given code set was billed by a clinician (including non-primary care providers) in 2024. Numbers are rounded to the nearest hundred thousand. The advanced primary care management code set is not shown since it was not yet billable in 2024.

Source: MedPAC analysis of Medicare claims data for 100 percent of fee-for-service beneficiaries.

In addition, in 2021, CMS increased payment rates for evaluation and management (E&M) office and outpatient visits (shown later in Figure 4-10, p. 136). This is estimated to have reduced the compensation gap between specialists and primary care providers (PCPs) by 2 percent, since office visits are billed more frequently by PCPs than by specialists (Neprash et al. 2023).

In 2024, CMS began offering the G2211 code, which adds \$16 to the payment rate for E&M visits when a clinician's services are the continuing focal point for all needed health care services and/or a clinician's

services are part of ongoing care related to a serious or complex condition (described earlier, pp. 125–126, and shown in Table 4-8, pp. 130–131). This add-on code was used disproportionately by primary care providers and frequently used by some specialists as well (e.g., cardiologists, urologists); In 2024, it was billed 25 million times (Figure 4-9). G2211 can be billed by multiple clinicians treating the same beneficiary, and there is no limit on the number of times it can be used per month.

In 2025, CMS began offering a monthly payment per beneficiary for advanced primary care management

(continued next page)

Primary care providers may benefit from recent changes to Medicare's physician fee schedule (cont.)

(APCM) services (G0556, G0557, and G0558). These APCM codes have the potential to see greater uptake than predecessor care-management codes since they do not have strict requirements about how much time must be spent engaging in specified activities per month. The APCM codes pay clinicians \$16 per month for FFS Medicare beneficiaries with zero to one chronic condition, \$54 per month for beneficiaries with two or more conditions, and \$117 per month for beneficiaries with two or more conditions who are also qualified Medicare beneficiaries (who generally have low incomes and limited resources and qualify for financial assistance). Only one clinician may bill an APCM code for a given patient in a given month, and patients must give consent for a clinician to begin billing the codes (since they will increase cost sharing for beneficiaries who lack supplemental insurance). Since payment rates for the APCM codes are higher for beneficiaries with low incomes, the codes are directionally consistent with our March 2023 recommendation that Medicare make safety-net add-on payments for physician fee schedule services delivered to low-income beneficiaries (Medicare Payment Advisory Commission 2023).

Finally, in 2026, CMS applied a new “efficiency adjustment” of –2.5 percent to the work relative value units (RVUs) of thousands of non-time-based services commonly provided by specialists (e.g., procedures). This adjustment will improve the accuracy of payment rates for services that clinicians can perform more quickly with practice, and is supported by the Commission (Medicare Payment Advisory Commission 2025a, Medicare Payment Advisory Commission 2018a). (When

the RVUs assigned to a billing code are higher than empirically justified, it results in “passive devaluation” of the other codes in the fee schedule, because it prevents a two-step process from occurring. If relatively overvalued services’ RVUs had been reduced, it would have been accompanied by positive budget-neutrality adjustments to the fee schedule’s conversion factor—which would have increased payment rates for all other services (e.g., time-based services such as 30-minute office visits).) CMS applied an efficiency adjustment to non-time-based codes in 2026 and plans to do so again in 2029 and every three years thereafter. Under budget-neutrality rules, these adjustments are expected to cause modest increases to payment rates for time-based codes (such as E&M visits).

The Commission has generally supported these various changes, which have the potential to reduce the size of the large compensation gap between specialists and primary care providers and make primary care a more financially appealing specialty. Although some of these policies may have contributed to compensation growing slightly more quickly for primary care specialties than many other specialties in the past few years (p. 128), the compensation gap between specialists and primary care providers nevertheless remains large and is likely continuing to influence physician trainees’ choice of specialty (Figure 4-8, p. 129). The codes and adjustments described in this text box have the potential to play a larger role in the future, as more of these changes take effect and uptake of new codes increases. We will continue to monitor use of these codes, the supply of different types of clinicians, beneficiaries’ access to care, and care quality. ■

insurance, and some academic research suggests that increasing Medicare fee schedule rates might not necessarily narrow the gap between Medicare and private-insurance rates. Specifically, one paper found

that a \$1.00 increase in Medicare rates was associated with a \$1.16 increase in private-insurance rates (Clemens and Gottlieb 2017).

The growth in private-insurance rates may result in part from greater consolidation of physician practices and hospitals' acquisition of physician practices that give providers greater leverage to negotiate higher prices for clinician services with private plans (Medicare Payment Advisory Commission 2020). In recent years, the share of physicians in larger groups and employed by hospitals has risen substantially. For example, according to an AMA survey, from 2012 to 2024, the share of physicians who were either directly employed by a hospital or in a practice with hospital ownership increased from about 29 percent to 47 percent (Kane 2025).

Studies have found that private-insurance prices for physician services are higher in markets with larger physician practices and in markets with greater physician-hospital consolidation (Capps et al. 2018, Clemens and Gottlieb 2017, Harris et al. 2025, Neprash et al. 2015). Similarly, the Commission has found that independent practices with larger market shares and hospital-owned practices have received higher private-insurance rates for E&M visits than other practices in their market (Medicare Payment Advisory Commission 2017). The AMA survey found that the most cited reason physicians gave for selling their practice to a hospital, hospital system, health system, private equity group, or insurer was to enhance their ability to negotiate higher payment rates with payers (71 percent of physicians working in an acquired practice indicated this reason was important); other commonly cited reasons were to improve access to costly resources and get help complying with payers' regulatory and administrative requirements (cited by just under two-thirds of respondents in these practices) (Kane 2025).³⁴ Another recent study found that physicians most likely to become hospital-integrated were those who generated less revenue per Medicare patient, treated more clinically complex patients, and who struggled to perform well on pay-for-performance quality measures (Alinezhad et al. 2024).

Compensation and productivity data indicate that clinicians who work in hospital-owned practices do not necessarily earn higher compensation, but they do tend to see fewer patients and bill for fewer services than clinicians in physician-owned practices (Medical Group Management Association 2024, Medical Group Management Association 2023, Medical Group

Management Association 2022, Post et al. 2024, Whaley et al. 2021). A Medscape survey of employed physicians found that the most appealing aspects of working as an employed physician were not having to run a small business and having stable income. The top drawbacks were having less autonomy and having to comply with more workplace rules (McKenna 2022).

In contrast to private insurance, Medicaid tends to have lower payment rates for clinician services compared with Medicare. One study found that Medicaid rates were 72 percent of Medicare rates for 27 common procedures in 2019 (Zuckerman et al. 2021). Research has also shown that fewer physicians accept new Medicaid patients compared with patients who have Medicare or private insurance (Medicaid and CHIP Payment and Access Commission 2025, National Center for Health Statistics 2021). Multiple factors could influence clinicians' decisions to accept Medicaid patients, including Medicaid's relatively high administrative burdens.

How payment rates are updated

Medicare's payment rates for clinicians are updated each year by updating the PFS's conversion factor.³⁵ (Increasing the conversion factor by 1 percent, for example, results in a 1 percent increase to payment rates.) In most years, the update to the conversion factor reflects two factors: (1) a percentage specified in statute and (2) a budget-neutrality adjustment if necessary. Statutory updates to the conversion factor are currently specified in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (shown in the first two rows of Table 4-9); MACRA specified that clinicians' payment rates were to be updated by 0 percent from 2020 to 2025. Meanwhile, the budget-neutrality adjustment is required by law and is a percentage calculated by CMS to ensure that any changes it has made to the relative values of specific billing codes in the fee schedule do not, in and of themselves, increase or decrease total fee schedule spending by more than \$20 million. During years in which the relative values for some services are increased, for example, and CMS anticipates that these changes would result in an increase in

**TABLE
4-9**

Physician fee schedule payment-rate updates and performance payment adjustments under current law

	2021	2022	2023	2024	2025	2026	2027
Updates							
Clinicians in A-APMs	—	—	—	—	—	0.75%	0.75%
Clinicians not in A-APMs	—	—	—	—	—	0.25%	0.25%
All clinicians (not cumulative)	3.75%	3.0%	2.5%	1.25%, 2.93%	—	2.5%	—
Performance payment adjustments							
Bonus for clinicians in A-APMs (not cumulative)	5%	5%	5%	5%	3.5%	1.88%	—
MIPS adjustments (not cumulative)	-7% to +1.8%	-9% to +1.9%	-9% to +2.3%	-9% to +8.3%	-9% to +2.2%	-9% to TBD	-9% to TBD

Note: A-APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System), TBD (to be determined). "Not cumulative" updates and adjustments apply in a given year only and are not included in subsequent years' payment rates. The fee schedule update in 2024 equaled 1.25 percent from January 1, 2024, through March 8, 2024, and was replaced by an update of 2.93 percent from March 9, 2024, through December 31, 2024, at which point the update expired. A "sequester" reduces Medicare payment rates by 2 percent in most years (not shown); the sequester was waived during the pandemic.

Source: MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); the Coronavirus Aid, Relief, and Economic Security (CARES) Act; the Consolidated Appropriations Act, 2021; An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes; the Protecting Medicare and American Farmers from Sequester Cuts Act; the Consolidated Appropriations Act, 2023; the law colloquially known as the One Big Beautiful Bill Act (PL 119-21); CMS QPP Participation and Performance Results At-A-Glance fact sheets; CMS's final rules for the physician fee schedule.

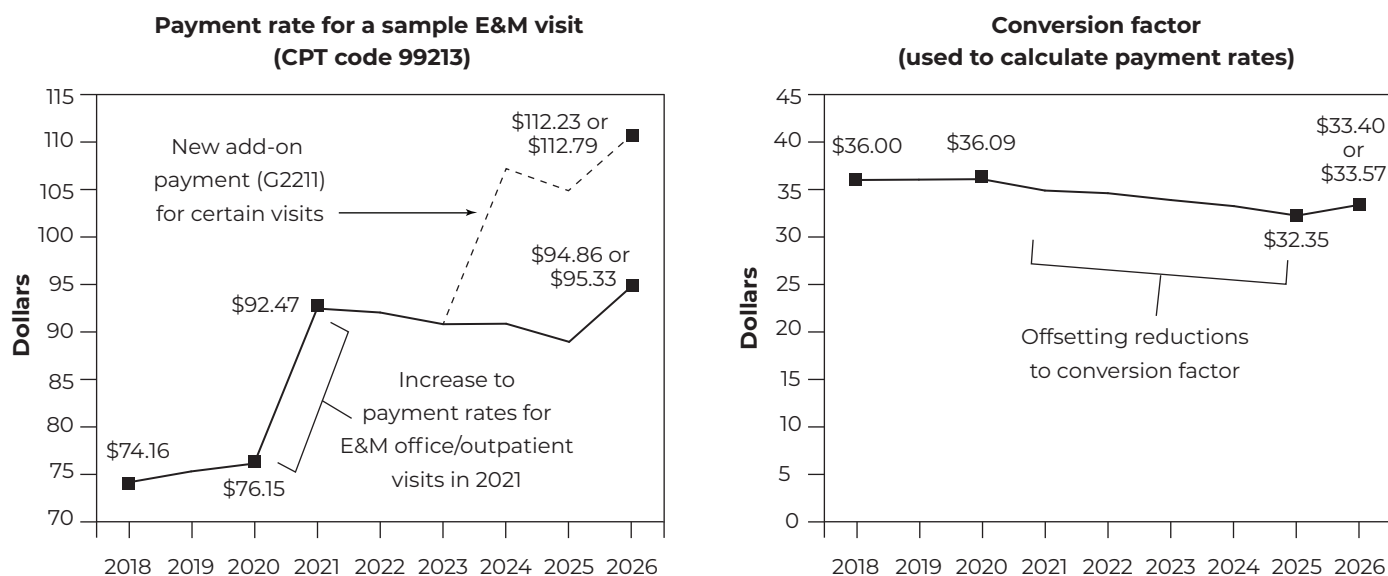
total fee schedule spending, a negative budget-neutrality adjustment is made to offset those costs. The net effect of an increase in relative values for some services and an across-the-board downward adjustment to the conversion factor redistributes fee schedule spending among different services but does not increase or decrease total expected spending. Nearly all other Medicare payment systems have budget-neutrality provisions, and they accomplish the same basic objective—ensuring that changes in relative weights do not increase or decrease overall spending.

Because of the fee schedule's budget-neutrality requirement, a recent increase in the values for some commonly used billing codes has resulted in

a decrease in the conversion factor over the past few years. Specifically, in 2021, CMS increased the payment rates for many types of E&M visits in the office and outpatient setting, upon the recommendation of the AMA/Specialty Society Relative Value Scale Update Committee. Increasing the payment rates for these billing codes required an offsetting -6.8 percent budget-neutrality adjustment to the fee schedule's conversion factor so that the change in payment rates for E&M visits did not increase total expected spending under the fee schedule. To avoid a reduction of this size to the conversion factor (and, thus, to payment rates) in 2021, the Congress subsequently passed laws that provided a series of temporary increases to the conversion factor from 2021 through 2024 (shown in

**FIGURE
4-10**

**Increases to payment rates for E&M office/outpatient visits
(including a new add-on payment) required offsetting
decreases to the fee schedule's conversion factor**



Note: E&M (evaluation and management), CPT (Current Procedural Terminology). The E&M office/outpatient visit code set comprises CPT codes 99202–99205 (new patients) and 99211–99215 (established patients). CPT code 99213 refers to a visit involving a low level of medical decision-making; if time is used for code selection, 20–29 minutes are spent on the date of the encounter. Payment rates shown for 99213 are nonfacility national payment rates. Code G2211 is an add-on code available to be billed with office/outpatient E&M visit codes when a clinician has a longitudinal relationship with a patient and meets other requirements. After 2021, CMS increased values for E&M services in other clinical settings as well, which contributed to declines to the conversion factor in subsequent years. In 2026, there are two different conversion factors (and therefore payment rates), depending on whether a clinician is a qualifying participant in an advanced alternative payment model.

Source: CMS. Physician fee schedule (interactive billing code payment rate look-up website), <https://www.cms.gov/medicare/physician-fee-schedule/search/overview>.

the third row of Table 4-9, p. 135). These increases effectively phased in the 6.8 percent reduction to the conversion factor over time. As a result, payment rates for office and outpatient E&M visits (which are provided by a wide variety of clinicians) have increased substantially (shown at left in Figure 4-10), while the conversion factor has gradually declined (shown at right in Figure 4-10).

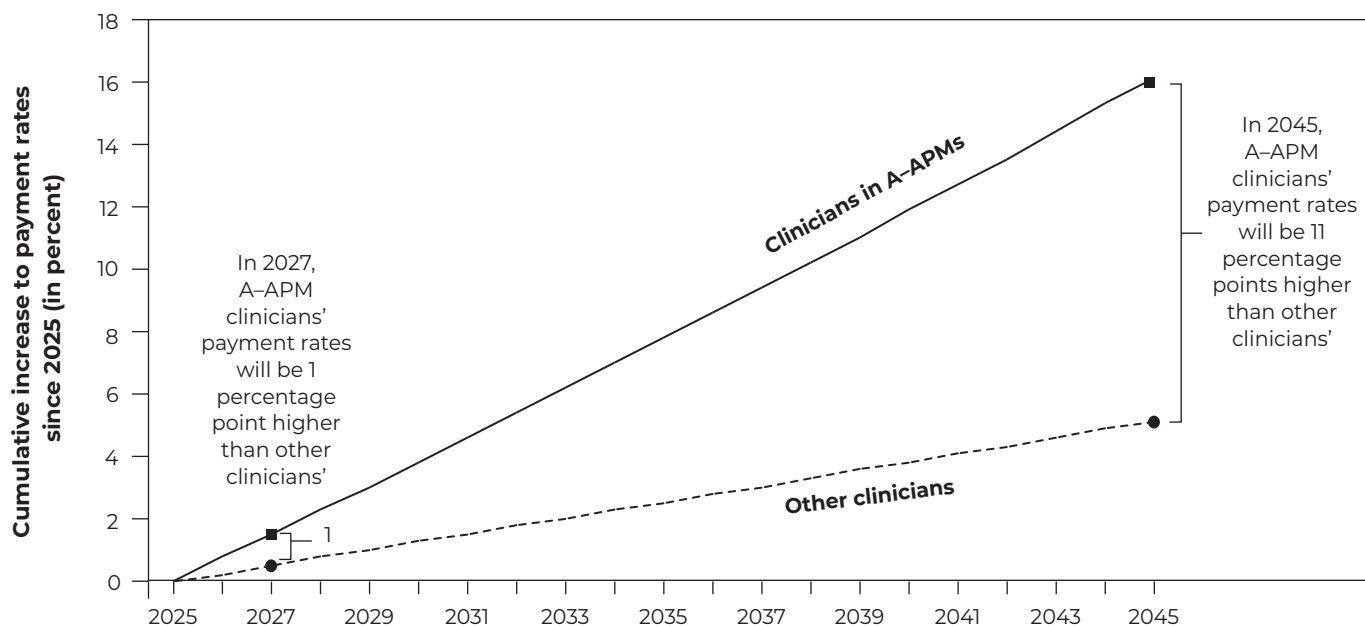
Part of the decline in the conversion factor (shown at right in Figure 4-10) also offsets the cost of the new G2211 add-on payment for E&M office/outpatient visits (described earlier in the chapter). This add-on code can be billed by clinicians who have an ongoing

relationship with a patient or are treating a patient's single serious condition (shown as the dotted line in the left graph of Figure 4-10). This add-on code is expected to be used by primary care clinicians and some specialists (Centers for Medicare & Medicaid Services 2023).

Although the decline in the conversion factor may seem like it would reduce clinicians' Medicare payments, it is important to remember that the accompanying increase to payments for E&M office/outpatient visits is expected to have produced a net increase in Medicare payments for clinicians who commonly provide E&M office or outpatient visits.

**FIGURE
4-11**

Under current law, the difference between payment rates for clinicians in A-APMs and other clinicians will be small in the 2020s but large by the 2040s



Note: A-APM (advanced alternative payment model). Graph does not show adjustments to payment rates prompted by budget-neutrality requirements, which take into account additions, deletions, or modifications of fee schedule billing codes and can result in payment updates that are larger or smaller than specified in statute. Graph also does not show (1) annual Merit-based Incentive Payment System adjustments, which can increase or decrease payments to individual clinicians based on performance measures, or (2) annual A-APM participation bonuses available from 2019 through 2026 because these adjustments are one time only and not built into subsequent years' payment rates. Graph also does not show the effects of the expiration of the 2 percent sequester that applies to payment rates through February 2033.

Source: MedPAC analysis of Medicare Access and CHIP Reauthorization Act of 2015 and subsequent laws.

Current law calls for two conversion factors starting in 2026

Starting in 2026, MACRA calls for payment rates to increase by 0.75 percent per year for qualifying clinicians in advanced alternative payment models (A-APMs) and by 0.25 percent for all other clinicians.³⁶ (Examples of A-APMs include accountable care organization models that put participating providers at risk of owing financial penalties if they miss cost and quality targets.) The difference between these two sets of clinicians' payment rates will initially be small but then grow large (shown in Figure 4-11). For example, in 2027, A-APM clinicians' payment rates will be only 1 percentage point higher than other clinicians' rates, but by 2045, A-APM clinicians' rates

will be 11 percentage points higher. An incentive this large could be unwarranted and unfair, especially if many clinicians continue to have limited access to A-APMs because of their geographic location, medical specialty, or other circumstances.

How should FFS Medicare payments change in 2027?

Current law calls for PFS payment rates to decline in 2027 by 1.7 percent for qualifying clinicians in A-APMs 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 qualifying clinicians in A-APMs and all other clinicians, respectively, in 2027 pursuant to MACRA.³⁷

Based on many of 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.

RECOMMENDATION 4

For calendar year 2027, the Congress should increase payment rates for physician and other health professional services by 0.5 percentage points more than current law.

RATIONALE 4

In aggregate, on the basis of many of our indicators (all of which measure conditions before a temporary 2.5 percent statutory increase took effect in 2026), fee schedule payment rates appear to be adequate. Overall, access to clinician services for Medicare beneficiaries appears to be comparable with, or better than, that of privately insured individuals. Quality of care is difficult to assess, but the metrics that we track suggest care quality has remained stable in recent years. Over the past two decades, clinicians' total annual fee schedule payments per FFS beneficiary have risen substantially faster than both payment rate updates and input costs as measured by the MEI. In addition, all-payer compensation for clinicians has continued to rise steadily.

However, input costs are projected to continue to grow faster than Medicare's payment rates in coming years. While evidence suggests that full MEI updates have not been necessary to maintain access to care, the Commission is concerned that ongoing cost increases that substantially exceed payment updates could be difficult for clinicians to absorb. The Commission is also concerned that differences in compensation between specialists and primary

care clinicians may be contributing to fewer clinicians practicing primary care, thereby negatively affecting beneficiary access to primary care. Actions taken by CMS to introduce primary care-focused codes (including higher paying codes for primary care furnished to low-income beneficiaries), and increased payments for existing primary care services, hold promise, and we will monitor their effects on beneficiaries' access and quality in the coming years.

Current law calls for payment rates to increase by 0.25 percent or 0.75 percent in 2027, depending on whether a clinician is participating in a qualified A-APM. The Commission's recommendation would allow the temporary 2.5 percent statutory increase to expire at the end of 2026 and then increase current-law updates by an additional 0.5 percentage points each. In light of the fact that most of our payment adequacy indicators have been positive without the addition of the temporary 2.5 percent payment increase, the Commission does not recommend continuing the increase beyond 2026.

Therefore, under our recommendation, after the expiration of the temporary 2.5 percent increase, rates in 2027 would increase by a total of 1.25 percent for clinicians participating in qualified A-APMs and by a total of 0.75 percent for other clinicians. Because of the expiration of the 2.5 percent increase, on net we expect our recommendation to result in 2027 payment rates for each group declining by 1.2 percent and 1.7 percent, respectively, relative to 2026 levels. These decreases would be smaller than what would otherwise occur under current law. It is worth noting that, after the expiration of 2026's temporary 2.5 percent update, the average impact of our recommended 1.25 percent and 0.75 percent increases would be very similar in magnitude to our June 2025 recommendation to replace all future current-law updates with a default update of MEI minus 1 percentage point (which would have yielded an estimated update of 1.1 percent in 2027) (Medicare Payment Advisory Commission 2025d).

In the Commission's view, this recommendation for 2027 strikes an appropriate balance between the need to provide adequate payments to clinicians and the need to limit growth in beneficiaries' cost sharing and premiums and maintain financial pressure on clinicians to constrain their costs.

IMPLICATIONS 4

Spending

- This recommendation would increase program spending relative to current law by \$750 million to \$2 billion in one year and by \$1 billion to \$5 billion over five years.

Beneficiaries and providers

- We expect that this recommendation will help ensure FFS Medicare beneficiaries' access to care by maintaining clinicians' willingness and ability to treat them while limiting increases to beneficiaries' cost sharing and Part B premiums. ■

4 A P P E N D I X A

Key findings from the Commission's 2025 access-to-care survey

**TABLE
4-A1**

In MedPAC's annual survey, Medicare beneficiaries ages 65+ generally report better access to care than privately insured people ages 50–64

Survey question	Medicare beneficiaries (ages 65 and older)				Privately insured (ages 50–64)			
	2022	2023	2024	2025	2022	2023	2024	2025
Received health care: “Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?”								
Yes	–	94% ^a	95% ^a	94% ^a	–	91% ^{ab}	91% ^a	92% ^a
Providers that accept your insurance: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that accept Medicare/your insurance?”								
Satisfied (“very” or “somewhat”)	–	96 ^{ab}	97 ^a	97 ^a	–	91 ^{ab}	93 ^a	93 ^a
Providers with timely appointments: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?”								
Satisfied (“very” or “somewhat”)	–	87 ^{ab}	88 ^{ab}	90 ^a	–	77 ^{ab}	79 ^a	81 ^a
Have a primary care provider: “A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?”								
Yes	96 ^a	96 ^a	96 ^a	96 ^a	92 ^a	92 ^a	91 ^{ab}	92 ^a
Long wait for an appointment: Among those who needed an appointment in the past 12 months, “How often did you have to wait longer than you wanted to get a doctor’s appointment . . . ?”								
For routine care								
“Never” or “sometimes”	88 ^a	87 ^a	87 ^a	89 ^a	80 ^a	77 ^{ab}	78 ^{ab}	80 ^a
“Always” or “usually”	12 ^a	13 ^a	13 ^a	11 ^a	20 ^a	23 ^{ab}	22 ^{ab}	20 ^a
For illness or injury								
“Never” or “sometimes”	93 ^a	92 ^a	93 ^a	93 ^a	87 ^a	85 ^{ab}	86 ^a	87 ^a
“Always” or “usually”	7 ^a	8 ^a	7 ^a	7 ^a	13 ^a	15 ^{ab}	14 ^a	13 ^a
Tried to get a new clinician: “In the past 12 months, have you tried to get a new . . . ?” (Share answering “Yes”)								
Primary care provider	11 ^a	12 ^a	11 ^a	12 ^a	14 ^a	15 ^a	16 ^{ab}	14 ^a
Specialist	26 ^{ab}	32	31 ^a	33	29 ^{ab}	33	34 ^a	33
Mental health professional	–	3 ^a	3 ^a	3 ^a	–	7 ^a	8 ^a	7 ^a
Problems finding a new clinician: Among those who tried to get a new clinician in the past 12 months, “How much of a problem was it finding a primary care provider/specialist/mental health professional who would treat you?” (Percentages in parentheses are among all respondents with this insurance, not just those looking for a new clinician.)								
“Big problem” finding a . . .								
Primary care provider	22 ^a (2 ^a)	23 ^a (3 ^a)	24 ^a (2 ^a)	21 ^a (2 ^a)	29 ^a (4 ^a)	33 ^a (5 ^a)	31 ^a (5 ^a)	28 ^a (4 ^a)
Specialist	10 ^a (3 ^{ab})	13 ^a (4 ^a)	11 ^a (3 ^a)	11 ^a (4 ^a)	15 ^a (4 ^{ab})	18 ^a (6 ^a)	18 ^a (6 ^a)	17 ^a (5 ^a)
Mental health professional	–	38 (1 ^a)	37 (1 ^a)	29 (1 ^a)	–	45 ^b (3 ^a)	42 (3 ^a)	36 (3 ^a)
Forgoing care: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”								
Yes	18 ^a	20 ^{ab}	18 ^a	17 ^a	24 ^{ab}	27 ^a	27 ^a	27 ^a

Note: Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: “Refused.” Survey sample sizes are approximately 4,000 Medicare beneficiaries and 4,000 privately insured people in 2022, and approximately 5,000 of each group in 2023, 2024, and 2025; sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. Significance tests were adjusted for all pairwise comparisons within each subtable row using the Bonferroni correction. For “a” footnotes, corrections were applied per year to Medicare vs. privately insured comparisons; for “b” footnotes, corrections were applied within each insurance group across years. Comparisons excluded cells with true 0 percent or 100 percent values or weighted bases <2.

^a Statistically significant difference between Medicare beneficiaries and the privately insured in a given year (at a 95 percent confidence level).

^b Statistically significant difference between 2025 and a prior year within the same insurance group (at a 95 percent confidence level).

Source: MedPAC’s Access to Care Surveys conducted July–September 2022, 2023, 2024, and 2025.

**TABLE
4-A2**

Lower-income beneficiaries reported obtaining less care than others in 2025

Survey question	Medicare beneficiaries (ages 65 and older)			Privately insured (ages 50–64)		
	Lower income	Middle income	Higher income	Lower income	Middle income	Higher income
Received health care: “Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?”						
Yes	92% ^a	95% ^{ab}	97% ^{ab}	88% ^a	91% ^a	94% ^{ab}
Providers that accept your insurance: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that accept Medicare/your insurance?”						
Satisfied (“very” or “somewhat”)	97 ^a	98 ^a	98 ^a	91 ^a	94 ^a	93 ^a
Providers with timely appointments: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?”						
Satisfied (“very” or “somewhat”)	92 ^a	88 ^a	90 ^a	82 ^a	82 ^a	80 ^a
Have a primary care provider: “A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?”						
Yes	95 ^a	96 ^a	98 ^{ab}	90 ^a	91 ^a	93 ^a
Tried to get a new clinician “In the past 12 months, have you tried to get a new . . . ?” (Share answering “Yes”)						
Primary care provider	12	12	11	15	14	13
Specialist	25	34 ^b	42 ^{ab}	24	29	36 ^{ab}
Problems finding a new clinician: Among those who tried to find a new clinician, “How much of a problem was it finding a primary care provider/specialist who would treat you?” (Percentages in parentheses are among all respondents with this insurance and household income, not just those looking for a new clinician.)						
“Big problem” finding a primary care provider	23 (3)	18 (2 ^a)	21 (2)	25 (4)	32 (4 ^a)	28 (4)
“Big problem” finding a specialist	12 (3)	11 (4)	10 ^a (4)	22 (5)	17 (5)	16 ^a (6)
Wait time for first appointment with a new clinician: Among those who tried to get a new clinician in the past 12 months, “How long did you have to wait to have an appointment with your new primary care provider/specialist?”						
Primary care provider						
0 to 2 weeks	37	41	36	40	25	26
3 to 5 weeks	20	24	22	19	22	23
6 weeks or more	31	24	28	31	37	34
I have not scheduled an appointment	10	9	12	7	15	15
Specialist						
0 to 2 weeks	37	29	33	32	24	29
3 to 5 weeks	30	29	31	26	32	28
6 weeks or more	25	37 ^b	31 ^a	36	36	38 ^a
I have not scheduled an appointment	5	4	3	6	5	4
Forgoing care: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”						
Yes	19 ^a	17 ^a	14 ^{ab}	28 ^a	29 ^a	26 ^a

Note: “Lower income” refers to respondents with annual household incomes of \$0 to \$49,999; “middle income” refers to household incomes of \$50,000 to \$79,999; and “higher income” refers to household incomes of \$80,000 or more. Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: “I don’t remember” and “Refused.” Survey sample consists of approximately 5,000 Medicare beneficiaries and 5,000 privately insured people; sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. Significance tests were adjusted for all pairwise comparisons within each subtable row using the Bonferroni correction. For “a” footnotes, corrections were applied within each income category to Medicare vs. privately insured comparisons; for “b” footnotes, corrections were applied within each insurance group to compare lower-income respondents with middle- or higher-income respondents. Comparisons excluded cells with true 0 percent or 100 percent values or weighted bases <2.

^a Statistically significant difference between Medicare beneficiaries and the privately insured within the same income category (at a 95 percent confidence level).

^b Statistically significant difference between lower-income respondents and middle-income respondents or between lower-income and higher-income respondents within the same insurance group (at a 95 percent confidence level).

Source: The 2025 MedPAC Access to Care Survey, conducted July 18–September 8, 2025.

**TABLE
4-A3**

Urban and rural patients generally reported comparable care in 2025

Survey question	Medicare beneficiaries (ages 65 and older)		Privately insured (ages 50–64)	
	Urban	Rural	Urban	Rural
Received health care: “Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?”				
Yes	95% ^{ab}	92% ^b	92% ^a	92%
Providers that accept your insurance: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that accept Medicare/your insurance?”				
Satisfied (“very” or “somewhat”)	97 ^a	98 ^a	93 ^a	92 ^a
Providers with timely appointments: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?”				
Satisfied (“very” or “somewhat”)	89 ^a	92 ^a	80 ^a	81 ^a
Have a primary care provider: “A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?”				
Yes	96 ^a	97 ^a	92 ^a	93 ^a
Tried to get a new clinician “In the past 12 months, have you tried to get a new . . . ?” (Share answering “Yes”)				
Primary care provider	12 ^a	11	14 ^a	11
Specialist	34 ^b	28 ^b	34 ^b	26 ^b
Problems finding a new clinician: Among those who tried to find a new clinician, “How much of a problem was it finding a primary care provider/specialist who would treat you?” (Percentages in parentheses are among all respondents with this insurance and area type, not just those looking for a new clinician.)				
“Big problem” finding a primary care provider	22 ^a	16	30 ^a	20
“Big problem” finding a specialist	11 ^a	13	17 ^a	17
Wait time for first appointment with a new clinician: Among those who tried to get a new clinician in the past 12 months, “How long did you have to wait to have an appointment with your new primary care provider/specialist?”				
Primary care provider				
0 to 2 weeks	33 ^{ab}	57 ^b	26 ^a	39
3 to 5 weeks	21	19	22	20
6 weeks or more	32 ^b	11 ^{ab}	35	34 ^a
I have not scheduled an appointment	10	11	15	7
Specialist				
0 to 2 weeks	34 ^a	32	29 ^a	28
3 to 5 weeks	29	31	29	27
6 weeks or more	31 ^a	30	37 ^a	40
I have not scheduled an appointment	4	4	4	4
Forgoing care: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”				
Yes	17 ^a	19 ^a	27 ^a	26 ^a

Note: “Urban” respondents reside in an urban or suburban part of a metropolitan statistical area (MSA), meaning they live in an urbanized area with a population of 50,000 or more or in adjacent territory that has a high degree of social and economic integration as measured by commuting. “Rural” respondents reside outside of an MSA. Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: “I don’t remember” and “Refused.” Survey sample size is approximately 5,000 Medicare beneficiaries and 5,000 privately insured people; sample sizes for questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. Significance tests were adjusted for all pairwise comparisons within each subtable row using the Bonferroni correction. For “a” footnotes, corrections were applied within each area type to Medicare vs. privately insured comparisons; for “b” footnotes, corrections were applied within each insurance group to compare urban and rural respondents. Comparisons excluded cells with true 0 percent or 100 percent values or weighted bases <2.

^a Statistically significant difference between Medicare beneficiaries and the privately insured within the same area type (at a 95 percent confidence level).

^b Statistically significant difference between urban and rural respondents within the same insurance group (at a 95 percent confidence level).

Source: The 2025 MedPAC Access to Care Survey, conducted July 18–September 8, 2025.

**TABLE
4-A4**

White, Black, and Hispanic patients generally reported comparable care in 2025

Survey question	Medicare beneficiaries (ages 65 and older)			Privately insured (ages 50–64)		
	White	Black	Hispanic	White	Black	Hispanic
Received health care: “Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?”						
Yes	95% ^a	94%	92% ^b	93% ^a	93%	89% ^b
Providers that accept your insurance: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that accept Medicare/your insurance?”						
Satisfied (“very” or “somewhat”)	98 ^a	97	98 ^a	93 ^a	97	92 ^a
Providers with timely appointments: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?”						
Satisfied (“very” or “somewhat”)	89 ^a	95 ^{ab}	91 ^a	81 ^a	86 ^a	75 ^a
Have a primary care provider: “A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?”						
Yes	96 ^a	95	98 ^a	93 ^a	93	90 ^a
Tried to get a new clinician “In the past 12 months, have you tried to get a new . . . ?” (Share answering “Yes”)						
Primary care provider	12	8 ^a	12	13	14 ^a	16
Specialist	35	20 ^b	25 ^b	34	25 ^b	32
Problems finding a new clinician: Among those who tried to find a new clinician, “How much of a problem was it finding a primary care provider/specialist who would treat you?” (Percentages in parentheses are among all respondents with this insurance and race/ethnicity, not just those looking for a new clinician.)						
“Big problem” finding a primary care provider	20 (2 ^a)	18 (1)	25 (3)	28 (4 ^a)	24 (3)	32 (5)
“Big problem” finding a specialist	12 ^a (4)	11 (2)	15 (4)	16 ^a (5)	15 (4)	22 (7)
Wait time for first appointment with a new clinician: Among those who tried to get a new clinician in the past 12 months, “How long did you have to wait to have an appointment with your new primary care provider/specialist?”						
Primary care provider						
0 to 2 weeks	38 ^a	32	46	26 ^a	37	29
3 to 5 weeks	20	19	24	22	21	26
6 weeks or more	30	22	18	35	32	31
I have not scheduled an appointment	9	16	12	15	10	12
Specialist						
0 to 2 weeks	33 ^a	43	44 ^b	26 ^a	39 ^b	34
3 to 5 weeks	28	20	30	30	25	24
6 weeks or more	32 ^a	27	22 ^a	40 ^a	21 ^b	37 ^a
I have not scheduled an appointment	4	7	4	4	11 ^b	4
Forgoing care: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”						
Yes	17 ^a	14 ^a	17 ^a	26 ^a	26 ^a	26 ^a

Note: “White” refers to non-Hispanic White respondents, “Black” refers to non-Hispanic Black respondents, and “Hispanic” refers to Hispanic respondents of any race. Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: “I don’t remember” and “Refused.” Survey sample size is approximately 5,000 Medicare beneficiaries and 5,000 privately insured people; sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. Significance tests were adjusted for all pairwise comparisons within each subtable row using the Bonferroni correction. For “a” footnotes, corrections were applied within each race/ethnicity category to Medicare vs. privately insured comparisons; for “b” footnotes, corrections were applied within each insurance group to compare White respondents with Black or Hispanic respondents. Comparisons excluded cells with true 0 percent or 100 percent values or weighted bases <2.

^a Statistically significant difference between Medicare beneficiaries and the privately insured within the same race/ethnicity category (at a 95 percent confidence level).

^b Statistically significant difference between White and Black or White and Hispanic respondents within the same insurance group (at a 95 percent confidence level).

Source: The 2025 MedPAC Access to Care Survey, conducted July 18–September 8, 2025.

Endnotes

- 1 Our count includes unique Healthcare Common Procedure Coding System codes for which Medicare made at least one payment during the year. We treat codes that have modifiers as a single code, and we do not include codes that clinicians could have billed for but did not.
- 2 For further information, see the Commission's *Payment Basics: Physician and Other Health Professional Payment System* at https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_Physician_FINAL_SEC.pdf.
- 3 Although most clinician services are paid under the PFS, some are paid through federally qualified health centers, rural health clinics, and critical access hospital Method II billing.
- 4 Our survey was fielded from July 18 to September 8, 2025, among a sample drawn from the Gallup Panel. The Gallup Panel is a probability-based panel generated by random-digit-dial and address-based sampling. Approximately 8 percent of people invited to join the Gallup Panel do so. When they join, they specify which language they would like to receive surveys in and through what mode they would like to receive surveys. Our survey was fielded via web in English or Spanish and via mail in English. We paid respondents a \$5 incentive to complete the survey or \$10 if they were a member of a subgroup whose response rate we were trying to increase (e.g., rural respondents). Among eligible individuals invited to participate in our survey, 48 percent completed it. Questions asked of all Medicare beneficiaries ages 65 and over ($n = 4,788$) have a margin of error of ± 1.79 percentage points at the 95 percent confidence level, and questions asked of all privately insured people ages 50 to 64 ($n = 5,079$) have a margin of error of ± 1.77 percentage points.
- 5 We annually conduct focus groups with beneficiaries and clinicians in different parts of the country to provide more qualitative descriptions of beneficiary and clinician experiences with the Medicare program. During these discussions, we hear from beneficiaries and providers about variation in experiences accessing care. In summer 2025, we conducted four focus groups with Medicare beneficiaries residing around St. Louis, Missouri. Beneficiaries included those with only Medicare coverage (divided into separate groups based on interviews to determine enrollment in FFS Medicare vs. MA) and beneficiaries who are eligible for both Medicare and Medicaid ("dually eligible" beneficiaries). We also conducted one virtual focus group with beneficiaries residing in rural areas. In addition, we conducted three focus groups with clinicians practicing in the St. Louis area: primary care physicians, specialist physicians, and nurse practitioners.
- 6 Our analyses of subgroups of Medicare beneficiaries in CMS's Medicare Current Beneficiary Survey in this and subsequent paragraphs combine fee-for-service beneficiaries and Medicare Advantage enrollees to maximize our ability to detect statistically significant differences between subgroups of beneficiaries with different characteristics (e.g., beneficiaries under age 65 vs. beneficiaries ages 65 and over).
- 7 Qualified Medicare beneficiaries must have incomes below 100 percent of the federal poverty level (plus \$20) and have limited resources. For example, in 2025, the federal monthly income limit for an individual is \$1,325 and the federal resource limit is \$9,660. Income limits are higher in Alaska and Hawaii. States can also set higher income and resource limits.
- 8 The limiting charge for nonparticipating clinicians who submit an unassigned claim is equal to 115 percent of 95 percent of the full Medicare fee schedule rate, which is effectively 109.25 percent. Thus, these clinicians receive up to a total of 109.25 percent of the full fee schedule rate. Medicare's portion of the payment is made to beneficiaries instead of directly to clinicians; beneficiaries are responsible for paying the clinician Medicare's portion and cost-sharing up to the limiting charge.
- 9 Clinicians who opted out of Medicare were concentrated in the specialties of behavioral and mental health (61 percent), oral health (15 percent), and primary care (8 percent) (Centers for Medicare & Medicaid Services 2025b).
- 10 An exception to this general approach is a new prior authorization model that will be tested in FFS Medicare from 2026 to 2031 in six states (Arizona, New Jersey, Ohio, Oklahoma, Texas, and Washington). The Wasteful and Inappropriate Service Reduction (WiSeR) Model will require prior authorization for certain items and services (e.g., skin and tissue substitutes, implantation of electrical nerve stimulators, knee arthroscopy for knee osteoarthritis). Companies that process prior authorization requests will earn a share of any savings they generate from averting wasteful or inappropriate care.
- 11 A substantial number of clinicians bill for 15 or fewer beneficiaries in a given year, but they account for a small share of services and allowed charges. For example, in 2023, about 19 percent of clinicians who billed the fee schedule billed for 15 or fewer beneficiaries, but these clinicians billed

- for less than 1 percent of total allowed charges. Further, we note that this threshold does not account for whether clinicians are practicing on a full- or part-time basis.
- 12 In prior reports, when calculating clinician-to-beneficiary ratios, we have included the total number of Medicare Part B beneficiaries enrolled in either FFS Medicare or MA in the denominator (i.e., the total number of Medicare beneficiaries). However, our analysis of MA encounter data indicates that a small but growing number of clinicians may see only MA beneficiaries and not beneficiaries enrolled in FFS Medicare. Since our count of clinicians is generated from FFS claims, MA-only clinicians would not be included in the numerator (i.e., count of clinicians). Including MA enrollees but not MA-only clinicians created a mismatch between the numerator and denominator in our ratio calculation. Therefore, we now include only Part B beneficiaries enrolled in FFS Medicare.
 - 13 Our definition of physician (both primary care physicians and specialists) includes only clinicians who hold a doctor of medicine (MD) or doctor of osteopathic medicine (DO) degree. Other types of more specialized physicians are included in the other practitioners category.
 - 14 APRNs include clinical nurse specialists, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives.
 - 15 At the time this report was written, application data for the 2024–2025 academic year were available for both MD and DO programs, but first-year enrollment data were not.
 - 16 We define an “encounter” as a unique combination of beneficiary identification number, claim identification number (for paid claims), and national provider identifier of the clinician who billed for the service.
 - 17 This number is based on our count of beneficiaries who had at least one encounter recorded in claims data, and the total number of FFS Medicare beneficiaries enrolled in Part B as reported in the 2025 annual report of the Boards of Trustees of the Medicare trust funds.
 - 18 Physical therapy includes stretching, strength training (with or without weights), and heat or cold therapy. Medicare beneficiaries are also eligible to receive occupational therapy to treat hand and arm disorders and to help with activities of daily living (such as getting dressed and bathing), and speech therapy, which provides treatment to regain and strengthen speech and language skills.
 - 19 The roughly 3,400 Dartmouth Atlas Project–defined HSAs are a collection of ZIP codes whose residents are hospitalized chiefly in that area’s hospitals.
 - 20 Both the FFS–CAHPS and MSSP ACO–CAHPS surveys collect information from Medicare beneficiaries enrolled in the FFS program. The FFS–CAHPS survey targets a sample of over 200,000 beneficiaries (Centers for Medicare & Medicaid Services 2024a). CMS anticipates sampling 860 beneficiaries per MSSP ACO for the CAHPS for MIPS survey (Centers for Medicare & Medicaid Services 2025a). In 2024, there were 480 MSSP ACOs serving 10.8 million beneficiaries (Medicare Payment Advisory Commission 2025c). CMS excludes beneficiaries who are included in the MSSP ACO–CAHPS sample from the FFS–CAHPS sample; therefore, the two surveys are measuring the experience of care of different FFS beneficiaries.
 - 21 Intensity growth refers to changes in the mix of services being furnished, which results in increases in the total number of relative value units.
 - 22 Allowed charges are a function of the PFS’s relative value units and conversion factor plus other payment adjustments, such as those determined by geographic practice cost indexes.
 - 23 Total Medicare payments tend to be higher for services furnished in a facility setting since the combined fee schedule and facility payments (e.g., the outpatient prospective payment system) are usually higher than nonfacility fee schedule payments.
 - 24 The full description of code G2211 is as follows: “Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient’s single, serious condition or a complex condition. (Add-on code, list separately in addition to home or residence or office/outpatient evaluation and management service, new or established).”
 - 25 MEI data in this report may vary from previously reported figures because of updates to productivity figures and MEI projections. MEI-growth data included in this chapter differ from data published in PFS rules because of methodological differences. Data in this chapter reflect the MEI growth that occurred or is projected to occur in a given year. In contrast, MEI-growth data in PFS rules reflect the most recently available actual historical data at the time of publication. For example, the final rule for payment year 2025 uses MEI growth from the second quarter of 2024 (i.e., actual historical MEI growth from the third quarter of 2023 to the second quarter of 2024). MEI growth reported in this chapter for 2025 is based on projected MEI growth from the fourth quarter of 2025 (i.e., projected MEI growth from the

- first quarter of 2025 to the fourth quarter of 2025). We also incorporate a productivity adjustment to match the period from which MEI growth was analyzed.
- 26 MEI-growth projections in this chapter are as of the second quarter of 2025 and are subject to change.
- 27 The growth in fee schedule spending per beneficiary, especially during the second half of this period, was restrained by the shift of services from clinician offices to hospital outpatient departments. For example, the Commission found that from 2012 to 2017, had shifts in site of service not occurred, average annual growth in the total number of relative value units (RVUs) billed (RVUs multiplied by units of service) would have been 1.5 percent per year instead of 1.1 percent, with larger differences for imaging services and tests (Medicare Payment Advisory Commission 2019). These figures represent lower-bound estimates of the effects of site-of-service shifts for fee schedule services because we were unable to adjust for shifts among certain types of services, such as radiation therapy, chemotherapy injections, and other tests. While this trend lowers fee schedule spending (because fee schedule payment rates are lower when a service is furnished in a facility), it increases Medicare's total spending generated by fee schedule services (fee schedule spending plus associated hospital outpatient spending).
- 28 Research conclusions on the relationship between prices and volume may vary for several reasons, such as the permanence of the price increase and the population studied. For example, the literature studying the effects of price on utilization for Medicaid beneficiaries is mixed (Medicaid and CHIP Payment and Access Commission 2025).
- 29 A limitation of the SullivanCotter compensation data is that a disproportionately large share of the provider organizations that contributed compensation data for this survey are affiliated with a hospital or health system.
- 30 The growth rates reported in this sentence were calculated using a sample restricted to staff clinicians who were in SullivanCotter's sample in both 2024 and 2025.
- 31 The growth rates reported in this paragraph were calculated using a sample restricted to staff clinicians who were in SullivanCotter's sample in both 2020 and 2025.
- 32 The physician compensation amounts in this paragraph and in Figure 4-8 (p. 129) were calculated using 2024 compensation for all staff physicians in SullivanCotter's 2025 sample.
- 33 The private insurer's payments reflect the insurer's allowed amount (including allowed cost sharing). The data exclude any remaining balance billing and payments made outside of the claims process, such as bonuses or risk-sharing payments. Only services paid under Medicare's PFS were included, and anesthesia services were excluded. Data do not include MA claims.
- 34 Less commonly selected reasons for selling a practice to a hospital in the AMA's survey were to better compete for employees, to increase availability of additional services that patients need, and to make it easier to participate in risk-based payment models.
- 35 Payment rates for a service can also change because of adjustments to the relative value units for that service.
- 36 MACRA also specified two types of additional payments for clinicians: (1) an annual bonus for clinicians with a sufficient share of patients or payments in A-APMs and (2) for clinicians not qualifying for the A-APM bonus, payment adjustments through the Merit-based Incentive Payment System (MIPS), which can be positive, neutral, or negative depending on a clinician's performance on measures of quality, cost, participation in clinical-improvement activities, and use of health information technology. Beginning in 2027, the A-APM bonus will no longer be available, but MIPS payment adjustments will continue for clinicians not in A-APMs. In 2025, about 464,000 clinicians (roughly 33 percent of the clinicians who bill Medicare) received MACRA's A-APM participation bonus. Another 438,000 clinicians received a positive MIPS adjustment to their PFS payments from Medicare, of up to 2.15 percent. About 78,000 clinicians received a negative MIPS adjustment to their payment rates, of up to -9 percent. Another 26,000 clinicians received a neutral (0 percent) MIPS adjustment because their MIPS score was the same as the MIPS performance threshold (see CMS's 2023 QPP Participation and Performance Results At-A-Glance at <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3238/2023-QPP-Results-At-A-Glance.pdf>). We estimate that roughly 394,000 clinicians were ineligible for A-APM bonuses or MIPS adjustments (e.g., because they saw a low volume of Medicare beneficiaries).
- 37 CMS operationalizes these provisions by reverting back to a lower conversion factor, that is no longer multiplied by the temporary 2.5 percent update, and then multiplying that lower conversion factor by one of the two MACRA updates.

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CHAPTER

5

Outpatient dialysis services

R E C O M M E N D A T I O N

- 5** For calendar year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rate for outpatient dialysis services.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Outpatient dialysis services

Chapter summary

Outpatient dialysis services are used to treat most individuals with end-stage renal disease (ESRD). In 2024, about 240,500 beneficiaries with ESRD on dialysis were covered under fee-for-service (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.

Assessment of payment adequacy

Our payment-adequacy indicators for outpatient dialysis services were generally favorable.

Beneficiaries' access to care—Measures of the capacity and supply of providers, beneficiaries' ability to obtain care, and changes in the volume of services suggest that access to dialysis services is generally favorable.

- **Capacity and supply of providers**—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 Medicare Advantage (MA). In addition, over the last decade (2012 to 2022), the growth in the number of patients newly diagnosed with ESRD (across all insurance

In this chapter

- Are FFS Medicare payments adequate in 2026?
- How should FFS Medicare payments change in 2027?

types) slowed. Between 2023 and 2024, the share of FFS beneficiaries dialyzing at home continued to increase.

- **Volume of services**—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, after the removal of a statutory provision that had prevented most beneficiaries on dialysis from enrolling in MA plans. The share of beneficiaries on dialysis enrolled in FFS Medicare fell by 18 percent between 2020 and 2021—the first year of the statutory change—and by about 12 percent annually between 2021 and 2023, and by 7 percent between 2023 and 2024. Although the number of FFS beneficiaries on dialysis and treatments declined between 2023 and 2024, the average number of dialysis treatments per FFS beneficiary per week remained steady at 2.8. 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 of 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 FFS beneficiaries dialyzing at home, which is associated with greater 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 FFS 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.

How should FFS Medicare payments change in 2027?

Under current law, the FFS Medicare 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. ■

Dialysis treatment choices

Dialysis replaces the filtering function of the kidneys when they fail. The two types of dialysis—hemodialysis and peritoneal dialysis (PD)—remove waste products from the bloodstream differently. Most patients on dialysis travel to a treatment facility to undergo hemodialysis three times per week, although patients can also undergo hemodialysis at home. Hemodialysis uses an artificial membrane encased in a dialyzer to filter the patient's blood. By contrast, PD, the most common form of home dialysis, uses the lining of the abdomen (peritoneum) as a filter to clear wastes and extra fluid and is usually performed independently in the patient's home or workplace five to seven days a week.

Each dialysis method has advantages and drawbacks; no one method is best for everyone. People choose a particular dialysis method for many reasons, including quality of life, patients' awareness of treatment methods and personal preferences, and physician training and recommendations. Some patients switch methods when their conditions or needs change. Although most patients still undergo in-center dialysis, home dialysis remains a viable option for many patients because of such advantages as increased patient satisfaction, better health-related quality of life, and fewer transportation challenges compared with in-center dialysis. ■

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. Such providers include dialysis facilities that provide outpatient dialysis services to FFS beneficiaries with end-stage renal disease (ESRD), the last stage of chronic kidney disease (CKD), which is characterized by permanent, irreversible kidney failure.

Background

Patients with ESRD include those who are treated with dialysis—a process that removes wastes and fluid from the body—and those who have a functioning kidney transplant. Because of the limited number of kidneys available for transplantation and the variation in patients' suitability for transplantation, about 70 percent of patients with ESRD undergo maintenance dialysis (see text box on dialysis treatment choices).¹ Patients receive additional items and services related to their dialysis treatments, including ESRD drugs and

biologics to treat conditions such as anemia and bone disease that result from the loss of kidney function.

About 7,600 dialysis facilities provided outpatient dialysis services to 240,500 FFS beneficiaries in 2024. The dialysis sector is highly consolidated, with two large dialysis organizations (LDOs)—Fresenius Medical Care and DaVita—dominating the industry. In 2024, these LDOs accounted for three-quarters of facilities and FFS Medicare treatments. Moreover, in 2024, the five largest dialysis organizations accounted for roughly 86 percent of facilities and 88 percent of FFS Medicare treatments.

Medicare pays facilities that provide dialysis services to FFS beneficiaries using a prospective payment system (PPS) bundle that includes ESRD drugs and services, such as laboratory services.^{2,3} The unit of payment is a dialysis treatment; FFS Medicare's payment rate is based on a regimen of three dialysis treatments per week. In 2024, the FFS Medicare program and its beneficiaries spent \$7.6 billion for outpatient dialysis services. This total includes roughly \$37 million in add-on payments associated with new ESRD drugs (Korsuva, Jesdubroq, and DefenCath). Additionally, in 2023 (the most recent year of data available), Part D

**TABLE
5-1****FFS beneficiaries on dialysis are disproportionately young, male, and Black or Hispanic compared with other FFS beneficiaries, 2024**

	Share of FFS beneficiaries	
	Beneficiaries on dialysis	Other beneficiaries
Age		
Under 45 years	10%	3%
45–64 years	31	7
65–74 years	29	47
75–84 years	23	32
85+ years	7	12
Sex		
Male	58	45
Female	42	55
Race		
White	45	81
Black	27	7
Hispanic	16	5
Asian	6	3
All others	6	4
Residence, by type of county		
Urban	84	80
Micropolitan	9	11
Rural, adjacent to urban	4	5
Rural, not adjacent to urban	2	4

Note: FFS (fee-for-service). "Other beneficiaries" excludes beneficiaries on dialysis and those who have received a kidney transplant. "Residence" reflects the beneficiary's county of residence in one of four categories based on an aggregation of the Urban Influence Codes. Components may not sum to 100 percent due to rounding.

Source: Data compiled by MedPAC from enrollment data and claims submitted by dialysis facilities to CMS, 2024.

gross spending for ESRD oral-only drugs that had not yet been included in the PPS—several phosphate binders—totaled nearly \$0.6 billion for FFS beneficiaries on dialysis.

Characteristics of fee-for-service beneficiaries on dialysis, 2024

Compared with other FFS Medicare beneficiaries, FFS beneficiaries on dialysis are disproportionately young (under 65), male, and Black or Hispanic (Table 5-1). In 2024, 41 percent of FFS beneficiaries on dialysis

were under 65 years old, 58 percent were male, 27 percent were Black, and 16 percent were Hispanic. By comparison, among other FFS Medicare beneficiaries, 10 percent were under 65 years old, 45 percent were male, 7 percent were Black, and 5 percent were Hispanic. A greater share of FFS beneficiaries on dialysis resided in urban areas compared with other FFS beneficiaries (84 percent vs. 80 percent).

FFS beneficiaries on dialysis are more likely than all other FFS beneficiaries to have full Medicaid benefits

(33 percent vs. 11 percent) (data not shown). FFS Part D enrollees on dialysis are more likely to receive the low-income subsidy than all other FFS Part D enrollees (58 percent vs. 21 percent). We estimate that roughly 59,000 FFS Medicare beneficiaries began dialysis in 2024 (a 2 percent increase compared with 2023).

Medicare pays for dialysis services under the fee-for-service ESRD prospective payment system

To treat ESRD, beneficiaries on dialysis receive care from two principal providers: (1) clinicians (typically nephrologists) who prescribe and manage the provision of dialysis and establish the beneficiary's plan of care, and (2) facilities that provide dialysis treatments in a dialysis center or support and supervise the care of beneficiaries on home dialysis.⁴ While our work in this report focuses on Medicare's payments to facilities, it is important to recognize that facilities and clinicians collaborate to care for beneficiaries on dialysis. Indeed, many dialysis facilities are operated as joint ventures between dialysis organizations and physicians. Joint ventures allow participating partners to share in the management of dialysis facilities and in their profits and losses. Both the LDOs and midsize provider groups, including Innovative Renal Care and U.S. Renal Care, have established joint ventures with physicians (Xia et al. 2025).⁵ Some have raised concerns that joint ventures between dialysis organizations and physicians create financial incentives for participating physicians that could inappropriately influence decisions about patient care (Berns et al. 2018). Under federal disclosure requirements, a dialysis facility must report certain ownership information to CMS and its state survey agency, but it is not required to disclose such information to patients, researchers, or members of the public.

The Commission's payment-adequacy indicators pertain to Medicare's payments to dialysis facilities for services provided to FFS beneficiaries under the ESRD PPS. Facilities are paid for a bundle of services provided during a single dialysis treatment, including ESRD drugs, laboratory tests, and other ESRD items and services. For adult beneficiaries on dialysis, the ESRD PPS base payment rate to dialysis providers does not differ by type of dialysis—in-center dialysis versus home dialysis (which is consistent with the Commission's principle that Medicare should pay the same amount for the same service, even when it is provided in different settings)—but rather by

patient characteristics (age, body measurement characteristics, onset of dialysis, and selected acute and chronic comorbidities) and facility factors (low treatment volume, rural location, and local input prices).⁶ Medicare pays facilities that furnish dialysis treatments in the facility or in a patient's home for up to three treatments per week, unless additional dialysis treatments are reasonable and necessary and there is documented medical justification for more than three weekly treatments.

Under the ESRD PPS, Medicare also makes separate add-on payments in certain circumstances for new drugs, devices, and equipment.⁷ Effective January 1, 2025, CMS pays a transitional drug add-on payment adjustment (TDAPA) for oral-only phosphate binders at 100 percent of each product's Part B average sales price, plus a \$36.41 per month flat rate to account for facilities' operational costs in furnishing these products; the TDAPA will be paid for at least two years. The two-year TDAPA for Jesduvroq (used to treat anemia) concluded on September 30, 2025, while the TDAPA for DefenCath (to reduce the incidence of catheter-related bloodstream infections) will end on June 30, 2026. Korsuva (an antipruritic) and DefenCath will be paid under a post-TDAPA for three years at the end of each drug's TDAPA period.^{8,9,10} In 2024, no ESRD-related equipment or supply was paid for under the two-year transitional payment adjustment for new and innovative equipment and supplies (TPNIES).¹¹

Are FFS Medicare payments adequate in 2026?

To address whether payments for 2026 are adequate to cover the costs to efficiently provide care and to determine how much payments should change in the update year (2027), we examine several indicators of payment adequacy. We assess beneficiaries' access to care by examining the capacity of dialysis facilities and changes over time in the volume of services provided relative to demand. We also examine quality of care, providers' access to capital, and the relationship between Medicare's payments and facilities' costs. Most of our payment-adequacy indicators for outpatient dialysis services are positive. The FFS Medicare margin rose from -0.2 percent in 2023 to 4.5 percent in 2024 because providers' cost per treatment dropped by

**TABLE
5-2**

The capacity of dialysis organizations declined between 2023 and 2024

	2024			Average annual percent change			
	Total number of facilities	Total number of stations	Mean number of stations	2019–2023		2023–2024	
				Number of facilities	Number of stations	Number of facilities	Number of stations
All dialysis facilities	7,605	137,195	18	0.2%	0.8%	–1.4%	–1.0%
Share of total							
Freestanding	95%	96%	18	0.3	0.9	–1.4	–1.0
Hospital based	5	4	14	–2.5	–2.1	–0.9	–0.1
Urban	84	87	19	0.4	1.0	–1.2	–0.8
Micropolitan	10	9	16	–0.5	–0.2	–1.5	–0.6
Rural, adjacent to urban	4	3	14	–2.5	–1.9	–1.3	–1.4
Rural, not adjacent to urban	2	1	12	–2.2	–1.4	0.6	1.0
For profit	90	91	18	0.5	1.1	–0.8	–0.3
Nonprofit	10	9	17	–2.5	–2.1	–6.8	–7.2
Two LDOs	74	75	18	0.1	0.8	–1.7	–1.1
All others	26	25	17	0.4	0.7	–0.6	–0.6

Note: FFS (fee-for-service), LDO (large dialysis organization (DaVita and Fresenius Medical Care)). “Location” reflects the type of county (urban, micropolitan, rural adjacent to urban, or rural nonadjacent to urban) in which the provider is located, based on an aggregation of the Urban Influence Codes. Components may not sum to 100 percent due to rounding.

Source: Data compiled by MedPAC from the Dialysis Compare database from CMS and claims submitted by dialysis facilities to CMS.

Erratum: The printed version of the March 2026 report to the Congress contained errors for several numbers in Table 5-2. The table has been corrected in the online version of the report.

3 percent in 2024 and the FFS payment per treatment increased by 2 percent.¹²

Beneficiaries’ access to care: Indicators continue to be positive

Our analysis of access indicators—including the capacity of providers to meet beneficiary demand and changes in the volume of services—shows that beneficiaries’ access to care remains generally favorable.

Capacity is aligned with demand from Medicare beneficiaries on dialysis

In 2024, there were 7,605 dialysis facilities nationwide. FFS Medicare accounted for about 34 percent of all treatments furnished by freestanding providers.¹³

Between 2019 and 2023, growth in the number of dialysis facilities and in-center treatment stations exceeded growth in the number of patients on dialysis, across FFS Medicare and Medicare Advantage (MA). During that period, the number of facilities and their capacity to provide care—as measured by dialysis treatment stations—both grew, by 0.2 percent and 0.8 percent annually, respectively (Table 5-2). By comparison, the number of Medicare beneficiaries on dialysis (in FFS Medicare and MA combined) declined by 1 percent per year between 2019 and 2023 (data not shown).

Between 2023 and 2024, however, the number of facilities’ in-center treatment stations declined by 1 percent while the number of beneficiaries on dialysis, across FFS Medicare and MA, also declined by 1 percent.

The decline in capacity may have been in response to declining demand attributable to factors such as the following:

- Excess mortality in the population of patients with ESRD, in part due to the coronavirus pandemic and the flu. Both LDOs reported in 2024 that mortality was elevated relative to prepandemic levels, exceeding the companies' forecast estimates (DaVita 2025c, DaVita 2024c, Fresenius Medical Care 2024a).
- Slower growth in the number of individuals newly diagnosed with ESRD (which includes patients with all types of health coverage who initiate dialysis or receive a kidney transplant) (United States Renal Data System 2024). Based on the most recent decade of data that are available (2012 to 2022), the number of patients newly diagnosed with ESRD increased on average by 2 percent per year between 2012 and 2017. By contrast, between 2017 and 2022, the growth in the number of newly diagnosed patients with ESRD grew by only 0.5 percent per year.
- An increase in the use of home dialysis, which has reduced the demand for in-facility treatments. The share of FFS beneficiaries dialyzing at home steadily increased from 9 percent per month in 2011 (the first year of the ESRD PPS) to 17 percent per month in 2023 and 18 percent per month in 2024. Based on data from FFS Medicare claims, the share of facilities offering home dialysis remained steady in 2023 and 2024, ranging from 56 percent to 57 percent. In addition, through 2025, the CMS Innovation Center's mandatory ESRD Treatment Choices (ETC) Model rewarded dialysis facilities and clinicians who were part of the model for increasing home dialysis use and kidney transplantation among adult beneficiaries on dialysis and penalized facilities and clinicians who were not.¹⁴

In response to lower patient census in some markets and increasing use of home dialysis, the two LDOs have closed and merged some of their facilities in recent years. Between 2023 and 2024, the total number of facilities operated by the two LDOs declined by 0.2 percent (DaVita 2024a, DaVita 2022b, Fresenius Medical Care 2024b). Closing or merging facilities can improve

efficiency by, for example, consolidating management and saving on fixed expenses such as rent and medical-director fees (DaVita 2024b).

For-profit, freestanding facilities provide most dialysis treatments: In 2024, freestanding facilities furnished 95 percent of FFS treatments, and for-profit facilities furnished 91 percent (data not shown). Between 2023 and 2024, capacity (as measured by the number of in-center stations) fell at freestanding facilities by 1 percent and at for-profit facilities by roughly 0.3 percent, while capacity at nonprofit facilities fell by roughly 7 percent (Table 5-2).

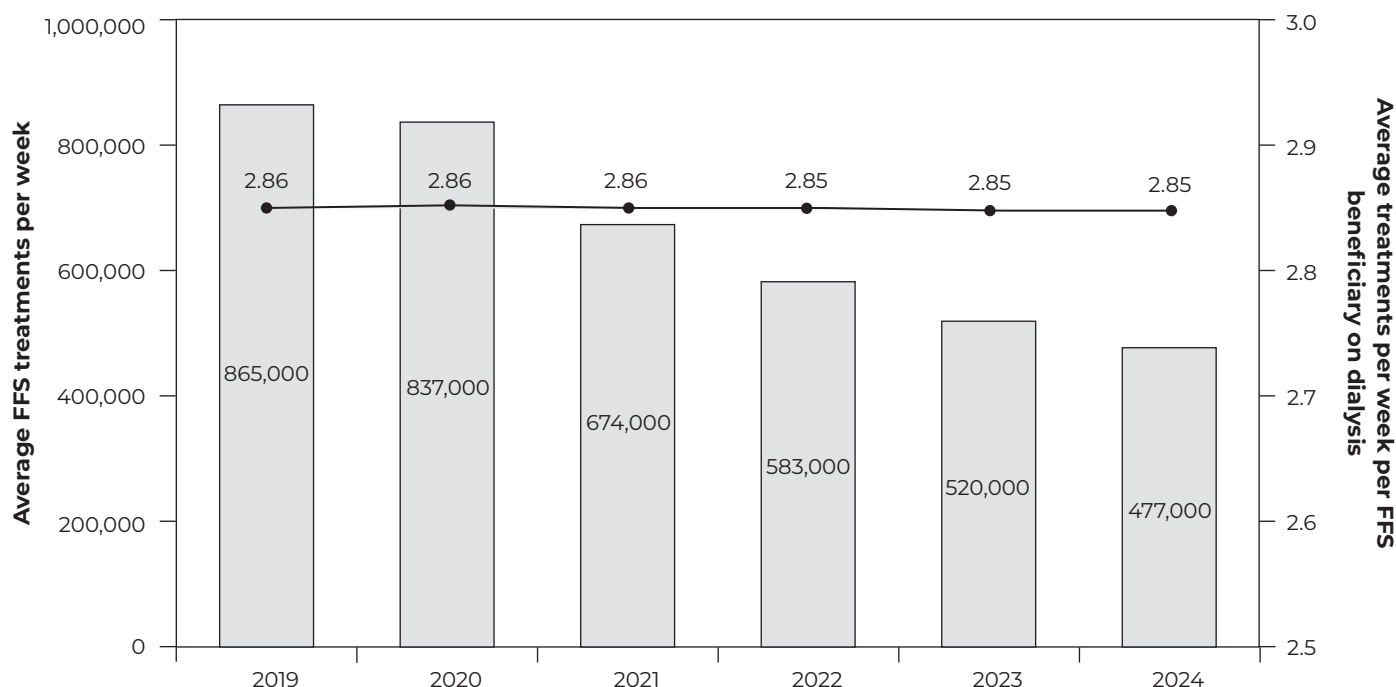
The capacity of facilities in urban and rural areas in 2024 was generally consistent with where FFS beneficiaries on dialysis lived: 87 percent of FFS treatments were provided in urban areas, and 87 percent of dialysis stations were located in urban areas. Between 2023 and 2024, capacity at urban facilities declined by 0.8 percent while capacity at all rural facilities declined by 0.6 percent.

We find that in 2024, rural facilities and low-volume facilities—which are smaller and furnish fewer total treatments than all facilities—are more likely to be hospital based and nonprofit. Specifically, compared to all facilities, rural facilities were more likely to be hospital based (9 percent vs. 4 percent) and nonprofit (16 percent vs. 10 percent), with roughly similar shares of LDOs and non-LDOs (72 percent vs. 74 percent) in 2024. In addition, compared to all facilities, the roughly 300 facilities that received the ESRD PPS's low-volume payment adjustment (LVPA) in 2024 were more likely to be nonprofit (25 percent vs. 10 percent), hospital based (16 percent vs. 4 percent) and non-LDOs (45 percent vs. 26 percent) (data not shown).

In June 2020, the Commission recommended that the Secretary replace the ESRD PPS's LVPA and rural adjustment with a single payment adjustment—a low-volume and isolated adjustment—to better support isolated, low-volume dialysis facilities that are critical to ensuring beneficiary access (Medicare Payment Advisory Commission 2020b). Instead, in the ESRD PPS final rule for 2025, CMS modified the LVPA policy by creating two-tiered adjustments for ESRD facilities: one adjustment for facilities that furnish fewer than 3,000 treatments and one for facilities that furnish between 3,000 and 3,999 treatments. CMS did not change the

**FIGURE
5-1**

Though the average number of weekly FFS treatments declined, the average number of FFS dialysis treatments per beneficiary per week remained steady, 2019–2024



Note: FFS (fee-for-service).

Source: Data compiled by MedPAC from claims submitted by dialysis facilities to CMS, 2019–2024.

current 0.8 percent rural-facility adjustment (Centers for Medicare & Medicaid Services 2024c).

Between 2021 and 2024, the share of beneficiaries on dialysis in FFS Medicare declined since the lifting of the prohibition on MA enrollment in 2021

Historically, Medicare beneficiaries with ESRD generally had traditional FFS coverage because they were largely prohibited from enrolling in MA plans, with a few exceptions (see text box on beneficiaries on dialysis enrolled in MA plans, pp. 164–165). Beginning in January 2021, a statutory change allowed beneficiaries on dialysis to enroll in any MA plan. Subsequently, the number of FFS beneficiaries on dialysis fell 10 percent per year from 2021 through 2024. By December 2024, just 45 percent of Medicare beneficiaries on dialysis were enrolled in FFS.

As FFS enrollment declined among beneficiaries on dialysis, the total number of FFS treatments fell 11 percent per year between 2021 and 2024.¹⁵ However, the number of dialysis treatments per beneficiary per week remained steady, ranging from 2.8 to 2.9 between 2019 and 2024, indicating that FFS beneficiaries with ESRD continue to have access to dialysis services (Figure 5-1).¹⁶

Use of most ESRD drugs has declined, with little impact on beneficiaries' outcomes

Under the ESRD payment method used before 2011, certain ESRD drugs were paid according to the number of units of the drug administered; thus, the more units of a drug were provided, the higher Medicare payments were. The Congress increased the incentive for dialysis providers to be more judicious in providing ESRD drugs by broadening the payment bundle in 2011 to include ESRD drugs that were previously billed separately.

**TABLE
5-3**

Under the ESRD PPS, use of ESRD drugs per treatment has declined, partly attributable to the shift to less costly, clinically similar products

Drug group	Pre-ESRD PPS use of ESRD drugs weighted by constant prices*	Percent of aggregate change between:		
	2010	2010–2011	2010–2024	2023–2024
ESAs	\$45	–23%	–69%	–4%
Iron agents	4	–7	–22	–2
Vitamin D agents	2	–20	–80	–19
Calcimimetics	N/A**	N/A	N/A	–6
Other drugs	2	–43	–85	–1
All drug groups above	53	–22	–54	–5

Note: ESRD (end-stage renal disease), PPS (prospective payment system), ESA (erythropoiesis-stimulating agent), N/A (not available). The ESRD PPS began in 2011. ESAs include epoetin alfa reference, epoetin alfa biosimilar, epoetin beta, and darbepoetin. Iron agents include iron sucrose and sodium ferric gluconate. Vitamin D agents include calcitriol, doxercalciferol, and paricalcitol. Calcimimetics include cinacalcet and etelcalcetide. Other drugs include daptomycin, vancomycin, alteplase, and levocarnitine. Before the ESRD PPS was implemented, Medicare paid dialysis facilities separately for vitamin D agents and drugs in the ESA, iron, and other groups; since 2011, these products have been included in the ESRD PPS bundle and paid under the base payment rate. This analysis includes ESRD drugs paid under the ESRD PPS base rate in 2024.

* To estimate drug use by therapeutic class, we weight use (i.e., drug units) by constant prices. That is, we hold the price of each drug constant and multiply drug units reported on claims in a given year by 2024 average sales price (ASP) plus 0 percent. Because 2024 ASP data are not available for cinacalcet (a calcimimetic), we used the payment limit for CMS's transitional drug add-on payment adjustment for the fourth quarter of 2020 and updated it to 2024 dollars using the pharmaceutical Producer Price Index (PPI). Because 2024 ASP data are not available for calcitriol (a vitamin D agent), we used average 2023 ASP data and updated them to 2024 dollars using the pharmaceutical PPI. By holding the price constant, we account for the different billing units assigned to a given drug.

** Since 2021, calcimimetics have been paid under the ESRD PPS base rate. Thus, utilization data under the ESRD PPS are not available for 2010.

Source: MedPAC analysis of 100 percent of claims submitted by dialysis facilities to CMS.

Table 5-3 shows changes between 2010 and 2024 (the most current year for which complete data are available) in the per treatment use of the leading ESRD drugs, which we aggregate into five therapeutic groups: erythropoiesis-stimulating agents (ESAs), iron agents, calcimimetics, vitamin D agents, and other products.¹⁷ We estimated per treatment use by multiplying ESRD drug units per treatment reported on CMS claims by each drug's 2024 average sales price (ASP) plus 0 percent; that is, we estimated the use of drugs weighted by constant prices.¹⁸ Thus, the change in our measure of drug use over time reflects shifts in the intensity of ESRD drugs prescribed to FFS beneficiaries on dialysis, which could reflect a combination of effects, such as changes in the (1) mix of drugs within a given therapeutic group furnished to beneficiaries, (2) share of beneficiaries receiving any ESRD drug in the five therapeutic groups, and (3) dose per treatment of a given drug.

As shown in Table 5-3, most of the decline in the per treatment use of ESRD drugs occurred in the early years after ESRD drugs were included in the bundle. For example, between 2010 and 2011, ESRD drug use per treatment across all therapeutic classes declined by 23 percent. Most of this overall decline was due to lower ESA use, which also fell by 23 percent per year during the same period. Some of the decline in ESA use may have stemmed from clinical evidence showing that higher doses of these drugs lead to increased risk of morbidity and mortality, which resulted in the Food and Drug Administration (FDA) changing the ESA label in 2011.

Most recently, between 2023 and 2024, holding price constant, use across the five therapeutic groups declined by 5 percent; this decline partly reflects changes in the dose per treatment furnished to beneficiaries as well as the shift to less costly, clinically

The majority of beneficiaries on dialysis are now enrolled in MA plans

Although individuals with end-stage renal disease (ESRD) have been entitled to Medicare Part A and Part B benefits since 1972, they were mostly prohibited from joining Medicare Advantage (MA) plans until 2021: Beneficiaries could enroll in a plan specifically designed for enrollees with ESRD, and those beneficiaries who had enrolled in MA before being diagnosed with ESRD could stay in the plan after they were diagnosed. In 2000, the Commission recommended that the Congress lift the bar prohibiting ESRD beneficiaries from enrolling in MA (Medicare Payment Advisory Commission 2000). Beginning in January 2021, the 21st Century Cures Act permitted beneficiaries on dialysis to enroll in any MA plan. The share of beneficiaries on dialysis enrolled in MA plans has since increased rapidly, from 27 percent in December 2020 to 55 percent by December 2024.

The increase in MA enrollment by beneficiaries on dialysis is likely linked to the same factors that have increased MA's popularity among beneficiaries without ESRD, including the availability of supplemental benefits (e.g., dental, hearing, and

vision services) and lower cost-sharing liability. For beneficiaries, the primary trade-off in choosing between MA and FFS Medicare is access to the additional benefits that plans provide versus a broader choice of providers participating in FFS Medicare. In exchange for additional benefits, MA plan enrollees accept provider networks and utilization-management tools such as higher cost sharing to access providers who are not in their plan's network. A 2021 policy change by CMS that excludes outpatient dialysis facilities from the list of specialty providers subject to Medicare's network-adequacy evaluation could affect access for some MA beneficiaries on dialysis. If MA plans include fewer dialysis facilities in their network, travel time for some MA beneficiaries to a dialysis facility could be affected. (See the Commission's comment letter on changes to the MA program for contract year 2021 for more discussion about proximity to a dialysis facility and dialysis care (Medicare Payment Advisory Commission 2020a).)

Given the magnitude of total health care expenses incurred annually by beneficiaries on dialysis (for dialysis and other outpatient and inpatient services

(continued next page)

similar products within a therapeutic group. For example, the share of FFS beneficiaries on dialysis who received epoetin beta increased between 2023 and 2024. This increase is linked to the transition by one LDO's patients from epoetin alfa to epoetin beta (DaVita 2022b). Thus, among the four ESA products in 2023 and 2024, use (as measured by units per treatment) of epoetin beta increased, while use of darbepoetin, epoetin alfa reference product, and epoetin alfa biosimilar declined. The Commission has previously reported other shifts over time in the use of ESAs and vitamin D agents (paricalcitol, doxercalciferol, and calcitriol) due to price competition among the products in each category (Medicare Payment Advisory Commission 2022).

Some of the change in ESRD drug use between 2023 and 2024 also reflects changes in the share of FFS beneficiaries on dialysis receiving an ESRD drug. Overall, the share of FFS beneficiaries on dialysis prescribed drugs to treat anemia—ESAs and iron agents—each declined by 1 percentage point between 2023 and 2024, while the share of beneficiaries prescribed drugs that treat bone and mineral metabolism disorders—calcimimetics and vitamin D agents—remained stable and declined by 2 percentage points, respectively. Although the ESRD PPS affected use of certain ESRD-related services, particularly the provision of drugs paid under the bundle, CMS has concluded that the agency's claims-based monitoring

The majority of beneficiaries on dialysis are now enrolled in MA plans (cont.)

and Part D drugs—averaging nearly \$106,000 in 2023, with beneficiary out-of-pocket liability averaging nearly \$14,000), these beneficiaries face significant out-of-pocket expenses when they are enrolled in FFS Medicare with no secondary or supplemental coverage. Thus, they might enroll in MA because MA plans are required by statute to offer a maximum out-of-pocket (MOOP) limit on annual spending that is not available in FFS Medicare. The mandatory MOOP limit was \$9,350 for in-network services in 2025 (and \$14,000 for in- and out-of-network services covered by preferred provider organizations). Beneficiaries who have full Medicaid coverage, as well as qualified Medicare beneficiaries with partial dual eligibility, have their cost sharing covered by Medicaid but may still find it desirable to enroll in an MA plan for the supplemental benefits offered.

Beneficiaries who do not have their cost sharing covered by Medicaid and prefer FFS Medicare may seek to limit cost-sharing liability by purchasing a Medigap policy; however, beneficiaries with ESRD, particularly those under age 65, may face difficulties obtaining Medigap insurance. Among

FFS beneficiaries without cost sharing covered by Medicaid, those on dialysis are less likely to purchase a Medigap plan than FFS beneficiaries who are not on dialysis (31 percent vs. 50 percent in 2024)¹⁹ because of:

- Constraints in federal guaranteed-issue rights in obtaining these supplemental plans. Medicare beneficiaries have guaranteed-issue rights for Medigap plans—meaning that a plan must be offered regardless of their age, sex, or health status—when they turn 65. However, about half of individuals with ESRD become eligible for Medicare before reaching age 65, and federal guaranteed-issue rights do not extend to those beneficiaries at the time of their initial enrollment in Medicare.²⁰
- The affordability of a Medigap plan. Even though beneficiaries with ESRD who are under 65 must be offered at least one Medigap plan in 36 states, the insurer can charge a higher premium based on age, sex, or existing health conditions, depending on state insurance-rating rules.²¹ ■

program has revealed no sustained decline of beneficiary health status from January 2010 through December 2023 (Centers for Medicare & Medicaid Services 2023a).²²

Quality of outpatient dialysis care is mixed

In 2023 and 2024, measures of dialysis adequacy and anemia management (hemoglobin levels) and blood transfusion rates remained generally stable. Hospitalization rates remained stable among FFS beneficiaries on dialysis, but use of the emergency department (ED) increased. Mortality rates remained stable between 2023 and 2024 but have remained elevated compared with before the coronavirus pandemic. In-center hemodialysis patient-experience

measures also remained steady. Use of home dialysis and the number of kidney transplants increased during this period.²³

Quality under the ESRD PPS

We use available claims and enrollment data for FFS beneficiaries on dialysis to assess process and outcome measures associated with the quality of outpatient dialysis care. Process measures include dialysis adequacy and anemia management, and outcome measures include rates of mortality, hospitalizations, and ED visits.

Beneficiaries' fluid management is related to factors such as the adequacy of the dialysis procedure, defined as having enough waste removed from their

blood. According to the Commission's analysis, the share of beneficiaries receiving adequate dialysis remained steady between 2021 and 2024, averaging between 97 percent and 98 percent of beneficiaries on hemodialysis and between 92 percent and 93 percent of beneficiaries receiving peritoneal dialysis (PD) at home. There was little difference between rural and urban areas in the share of beneficiaries on hemodialysis and PD receiving adequate dialysis.

We assess the quality of anemia management by examining changes over time in (1) beneficiaries' hemoglobin levels, as assessed by a blood test that measures the level of hemoglobin (the protein that carries oxygen in red blood cells); and (2) frequency of red blood cell transfusions.²⁴ Lower hemoglobin levels (which suggest underuse of ESAs and iron agents) can increase the frequency of red blood cell transfusions, while higher hemoglobin levels (greater than 12 grams per deciliter (g/dL)) among patients maintained on higher doses of ESAs can increase their risk of death and cardiovascular events (congestive heart failure, myocardial infarction, and stroke). We found that, between 2021 and 2024, median hemoglobin levels remained constant, averaging 10.5 g/dL. During this period, the share of FFS beneficiaries on dialysis with lower (less than 10 g/dL) and higher (exceeding 12 g/dL) hemoglobin levels remained steady, averaging 31 percent and 6 percent of beneficiaries, respectively. There was little difference in the hemoglobin status of beneficiaries on dialysis residing in rural versus urban areas. Between 2021 and 2024, the share of beneficiaries treated with a blood transfusion remained relatively steady, averaging between 2.7 percent and 2.8 percent per month.

As for outcome measures of mortality, hospitalizations, and ED visits:

- In 2020, as the coronavirus pandemic took hold, mortality averaged 1.9 percent per month, up from an average of 1.6 percent in 2019. The rate of mortality per month remained elevated, averaging about 2.0 percent per month in 2021 through 2024.
- Between 2021 and 2024, the share of FFS beneficiaries on dialysis who were admitted to a short-stay hospital (beneficiaries with at least one admission in a given month) remained relatively steady, averaging 14 percent to 15 percent per month. During the same period, 30-day

readmission rates on an annual basis remained relatively steady at 21 percent of admissions.²⁵

- Between 2021 and 2023, the share of FFS beneficiaries on dialysis who used the ED (beneficiaries with at least one ED visit in a given month) averaged around 18 percent per month and increased to 20 percent in 2024.

Patient-experience measures

The In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH-CAHPS) survey provides patient ratings of their dialysis facility, center staff, and nephrologist for their communications, care, operations, and provision of information (Centers for Medicare & Medicaid Services 2024a). Among survey respondents, roughly 60 percent to 80 percent gave the top ratings across the six measures we examined (Table 5-4). Survey results did not differ between urban and rural facilities (data not shown). Patient experience remained relatively stable between reporting years 2023 and 2025, but there remains room for improvement. In particular, the global rating of nephrologists consistently scored the lowest, with only 60 percent of patients giving their nephrologist a rating of 9 or 10 out of 10 (best possible) in 2025. Per the 2026 ESRD PPS final rule, however, CMS is removing from the ICH-CAHPS all measures related to rating nephrologists (e.g., nephrologists' communication and caring, and rating of the nephrologist) (Centers for Medicare & Medicaid Services 2025b).²⁶

Access to home dialysis

Researchers have concluded that the ESRD PPS, which began in 2011, is associated with an overall increase in the use of home dialysis (Lin et al. 2017).²⁷ The share of beneficiaries dialyzing at home steadily increased from 9 percent per month in 2011 to 18 percent per month in 2024. Differences by race have persisted over time: Although about 27 percent of FFS Medicare beneficiaries with ESRD on dialysis are Black, they represent only 23 percent of beneficiaries who dialyze at home.

Researchers have identified many factors that affect the use of home dialysis, both clinical (e.g., patients' other health problems and prior nephrology care) and nonclinical (e.g., patients' social circumstances and knowledge of treatment options, as well as

**TABLE
5-4**

In-center hemodialysis patient-experience scores, 2023–2025

ICH-CAHPS measures	2023	2024	2025
Share of patients giving top ratings for:			
Nephrologists' communication and caring	67%	67%	67%
Quality of dialysis center care and operations	64	64	65
Providing information to patients	79	79	80
Share of patients rating a 9 or 10 out of 10 (best possible):			
Rating of the nephrologist	59	59	60
Rating of the dialysis center staff	64	65	66
Rating of the dialysis facility	69	69	70

Note: ICH-CAHPS (In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems). The ICH-CAHPS is a survey of patient experiences with the dialysis facility, facility doctors and staff, and care received. The survey's measures included in the table are "top box," or the most positive, response to ICH-CAHPS survey items. The first three measures are composite measures of multiple survey questions that have responses of "never," "sometimes," "usually," and "always." Share of patients giving top ratings include those who reported "always." Survey results are publicly reported twice a year, based on data from the two most recent survey periods. Each year, spring survey data are collected from April through July and fall survey data are collected from November through January. The years indicate reporting years: Data for reporting year 2025 include surveys collected from the 2024 spring and 2024 fall surveys. Among facilities reporting ICH-CAHPS data (2,363 facilities in reporting year 2025), the survey-response rate was, on average, 27 percent.

Source: CMS summary of national average for ICH-CAHPS survey measures, 2023–2025.

physicians' training and preference). For example, nephrology trainees have reported low and moderate levels of preparedness for managing patients on home hemodialysis and PD, respectively (Gupta et al. 2021). Some beneficiaries report that they were never informed about their dialysis modality options. Facility factors, such as unused in-center capacity or additional in-center shifts and dialysis-facility staff experience, can also affect use of home dialysis (Walker et al. 2010).²⁸ Some clinical and nonclinical factors affecting use of home dialysis are amenable to intervention. For example, between 2008 and 2018, under an integrated care delivery system (Kaiser Permanente Northern California), PD use among patients new to dialysis more than doubled, from 15 percent to 34 percent. To augment the use of home dialysis, the health care system implemented a multidisciplinary, system-wide approach that increased patient and family education, educated health care professionals about the importance of PD, adopted operational improvements, monitored outcomes, and shared best practices with staff (Pravoverov et al. 2019).

Access to kidney transplantation

Kidney transplantation is widely regarded as a better ESRD treatment option than dialysis in terms of patients' clinical outcomes and quality of life. In addition, transplantation is associated with lower Medicare spending. In 2021, average annual Medicare spending for patients on dialysis (roughly \$105,000) was more than twice the annual spending for those who had a functioning kidney transplant (nearly \$49,000 in 2022) (United States Renal Data System 2024). However, demand for kidney transplantation exceeds the supply of available kidneys. Besides donation rates, factors that can affect access to kidney transplantation include the clinical allocation process; patients' health literacy, clinical characteristics, and preferences; the availability of education for patients; clinician referral for transplant evaluation at a transplant center; communication between the dialysis facility and the transplant center; transplant-center policies; and, specific to beneficiaries enrolled in MA, contracts between MA networks and transplant centers. On July 1, 2025, the CMS Innovation Center began the

Increasing Organ Transplant Access (IOTA) Model, a six-year mandatory model, intended to reduce Medicare expenditures and improve performance in kidney transplantation among participating kidney transplant hospitals (Centers for Medicare & Medicaid Services 2024b).

Between 2023 and 2024, according to the Organ Procurement and Transplantation Network, the number of kidney transplants increased by about 2 percent, to 27,760 (Table 5-5).²⁹ According to researchers, a kidney-allocation system implemented in 2014 by the United Network for Organ Sharing led to a narrowing of the disparities in national kidney-transplant rates among White, Black, and Hispanic patients on the transplant waiting list (Melanson et al. 2017). Between 2019 and 2024, there was a marginal increase in the share of transplants for Black and Hispanic patients (Table 5-5).³⁰

Access to capital for most dialysis providers appears to be strong

Dialysis providers need access to capital to maintain and modernize their facilities and to improve patient care delivery. In general, current growth trends among dialysis providers indicate that the dialysis industry is attractive to for-profit facilities and investors, with the two LDOs and other renal companies appearing to have adequate access to capital. For example:

- In 2024, DaVita continued its investment in a kidney care-focused medical-device company with Medtronic that specializes in developing novel kidney-care products and solutions, including home-based products to make different dialysis treatments more accessible, and it increased its international footprint (DaVita 2025a).
- In 2024, DaVita Venture Group (a corporate venture arm of DaVita) continued to fund select venture-capital investments in early-stage companies, including (1) acquiring a transplant software company to create greater connectivity among transplant candidates, transplant centers, physicians, and care teams; (2) investing in a company that offers advance care planning and virtual palliative care; and (3) investing in a new pharmaceutical company to bring ESRD drugs to market (DaVita 2025a).
- Fresenius received initial FDA 510(k) clearance for its high-volume hemodiafiltration (HVHDF) machine in 2024 (Food and Drug Administration 2024b). In 2025, the company received FDA clearance for an updated machine that includes additional features that allow access to providers' medical information systems directly at chairside (Food and Drug Administration 2025). In 2025, the company announced the second phase of the company's efforts to introduce HVHDF kidney-replacement therapy across the U.S., which includes offering HVHDF therapy in its U.S. Fresenius Kidney Care dialysis clinics; they also announced that the full-scale commercial launch is anticipated in 2026 (Fresenius Medical Care 2025c).

In recent public financial filings, the two LDOs reported generally positive financial performance related to their dialysis business for 2025, including improvements in productivity (DaVita 2025c, Fresenius Medical Care 2025b). Other positive results recently reported by the LDOs as of the third quarter of 2025 include positive U.S. same-market treatment growth and strong organic revenue growth by Fresenius and DaVita's third-quarter performance, in line with the latter company's expectations to achieve full-year guidance (DaVita 2025d, Fresenius Medical Care 2025b).

Since 2010, both LDOs have grown through large acquisitions of and mergers with other dialysis facilities and health care organizations. For example, during this period, both LDOs acquired midsize for-profit organizations: DaVita acquired Purity and Renal Ventures, and Fresenius Medical Care acquired Liberty Dialysis. The LDOs have also entered into value- and risk-based programs with private payers to provide care to commercial and MA patients with ESRD and CKD. Under these arrangements, the companies' financial performance is based on their ability to manage a defined scope of medical costs within certain parameters for clinical outcomes (Fresenius Medical Care 2022). Both LDOs are participants in the CMS Innovation Center's current Kidney Care Choices Model.

The two LDOs, in addition to operating three-quarters of all dialysis facilities, are both vertically integrated (DaVita 2023, Fresenius Medical Care 2023). For example, other health care services that one or both LDOs operate include an ESRD-related

**TABLE
5-5****The number of kidney transplants has increased**

	2019	2023	2024
Total transplants	23,401	27,332	27,760
Share of total transplants from live donors	29%	23%	23%
Share receiving a transplant			
White	45	40	39
Black	27	30	30
Hispanic	19	20	20
Asian	7	8	7
All others	2	2	3

Note: Individuals receiving a kidney transplant include individuals with end-stage renal disease on dialysis (which replaces the filtering function of the kidneys when they fail) and individuals who receive a kidney transplant before their kidney function deteriorates to the point of needing dialysis. Components may not sum to 100 percent due to rounding.

Source: Organ Procurement and Transplantation Network.

laboratory, a pharmacy, and centers that provide vascular access services; they both provide ESRD-related care-coordination and disease-management services to government and nongovernment payers (including MA plans); and they operate dialysis facilities internationally. One LDO manufactures, acquires, in-licenses, and distributes ESRD pharmaceutical products (e.g., phosphate binders and iron-replacement products) and manufactures dialysis products (hemodialysis machines, peritoneal cyclers, dialyzers, peritoneal solutions, hemodialysis concentrates, bloodlines, and systems for water treatment) and nondialysis products, including acute cardiopulmonary and apheresis products. For example, this LDO established a company (Vifor Fresenius Medical Care Renal Pharma) that, since 2014, markets a phosphate binder (Velphoro) as well as other renal-dialysis drugs prescribed to patients on dialysis. In 2023, Part D spending on Velphoro for FFS beneficiaries on dialysis was nearly \$237 million. This LDO supplies dialysis facilities that it owns, operates, or manages with dialysis products, and it sells dialysis products to other dialysis-service providers.

Another positive indicator of the dialysis sector's strong access to capital is its all-payer margin. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability, p. 55.) Using cost-report data submitted by freestanding dialysis facilities to CMS, we estimated that the 2024 all-payer margin was roughly 16 percent. The all-payer margin is affected by the revenues that providers derive from furnishing care to patients with all sources of coverage, including FFS Medicare, MA, other government payers, and commercial payers, as well as to patients with acute kidney injury.³¹ Although commercial payment rates vary, average rates established under commercial contracts are generally significantly higher than Medicare rates. According to one LDO, in 2024, patients with commercial coverage (including hospital dialysis services) accounted for 11 percent of its U.S. patients on dialysis but about 33 percent of its U.S. dialysis revenues, while patients with government coverage accounted for 89 percent of its U.S. patients on dialysis and 67 percent of its U.S. revenues (DaVita 2025a). Similarly, researchers found that in 2017, the median MA payment for dialysis was 27 percent above FFS rates, and the payments were higher

to LDOs than to regional chains and independently owned dialysis facilities (Lin et al. 2022).

Medicare payments and providers' costs: Lower cost growth contributed to increase in FFS Medicare margin in 2024

Between 2023 and 2024, Medicare's payments per FFS dialysis treatment increased 2 percent, while total costs per treatment declined by 3 percent. In 2024, the FFS Medicare margin rose to 4.5 percent from -0.2 percent in 2023. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.)

Medicare payments for outpatient dialysis services

Between 2023 and 2024, FFS per capita annual spending for outpatient dialysis services for FFS beneficiaries (i.e., for dialysis treatments furnished by ESRD freestanding and hospital-based facilities) remained steady at nearly \$31,000. Total FFS Medicare spending for these services, however, declined 6 percent from 2023, to \$7.6 billion. As discussed earlier in the chapter, the decline is predominantly due to MA plans' increasing enrollment of beneficiaries on dialysis beginning in 2021. A statutory update (of 2 percent) increased the ESRD PPS base payment rate in 2024.

Between 2022 and 2023, Part D spending for ESRD oral-only phosphate binders declined for FFS beneficiaries on dialysis

Phosphate binders were the last oral-only drug group that were included in the ESRD PPS bundle in 2025 (the inclusion of oral-only drugs in the ESRD PPS bundle has been delayed by regulation and statute). The most current data that we have on the use of these products are from 2023, when they were covered under Part D. Between 2022 and 2023, spending for phosphate binders furnished to FFS beneficiaries on dialysis declined by 16 percent to \$0.6 billion.³² The decline in total FFS spending for phosphate binders for beneficiaries on dialysis is linked to the substantial decrease in beneficiaries on dialysis in FFS as enrollment shifted to MA beginning in 2021. Among FFS beneficiaries on dialysis who used phosphate binders, per capita spending between 2022 and 2023 declined by 5 percent to \$4,300 per

patient. Similar shares (ranging from 65 percent to 66 percent) of FFS beneficiaries on dialysis with Part D coverage were prescribed phosphate binders in 2022 and 2023, and phosphate binders accounted for 29 percent to 32 percent of their Part D spending. Medicare spending for ESRD drugs under Part D is not included in the Commission's analysis of dialysis facilities' financial performance under the ESRD PPS.

As of January 1, 2025, phosphate binders are paid for under the ESRD PPS.³³ Dialysis facilities receive a TDAPA payment based on 100 percent of each product's ASP plus a fixed-rate addition of \$36.41 per monthly claim for at least two years (2025 and 2026).³⁴ CMS derived the fixed-rate addition of \$36.41 based on the weighted average of Medicare expenditures for phosphate binders per month under Part D, using utilization patterns in 2023 among Part D-eligible beneficiaries. According to the agency, the monthly fixed-rate addition approximates 6 percent of ASP and is intended to offset the incremental operational cost incurred by dialysis facilities in storing, managing, and dispensing phosphate binders to patients because such costs were not addressed when the ESRD PPS base rate was implemented in 2011 (Centers for Medicare & Medicaid Services 2024c).

Providers' costs for outpatient dialysis services under the ESRD PPS

We examine aggregate dialysis-facility costs using 2023 and 2024 cost reports and claims submitted to CMS by freestanding dialysis facilities. For those years, we looked at the growth in the cost per treatment and how the total volume of treatment affected that cost.

Cost growth under the PPS Between 2023 and 2024, total cost per treatment declined by 3 percent, from \$291 per treatment to nearly \$284 per treatment. The 3 percent decline in cost per treatment in 2024 relative to 2023 is attributable to a drop in cost per treatment for overhead and ESRD drugs, which was only partially offset by growth in other costs.

Costs fell for:

- overhead, by 13 percent, and accounted for 27 percent of cost per treatment in 2024; and

- ESRD drugs, by 15 percent, and accounted for 6 percent of providers' cost per treatment in 2024.

Costs increased for:

- labor, by 5 percent, and accounted for 37 percent of 2024 providers' cost per treatment;
- capital and supplies, which each increased by 2 percent and accounted for 18 percent and 11 percent of providers' cost per treatment, respectively; and
- laboratory services, by 1 percent, and accounted for 1 percent of 2024 providers' cost per treatment.

The 13 percent decline in overhead cost per treatment in 2024 contrasts with the relatively high cost growth of 9 percent per year between 2020 and 2023 (i.e., during the coronavirus pandemic). Our finding that ESRD drug costs declined in 2024 is attributable to the drop in the cost per treatment for ESAs. The continued decline in ESA costs is expected: Under the ESRD PPS (i.e., since 2011), ESA cost per treatment has declined on average by 10 percent per year.

Variation in cost growth across freestanding dialysis facilities shows that some facilities were able to hold their cost growth well below that of others. For example, between 2023 and 2024, average per treatment costs fell by 8 percent for facilities in the 25th percentile of cost growth, compared with a rise of 2 percent for facilities in the 75th percentile. The change in cost per treatment is related to facility size. Between 2023 and 2024, total cost per treatment for the smallest facilities (e.g., facilities furnishing fewer than 4,000 treatments) declined on average by 1 percent; by comparison, for all other facilities, total cost per treatment declined by 3 percent.

The extent to which some of the variation in costs among facilities results from differences in the accuracy of facilities' reported data is unknown. Our analysis of cost-report data shows substantial variation in selected categories as reported by the five largest dialysis organizations. For example, in 2024, labor and capital costs each varied by \$40 per treatment. The Commission has estimated, based on findings from CMS's audit of facility cost reports, that unallowable costs reported by dialysis facilities could have

amounted to about 4 percent of total reported costs in 2018 (Medicare Payment Advisory Commission 2022).

Cost per treatment is correlated with facility service volume

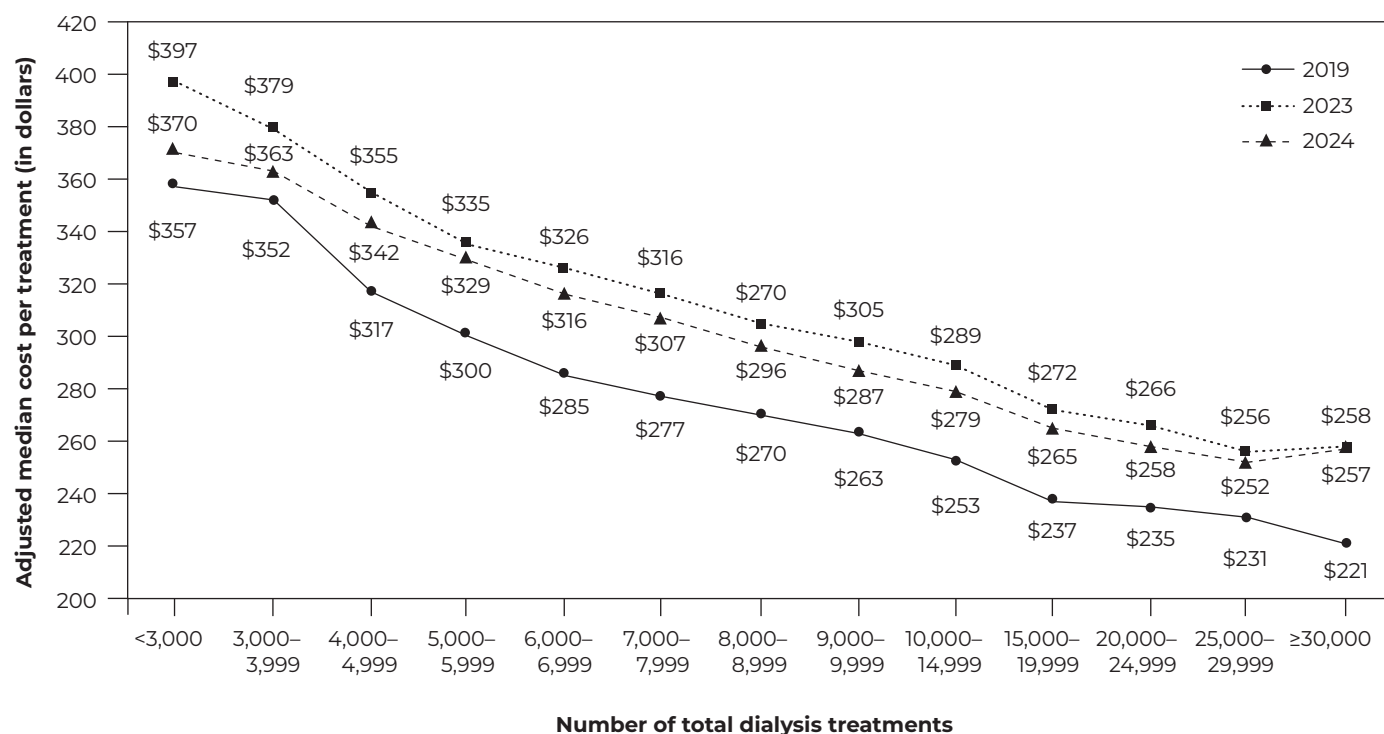
To examine the relationship between a facility's cost per treatment and the total number of treatments a facility furnishes, we adjusted the cost per treatment to remove differences in the cost of labor across geographic areas and included all treatments regardless of payer. Our analysis showed a statistically significant relationship between the total number of treatments and cost per treatment (correlation coefficient equaled -0.5) in each year between 2019 and 2024 (Figure 5-2, p. 172). That is, the greater the facility's service volume, the lower its costs per treatment. In each year, facilities that qualified for increased Medicare payment due to low volume had substantially higher cost per treatment for capital as well as administrative and general services compared with all other facilities.

The trend in the FFS Medicare margin for freestanding dialysis facilities

The Commission assesses current payments and costs for FFS dialysis services for freestanding dialysis facilities by comparing Medicare's payments with facilities' Medicare-allowable costs. The latest and most complete data available on payments and costs are from 2024.³⁵

The FFS Medicare margin reached 8.4 percent in 2019 (the highest since the ESRD PPS was implemented in 2011)³⁶ but has since declined, falling to -1.1 percent in 2022 and -0.2 percent in 2023 (Figure 5-3, p. 173). Due to lower cost growth and a statutory update (of 2 percent), dialysis facilities' FFS Medicare margin rose in 2024, to 4.5 percent. While the margin has varied over time—including some periods in which it was negative or near zero and other periods where it was substantially positive—beneficiaries' access to care has remained positive throughout.

Dialysis facilities' financial performance under the ESRD PPS has been variable due to statutory and regulatory changes as well as the use and profitability of certain ESRD drugs (Figure 5-3, p. 173). During the initial years of the ESRD PPS, the FFS Medicare margin increased as providers furnished fewer ESRD drugs per treatment. Between 2014 and 2017, facilities' financial

**FIGURE
5-2****Higher-volume freestanding dialysis facilities had lower cost per treatment, 2019–2024**

Note: Cost per treatment is adjusted to remove geographic differences in the cost of labor.

Source: MedPAC analysis of cost reports submitted by freestanding dialysis facilities to CMS and the end-stage renal disease wage-index files.

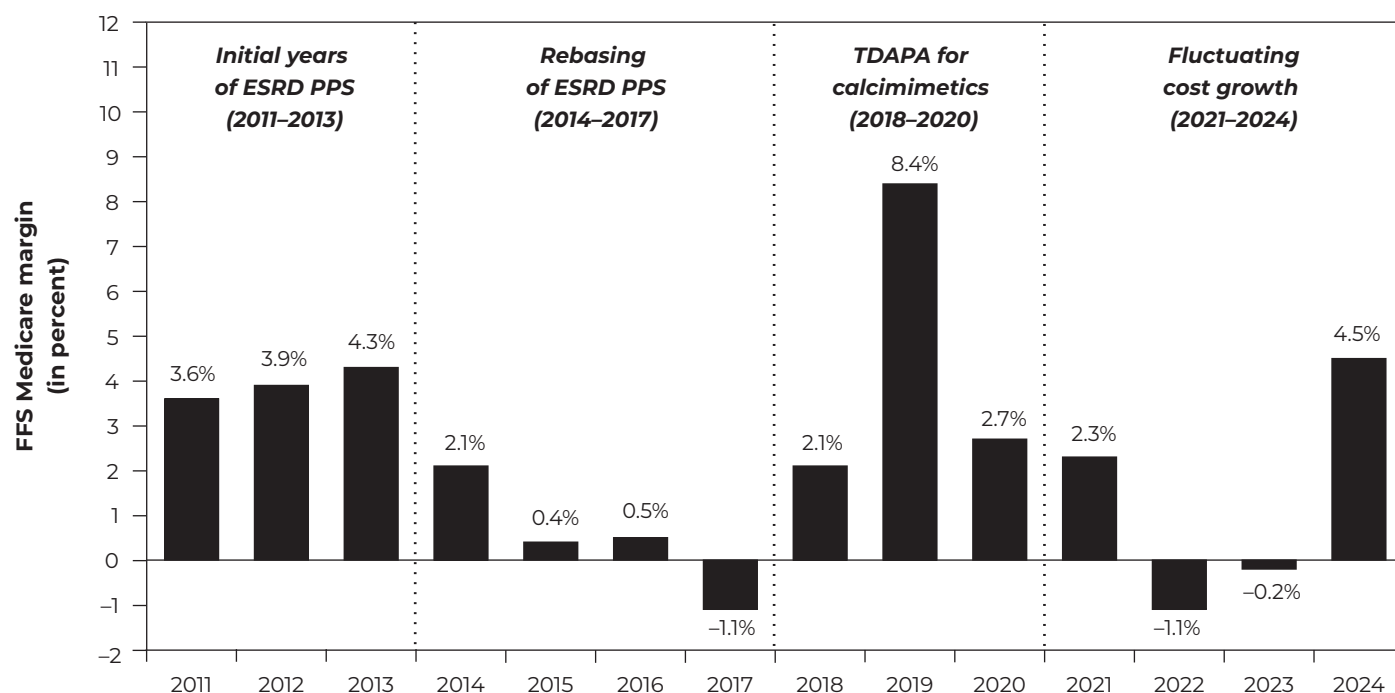
performance under FFS Medicare reversed, and the FFS Medicare margin declined from 2.1 percent to –1.1 percent because of statutorily required payment adjustments to account for the decline in ESRD drug use under the ESRD PPS. Provisions in the statute required CMS to rebase the payment rate in 2014 (reducing the payment rate by about 3.4 percent) and limit payment updates from 2015 through 2018.

In 2018 and 2019, the FFS Medicare margin increased due to the profitability of calcimimetics paid under the TDAPA policy—to 2.1 percent in 2018 and 8.4 percent in 2019 (Figure 5-3).^{37,38} In 2020, the FFS Medicare margin decreased to 2.7 percent (3.7 percent when including FFS Medicare’s share of pandemic relief funds) because cost per treatment increased and the TDAPA payment for eligible drugs, including calcimimetics, declined from ASP plus 6 percent to

ASP plus 0 percent. In 2021, the FFS Medicare margin declined again to 2.3 percent due to increasing cost per treatment for all cost categories except ESRD drug costs.

The FFS Medicare margin further declined to –1.1 percent in 2022, partly due to growth in labor and capital costs, which both increased by 7 percent between 2021 and 2022, well above the historical average. Due to lower cost growth and because growth in payment per treatment exceeded growth in cost per treatment, dialysis facilities’ FFS Medicare margin rose in 2023, to –0.2 percent.

The increase in the FFS Medicare margin from –0.2 percent to 4.5 percent in 2024 is partly attributable to (1) lower overhead and ESRD-drug cost per treatment compared with 2023, and (2) the statutory update of the ESRD PPS base payment rate in 2024. Partially

**FIGURE
5-3****FFS Medicare margin has varied over time**

Note: FFS (fee-for-service), ESRD (end-stage renal disease), PPS (prospective payment system), TDAPA (transitional drug add-on payment adjustment). Pandemic-related federal relief funds are not included in the data presented in this figure.

Source: Compiled by MedPAC from cost reports and claims submitted by facilities to CMS.

offsetting these factors were increases in the other cost categories, including labor and capital, between 2023 and 2024. In addition, the two LDOs experienced a 0.2 percent increase in total treatment volume (across all payers) between 2023 and 2024 (DaVita 2025a, Fresenius Medical Care AG 2025).

The FFS Medicare margin varies by treatment volume

FFS Medicare margins in 2024 decidedly varied by treatment volume: Facilities in the lowest-volume quintile had margins below -11 percent, while facilities in the top-volume quintile had margins of over 11 percent (Table 5-6, p. 175). Urban facilities averaged higher margins than rural facilities (5.2 percent vs. -0.3 percent). Total treatment volume accounted for much of the difference in margins between urban and rural

facilities: Urban dialysis facilities are larger, on average, in terms of the number of treatment stations and total treatments provided. For example, in 2024, urban facilities averaged roughly 11,000 treatments while rural facilities averaged nearly 7,700 treatments (data not shown). Higher-volume facilities had lower cost per treatment (Figure 5-2).

Although some rural facilities in 2024 benefited from the ESRD PPS's 23.9 percent LVPA (for those furnishing fewer than 4,000 treatments) and 0.8 percent rural adjustment, the Commission has found that neither adjustment appropriately targets low-volume, geographically isolated facilities that are critical to beneficiary access (Medicare Payment Advisory Commission 2016, Medicare Payment Advisory Commission 2015, Medicare Payment Advisory Commission 2014). Beginning in 2025, dialysis facilities

furnishing fewer than 3,000 treatments receive a 28.9 percent upward payment adjustment, and those furnishing between 3,000 and 3,999 treatments receive an 18.3 percent upward payment adjustment per the two-tiered LVPA policy finalized in the 2025 ESRD PPS final rule. CMS contends that this modification better targets payment increases to facilities with higher costs (Centers for Medicare & Medicaid Services 2024c). In June 2020, the Commission recommended that the Secretary replace the current low-volume and rural payment adjustments with a single payment adjustment that considers both a facility's distance to the nearest facility and its treatment volume, thereby directing extra payments to the low-volume and isolated facilities that are most necessary to ensure beneficiary access to care (Medicare Payment Advisory Commission 2020b). We expect that this recommendation would increase the aggregate Medicare margin for isolated, low-volume facilities located in rural areas.³⁹

Projecting payments and costs for 2026

To estimate the projected 2026 margin, the Commission considers providers' cost growth between 2019 and 2024 and policy changes affecting payments in 2025 and 2026. These factors include:

- statutory updates to the dialysis base payment rate (based on the ESRD market basket offset by a productivity adjustment) of 2.2 percent in 2025 and 2.1 percent in 2026; and
- reductions in payments of 0.37 percent in 2025 and 0.23 percent in 2026 due to the ESRD Quality Incentive Program.

Factors not considered in this projection that could have a positive effect on providers' financial performance include:

- add-on payments in 2025 and 2026 for new ESRD drugs (including Vafseo (for treatment of anemia), Korsuva (for treatment of pruritus), and DefenCath (which reduces incidence of catheter-related bloodstream infections)) and in 2025, for at least two years, for phosphate binders; and
- both LDOs' productivity efficiencies in 2025; for example, one LDO reduced ESRD drug costs by switching its patients to epoetin beta, and

both LDOs have been maximizing their capacity utilization by merging and closing facilities and promoting home dialysis.

We project that the FFS Medicare margin will decline from 4.5 percent in 2024 to 4 percent in 2026, in aggregate.

How should FFS Medicare payments change in 2027?

Most payment-adequacy indicators—beneficiary access to care, quality of care, provider access to capital—for outpatient dialysis facilities are adequate, and the projected FFS Medicare margin for 2026 is 4 percent. Under current law, Medicare's base payment rate under the ESRD PPS will be increased in 2027 based on the forecasted increase in the ESRD market basket less a forecasted increase in productivity. CMS will revise its estimates before setting rates for 2027; however, we note that CMS currently forecasts a 1.6 percent increase in the base payment rate. The final 2027 update will include newer forecasts of growth in input prices and productivity and thus could be lower or higher than the current projected update.

In addition to the base payment rate, Medicare pays dialysis facilities for qualifying new drugs that treat a condition included in 1 of 11 functional categories of products that are covered under the ESRD PPS TDAPA and post-TDAPA for a five-year period. The new ESRD drugs paid under such add-on payment policies may increase FFS Medicare payments relative to facilities' costs. Specifically, CMS does not reconcile the cost and utilization of the new drug paid under an add-on payment in an existing functional category (e.g., anemia category) with the cost and utilization of the drugs already included in the functional categories that are paid under the ESRD PPS payment bundle. Essentially, the current add-on payment policies for ESRD drugs in an existing ESRD functional category create a second (duplicative) payment for new ESRD drugs that treat the same clinical condition as drugs already included in the payment bundle.

The TDAPA for phosphate binders that began in 2025 may increase FFS Medicare payments relative to facilities' costs, like the TDAPA for calcimimetics did

**TABLE
5-6**

In 2024, the FFS Medicare margin of freestanding dialysis facilities varied by treatment volume

Provider type	FFS Medicare margin	Share of freestanding dialysis facilities	Share of freestanding dialysis facility treatments
All	4.5%	100%	100%
Urban	5.2	85	89
Rural	-0.3	15	11
Treatment volume (quintile)			
Lowest	-11.6	20	8
Second	-5.1	20	13
Third	1.9	20	18
Fourth	6.0	20	24
Highest	11.3	20	38

Note: FFS (fee-for-service). Components may not sum to 100 percent due to rounding.

Source: Compiled by MedPAC from cost reports and claims submitted by freestanding dialysis facilities to CMS and from the Dialysis Compare database.

between 2018 and 2020 (Figure 5-3, p. 173). Although some stakeholders have raised concerns that paying for phosphate binders under the ESRD PPS may have a negative effect on providers' financial performance, three of the five largest dialysis organizations operate their own pharmacies, which gives them advantages such as managing costs and maintaining greater control of and more complete information on their patients' prescriptions (Government Accountability Office 2023). Furthermore, both LDOs reported a positive impact from furnishing phosphate binders (Fresenius Medical Care 2025a). Indeed, one of the LDOs reported that revenue per treatment for phosphate binders exceeded their cost per treatment (\$10 vs. \$8, respectively) (DaVita 2025b).

There is some evidence that dialysis facilities have generally become more efficient under the ESRD PPS, as measured by declining use of most injectable ESRD drugs with little to no measurable impact on beneficiaries' health outcomes. Facilities have additional incentives to maximize the efficiency of their in-center capacity utilization: increased demand for home dialysis, the excess mortality during the

coronavirus pandemic, and the slower growth of ESRD incidence over the past decade.

RECOMMENDATION 5

For calendar year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rate for outpatient dialysis services.

RATIONALE 5

Our indicators of payment adequacy are generally positive, including beneficiaries' access to care, the supply and capacity of providers, volume of services, and access to capital. Providers have become more efficient in the use of ESRD drugs under the ESRD PPS. Indicators of quality of care are mixed. The FFS Medicare margin was 4.5 percent in 2024 and is projected to be 4 percent in 2026. We do not yet know the effect of Medicare's add-on payments for new renal dialysis drugs and phosphate binders on facilities' financial performance in 2025 and 2026, but our prior analysis showed that add-on payments for calcimimetics between 2018 and 2020 contributed to a substantial increase in facilities' FFS Medicare

margin during that period. The two LDOs—companies that account for three-quarters of dialysis facilities—recently made optimistic statements about their dialysis business, including productivity gains in 2025. Low-volume dialysis facilities, which tend to have higher costs due to fewer economies of scale, may be helped by increased payments under the ESRD PPS's refined low-volume payment adjustment beginning in 2025.

Spending

- Current law is expected to increase the base payment rate by 1.6 percent in 2027. This recommendation would lower spending relative to current law by between \$50 million and \$250 million over one year and between \$1 billion and \$5 billion over five years.

Beneficiary and provider

- We expect beneficiaries on dialysis to continue to have good access to outpatient dialysis care. This recommendation is expected to have a minimal effect on providers' willingness and ability to care for Medicare beneficiaries. ■

Endnotes

- 1 In this chapter, the term “beneficiaries” refers to individuals covered by Medicare, and “patients” refers to all individuals (across all types of health coverage) who have ESRD.
- 2 In this chapter, the term “drugs” refers to both drugs and biologics. The term “biologics” refers to biological products.
- 3 Individuals with ESRD have been entitled to Medicare Part A and Part B benefits since the 1972 amendments to the Social Security Act that extended Medicare benefits to this population (Social Security Administration 2024). For individuals with ESRD to qualify for Medicare, including those under age 65, they must be fully or currently insured under the Social Security or Railroad Retirement program or be the spouse or dependent child of an eligible beneficiary. When a beneficiary enrolls in Medicare based on ESRD, Medicare coverage usually begins on the first day of the fourth month of dialysis treatment in a dialysis facility. The 1972 law included a three-month waiting period to address financing issues (Institute of Medicine Committee to Study Decision Making 1991). Per the ESRD Program Amendment of 1978 (P.L. 95-292), Medicare coverage can start as early as the first month of dialysis if the beneficiary takes part in a home dialysis training program (Centers for Medicare & Medicaid Services 2025a). According to Eggers (1984), the 1978 law included this waiver to promote home dialysis and to increase the cost-efficiency of the ESRD program (Eggers 1984).
- 4 Clinicians receive a monthly capitated payment established in the Part B physician fee schedule for outpatient dialysis-related management services (which include managing the dialysis prescription and prescribing ESRD drugs); payment varies based on the number of visits per month, the beneficiary’s age, and whether the beneficiary receives dialysis in a facility or at home.
- 5 In 2021, private equity firm Nautic Partners and its portfolio company, Innovative Renal Care, acquired American Renal Associates (American Renal Associates 2021).
- 6 For pediatric beneficiaries on dialysis (ages 17 years and under), the base rate is adjusted for age and type of dialysis.
- 7 New drugs ineligible for a separate add-on payment include generic drugs, which the Food and Drug Administration (FDA) approves under Section 505(j) of the Federal Food, Drug, and Cosmetic Act, and drugs approved for a new dosage form (e.g., pill size, time-release forms, chewable or effervescent pills); drugs approved for a new formulation (e.g., new inactive ingredient); drugs approved that were previously marketed without a new-drug application; and drugs approved that changed from prescription to over-the-counter availability. CMS identifies these drugs using the application classification code for new drugs, which the FDA assigns to a given drug.
- 8 CMS calculates the TDAPA and post-TDAPA payments differently. The TDAPA payment for new, qualifying drugs is based on the number of units of the new drug furnished to the beneficiary multiplied by average sales price plus 0 percent. CMS pays a post-TDAPA on all ESRD PPS claims; the payment rate is case-mix adjusted and set at 65 percent of the estimated expenditure levels for the given ESRD drug in the prior year.
- 9 The receipt of post-TDAPA add-on payment adjustments is conditional on continued receipt of the latest full calendar quarter of average sales price data.
- 10 In the 2026 ESRD PPS final rule, CMS finalized the proposed rule to not pay a post-TDAPA for Jesdubroq after the end of the product’s TDAPA period on September 30, 2025. The manufacturer of Jesdubroq withdrew the product from the market for reasons unrelated to safety or effectiveness (Food and Drug Administration 2024a).
- 11 Unlike for new ESRD drugs paid under a TDAPA, a substantial-clinical-improvement standard is used to determine eligibility for a TPNIES add-on. According to CMS, the two-year TDAPA for new ESRD drugs in an existing functional category does not include a standard for substantial clinical improvement because “allowing all new drugs to be eligible for TDAPA will provide an opportunity for the new drugs to compete with other similar drugs in the market which could mean lower prices for all drugs. We believe drug manufacturers understand that if they are to compete with drugs currently in the ESRD-PPS bundle, they need to not only be better, but they also must come in at a lower price in order to continue to be utilized by facilities in the post-TDAPA period. The 2-year TDAPA period gives the innovative product an opportunity to demonstrate its clinical value and financial worth, while buffering the risk to both the manufacturer and the facility. If the facility finds the product sufficiently worthy of use among its patients, then the manufacturer has an incentive to keep the price lower than the drug it is replacing that is currently in the bundle. In addition, the effectiveness of drugs can depend on age, gender, race, genetic predisposition and comorbidities. Innovation can provide options for those that do not respond to a certain preferred treatment regimen the same way the majority

- of patients respond” (Centers for Medicare & Medicaid Services 2018). The Commission’s *Payment Basics* series provides more information about Medicare’s method of paying for outpatient dialysis services (see “Outpatient Dialysis Services Payment System” in our *Payment Basics* series, available at https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_dialysis_FINAL_SEC.pdf).
- 12 The payment rate reflects (1) the base rate adjusted for each beneficiary’s and facility’s characteristics, (2) add-on payments for qualifying technologies, (3) a training add-on payment for home and self-dialysis modalities, (4) a transitional pediatric add-on payment, (5) payment for high-cost outliers due to unusual variations in the type or amount of medically necessary care, (6) the ESRD quality incentive adjustment, (7) payment adjustments due to the ESRD Treatment Choices Model, and (7) the Medicare sequester.
 - 13 This figure is based on the Commission’s analysis of Medicare and total treatments reported by freestanding facilities on cost reports submitted to CMS.
 - 14 In the 2026 ESRD PPS final rule, CMS terminated the ETC Model as of December 31, 2025. According to CMS, the early termination of this mandatory model stems from it having no impact on home dialysis, waitlisting for kidney transplants, and living donor transplant rates in the first three years of the model (Centers for Medicare & Medicaid Services 2025b).
 - 15 Some portion of the decline in 2021 in the number of FFS beneficiaries on dialysis and treatments may also have been due to the ongoing effects of the coronavirus pandemic. According to one of the LDOs, the overall number of patients that the company treated in 2021 fell by about 0.5 percent from 2020, primarily due to an increase in mortality rates because of COVID-19. These rates were partially offset by patients starting dialysis (DaVita 2022a).
 - 16 Medicare pays for up to three dialysis treatments per week, though exceptions can be made with medical justification (Centers for Medicare & Medicaid Services 2023b).
 - 17 ESAs include epoetin alfa reference, epoetin alfa biosimilar, epoetin beta, and darbepoetin. Iron agents include iron sucrose and sodium ferric gluconate. Vitamin D agents include calcitriol, doxercalciferol, and paricalcitol. Calcimimetics include cinacalcet and etelcalcetide. Other drugs include daptomycin, vancomycin, alteplase, and levocarnitine.
 - 18 To measure changes in the use of most drugs in the payment bundle, we combine drugs within and across therapeutic classes by multiplying the number of drug units reported on claims in a given year by each drug’s 2024 average ASP. However, because 2024 ASP data were not available for cinacalcet, we used CMS’s TDAPA payment limit for the fourth quarter of 2020 and updated it to 2024 dollars using pharmaceutical Producer Price Indexes. Also, because 2024 ASP data were not available for calcitriol, we used CMS’s published 2023 ASP data and updated them to 2024 dollars using pharmaceutical Producer Price Indexes. By holding the price constant, we account for the different billing units assigned to a given drug.
 - 19 Our analyses of CMS enrollment and supplemental coverage data show that in 2024, approximately 45 percent of FFS beneficiaries on dialysis without cost sharing covered by Medicaid had no supplemental coverage (that is, coverage from other sources, such as Medigap or employer-sponsored health plans) compared with 25 percent of all other FFS beneficiaries without cost sharing covered by Medicaid.
 - 20 Once beneficiaries with ESRD turn 65, for a six-month period that begins on the first day of the month in which they turn 65 (and are enrolled in Medicare Part B), they can purchase a Medigap plan without regard to their age, sex, or health status. Outside of the federal guaranteed-issue window, Medigap plans offered to beneficiaries with ESRD are limited: 36 states require insurers to offer at least one Medigap plan to beneficiaries under age 65 (American Kidney Fund 2024, Freed et al. 2024).
 - 21 Some FFS beneficiaries on dialysis get financial assistance from the American Kidney Fund, a nonprofit organization whose funding sources include dialysis providers and pharmaceutical manufacturers and through need-based grants to pay for health insurance premiums, prescription medications, and other items and services.
 - 22 For example, blood transfusion use, which initially increased under the PPS, has declined since 2013 (Centers for Medicare & Medicaid Services 2023a).
 - 23 While this section focuses on changes in individual quality metrics, it is worth noting that Medicare has implemented numerous programs that aim to improve the quality of care for late-stage chronic kidney disease and ESRD. A discussion of these programs can be found in the Commission’s March 2023 report to the Congress at https://www.medpac.gov/wp-content/uploads/2023/03/Ch6_Mar23_MedPAC_Report_To_Congress_SEC.pdf.

- 24 Blood transfusions are of concern to patients because they (1) carry a small risk of transmitting blood-borne infections to the patient, (2) may cause some patients to develop a reaction, and (3) are costly and inconvenient for patients. Blood transfusions are of particular concern for patients seeking kidney transplantation because they increase a patient's alloantigen sensitization, which can require a patient to wait to receive a transplant.
- 25 According to CMS, the monthly share of beneficiaries going to the ED varies based on beneficiaries' age, race, and eligibility for Medicaid. In 2023, the share of beneficiaries going to the ED is higher among (1) older beneficiaries compared to younger beneficiaries, (2) White, Black, or Hispanic beneficiaries compared to Asian beneficiaries; and (3) dually eligible beneficiaries compared to non-dually eligible beneficiaries (Centers for Medicare & Medicaid Services 2023a).
- 26 CMS cites "survey fatigue" and declining survey response rates as the motivation for reducing the length of the ICH CAHPS, and notes that the decision to remove measures related to nephrologists was based on feedback that "(1) patients are not always able to differentiate a kidney doctor from other dialysis center staff when answering questions, (2) nephrologists are often separate from the facility and may have patients in multiple facilities, and (3) there is nothing actionable that a facility can do based on the nephrologists' communication and caring scores or nephrologists' ratings" (Centers for Medicare & Medicaid Services 2025b).
- 27 Lin and colleagues analyzed data for individuals starting dialysis between 2006 and 2013 across all insurance types (Lin et al. 2017). The authors concluded that (1) the bundling implemented in the ESRD PPS was associated with substantial increases in home dialysis, which were identical for both Medicare and non-Medicare patients; and (2) the increase in home dialysis use among patients with other insurance types (i.e., not enrolled in FFS Medicare) indicates spillover effects of the ESRD PPS.
- 28 See our March 2020 report to the Congress for more information on the factors that affect use of home dialysis and the factors associated with some patients' discontinuation of home dialysis (available at https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch6_sec.pdf).
- 29 Individuals receiving a kidney transplant include individuals with ESRD on dialysis (which replaces the filtering function of the kidneys when they fail) and individuals who receive a kidney transplant before their kidney function deteriorates to the point of needing dialysis.
- 30 In the 10 years since the implementation of the kidney-allocation system by the United Network for Organ Sharing, between 2014 and 2024, the share of transplants for Black and Hispanic patients rose from 25 percent to 30 percent and 16 percent to 20 percent, respectively.
- 31 Since 2017, dialysis facilities are able to furnish dialysis to beneficiaries with acute kidney injury (AKI), as mandated by the Trade Preferences Extension Act of 2015. AKI is the sudden loss of kidney function, typically caused by an event that leads to kidney malfunction, such as dehydration, blood loss from major surgery or injury, or the use of medicines. In 2023, Medicare spending for outpatient dialysis services for FFS beneficiaries with AKI was \$75 million, a 4 percent increase compared with 2022. Medicare pays facilities the ESRD PPS base rate adjusted by the PPS wage index for the treatment of beneficiaries with AKI. In addition, for beneficiaries with AKI, Medicare pays dialysis facilities separately for drugs, biologics, and laboratory services that are not renal-dialysis services.
- 32 Between 2017 and 2019, the FDA approved generic versions of several types of phosphate binders (including lanthanum, sevelamer carbonate, and sevelamer hydrochloride).
- 33 Statutory changes (in the American Taxpayer Relief Act of 2012, the Protecting Access to Medicare Act of 2014, and the Stephen Beck, Jr., ABLE Act of 2014) delayed the inclusion of oral-only ESRD drugs in the ESRD PPS bundled payment until January 1, 2025.
- 34 In the 2025 ESRD PPS final rule, CMS said that the agency may reevaluate the amount of the monthly fixed-rate addition in future rulemaking, if appropriate.
- 35 The FFS Medicare margin includes Medicare's payments and providers' allowable costs for qualifying ESRD drugs and items paid under the TDAPA, post-TDAPA, and TPNIES.
- 36 Add-on payments for calcimimetics between 2018 and 2020 contributed to a substantial increase in facilities' FFS Medicare margin during that period.
- 37 In 2019, there was an anomalous increase compared with prior years in non-ESRD-related drug costs for facilities associated with a dialysis organization.
- 38 The sharp increase in the FFS Medicare margin in 2019 was driven by the availability of generic versions of the oral calcimimetic in 2019. There is a two-quarter lag in the data used to set ASP-based payment rates under the TDAPA policy, which can result in a difference between the average provider acquisition cost for a drug and the ASP used to set the Medicare payment amount for a quarter. When prices

increase or decrease, it takes two quarters before that change is reflected in the ASP data that Medicare uses to pay providers. When newly available generic drugs enter the market, their ASPs are often substantially lower than their brand counterparts, but payment amounts remain at the higher brand level for typically two quarters (or more).

39 According to CMS, Section 1881(b)(14)(D)(iii) of the Social Security Act—which requires that the LVPA reflect the extent to which low-volume facilities incur higher costs relative to other facilities—limits the agency’s ability to address the geographic isolation of a dialysis facility through the LVPA because its analysis found that low-volume facility costs do not vary by geographic isolation (Centers for Medicare & Medicaid Services 2024c).

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C H A P T E R

6

**Post-acute care:
Trends and key issues**

Post-acute care: Trends and key issues

Chapter summary

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 fee-for-service (FFS) Medicare, which can shape service use.

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 Medicare Advantage (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 inaccurate reporting of patient-assessment information that

In this chapter

- Overlap in the types of patients treated in different PAC settings
- Concerns about measuring and improving quality in nursing homes
- High FFS Medicare payments, FFS incentives, and Medicare benefits may encourage inefficient care
- Alternative payment models create incentives to lower FFS spending by using less post-acute care
- MA plans have an incentive to lower their costs by using less PAC

may reflect payment and other incentives rather than actual differences in patients and the lack of patient-experience data for SNFs and IRFs—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 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 establishing 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 equivalent 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.

Alternative payment models (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 could go home, as well as to avoid some PAC use altogether. Such changes in PAC use could reflect more efficient service use but 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 Medicare Advantage (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 could 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. ■

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).¹ The care is referred to as “post-acute care” (PAC) because it often follows inpatient hospital care.² In 2023, about 41 percent of fee-for-service (FFS) Medicare hospital discharges were followed by PAC, though the share varies by condition.³ Under FFS Medicare, each setting has its own coverage rules, cost-sharing requirements, conditions of participation, and payment system to establish payment rates.

Background

SNFs, HHAs, and IRFs all provide rehabilitation, skilled nursing, and personal care, but the level of care varies, with each having distinct features.⁴ HHAs care for beneficiaries who can be safely treated at home and do not require facility-based care. Under FFS Medicare, HHA users are a mix of beneficiaries who had a prior hospital stay and those who did not. SNFs provide facility-based care to beneficiaries who require daily skilled care but do not need the intensity of rehabilitation care offered in IRFs or cannot meet IRF admission criteria.⁵ Most SNFs are a part of a nursing home that also provides long-term care (which Medicare does not cover). The mix of short-term PAC and long-term care and the availability of specialized services such as ventilator care vary by provider. One study found that nursing homes that specialize in short-term PAC (rather than long-term care) reported better patient outcomes for their PAC users (Templeton et al. 2023). There is wide variation in the improvement in patient health (using a composite measure of health outcomes) across SNFs within and across markets (Einav et al. 2025). IRFs offer the most intensive rehabilitation services and care must be supervised by a rehabilitation physician. To be paid as an IRF, 60 percent of a facility’s admissions must be for patients with 1 of 13 conditions that typically require intensive rehabilitation (known as the 60 percent rule or the “compliance threshold”).

Medicare’s benefit and cost-sharing requirements differ by PAC setting

The three settings differ in terms of benefits and cost-sharing requirements under FFS Medicare (Table 6-1, p. 192). To qualify for care in HHAs or

SNFs, beneficiaries must require skilled nursing or rehabilitation services. Medicare covers up to 100 days of SNF care per spell of illness as long as the beneficiary has had a prior 3-day hospital stay, with daily copayments beginning on Day 21 of the stay.⁶ A beneficiary can receive covered home health services for an unlimited period so long as beneficiaries meet coverage rules (such as being homebound). There is no cost sharing for home health use. To qualify for IRF care, a beneficiary is expected to participate in and benefit from an intensive rehabilitation program (typically three hours of therapy a day, five days a week) involving at least two therapy disciplines and requiring supervision by a rehabilitation physician. IRFs are licensed as hospitals, and beneficiaries are responsible for the inpatient deductible if they have not already met it with a preceding hospital stay.

PAC spending and use under FFS Medicare

HHAs and SNFs are the most numerous PAC providers, with over 12,200 HHAs and 14,500 SNFs in 2024 (Table 6-2, p. 193). There are far fewer IRFs (1,170). In 2024, far more beneficiaries used home health care than SNF or IRF services. Almost all beneficiaries (96 percent) live in markets with at least two SNFs, and similar shares live in markets with two HHAs (data not shown). In contrast, less than one-third of hospital markets have an IRF. Beneficiaries needing IRF-level care living in those markets either remain in an acute care hospital for longer periods of time, travel to an IRF, or get their rehabilitation care in a SNF.

In 2024, FFS Medicare spending on PAC was \$57.7 billion, including \$5.6 billion in beneficiary cost sharing (the majority being SNF copayments). Spending was the highest for SNF care (\$31 billion), followed by home health care (\$15.7 billion), and IRF services (\$11 billion). (Not included in these figures is spending for skilled nursing services provided in hospital “swing beds,” which was \$2 billion in 2024.) Differences in the level and cost of services across settings are reflected in the average payment per stay. Home health care has the lowest FFS Medicare payments per unit of service (\$1,937 per 30-day period in 2024) and IRFs have the highest (\$25,300 per stay).

Home health stays were the longest (49.3 days in 2023), indicating multiple 30-day periods for many beneficiaries. The SNF average length of stay was

**TABLE
6-1**

Eligibility, benefits, and cost sharing for care in skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities

Setting	Eligibility	Benefits	Cost sharing
SNF	- Beneficiary must need daily skilled nursing or therapy care - Beneficiary must have a prior 3-day hospital stay (unless waived)	Benefit covers up to 100 days per spell of illness	Beneficiary must pay daily copayments (\$217 in 2026) beginning on Day 21
HHA	- Beneficiary must need part-time or intermittent skilled care (nursing or therapy) - Beneficiary must be unable to leave their home without considerable effort	Benefit covers part-time or intermittent care; no limits on the number of visits	None
IRF	- Beneficiary must be able to actively participate in intensive rehabilitation services (e.g., 3 hours per day, 5 days a week) - Beneficiary is expected to benefit from intensive therapy - Beneficiary requires 2+ therapy modalities - Beneficiary requires supervision by a rehabilitation physician	Benefit covers 90 days per spell of illness, with an additional 60-day lifetime reserve	- Beneficiary must pay the inpatient hospital deductible (\$1,736 in 2026) per spell of illness (most are transferred from an acute hospital and have already met this deductible) - Beneficiary must pay daily copayments (\$434 for any inpatient hospital days 61–90; the daily copayment for lifetime-reserve days is \$838)

Note: SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehabilitation facility). A skilled service is one that requires the skills of technical or professional personnel, such as registered nurses and physical therapists. A spell of illness begins with the first day of a hospital or SNF stay and ends when there have been 60 consecutive days during which a patient was not in a hospital or a SNF.

more than double that for IRF stays (30.7 days in 2024 vs. 12.4 days).

Aggregate FFS spending on PAC declined slightly (0.6 percent) over the past decade due partly to the shift in enrollment from FFS to Medicare Advantage (MA). In addition, declines in acute care hospital stays, which precede much PAC, have reduced referrals to PAC. In 2019, before the coronavirus public health emergency (PHE), there were 244 inpatient hospital stays per 1,000 FFS beneficiaries. Hospitalizations declined sharply during the PHE and remained well below the prepandemic rate in 2023, at 205 stays per 1,000 FFS beneficiaries. During the PHE, PAC spending decreased 2.3 percent but has since rebounded.⁷

Staffing shortages have constrained the supply of open and staffed SNF beds and home health visits, and they can delay placement of patients into PAC. Delays in institutional PAC placement can result in beneficiaries occupying hospital beds that could be used by other patients who require acute medical services. For beneficiaries, the delays could be harmful or beneficial, depending on the patient's care needs and the services provided while awaiting placement. On the one hand, delays may contribute to further impairment if the beneficiary does not receive needed rehabilitation care. On the other hand, delays could facilitate the provision of certain medical services while still in the hospital, such as dialysis or specialized wound care. While placement in home

**TABLE
6-2**

Number of providers, spending, and mean lengths of stay in skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities under FFS Medicare, 2024

Setting	Provider counts	FFS users	Total FFS Medicare spending	Average payment	Mean length of stay
SNF	14,500	1.1 million	\$31 billion, including \$5.4 billion cost sharing	\$20,970 per stay	30.7 days
HHA	12,220	2.6 million	\$15.7 billion	\$1,937 per 30-day period	49.3 days
IRF	1,170	377,000	\$11 billion, including \$0.2 billion cost sharing	\$25,300 per stay	12.4 days

Note: FFS (fee-for-service), SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehabilitation facility). The average payment includes beneficiary cost sharing. Medicare pays SNFs on a per diem basis and pays HHAs for 30-day periods. The "mean length of stay" for SNFs refers to Medicare-covered days. The figure for the mean length of stay in HHAs is from 2023.

Source: Medicare Provider Analysis and Review and Standard Analytic Files, 2023, 2024.

health care may not be delayed, the start of care can be, which may increase the risk of hospitalization and emergency department (ED) use (Kaltwasser 2022). The nursing home industry reported in 2024 that, of the 441 nursing homes included in its survey, over half had trouble hiring staff such that their occupancy rates were affected (American Health Care Association 2024). At the same time, high staffing turnover rates in HHAs and SNFs place additional burdens on an already taxed workforce. While our analyses indicate that access is generally positive (see later chapters in this report on the adequacy of Medicare's FFS payments to SNFs and HHAs), there can be markets where delays in placement exist (Massachusetts Health & Hospital Association 2025).

Between 2015 and 2024, spending per FFS beneficiary on PAC increased about 11 percent, partly reflecting rate increases over time. There were large differences by setting, ranging from a 1 percent decline in home health per capita FFS spending to an 8 percent increase in SNF per capita spending and a 56 percent increase in IRF per capita spending. During the same period, there was also wide variation in volume changes. SNF volume (measured as admissions per

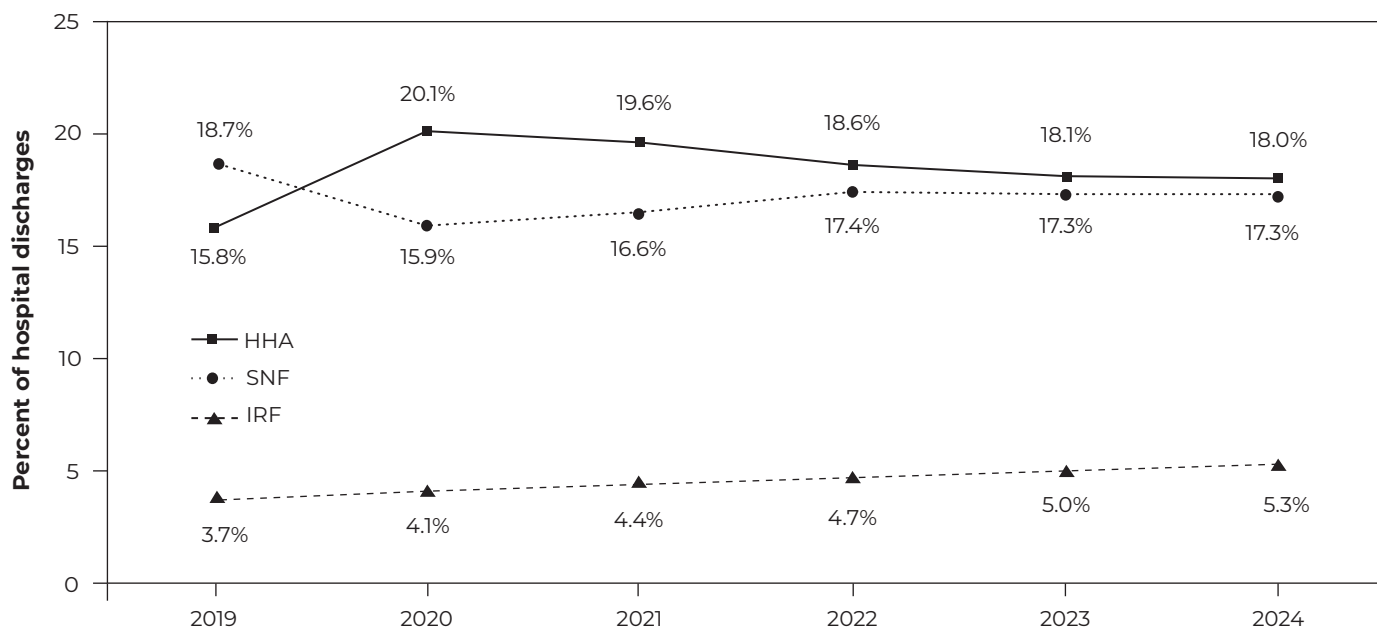
FFS beneficiary) declined 35 percent, while IRF volume rose 31 percent. The growth in IRF spending and use are partly explained by an increase in providers (4 percent), predominantly for-profit providers. Like SNF volume, home health volume also declined over the period (a 6 percent decline in episodes per FFS beneficiary between 2015 and 2019 and a 4 percent decline in 30-day periods per FFS beneficiary between 2020 and 2024).

Hospital referrals to PAC

Before the coronavirus PHE, SNFs were the most common PAC destination after discharge from an acute care hospital, with 18.7 percent of hospital discharges in 2019 (Figure 6-1, p. 194). HHAs accounted for 15.8 percent of discharges. However, SNF use dropped during the PHE, concurrent with the drop in hospital admissions, and while SNF volume rose in 2021 and 2022, it has not returned to prepandemic levels. During the PHE, HHAs' share of hospital discharges increased to 20.1 percent, and though it has declined since 2020, it remains the most common PAC setting. The share of hospital discharges going to IRFs has steadily increased since 2019 and in 2024 accounted for 5.3 percent of hospital discharges.

**FIGURE
6-1**

Shifts in the shares of FFS hospital discharges going to different post-acute care settings between 2019 and 2024



Note: FFS (fee-for-service), HHA (home health agency), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility). This chart shows where FFS Medicare beneficiaries received post-acute care after hospitalization.

Source: MedPAC analysis of Medicare claims data.

Overlap in the types of patients treated in different PAC settings

Although the level of services differs across the PAC settings, the Commission and others have documented the overlap in some of the types of patients treated (Gage 2012, Medicare Payment Advisory Commission 2024a, Medicare Payment Advisory Commission 2014a, RTI International 2022). In general, if beneficiaries can be safely treated at home, they prefer home to an institutional setting. Nevertheless, there is some overlap in the types of patients treated in SNFs and HHAs. Beneficiaries with adequate home support may be referred to HHAs, while similar beneficiaries without such support may be referred to SNFs. There is also overlap in the types of patients going to IRFs and SNFs. Some beneficiaries could be referred to an IRF or a SNF, depending on many factors (see discussion below). Because IRFs are licensed as hospitals, their

requirements for registered nurse and physician supervision are higher than the supervision available in most SNFs. Thus, clinically complex beneficiaries who require close medical supervision may be referred to an IRF rather than a SNF, if they meet admission criteria. Some IRF admissions are beneficiaries who do not have a prior three-day hospital stay and do not qualify for a covered SNF stay. Reflecting the potential overlap, the Congress mandated that the Commission submit two reports on the design of a single payment system for all PAC providers in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) (see p. 202).

One indicator of the substitutability of PAC is the lower use of high-cost PAC in alternative payment models (APMs), such as accountable care organizations (ACOs) and episode-based bundled-payment models. APM participants have pursued cost savings in part by substituting SNF care for IRF care and substituting home health care for SNF care, in addition to

shortening SNF stays and avoiding PAC altogether (see discussion, p. 203).

There are many reasons for the overlap in the types of patients treated across PAC settings: the variation in the supply and use of PAC across the country, the lack of clear criteria identifying which patients require what level of PAC, and a lack of evidence-based research that could be used to direct beneficiaries to the setting with the best outcomes. (One exception is the stroke guidelines established by the American Heart Association/American Stroke Association (Winstein et al. 2016).) While many providers, clinicians, and caregivers use some sort of guidelines to make placement recommendations, these guidelines may be based on Medicare coverage rules rather than on evidence of what practices result in the best outcomes for a given clinical condition. At the same time, local referral recommendations will be informed by the availability of providers in each market as well as the quality of care and service capabilities of each. A beneficiary may be referred to a SNF if there is one in the market that can meet their care needs; otherwise, they might be referred to an IRF (if they meet admission criteria).

Differences in clinical judgment and experience can also lead to variation in referral decisions, such as the appropriateness of an IRF admission for any given patient. Such variation is expected. For example, one IRF industry stakeholder said there can be differences of opinion regarding the need for medical supervision by a rehabilitation physician (American Medical Rehabilitation Providers Association 2025). Interpretation (and adequate documentation) of the need for intensive versus moderate assistance for some activities of daily living can also lead to differences in whether an IRF stay meets admission criteria (Snecinksi 2025). Reflecting the wide range in practices, the directors of hospital stroke centers we interviewed told us they each had clear decision rules about how IRFs were used (Medicare Payment Advisory Commission 2015b). Yet, those rules were very different across facilities except that the patient had to be able to tolerate intensive therapy and be expected to be discharged home within the typical time frame of an IRF stay (two weeks). There could also be differences of opinion about whether a beneficiary has the potential to significantly benefit from an intensive rehabilitation program, a requirement for Medicare coverage.

In our work on IRF and SNF use, hospital discharge planners we spoke with talked about differing approaches taken by IRFs when considering potential admissions (L & M Policy Research 2023). While only 60 percent of an IRFs' total inpatient population must require treatment for specified conditions to be paid under the IRF PPS, some IRFs were strict about admitting only patients with conditions that contribute to the compliance threshold, while other IRFs admitted patients who did not have such conditions. Some hospital discharge planners reported having a hard time predicting whether beneficiaries who did not have a condition that contributes to the 60 percent threshold would be accepted for admission by an IRF. Some IRFs were flexible about providing bedside therapy to accommodate the changing care needs of a patient and enable the IRF to meet the intensive therapy requirement. Some discharge planners referred beneficiaries to SNFs to gain strength, with an expected subsequent transfer to an IRF once the beneficiary can tolerate and participate in intensive therapy.

No easy algorithm can predict whether a beneficiary requires intensive therapy and meets IRF admission criteria. Discharge planners told us that the list of conditions used to qualify IRFs for payments under the IRF prospective payment system (PPS) was imperfect at identifying patients who require IRF-level care, often saying that the list was too restrictive. For example, they said that patients with conditions such as cancer, congestive heart failure, chronic obstructive pulmonary disease, or post-COVID acute respiratory failure may require intensive services but are not counted toward meeting the compliance threshold. On the other hand, we heard that not all patients recovering from a stroke (a condition that does count toward the compliance threshold) require the intensity of services furnished by IRFs. We also heard that on any given day, placement decisions could be influenced by how close the IRF was to meeting the compliance threshold. Hospital discharge planners also told us that IRFs were less likely than SNFs to admit patients who were not expected to go home after the PAC stay. The lack of clear guidelines and an imperfect list of conditions that count toward compliance make for ambiguous guardrails for the appropriate use of IRFs. In addition, hospital discharge planners said that travel time for family members was a key consideration for beneficiaries when deciding between an IRF and a SNF. Some beneficiaries who

qualified for IRF care wanted to be treated in a SNF if it was closer to home.

Concerns about measuring and improving quality in nursing homes

To assess the value of Medicare's PAC purchases and help consumers make informed decisions about where to get care, it is important to be able to meaningfully compare quality of care across providers and settings. Information gathered from patient assessments is central to such comparisons, but the tools historically were different enough that, for many years, comparisons were not possible. The assessment tools differed in their time frames, methods of collecting the data, the assessment scales, and definitions of common dimensions of care assessed (such as walking or cognitive status) (Medicare Payment Advisory Commission 2005).

Since 1999, the Commission has discussed the importance of being able to compare PAC patients and their outcomes (Medicare Payment Advisory Commission 2014b, Medicare Payment Advisory Commission 2013, Medicare Payment Advisory Commission 2010, Medicare Payment Advisory Commission 2007, Medicare Payment Advisory Commission 2006, Medicare Payment Advisory Commission 1999). The Commission noted that the lack of comparable data undermined the program's ability to purchase high-quality care in the least costly setting (Medicare Payment Advisory Commission 2007). In 2014, the Commission recommended the collection of common patient-assessment information across PAC providers (Medicare Payment Advisory Commission 2014b).

When the Congress enacted IMPACT, it required the Secretary to collect uniform patient-assessment items in each setting and develop quality measures that would be used in each setting. CMS developed uniform measures for discharge function, changes in skin integrity (new or worsened pressure sores), Medicare spending per beneficiary, discharge to community, hospital readmissions, medication reconciliation, incidence of falls with major injury, and transfer of health information and care preferences when an individual transitions home or to another setting;

all SNFs, HHAs, and IRFs report them as part of the quality-reporting programs. The Commission uses a subset of these measures (all claims-based outcome measures) to examine quality of care as part of its annual assessment of the adequacy of Medicare's FFS payments for PAC providers.

Although Medicare now requires PAC providers to report certain patient-assessment information and several outcome measures to facilitate comparisons of care within and across settings, challenges remain in measuring quality and comparing it across settings, as discussed below. First, payment and other incentives may encourage providers to inaccurately report information. Second, a key dimension of quality, patient experience/patient satisfaction, is not collected in each setting. Third, controlling for underlying differences in patient populations across and within settings remains an issue, due in part to the service capabilities and admission requirements that vary across settings. Perhaps because of these data limitations, studies comparing outcomes across settings have reached different conclusions.

Inaccurate reporting of patient-assessment information may reflect payment and other incentives

The Commission and others have raised concerns about the accuracy of the information gathered by patient assessments (Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2019, Office of Inspector General 2012, Sanghavi et al. 2020). An Office of Inspector General (OIG) study found that nursing homes failed to report 43 percent of falls with major injury and hospitalization for Medicare beneficiaries, resulting in misinformation reported on Care Compare (Office of Inspector General 2025). OIG also found that falls with major injury were underreported in the patient assessments completed by HHAs (Office of Inspector General 2023). Researchers found that nursing homes underreported the use of antipsychotic medications but overreported the conditions that qualify nursing homes for an exemption from the star-rating measure (Chen and Grabowski 2023).

Providers may record certain patient-assessment information inaccurately because they have a financial incentive to do so. Some patient-assessment

information is used by Medicare's case-mix systems to establish payment rates for a SNF day, a home health period, or an IRF stay. For example, functional status at admission is included in the case-mix systems for all three settings, and a small difference in the function score can shift the assignment of the patient to a different case-mix group, thus giving providers a financial incentive to record patients' functional status as worse than it is. In 2016, the Commission reported that high-margin IRFs had patients who were, on average, less severely ill in their preceding acute care hospital stay but were coded as more functionally disabled upon admission to the IRF. This discrepancy suggests that assessment and coding practices might contribute to greater profitability in some IRFs (Medicare Payment Advisory Commission 2016b). In other work, the Commission compared assessments of patients who transferred between PAC settings and found that functional status recorded at discharge from one setting and admission to another were often different, and the differences favored reporting function levels that would raise payments (Medicare Payment Advisory Commission 2019).

Inaccurate recording of patient-assessment information may also be influenced by the star ratings. Providers pay attention to their star ratings because they are used by consumers, MA plans, and participants in APMs to select PAC providers (see discussion of the star ratings for nursing homes in Chapter 7 of this report). The Commission supports public reporting of provider quality. However, inaccurate reporting of information may result in overstatements of quality for some providers. One study found that the correlation between provider-level hospitalization rates (a fairly objective measure based on claims) and nursing home star ratings was weaker after the ratings were made available to the public (Ryskina et al. 2018). Another study found evidence that some nursing homes increased their staffing, reduced admissions, increased discharges, and improved patient care around the time of their inspections, but the changes were temporary (Chen and Dillender 2025). The Commission compared setting-specific functional assessment items used for payment rather than the uniform item used for quality reporting (Medicare Payment Advisory Commission 2019). We found that the items used for quality reporting were likely to indicate a higher level of independence than the functional-status information

that was used to establish payment. (A lower level of independence generally results in higher payment, all else equal.) A study of HHA outcome measures before and after the introduction of the star ratings for HHAs found improvements in provider-reported patient-assessment measures but not in claims-based measures of hospitalizations and timely initiation of care (Chen et al. 2024).

The Commission has discussed strategies to improve the quality of the patient-assessment information, including monitoring and auditing assessment information that PAC providers submit, requiring hospitals to collect patient-assessment information at discharge, and gathering patient-reported outcomes (Medicare Payment Advisory Commission 2019). CMS has taken steps to improve the quality of the data collected in the patient assessments and outcome measures it reports. The Consolidated Appropriations Act, 2021, requires CMS to validate the patient-assessment information used in the SNF VBP and quality-reporting programs (including functional status). The limited validation process (it will review up to 10 records for a random sample of 10 percent of SNFs each year) will begin in January 2026. In response to OIG's 2025 report on nursing homes' underreporting of falls, CMS now uses data from Medicare and Medicaid claims and encounter data, in addition to patient assessments, to capture major injuries resulting from falls in nursing homes (Office of Inspector General 2025). In 2023, OIG recommended that CMS take steps to ensure the completeness and accuracy of the HHA-reported Outcome and Assessment Information System data used to calculate the falls (Office of Inspector General 2023). In July 2025, CMS convened an expert panel to discuss a common approach to measuring falls across PAC settings that could include adding claims data and revisions to the diagnosis codes to identify falls and major injuries (RTI International 2025). In the HHA VBP program, the calculation of the rates of discharge to community are now based on claims, rather than the patient-assessment information.

Patient-experience data are not collected in all PAC settings

Medicare does not collect data on patient experience for beneficiaries treated in SNFs or IRFs, even though their experience is a key dimension of quality. The Commission has recommended that the Secretary

finalize the development of and begin to report patient experience in nursing homes (Medicare Payment Advisory Commission 2021). For fiscal year 2024, CMS proposed but did not implement a SNF patient-experience measure, citing comments it received about the small number of questions the tool included (four), the exclusions allowed in calculating the satisfaction rates, and the need for SNFs to contract with a vendor to submit weekly survey-response data (Centers for Medicare & Medicaid Services 2023b). The following year, CMS requested information about a patient-experience/patient-satisfaction measure and said it would consider comments in future measure development (Centers for Medicare & Medicaid Services 2024c).

CMS also explored patient-experience/patient-satisfaction measures for IRFs. Under contract to CMS, RTI tested a patient-experience survey for IRFs in 2017 and found ceiling effects (too many IRFs had high scores to differentiate performances) and that the measures were reliable if the facility had a minimum of 240 responses (RTI International 2018). In 2023, CMS solicited comments on patient-experience/patient-satisfaction measures and received mixed support, including concerns about the administrative and financial costs associated with data collection (Centers for Medicare & Medicaid Services 2023a). An industry stakeholder commented that the number of survey responses required for reliable results would be problematic for most IRFs (Encompass Health 2024). To date, CMS has not required IRFs to collect this information.

HHAs are required to collect information about patient experiences using the Home Health Consumer Assessment of Healthcare Providers and Systems, and this information is scored in the home health care VBP program.

Comparing outcomes for beneficiaries treated in SNFs, HHAs, and IRFs is complicated

To accurately compare patient outcomes in SNFs, HHAs, and IRFs, analyses must control for differences in patient populations within and across settings. Yet, even with robust risk adjustment, using information from claims and patient assessments is unlikely to fully capture patient selection. Differences in outcomes could reflect unmeasured differences in the patients

treated in each setting and across providers. In addition, providers are not required to admit every beneficiary who is referred to them and can avoid patients with certain care needs that they do not have the staffing or equipment to treat. For example, Medicare's coverage rules require that IRFs admit only patients who can tolerate intensive therapy. Industry stakeholders told us that IRFs admit less than 40 percent of the patients referred to them (American Medical Rehabilitation Providers Association 2023). Among patients who meet this requirement, hospital discharge planners we spoke with told us that IRFs avoid certain types of patients, such as those unlikely to go home after their IRF stay or those with behavioral health issues (L & M Policy Research 2023). One study concluded that the discharging hospital had a large effect on the probability of whether patients were discharged to IRFs or SNFs (Simmonds et al. 2024). In addition, the three settings have varying service capabilities that result from licensure requirements and Medicare's conditions of participation for each setting. For example, IRFs are licensed as hospitals and are equipped to treat the worsening of many clinical conditions that many SNFs would not be able to treat. As a result of these factors, we would expect IRFs to have lower hospital readmission rates than HHAs or SNFs—and in fact they do. The median hospital readmission rate for the period 2023 to 2024 was 9.2 percent for IRFs and 10.7 percent for SNFs.

In addition to the complications of controlling for patient selection, studies comparing outcomes across settings have had mixed results in part because they differed in the settings, the clinical conditions, and the outcomes examined (Cogan et al. 2021, Cogan et al. 2020, Mallinson et al. 2014, Medicare Payment Advisory Commission 2024a, Osundolire et al. 2024, Padgett et al. 2018, Riester et al. 2023). The studies typically examined patients recovering from joint replacement, hip fracture, total knee arthroplasty, and/or conditions that do not contribute to the IRF compliance threshold. In terms of outcome measures, the studies examined some combination of functional improvement and rates of hospital readmissions, discharge to community, and mortality. Studies do not have consistent conclusions for similar measures or across measures.

Two studies comparing outcomes for SNFs and HHAs included patients with all conditions, though

one included only patients who had dementia (in addition to their reason for rehabilitation care) (Burke et al. 2021, Werner et al. 2019). The studies found that HHAs and SNFs had similar mortality rates but drew different conclusions about readmission rates. Werner et al. also found that HHAs and SNFs had similar functional outcomes (Werner et al. 2019). Another study comparing outcomes after total knee arthroplasty for HHAs, SNFs, and IRFs found that HHAs had lower readmission and complication rates, even after controlling for demographics and comorbidities (Whitaker et al. 2024).

The one exception to the mixed outcomes is the study of outcomes for patients recovering from strokes. Studies found that IRFs had better outcomes than SNFs (as measured by functional improvement, discharge to community, and mortality) (Alcusky et al. 2018, Chan et al. 2013, Hong et al. 2019, Prvu Bettger et al. 2019). Another study analyzing outcomes for stroke patients included HHAs, and it also concluded that IRF outcomes had the lowest mortality rates, followed by HHAs, then SNFs, but noted that the severity of the stroke is a factor in PAC placement (Springer et al. 2022).

Chronic quality problems in some nursing homes persist despite regulatory and quality initiatives

Despite numerous regulatory and quality initiatives over many years, the quality of care provided to many nursing home residents and PAC users remains poor (Medicare Payment Advisory Commission 2025b). Continued quality problems partly reflect the low Medicaid payment rates that, on average, do not cover the cost of care (Medicaid and CHIP Payment and Access Commission 2023). Low payment rates appear to affect nursing home staffing levels, which in turn affect the quality of care (Medicaid and CHIP Payment and Access Commission 2022). In addition, low Medicaid payment rates create financial incentives for providers to hospitalize their long-stay residents to requalify those with Medicare coverage for a higher-payment Medicare-covered stay once they return to the facility. While inpatient hospital stays are financially advantageous to the nursing home, they are disorienting to beneficiaries and unnecessarily expose them to risks associated with hospitalizations.

Nursing homes must meet federal requirements regarding many dimensions of quality of care,

quality of life, residents' rights, and the safety of the physical environment. There are also federal staffing minimums regarding the availability of on-duty registered nurses and licensed nurses as well as requirements for sufficient staffing to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Nevertheless, overall quality problems remain, though select outcomes have improved (National Academies of Sciences Engineering and Medicine 2022). While inspections play a key role in ensuring that minimum quality standards are met, they often fall short for a variety of reasons, including timeliness and variation across states in conducting the inspections and citation of serious deficiencies (KFF 2024, Office of Inspector General 2022a). Even with the staffing requirements, workforce shortages and high turnover rates are major factors that undermine the quality of care in nursing homes (National Academies of Sciences Engineering and Medicine 2022). The majority of states (38 plus the District of Columbia) have implemented stricter minimum staffing requirements than the federal requirements (Medicaid and CHIP Payment and Access Commission 2022).

CMS has several programs focused on improving quality, but only the star-rating program has had some success. The Quality Reporting Program posts provider performance on a variety of quality measures, and a subset of these measures are used to rate providers using 1 to 5 stars (for more information, see the discussion of nursing home star ratings in Chapter 7). Researchers found that some consumers appear to use the ratings to select higher-quality facilities and that providers try to improve their ratings (Konetzka et al. 2021). By contrast, the Quality Improvement Organization (QIO) Program offers resources to help providers improve their quality, but there is a lack of evidence showing that the program is effective (National Academies of Sciences Engineering and Medicine 2022). In addition, as discussed below, we and others have concluded that the SNF value-based purchasing program has not been effective at lowering hospitalization rates (the single performance measure through 2025).

The lackluster results of regulatory and quality initiatives over many years suggest that significant improvement in nursing home quality will require

substantial changes to the way Medicare (and Medicaid, for long-term care) oversees and pays for care. MedPAC has examined accountable care organizations that focus on beneficiaries in nursing homes (the High Needs ACOs) and MA plans that serve beneficiaries in nursing homes (the institutional special-needs plans, or I-SNPs) (Medicare Payment Advisory Commission 2025b). Both models offer more patient monitoring, hands-on care, and assistance with care transitions. Though limited in their current enrollment of beneficiaries, the models have shown some potential to improve care for beneficiaries. The Commission will continue to monitor these models.

High FFS Medicare payments, FFS incentives, and Medicare benefits may encourage inefficient care

By its nature, FFS has incentives that encourage volume, and those incentives may be stronger when FFS margins are high, as they are in SNFs, HHAs, and IRFs. The incentives of the VBP programs are too small to encourage providers to improve quality. Policies to narrow the prices that Medicare pays for similar cases treated in different settings would be complex to implement.

FFS incentives and Medicare benefits may encourage unnecessary care

FFS incentives may encourage unnecessary 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. As noted above, determining whether an admission is appropriate without medical-record review is hard to discern and, even then, clinicians could disagree.

Within each payment bundle of service (the IRF stay, the SNF day of care, or the home health 30-day period), providers have incentives to control their costs (and the services they provide). The original designs of the HHA and SNF PPSs encouraged providers to furnish unnecessary therapy that boosted payment because rates were based on, among other factors, the amount of therapy provided.⁸ The Commission recommended that those PPSs be redesigned without a therapy

adjustment (Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2008). In payment year 2020, CMS revised both PPSs and removed therapy as an adjuster. Providers responded to the revised PPSs, with SNFs reducing the number of minutes of therapy and HHAs reducing the number of therapy visits (Medicare Payment Advisory Commission 2025c, Medicare Payment Advisory Commission 2023b). Despite beneficiaries getting fewer therapy services, our indicators of quality showed either no change or slight improvement, suggesting that the therapy declines were “right sizing” the amount of therapy based on a patient’s care needs. Studies of the revised SNF case-mix groups found that spending increased, which could be the result of increased patient complexity, improved coding of patient complexity, or increased coding that does not correspond to changes in patient complexity (Geng et al. 2025, Wang et al. 2025). Future work could examine whether the redesigned payment systems have resulted in more accurate payments.

The three PPSs rely on provider-reported functional status data that may not always reflect patient care needs. Because this information is key to differentiating patients’ care needs and the design of case-mix groups, it is important that CMS do all it can to ensure its accuracy. The Commission outlined strategies that CMS could undertake, including the monitoring of provider-reported assessments, requiring hospital discharge assessments (to corroborate the PAC assessment data), and gathering patient-reported outcomes for SNFs and IRFs (Medicare Payment Advisory Commission 2019). As noted above, CMS will undertake a limited validation program for SNFs but has not planned similar efforts for IRFs and HHAs.

In 2024, the Commission examined the accuracy of IRF payments and found that payments do not track costs per stay (Medicare Payment Advisory Commission 2024b). Higher-severity cases are more profitable than lower-severity cases, and the relationship between costs per stay and case mix (that raise or lower payments) has deteriorated over time. The Commission concluded that replacing the way CMS calculates the IRF case-mix weights (it uses hospital-specific relative value weights) with cost-based weights (used in other settings) would result in more uniform profitability across case types.⁹ Cost-based weights could help

dampen providers' incentives to inaccurately record the severity of patients.

Medicare benefits may also encourage the provision of unnecessary care if beneficiaries meet coverage rules (such as needing a skilled service or, in the case of home health care, being homebound). The home health benefit is unlimited, and there is no cost sharing. Both features could extend care that may be of marginal value. For SNFs, there is no cost sharing until Day 21, which may dampen beneficiaries' and providers' interest in shortening stays.

FFS Medicare margins indicate FFS payments are considerably higher than the cost of PAC

FFS Medicare margins for SNFs, HHAs, and IRFs have been high for more than two decades—above 10 percent for more than 20 years, with only minor exceptions (between 2008 and 2011, IRF margins dipped to between 8 percent and 9 percent). Because updates to PPS payment rates are in statute, CMS does not have the authority to rebase payment rates without congressional action. The Commission has routinely recommended that the Congress reduce the base payment rates across Medicare's PAC payment systems.

CMS's efforts to lower improper payments to PAC providers

Each year, CMS estimates the share of claims that were improperly paid under Medicare's coverage, coding, and billing rules, or the share of claims with insufficient documentation to support the submitted claim.¹⁰ In 2024, across all FFS Medicare, the improper-payment rate was 7.7 percent, but for SNFs and IRFs the rates were substantially higher (17 percent and 29 percent, respectively) (Centers for Medicare & Medicaid Services 2024a). The most common reason for improper payment to SNFs was insufficient documentation, whereas for IRFs it was lack of medical necessity. Compared with SNFs, IRFs have more eligibility rules that could contribute to the denials. HHAs had a rate comparable with the FFS Medicare average, and the key reasons were insufficient documentation (51 percent) and lack of medical necessity (34 percent).

CMS currently has two demonstrations that target improper payments to HHAs and IRFs in states with high rates.¹¹ Each IRF and HHA in the selected states is

subjected to 100 percent claims review until it reaches acceptable approval rates. Providers must submit documentation supporting the medical necessity of the admission. The HHA demonstration aims to reduce the number of Medicare appeals and improve provider compliance with Medicare program requirements without delaying care to beneficiaries or altering the home health benefit. Beginning in 2016 and recently extended an additional five years (through May 2029), the demonstration includes HHAs in Florida, Illinois, Ohio, Oklahoma, North Carolina, and Texas. The five-year IRF demonstration began in May 2023 in Alabama and was expanded to Pennsylvania in 2024, with plans to expand to Texas and California in 2026. Its goal is to test improved methods for the identification, investigation, and prosecution of potentially medically unnecessary admissions and to decrease appeals.

In 2023, CMS launched a 5-Claim Probe and Educate Review Program for SNF claims that audited five claims per SNF and educated providers about proper billing. In June 2025, CMS ended the augmented auditing.

Current value-based purchasing programs are unlikely to change provider behavior

By adjusting payment rates based on the quality of care provided, VBP programs are intended to create incentives for providers to furnish high-quality care. As required by the Congress, CMS implemented a VBP program in SNFs (in fiscal year 2019). To date, the SNF VBP has not reduced hospital readmissions (Burke et al. 2025). Since 2018, the readmission rate has increased from 19.6 percent to 20.5 percent in 2024 (Centers for Medicare & Medicaid Services 2025c). The Commission and others have concluded that the incentives of the SNF VBP program (a 2 percent withhold) are too small to incentivize changes in care (Burke et al. 2025, Government Accountability Office 2021, Medicare Payment Advisory Commission 2021). We also have noted that the scoring approach (requiring providers in the lowest 40 percent of rankings to have their payments lowered by the program each year) does not provide enough financial incentive for providers to improve. In 2021, the Commission recommended that the SNF VBP program be eliminated and replaced with one that meets its principles for a value incentive program (Medicare Payment Advisory Commission 2021).

The HH VBP model is an expansion of a previous multiyear model test that saw improvements in the quality of the HHAs in the nine states that participated in the original model (Centers for Medicare & Medicaid Services 2024b). The original model resulted in an average 4.6 percent improvement in the participating HHAs' composite performance, as well as reductions in unplanned acute care hospitalizations and SNF stays, with no evidence of adverse risks and with average annual program savings of \$141 million (Centers for Medicare & Medicaid Services 2025a). Based on these results, the model was expanded to include all HHAs beginning in 2025 and includes payment adjustments ranging from -5 percent to +5 percent. The nationwide VBP is too new to draw conclusions about its results. For 2026, CMS estimated that the average payment adjustment would be about -0.09 percent. The top and bottom 10 percent of HHAs' performances are estimated to have their payments adjusted upward or downward by about 2.5 percent (Centers for Medicare & Medicaid Services 2025a). As with the SNF VBP program, the size of these adjustments in the HH VBP model may not be large enough to prompt HHAs to improve their care.

There is no VBP for IRFs.

Site-neutral Medicare FFS payment policies across PAC settings for similar patients would be complex to implement

The overlap in some of the types of patients treated in different settings and the broad similarities in the services offered raise questions about whether Medicare's FFS payment rates could be made more equivalent for providers in different settings that treat similar patients. The Congress mandated that the Commission and the Secretary evaluate a prototype design for a unified PPS that would use patient characteristics to establish payments across SNFs, HHAs, IRFs, and long-term care hospitals (Medicare Payment Advisory Commission 2016a). In the first of two required reports, the Commission concluded that a reasonably accurate PAC PPS could be designed using patient and stay characteristics. A unified PPS would use a common set of parameters to adjust payments across the settings, with an additional adjuster to lower payments for home health care, given its much lower costs. (Otherwise, home health care stays would be highly overpaid and institution-based care would be

severely underpaid.¹²) Our modeling indicated several design features that should be considered in a unified PPS (such as outlier policies for high-cost stays and short stays). Building on this work, the Commission subsequently explored various implementation issues, including the length of a phase-in period and the level of payments, the need to lower payment rates for later stays in sequential PAC stays (such as when a home health stay follows a SNF), and an episode-based design (including only PAC, excluding hospital and physician and other Part B services) (Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2018, Medicare Payment Advisory Commission 2017).

In a mandated report to the Congress, the Secretary outlined a prototype PPS design that was broadly consistent with the features identified by the Commission. One key difference was that the design included adjusters that would set different payment rates by setting. The report discussed other important considerations, including unified benefits, cost sharing, and value-based payment (RTI International 2022).

In our second report, the Commission confirmed that a reasonably accurate design was possible (Medicare Payment Advisory Commission 2023a). However, we concluded that, while designing a unified PAC PPS would be relatively straightforward, implementing one would not be. In addition to designing a unified PPS, CMS would need considerable resources to develop and implement the requisite accompanying policies, such as a common set of conditions of participation, aligned cost sharing, and a value-incentive program. Changes to the individual PPSs would require congressional action. Given the complexities associated with implementing a PAC PPS, the Commission stated that policymakers could look for opportunities to adopt smaller-scale policies that would narrow price differences for similar patients treated in different settings.

One example of more targeted alignment of Medicare's prices for PAC is the overlap of some patients treated in IRFs and SNFs. The Commission considered alternative pricing that would lower FFS Medicare payments to IRFs for patients who could have been treated in SNFs (Medicare Payment Advisory Commission 2024a). To identify case types that would be candidates for price

reductions, we focused on conditions that do not contribute to the IRF compliance threshold. (These are conditions that CMS determined do not typically require intensive therapy.) However, as discussed above (p. 195), the list of conditions that contribute to the compliance threshold (or any list) does not necessarily identify patients who require IRF-level care. Implementing price reductions for select conditions that do not contribute to the compliance threshold could result in IRFs avoiding patients with these conditions (even if the patients required IRF-level care). Further, because our research found that cases that do and do not contribute to the compliance threshold were equally profitable, it was not clear why rates would be lowered for only some conditions. Moreover, unmeasured differences in the patients treated in IRFs and SNFs undermined our ability to draw conclusions about the characteristics and outcomes of the patients treated in each setting. These factors persuaded the Commission that there was not a solid evidentiary basis to lower prices for a select group of conditions and that our standing recommendation to lower prices for all cases (a recommendation that is reassessed each year) was the best course of action.

Alternative payment models create incentives to lower FFS spending by using less post-acute care

APMs—such as ACOs and bundled-payment initiatives—hold participating entities at risk for the total cost of care, with limited exceptions. Entities are typically paid under FFS Medicare for the care provided and, at the end of the performance period, their spending is compared with a benchmark. If their spending is below the benchmark, the entities share in any program savings. In some models, entities must also maintain or improve quality to qualify for any program savings. ACOs are accountable for a defined group of beneficiaries during a performance period (such as a year), whereas entities participating in bundled-payment initiatives are typically at financial risk for episodes of care (30, 60, or 90 days) for beneficiaries with specific conditions (such as hip fracture).

To lower spending, entities participating in APMs have an incentive to avoid unnecessary PAC use altogether

or shift higher-cost IRF use to SNFs and SNF care to HHAs for beneficiaries who could go home. Because SNFs are paid on a per diem basis, entities also have an incentive to shorten SNF stays. It is important to note that shifts in PAC use could reflect more efficient service use, but it could also mean that some beneficiaries do not get the care they need. Given their financial incentives, the models could increase providers' incentives to selectively admit certain types of patients, which could worsen racial disparities; bundled-payment initiatives also could encourage volume (Liao et al. 2020). The models could also lead to narrower referral networks, which could affect beneficiaries' care, depending on the quality of the PAC providers.

Older ACO models (ACO Investment Model, Next Generation, and Global and Professional Direct Contracting (now known as the ACO REACH model)) did not consistently lower program spending after accounting for reconciliation payments (Abt Associates 2020, NORC at the University of Chicago 2024a, NORC at the University of Chicago 2024b). All models used less PAC—some combination of fewer SNF admissions and shorter stays and fewer HHA and IRF days. Despite the service reductions, quality scores—as measured using a mix of mortality, hospital admissions, hospital readmission, ED use, and patient experiences—were maintained or improved. Next Generation ACO model participants also improved prevention and screening (fall risk, breast cancer, colorectal cancer, and clinical depression) and management of chronic conditions such as diabetes, hypertension, and cardiovascular disease (NORC at the University of Chicago 2024b). More recent results of the Medicare Shared Savings Program ACOs (performance year 2024) show that the program achieved net savings by lowering hospital, ED, and SNF use (Centers for Medicare & Medicaid Services 2025b). Compared with similar physician groups, the ACOs had higher rates of screening for depression, controlling blood pressure, and patient satisfaction.

ACOs can apply for a waiver from the required three-day hospital stay for Medicare coverage of SNF care, but such waivers are used relatively infrequently. A study of waiver use by ACOs between 2014 and 2019 found that less than 5 percent of ACO stays were waiver stays (Centers for Medicare & Medicaid Services 2023c).

CMS has tested three versions of bundled-payment initiatives—Bundled Payments for Care Improvement (BPCI), BPCI-Advanced (BPCI-A), and the Comprehensive Care for Joint Replacement (CJR) models. The BPCI-A and CJR models held entities accountable for maintaining or improving quality when calculating incentive payments to participants. The CJR model was mandatory for hospitals in certain areas. The original BPCI lowered spending but did not achieve net savings once reconciliation payments were made, while BPCI-A (especially for surgical cases and in later years) and the CJR models achieved net savings to Medicare, though the results varied depending on the year (Lewin Group et al. 2025, Lewin Group et al. 2024, Lewin Group et al. 2021). Each iteration of the models offered important lessons on risk adjustment and setting the target prices so that the benchmarks were realistic. All initiatives curbed PAC use by shortening SNF stays and lowering SNF and IRF use. Despite less PAC use, quality was generally maintained or improved—gauged by a mix of measures including ED visits, functional outcomes, or rates of readmissions, mortality, and complications. The BPCI and BPCI-A models had less success in maintaining positive patient experiences. A review of 20 studies of CMS's Acute Care Episode Demonstration, the BPCI, and the CJR model confirmed these findings (Agarwal et al. 2020). Some of the studies did not find differences in the case mixes of hospitals that did and did not participate in the initiatives, suggesting that participating hospitals did not avoid higher-risk patients. Some of the studies concluded that initiatives did not increase the volume of episodes. A study of hospital referrals to SNFs found that the BPCI did not change the number or concentration of SNFs used by the participating hospitals (Lin et al. 2024, Zhu et al. 2019). A study of the BPCI model for lower-extremity joint replacement found that patient selection accounted for over one-quarter of the model's savings (Navathe et al. 2020).

Beginning in January 2026, CMS is testing a mandatory bundled-payment model for five high-cost procedures for hospitals in 188 markets—the Transforming Episode Accountability Model (TEAM). The procedures include lower-extremity joint replacement, surgical hip/femur fracture treatments, coronary artery bypass graft, spinal fusion, and major bowel surgery. The bundle includes all services during the initial hospitalization and the 30 days after discharge. Participating hospitals will earn an extra payment if they keep their spending

below a target price and score well on clinical and patient-experience measures, while other hospitals may be subject to a repayment amount for spending over the target price.

MA plans have an incentive to lower their costs by using less PAC

As beneficiaries increasingly enroll in MA plans, FFS Medicare volume in PAC has declined. This shift could have important implications for PAC providers and beneficiaries. In the future, we plan to review the literature comparing MA and FFS use of PAC, but we offer a preview of possible trends for PAC providers here.

MA plans are another way to counter FFS volume incentives. Because plans are paid a monthly per member amount, they have an incentive to lower their costs by lowering unnecessary service use. MA plans may use physicians and nurse practitioners to coordinate care and furnish preventive care to lower the use of more expensive services.

MA plans have a financial incentive to prolong hospital stays and avoid PAC altogether, use lower-cost PAC, and shorten SNF stays. By extending a hospital stay, a plan can avoid making a referral to (and incurring the cost of) a separate PAC stay or enabling a referral to a lower-intensity (and lower-cost) PAC setting. A study conducted by NORC at the University of Chicago found that MA enrollees' observed hospital lengths of stay were 40 percent longer than stays for beneficiaries enrolled in FFS Medicare and that a smaller share of MA enrollees' hospitalizations were discharged to PAC (NORC at the University of Chicago 2025). The Commission has found that, after a hospital discharge, MA enrollees used HHAs more often than beneficiaries in FFS Medicare, but that the MA home health stays included fewer visits (Medicare Payment Advisory Commission 2025b). Among MA plans, those with cost-sharing requirements had lower use compared with other plans. This pattern likely reflects the utilization-management tools that MA plans employ to control service use. Over the coming year, we plan to examine differences in FFS and MA use of SNF and IRF services for beneficiaries who did and did not have a prior hospital stay, controlling for differences in beneficiary characteristics.

Potential effects on providers

MA plans typically use prior authorization and provider networks to manage service use by their enrollees. For providers, these management tools can mean burdensome processes and requirements to get initial approval and to extend care if additional care is needed. Plans often establish networks of providers that steer volume toward some providers and away from others. A provider's volume could be affected by whether it is included in a network and would be more likely to receive referrals.

Some industry representatives report that MA plans' payment rates to HHAs and SNFs may be lower than FFS Medicare rates (Medicare Payment Advisory Commission 2025b, Medicare Payment Advisory Commission 2025c). Therefore, the total financial performance (that considers all sources of revenues and expenses for all patients) may be affected by a provider's share of MA revenues and lower MA rates, all else equal. In the future, we plan to examine the impact of MA on the financial performance of PAC providers.

Potential effects on beneficiaries

Utilization-management tools may also affect beneficiaries. Some plans manage the PAC of their enrollees (such as helping beneficiaries with their transition home or coordinating the initiation of home health services), and beneficiaries may benefit from this oversight. Provider networks can restrict beneficiary choice of setting and/or provider. As a result, a beneficiary's preferences may not factor into a placement decision and could increase travel times if the approved location is further away from the beneficiary's home.

Prior authorization for initial or subsequent care (such as recertification of home health care) can delay the start of PAC or deny it altogether. It is not clear whether these tools delay or deny needed care or result in service delivery that is more efficient. Denials could simply indicate that the documentation accompanying the initial request for care was insufficient. OIG found that SNF and IRF services were among the most frequently denied, even though requests met Medicare coverage rules and MA billing rules (Office of Inspector General 2022b). OIG noted that the denials could delay or prevent beneficiaries from getting medically necessary care. A Senate investigation of three large MA plans found that between 2019 and 2022, the use

of prior authorization increased and their denial rates of PAC were higher than for other services (U.S. Senate Permanent Subcommittee on Investigations 2024). During this period, the Senate Committee reported that the companies' use of algorithms to review requests increased. In a class action lawsuit against one large plan, plaintiffs alleged that the use of an artificial intelligence model wrongfully denied PAC by overriding physicians' determinations about medically necessary care (U.S. District Court for the Western District of Kentucky 2023).

Delays in approving PAC can result in beneficiaries staying in hospitals longer as they await approval for PAC placement. A recent study comparing hospital lengths of stay for FFS Medicare and MA found that MA enrollees had a higher probability of hospital stays that were 14 days or longer (McGarry et al. 2025). The authors said that longer hospital stays could be due to MA plans' approval requirements and could increase beneficiaries' risk of hospital-acquired infections and delay timely rehabilitation. Hospital discharge planners we spoke with about IRF and SNF placement told us that MA enrollees often were hard to place in IRFs and that delays in getting the plan's determination could mean that some beneficiaries' functional status deteriorated such that they no longer qualified for IRF care (L & M Policy Research 2023). A recent survey of nursing homes found that two-thirds of respondents said they had experienced denials or delays of medically necessary care daily or weekly and had instances where care was shortened against medical advice (American Health Care Association 2025). These limitations could affect beneficiaries' treatment plans and families' arrangements for care at home. We will continue to monitor MA enrollees' use of PAC. ■

Endnotes

- 1 Some chronically critically ill beneficiaries receive care in long-term care hospitals (LTCHs). Because there are few providers and beneficiaries who use this service, we have not included LTCHs in this chapter. A small number of hospitals provide SNF services in hospital beds normally used for acute care services. The use of “swing beds” is discussed in Chapter 7 of this report.
- 2 Earlier work by the Commission found that about one-third of PAC use involved combinations of PAC stays, including transitions within a setting (the most common was from one HHA to another) and discharges from IRFs or SNFs to home health care (Medicare Payment Advisory Commission 2019).
- 3 Though the number of FFS discharges from acute care hospitals has declined in recent years, the share of beneficiaries discharged from an acute hospital to PAC has been fairly stable over time (Medicare Payment Advisory Commission 2025a, Medicare Payment Advisory Commission 2020).
- 4 Although SNFs, IRFs, and HHAs all have nurses and therapists, their skills may differ depending on the patients they treat. For example, an IRF that routinely treats spinal cord injury patients will have therapists who have the training and skills to treat this specialized population.
- 5 A skilled service is one that requires the skills of technical or professional personnel, such as registered nurses and physical therapists.
- 6 A spell of illness begins with the first day of a hospital or SNF stay and ends when there have been 60 consecutive days during which a patient was not in a hospital or a SNF. In 2015, the Commission recommended that the Congress revise the three-day requirement to allow for up to two outpatient observations days to count toward meeting the requirement (Medicare Payment Advisory Commission 2015a). SNFs with at least a 3-star rating that participate in certain accountable care organizations may apply for a waiver from CMS for the three-day hospital-stay requirement. We previously reported that although many accountable care organizations obtain waivers, very few SNF stays use them (Medicare Payment Advisory Commission 2025b).
- 7 During the coronavirus public health emergency, the three-day hospital-stay requirement for SNFs was waived.
- 8 The Commission tracked the accuracy of the SNF PPS between 2006 and 2014 and concluded that payments were not aligned with costs of care and that the inaccuracies had grown over time (Urban Institute and Medicare Payment Advisory Commission 2015). The inaccuracies were due in part to the growth in the provision of therapy, which increased costs but raised payments even more.
- 9 The range in the payment-to-cost ratios using the current case-mix weights range from 1.07 to 1.29 (where 1.0 means that payments equal costs). Under cost-based weights, the weights would range from 1.15 to 1.18.
- 10 Improper payments may include payments for an ineligible good or service; duplicate payments; and payment for a good or service not received; but they also include payments made when the information is not sufficient to determine whether payment is proper. Thus, an improper payment should not itself be considered evidence of fraud, which involves willful misrepresentation (Government Accountability Office 2023).
- 11 A third program was in effect between 2016 and 2019 to combat fraud and the growth in the number of new agencies. CMS set a temporary enrollment moratorium on new HHAs in four states (Texas, Florida, Illinois, and Michigan). The moratorium ended when CMS expanded its anti-fraud capabilities with new rules regarding provider enrollment, expanded reporting of provider information, the use of analytics to identify potential problems, data sharing across providers, and staff training.
- 12 Home health stays were defined as 30-day episodes.

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C H A P T E R

7

Skilled nursing facility services

R E C O M M E N D A T I O N

- 7** For fiscal year 2027, the Congress should reduce the 2026 Medicare base payment rates for skilled nursing facilities by 4 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Skilled nursing facility services

Chapter summary

Medicare covers short-term skilled nursing and rehabilitation services for beneficiaries in skilled nursing facilities (SNFs) after a recent inpatient hospital stay. Most SNFs also provide long-term care services not covered by Medicare. Medicare SNF services make up a small share of the overall volume for the average SNF. In 2024, about 14,400 freestanding SNFs furnished about 1.5 million Medicare-covered stays to 1.1 million fee-for-service (FFS) beneficiaries. 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.)

Assessment of payment adequacy

Our indicators of payment adequacy 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 were mostly positive.

- **Capacity and supply of providers**—The number of SNFs declined by about 1 percent in 2024. Given that Medicare is a relatively small share of most nursing homes' business (13 percent of total facility revenue)

In this chapter

- Are FFS Medicare payments adequate in 2026?
- How should FFS Medicare payments change in 2027?
- Alternative approaches to calculating 5-star ratings
- Medicaid trends

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.

- **Volume of services**—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 rate**—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 2022 and 2023 two-year period. 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 agency 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 cost 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.

How should Medicare payment rates change in 2027?

Based on our assessment of the payment-adequacy indicators listed 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 fiscal year 2027, the Congress reduce the 2026 base payment rates for skilled nursing facilities 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 nursing homes and 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 1 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 nursing homes. 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. ■

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare’s traditional fee-for-service (FFS) payment systems. Such providers include skilled nursing facilities (SNFs) that provide short-term skilled nursing care and rehabilitation services such as physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services.

Background

SNF patients include those recovering from surgical procedures such as hip and knee replacements or from medical conditions such as infections, stroke, and pneumonia. In 2024, the FFS Medicare program and its beneficiaries spent about \$31 billion under the SNF prospective payment system (PPS) for 1.5 million FFS Medicare-covered SNF stays. FFS Medicare and its beneficiaries also paid an additional \$2 billion for SNF care provided in hospital swing beds, but most of those stays are not paid under the SNF PPS. (See the text box on skilled nursing facility care provided in swing beds.)

Medicare coverage and payment

Medicare covers up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital

stay of at least three days.¹ To qualify for Medicare coverage, a beneficiary must need daily skilled nursing or rehabilitation services.^{2,3} Medicare’s SNF PPS pays SNFs for each day of service.⁴ For beneficiaries who qualify for SNF care, Medicare pays 100 percent of the daily amount for the first 20 days. Beginning on Day 21, beneficiaries are responsible for copayments through Day 100 of the covered stay; in 2026, the copayment is \$217 per day.⁵ This copayment structure impacts the use of SNF services: Beneficiaries may elect to discharge rather than incur copayments, and SNFs can discharge residents for nonpayment (Centers for Medicare & Medicaid Services 2017). Our analysis of claims from 2023 found that the share of stays discharged on Day 20 (3.6 percent) is higher relative to the share discharged on Day 19 (2.5 percent) and Day 21 (2.6 percent). The evidence on whether shorter stays affect patient outcomes is mixed. One study found that stays that were one day shorter were associated with higher readmissions rates, while another found that shorter stays were not associated with worse mortality rates, rates of hospitalization for fall-related injuries, or all-cause hospitalization rates (McGarry et al. 2021, Werner et al. 2019).

FFS Medicare’s daily payments to SNFs are determined by adjusting base payment rates for geographic differences in labor costs and for case mix. The case-mix system, the Patient-Driven

Skilled nursing facility care provided in swing beds

With approval from CMS, certain Medicare-certified hospitals may provide skilled nursing services in the hospital beds normally used to provide acute care services. These are called “swing beds,” and they are typically located in small rural hospitals and critical access hospitals (CAHs). In 2024, about 4 percent of skilled nursing facility (SNF) care was provided in swing beds. That year, the fee-for-service (FFS) Medicare program paid \$2 billion for about 66,000 Medicare-covered swing-bed stays. In 2024, 87 percent of swing-bed stays were in CAHs and 13 percent were in short-term acute care hospitals.

SNF-level services of non-CAH swing-bed facilities are paid under the SNF prospective payment system (PPS). The SNF-level services of CAHs with swing beds are exempt from the SNF PPS and are paid based on 101 percent of reasonable costs. Spending on CAH swing beds accounted for 98 percent of FFS Medicare program spending on swing beds, owing to the much higher average daily rate (about \$2,800 per day) for CAH swing-bed days compared with the average SNF PPS daily rate (about \$540 per day) paid for swing-bed days provided in short-term acute care hospitals. Unless otherwise specified, analyses in this chapter do not include swing beds. ■

Payment Model (PDPM), considers the clinical reason for treatment, comorbidities, and functional status at admission in setting payment rates so that providers are paid more to treat medically complex patients who are more costly to treat. Payments are no longer based on minutes of therapy provided and are calculated using information gathered from a standardized patient-assessment instrument called the Minimum Data Set (MDS).

After the change in the case-mix system (October 1, 2019), the therapy minutes per stay dropped dramatically (total minutes decreased 23 percent in the first three months) and continued to decline through 2022 but leveled off between 2023 and 2024. Therapy minutes per covered day dropped 3 percent from 2023 to 2024. The change in defining case-mix groups appears to have influenced providers' coding of patients' clinical conditions. For example, when the revised SNF case-mix groups included difficulty swallowing and malnutrition as case-mix-group factors, the coding of them increased (Medicare Payment Advisory Commission 2023). A study of the impact of the revised SNF PPS case-mix system found that per day spending increased after the revision, which the authors noted could be the result of more complete coding of patients' severity and/or "upcoding" (Wang et al. 2025). Another study compared hospital and SNF comorbidity indexes before and after the implementation of the revised case-mix system and found that patients' hospital comorbidity indexes did not change, but the SNF comorbidity indexes had increased (Geng et al. 2025). The authors concluded that the composition of the SNF admissions had not changed but that providers had responded to the new case-mix system by increasing their coding intensity, which the authors stated could represent more complete coding or strategic upcoding.

Skilled nursing facility sector profile

A SNF is a provider that meets Medicare's requirements of participation for Part A coverage of SNF care and agrees to accept Medicare's payment rates. Medicare's requirements relate to many aspects of staffing and care delivery, such as requiring a registered nurse in the facility for 8 consecutive hours per day and licensed nurse coverage 24 hours a day; providing PT, OT, and SLP services as delineated in

each patient's plan of care; and providing or arranging for physician services 24 hours a day in case of an emergency.

FFS Medicare accounts for a small share of most nursing facilities' total patient days

Most SNFs (96 percent) are dually certified to provide Medicare Part A–covered SNF care and Medicaid–covered long-term care. FFS Medicare–covered SNF days typically account for a small share of a facility's total patient days. Long-term care services, which are less intensive, typically make up the bulk of a facility's business. Medicaid pays for the majority of this care. In freestanding facilities in 2024, FFS Medicare–covered days made up just 8 percent of facility days in the median facility compared with 64 percent of facility days paid by Medicaid. The share of both FFS Medicare–covered days and Medicaid–covered days in 2024 declined slightly from 2023, in part due to the continued growth of Medicare Advantage (MA) enrollment. As FFS Medicare's share of covered days declined, so did its share of facility revenue, which fell from 14 percent in 2023 to 13 percent in 2024. (Because of FFS Medicare's relatively high payment rates, the program makes up a larger share of facility revenue than of covered days.)

SNFs are overwhelmingly freestanding, and the majority are for profit

In 2024, 97 percent of facilities were freestanding, and they accounted for 98 percent of FFS Medicare SNF stays and 98 percent of spending (Table 7-1). Seventy-four percent of providers were for profit. Rural facilities make up the minority of SNFs, SNF stays, and SNF spending. (About 15 percent of FFS SNF users saw a rural provider; data not shown.) About 4 percent of SNF care was provided in swing-bed facilities (data not shown).

Freestanding SNFs vary in size. In 2024, the median SNF had 100 beds, while 10 percent of facilities had 176 or more beds, and 10 percent of facilities had 50 beds or fewer. Nonprofit facilities and rural facilities are generally smaller than for-profit and urban facilities. However, the majority (59 percent) of small facilities (fewer than 50 beds) in 2024 were in urban areas.

The SNF sector is fragmented and characterized by independent providers and regional and local chains. Complex ownership structures can make it difficult

**TABLE
7-1****Freestanding SNFs and for-profit SNFs accounted for the majority of facilities, FFS Medicare stays, and FFS Medicare spending in 2024**

Type of SNF	Facilities	Medicare-covered stays	Medicare spending
Total	14,400	1,500,000	\$26 billion
Freestanding	97%	98%	98%
Hospital based	3	2	2
Urban	73	86	88
Rural	27	14	12
For profit	74	76	81
Nonprofit	20	21	17
Government	6	3	3

Note: SNF (skilled nursing facility), FFS (fee-for-service). Total numbers are rounded. Components may not sum to 100 percent due to rounding and missing values. Table includes FFS Medicare-covered stays and program spending in SNFs and does not include swing beds. Swing beds are hospital beds used for both acute care patients and SNF patients. For swing-bed information, see the text box on p. 219. Hospital-based SNFs are used only for SNF services; their beds do not “swing” between acute and SNF care. The facility count differs from the count in Table 7-2 (p. 222) because this table includes only SNFs that billed Medicare for services in 2024.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review file for 2024.

to identify common ownership of facilities and to determine the profitability of a SNF and its ancillary businesses and affiliated entities (Harrington et al. 2021). For example, many SNF owners have separate companies to operate the facility and to hold the property. This separation may shield owners from potential lawsuits, generate capital for operations, or shift profits into related entities to benefit an owner. In late 2022, to better identify common ownership of SNFs, CMS began publicly releasing detailed information on Medicare-certified nursing facilities—including direct and indirect facility owners, changes of ownership, and common ownership across affiliated entities. However, one study found major gaps in this information, suggesting that the data do not offer substantial insights into complex or underreported ownership structures (Chen et al. 2024).

Stevenson et al. found that private equity (PE) investment makes up about 5 percent of all facilities, and real estate investment trusts (REITs) make up another 9 percent (Stevenson et al. 2023).⁶

However, this research, as well as work done by others, identified gaps and errors in the ownership data (Chen et al. 2024, Government Accountability Office 2023, Stevenson et al. 2023). In November 2023, CMS issued a final rule defining PE and REIT ownership and requiring nursing facilities to disclose information about entities with operational, financial, or managerial control, including whether they are PE or REIT investors (Centers for Medicare & Medicaid Services 2023b). Providers will be required to furnish this information when initially enrolling or revalidating their enrollment (required every five years) and when there are changes in their ownership information. To improve the accuracy of ownership and third-party information, CMS originally required SNFs to revalidate this information by March 2025, but repeatedly extended the deadline, and in December 2025 indefinitely suspended it (Centers for Medicare & Medicaid Services 2025c). Literature on the impact of PE on nursing homes is limited and mixed, though there is some evidence that PE-acquired nursing homes have slightly higher staffing expenditures

**TABLE
7-2**

Supply of SNFs continued to decline in 2025

	2019	2020	2021	2022	2023	2024	2025	Average annual percent change 2019–2024	Percent change 2024–2025
Count of Medicare-participating SNFs	15,297	15,160	15,084	14,947	14,798	14,634	14,518	–1.0%	–0.8%

Note: SNF (skilled nursing facility). The figure for 2024 was calculated through October; it does not include data from the full calendar year. Counts for 2025 are through July 10, 2025. Counts include active providers serving Medicare beneficiaries in the calendar year for Medicare-certified SNFs in the 50 states and the District of Columbia. Counts do not include nursing facilities that are not Medicare certified.

Source: MedPAC analysis of active provider counts from CMS's Quality, Certification and Oversight Reports, accessed on November 3, 2025.

in highly competitive markets but lower staffing expenditures in the least competitive markets (Gandhi et al. 2025).

Are FFS Medicare payments adequate in 2026?

To examine the adequacy of Medicare's FFS payments, we analyze beneficiaries' access to care (including the supply of providers and volume of services), quality of care, providers' access to capital, FFS Medicare payments in relation to costs to treat Medicare beneficiaries, and the relationship between Medicare's payments and SNFs' costs. Overall, our indicators of payment adequacy were positive.

Beneficiaries' access to care: SNF supply and admissions declined while occupancy rates and days increased

To assess FFS beneficiaries' access to SNF care, we consider the supply and capacity of providers and evaluate changes in service volume.

SNF supply declined slightly in 2025 but reflected factors other than the adequacy of Medicare's payments

The supply of SNFs has steadily declined since 2019, averaging –1.0 percent per year. In the first six months

of 2025, the number of SNFs participating in the Medicare program declined 0.8 percent from 2024 to 14,518 (Table 7-2). There were 20 new facilities from January 2025 to July 2025. Of the 50 terminations, 27 were for-profit facilities, and all but 9 closed at their own initiative (i.e., they were not terminated by Medicare). Note that providers that stop participating in Medicare (either voluntarily or due to termination) have not necessarily closed. No longer participating in Medicare could indicate that the facility was purchased by another entity and has a new provider number or that the facility remained open but stopped accepting Medicare patients (to become a nursing facility for long-stay residents only). When a SNF terminates participation in the Medicare program, access could be affected if beneficiaries must travel long distances to another facility. We examined closed SNF or swing beds from 2021 through 2024 and found that the median distance of these facilities to the nearest open SNF or swing bed was similar for both rural and urban areas (less than three miles, though there was more variation in rural areas).

Since 2019, the year-to-year declines have been fairly consistent and are likely related to several factors that lowered utilization, such as states shifting to more home- and community-based long-term care, staffing difficulties that limit how many beds can remain open, low reported Medicaid payment rates for long-term care, and patient preference for receiving care in non-SNF settings when possible.

Because Medicare constitutes a relatively small share of most SNFs' businesses and its payment rates are high relative to the cost of care (see p. 231), the closures do not necessarily reflect the adequacy of Medicare's payments.

In past years, we have reported that the share of Medicare beneficiaries with Part A coverage who lived in counties with three or more SNFs or swing-bed facilities was high (88 percent in 2024) and the share of beneficiaries who lived in counties with no or only one SNF or swing-bed facility was low (less than 6 percent in 2024). However, the presence of a facility alone does not ensure access. Beneficiaries who live in areas with very high SNF occupancy rates may have a harder time accessing SNF care close to home. Even if a facility has an available bed, some beneficiaries may encounter access problems if they need specialized services or long-term care, as discussed below.

SNF occupancy had mostly recovered to pre-pandemic levels in 2024

Before the public health emergency (PHE), between 2010 and 2019, median occupancy rates for freestanding SNFs were declining—from 88 percent to 85 percent (based on cost-report data). Occupancy rates also varied by state. Nationally, average occupancy fell during the coronavirus pandemic due to death, move outs, and avoidance of the setting. SNF occupancy hit its lowest point in January 2021, when the median occupancy rate was 69 percent. Since then, occupancy rates have increased to about where they were before the PHE. In 2024, the median national SNF occupancy rate was 83 percent; one-quarter of SNFs had greater than 91 percent occupancy, and one-quarter of SNFs had occupancy rates of 70 percent or less. SNF occupancy can depend on many factors such as labor availability, market conditions, and ability of a SNF to care for a prospective patient's specific needs.

SNF employment remained below pre-pandemic levels but showed gains through August 2025

As occupancy declined in 2020 and 2021, the number of SNF employees also fell steeply. According to the Bureau of Labor Statistics, between March 2020 and a PHE low in March 2022, the number of employees in the SNF sector declined nearly 15 percent (Bureau of Labor Statistics and Department of Labor 2025). Overall employment in the sector has been growing since 2022,

but in August 2025, despite growing 4 percent from the previous year, it remained 2 percent lower than in March 2020.

While we do not have empirical data on the extent to which staffing shortages may have constrained access to SNF care, the industry reports that inadequate staffing levels have limited access for prospective patients and residents. An industry-sponsored survey of 411 providers reported in March 2024 that about half of those surveyed had turned away potential residents and 19 percent had closed a unit, wing, or floor (American Health Care Association 2024). Hospitals have reported delays in transferring patients to SNFs, increasing lengths of stays in acute care for these patients (Siddiqi 2024).

SNF admissions decreased in 2024, but days per admission rose

SNF use among FFS Medicare beneficiaries was in decline for years before the pandemic. Between 2010 and 2019, covered admissions per FFS beneficiary fell 18.5 percent, and covered days fell 25.2 percent, indicating that fewer FFS beneficiaries were using SNF care and having shorter stays. Several factors likely contributed to the decline in SNF use during this period, including a contemporaneous reduction in the inpatient hospital stays needed to qualify for SNF coverage (Medicare Payment Advisory Commission 2021b).

In the aftermath of the PHE, the rate of covered admissions continued to decline, but covered days per admission rose. Covered admissions per FFS beneficiary dropped 4 percent from 2023 to 2024, while covered days rose 1 percent, resulting in a 5 percent increase in days per admission (Table 7-3, p. 224). We will continue to monitor length of stay to see whether these trends persist and whether the mix of patients has changed over time.

Quality of care: All measures were stable but varied across facilities

We report two FFS Medicare claims-based outcome measures for SNFs (risk-adjusted potentially preventable hospital readmissions after discharge and risk-adjusted discharge to the community) and two measures of staffing (risk-adjusted registered nurse hours per resident day and total nurse staffing turnover rates).

**TABLE
7-3**

SNF admissions and days, 2019–2024

Volume measure	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2024	Percent change 2023–2024
Covered admissions per 1,000 FFS beneficiaries	55	50	49	54	47	45	–3.9%	–3.8%
Covered days per 1,000 FFS beneficiaries	1,447	1,429	1,361	1,498	1,385	1,396	–0.7	1.0
Covered days per admission	26.1	28.5	28.0	28.0	29.2	30.7	3.3	4.9

Note: SNF (skilled nursing facility), FFS (fee-for-service). Data are for the calendar years and include SNFs in the 50 states and the District of Columbia. Data do not include swing-bed stays. To be consistent with other sectors, we use our own analysis of claims data to assess SNF use. Percent changes were calculated on unrounded data.

Source: MedPAC analysis of 2019–2024 Medicare Provider Analysis and Review and Common Medicare Environment data.

Discharge to the community

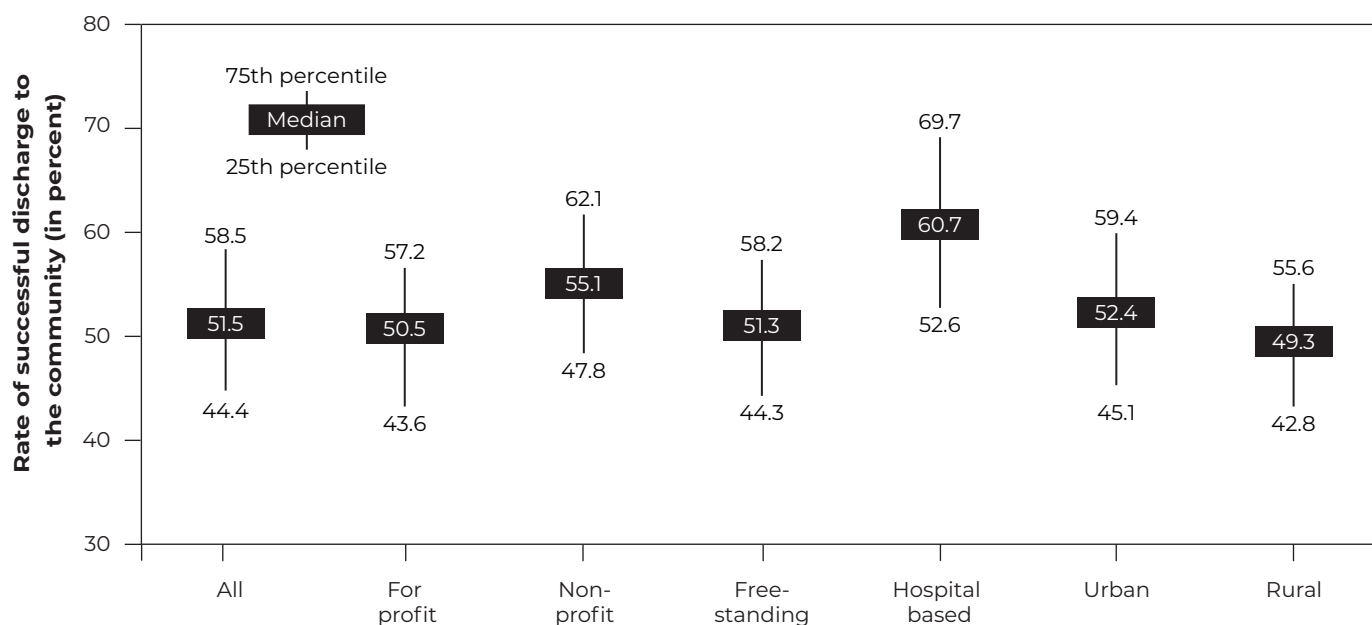
The measure of discharge to the community is a SNF’s risk-adjusted rate of FFS Medicare residents who are discharged to the community after a SNF stay, do not have an unplanned readmission to an acute care hospital or long-term care hospital in the 31 days following discharge to the community, and remain alive during those 31 days (higher rates are better) (RAND Corporation and RTI International 2019).⁷ Baseline nursing facility residents—those who were nursing facility residents before their Part A-covered SNF stay—are excluded from the measure because discharge to the community may not be a safe or expected outcome for these patients (RAND Corporation and RTI International 2019).⁸ SNFs can improve their rate of discharge to the community by providing recuperative nursing care, rehabilitation to improve functional ability, discharge planning care and coordination, and patient and family education.

In fiscal year (FY) 2023 and FY 2024 (combined), the median facility risk-adjusted rate of discharge to the community was 51.5 percent. The risk-adjusted rate has been fairly stable over time and is similar to the

FY 2022 and FY 2023 period (when it was 50.9 percent (data not shown)). In FY 2023 and FY 2024, one-quarter of facilities had a risk-adjusted rate below 44.4 percent and one-quarter had a rate above 58.5 percent (Figure 7-1). Median rates varied considerably by ownership, facility type, location, and size. Nonprofit SNFs and hospital-based SNFs had higher (better) rates than for-profit SNFs and freestanding SNFs. Urban facilities had higher rates than rural facilities. Smaller facilities had higher rates than larger facilities, reflecting their relatively large shares of hospital-based SNFs, urban SNFs, and nonprofit SNFs (data not shown). The within-group variation in rates was consistent across groups (about a 1.3-fold difference between the 25th percentile and 75th percentile).

Potentially preventable readmissions

Potentially preventable readmissions after discharge from the SNF are calculated as the percentage of FFS Medicare patients discharged from a SNF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented (lower percentages are better) (RTI International 2016). A SNF can reduce the number of potentially

FIGURE 7-1**Median and interquartile range of SNFs' risk-adjusted FFS Medicare rates of successful discharge to the community in FY 2023–2024**

Note: SNF (skilled nursing facility), FY (fiscal year), FFS (fee-for-service). "Successful discharge to the community" is a SNF's risk-adjusted rate of FFS Medicare patients who were discharged to the community after a SNF stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. "Freestanding" and "hospital based" designations reflect the SNF's Medicare provider number, with "hospital based" indicating a separately certified unit of a hospital. "Urban" refers to metropolitan counties, which contain an urban cluster of 50,000 or more people; all other counties are classified as "rural." Higher rates of successful discharge to the community are better. The measure is calculated uniformly across post-acute care settings; providers with fewer than 25 stays or missing data were excluded, as were swing beds. Data cover 24 months (FY 2023 and FY 2024 combined).

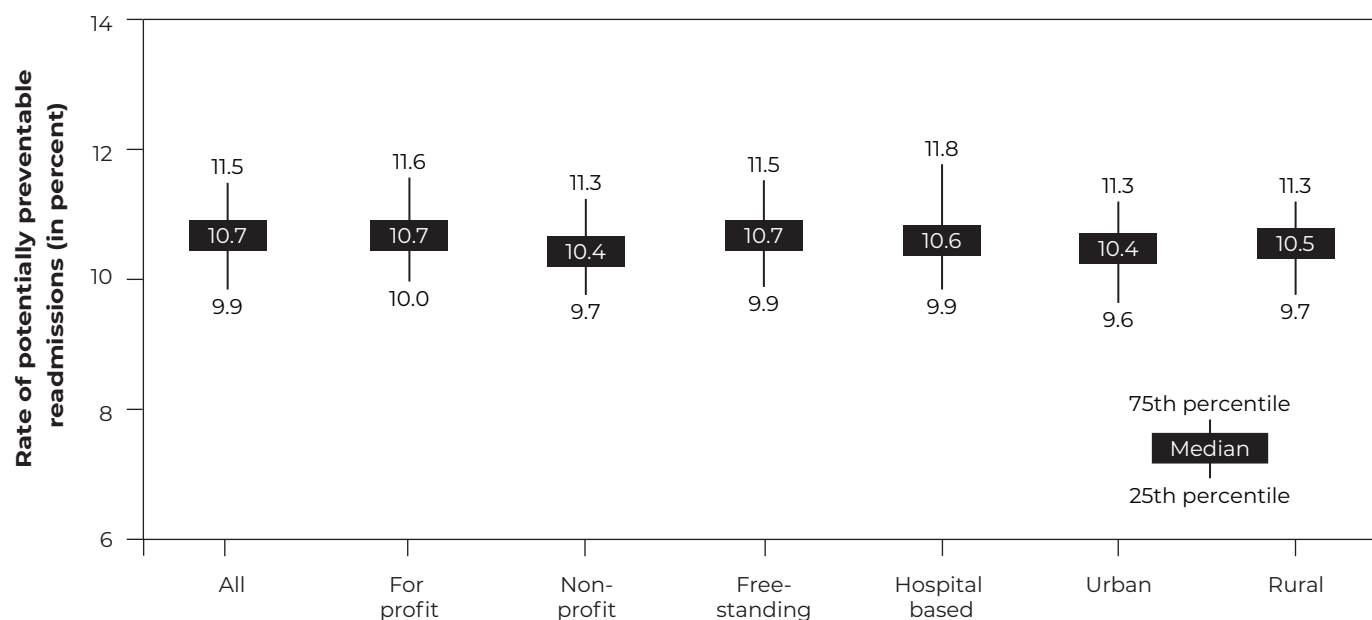
Source: MedPAC analysis of claims-based outcome measures from CMS's Provider Data Catalog.

preventable hospital readmissions by preventing complications, providing clear discharge instructions to patients and families, and ensuring a safe discharge plan and follow-up care.

During the FY 2023 and FY 2024 period, the national median risk-adjusted rate of potentially preventable readmissions was 10.7 percent, similar to the FY 2022 and FY 2023 period when it was 10.4 percent (latter data not shown) (Figure 7-2, p. 226). One-quarter of facilities had rates below 9.9 percent, and one-quarter had rates above 11.5 percent. The differences in the median rates were small across ownership type, facility type, location, and SNF size (data on size are not shown). The across-group and the within-group variations were small.

In addition to potentially preventable readmissions after the SNF stay, readmissions that occur during the stay are an important gauge of the care SNFs provide. In FY 2028, CMS will include potentially preventable readmissions that occur any time within the entire SNF stay as a performance measure in the SNF value-based purchasing (VBP) program. This measure will replace the rate of all-cause readmissions within 30 days of admission to the SNF that is included in the current VBP. When these new data become available, we will report the rates of readmission during the entire SNF stay.⁹

Readmissions and discharge to the community measures assess key outcomes of SNF care, but they

**FIGURE
7-2****Median and interquartile range of SNFs' risk-adjusted FFS Medicare rates of potentially preventable readmissions in FY 2023-2024**

Note: SNF (skilled nursing facility), FY (fiscal year), FFS (fee-for-service). "Potentially preventable readmissions" is a SNF's risk-adjusted rate of FFS Medicare patients who were readmitted to a hospital within 30 days of discharge from the SNF stay for a medical condition that might have been prevented. "Freestanding" and "hospital based" designations reflect the SNF's Medicare provider number, with "hospital based" indicating a separately certified unit of a hospital. "Urban" refers to metropolitan counties, which contain an urban cluster of 50,000 or more people; all other counties are classified as "rural." Lower rates of potentially preventable readmissions are better. The measure is calculated uniformly across post-acute care settings; providers with fewer than 25 stays or missing data were excluded, as were swing beds. Data cover 24 months (FY 2023 and FY 2024 combined).

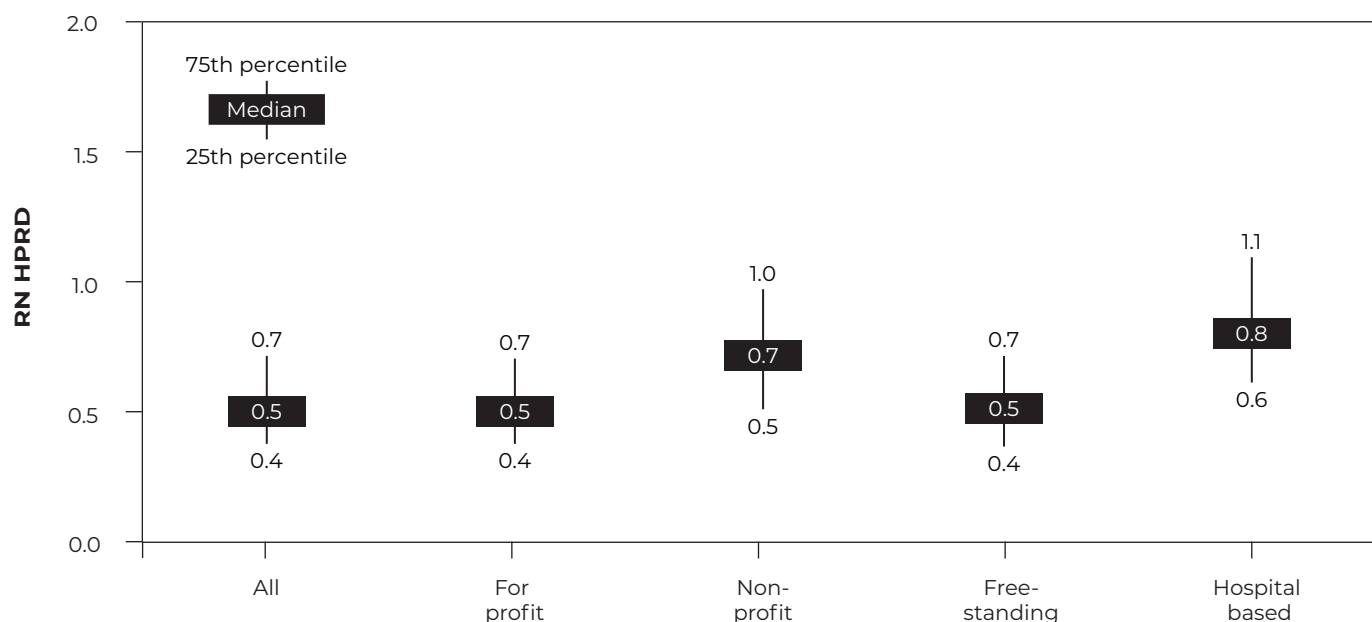
Source: MedPAC analysis of claims-based outcome measures from CMS's Provider Data Catalog.

do not capture all aspects of quality in SNFs. Ideally, we could also measure other outcomes and the experience of SNF care for Medicare beneficiaries in a Part A stay. However, lack of data on patient experience and concerns about the validity of function data derived from the MDS limit our set of quality measures, as discussed below. Claims-based quality measures for MA patients are also not tracked, and the data are not currently available.

Staffing measures

While the Commission has long tracked the quality of care using outcome measures, more recently it expanded its focus to include staffing measures because staffing plays a key role in shaping the quality

of care in nursing homes and SNFs. The National Academies of Sciences concluded that the number and continuity of staff can impact quality of life and patient safety in a SNF (National Academies of Sciences Engineering and Medicine 2022). Higher staffing levels translate to more staff providing care to patients, while lower turnover represents staff who are more familiar with the facility's patients and therefore could be more likely to detect changes in patients' clinical conditions that warrant attention before they worsen. We previously summarized the literature concluding that having more registered nurses (RNs) per resident day has been associated with better outcomes and lower staff turnover rates (Medicare Payment Advisory Commission 2024). In their review of the literature in

FIGURE 7-3**SNFs' median and interquartile range of acuity-adjusted RN hours per resident day by facility characteristics, 2024**

Note: SNF (skilled nursing facility), RN (registered nurse), HPRD (hours per resident day). Staffing ratios for the year are determined by averaging the quarterly values of the calendar year for each provider. All Medicare- and Medicare/Medicaid-certified SNFs with valid data are included.

Source: MedPAC analysis of quarterly nursing facility staffing measures from CMS's Provider Data Catalog, Medicare freestanding-SNF cost reports, and CMS Common Medicare Environment.

a report to CMS, researchers at Abt Associates noted that the higher staffing levels were associated with fewer pressure ulcers, emergency department visits, and rehospitalizations (White and Olsho 2023).

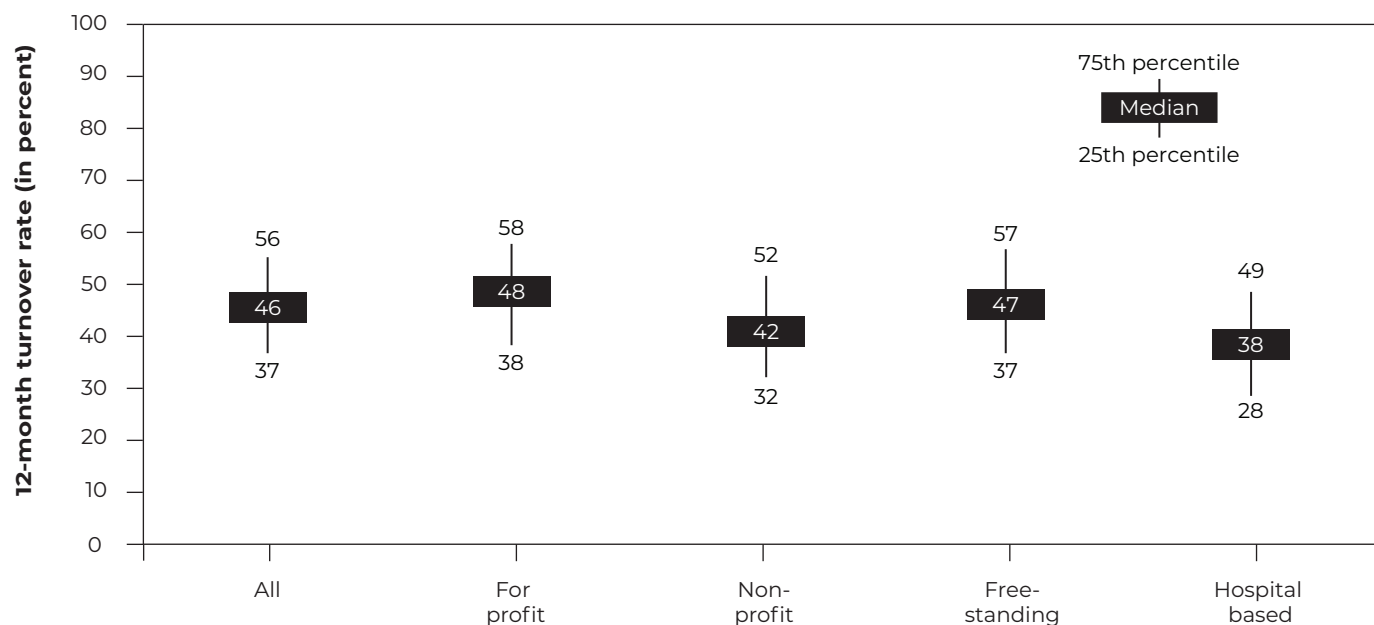
We examined two staffing measures that researchers found are related to nursing home quality: the level of RN staffing and total staff turnover (Clemens et al. 2021, Gorges and Konetzka 2020, Kennedy et al. 2020, Mukamel et al. 2022, Zheng et al. 2022). Although nursing facility staffing ratios and turnover rates refer to the entire facility (not just to Medicare-covered stays), these broad measures are likely to reflect the care beneficiaries receive during Medicare-covered stays. Many nursing homes (those with beds that are dually certified for Medicare and Medicaid) can use their beds interchangeably for long-stay residents and

short-stay patients, and indeed, many beneficiaries switch between Medicare-covered post-acute care (PAC) and long-term care covered by other payers.

In 2024, the median case-mix-adjusted RN hours per resident day were similar to the previous years we examined. The median SNF in 2024 provided 0.5 case-mix-adjusted RN hours per resident day (HPRD) (Figure 7-3). Freestanding SNFs had lower median case-mix-adjusted RN staffing (0.5 HPRD) than hospital-based SNFs (0.8 HPRD), and for-profit SNFs (0.5 HPRD) had lower median case-mix-adjusted RN staffing than nonprofit SNFs (0.7 HPRD). Urban facilities (0.5 HPRD) had case-mix-adjusted RN staffing similar to that at rural facilities (0.6 HPRD) (data not shown). Although the staffing ratios are adjusted for acuity, some of the differences we observe could nevertheless reflect the

**FIGURE
7-4**

SNFs' median and interquartile range of acuity-adjusted total nursing staff 12-month turnover rates by facility characteristics, 2024



Note: SNF (skilled nursing facility). All Medicare- and Medicare/Medicaid-certified SNFs with valid data are included.

Source: MedPAC analysis of quarterly nursing facility staffing measures from CMS's Provider Data Catalog, Medicare freestanding-SNF cost reports, and CMS Common Medicare Environment.

mix of long-stay residents and short-stay PAC patients in a facility and unmeasured differences in case mix.

CMS began reporting data on nursing staff turnover as part of Care Compare, starting with 2021 data. The 12-month rate of nursing staff turnover as of 2024 was 46 percent for the median SNF, and one-quarter of facilities had turnover rates greater than 56 percent (Figure 7-4).¹⁰ Although a methodology change in the turnover calculation makes the 2024 rate not directly comparable with previous years, the 2023 rate of 49 percent represented an improvement from 2021 and 2022, when the rate was around 53 percent (data not shown). A facility can have a high turnover rate because it has very high turnover for select positions (but otherwise relatively stable staffing) or high turnover across many positions. For-profit SNFs and freestanding SNFs had higher turnover rates compared

with nonprofit SNFs and hospital-based SNFs. Urban facilities (47 percent) had turnover rates similar to rates at rural facilities (46 percent), although RN-specific turnover was higher in urban facilities (43 percent) than in rural facilities (40 percent) (data not shown).

Implementation of the minimum-staffing rule was repealed

In May 2024, CMS finalized rules that would have revised the current staffing requirements for nursing homes, adding new minimums and making current RN requirements stricter, beginning in May 2026 (Centers for Medicare & Medicaid Services 2024a). However, in December 2025, CMS formally repealed the staffing requirements (Centers for Medicare & Medicaid Services 2025e). The Commission has not taken a position on stricter staffing requirements.

Challenges remain in the reporting of SNF quality

Nursing homes must report many quality measures—yet the list is missing patient experience, a key dimension of quality. In 2021, the Commission recommended that the Secretary finalize patient-experience measures for SNFs and begin to report them. The Commission also noted that such measures should become part of the measure set for the SNF value-incentive program (Medicare Payment Advisory Commission 2021a). In 2023, CMS proposed adopting a patient-experience survey but opted not to implement this provision and subsequently requested information on patient-experience measures that would be considered in future measure development (Centers for Medicare & Medicaid Services 2024b, Centers for Medicare & Medicaid Services 2023c). (See discussion in Chapter 6 of this report.)

Maintaining and improving patients' function is a key outcome of post-acute care. SNFs assess and record information on each beneficiary's level of function at admission to and discharge from a SNF using the MDS. However, because provider-reported function data are used to assign patients to case-mix groups to adjust payment, the Commission and others have raised concerns about the validity of the provider-reported patient-assessment information (see discussion in Chapter 6 of this report) (Medicare Payment Advisory Commission 2019, Office of Inspector General 2012). The Commission discussed strategies to improve the quality of this information, and beginning in January 2026, CMS will validate a small sample of MDS information used in the value-based purchasing program and quality-reporting program for FY 2027 (FY 2025 performance period).

Providers' access to capital remains adequate

Access to capital allows SNFs to maintain, modernize, and expand their facilities. The vast majority of SNFs are part of nursing facilities. Therefore, in assessing SNFs' access to capital, we look at the availability of capital for the entire facility. Because Medicare makes up a minority share of most SNFs' revenue, access to capital can often reflect factors other than the adequacy of Medicare's payments, such as the adequacy of Medicaid payment rates.

Capital in this sector is less likely to finance new construction than to update facilities or finance

purchases of existing facilities because of state certificate-of-need (CON) laws that limit bed supply. Currently, 34 states and the District of Columbia maintain some form of CON program for nursing homes, and three others have a moratorium on supply (National Conference of State Legislatures 2025).

Each year, Irving Levin Associates produces data and commentary on the volume of SNF transactions and the price per bed. These indicators provide information on buyer interest and their willingness to invest in the sector. After a record-high average price per bed in 2022 (\$114,200), prices reported in transactions dropped over 14 percent in 2023 and another 14 percent in 2024 to \$83,800 (Irving Levin Associates LLC 2025b).¹¹ In the first six months of 2025, price per bed was up 2 percent from 2024 (Irving Levin Associates LLC 2025b, Irving Levin Associates LLC 2025c).

Buyer interest in 2025 was high, especially in states that raised their Medicaid rates (Irving Levin Associates LLC 2025a). REITs had more activity in the first three quarters of 2025 than in the last few years. SNFs continue to offer attractive yields to investors, especially when considering the additional sources of revenue from other businesses (such as therapy services) and incentives to grow one's patient population. Low-performing assets may offer even more opportunity because a new owner may be able to expand referrals and improve payer mix, efficiencies, and case-mix coding (Irving Levin Associates LLC 2024). Large operator chains such as the Ensign Group and the CareTrust REIT continued to expand their portfolios in 2025 (CareTrust REIT 2025, Ensign Group 2025).

The Department of Housing and Urban Development (HUD) is an important lending source for this sector. Section 232 loans help finance SNFs by providing lenders with protection against losses if borrowers default on their mortgage loans. In FY 2025, HUD implemented an "express lane" for these loans, expediting the approval process for applications that meet certain low-risk criteria. In FY 2025, HUD financed 337 projects, an increase from 220 projects in 2024 (Department of Housing and Urban Development 2025, Department of Housing and Urban Development 2024). The total HUD-insured amount in 2025 was \$6.0 billion, compared with \$3.2 billion in 2024. A minority of facilities access capital via private equity, as discussed

above, in addition to HUD and commercial bank loans (ATI Advisory 2022).

The SNF sector remains attractive for investors because demand is expected to increase from an aging population and because of the setting's relative low cost for insurance plans or models when compared with inpatient rehabilitation facilities. In addition, investors and facility-owners welcomed the expected repeal of the minimum staffing requirements (Irving Levin Associates LLC 2025c, Omega HealthCare Investors 2025). Recent increases in hiring have improved occupancy rates; many Medicaid programs have increased rates (see section on Medicaid, pp. 242–244); and, for providers that borrowed or are considering borrowing, interest rates were lowered in September 2024. Any reluctance to invest in this setting does not principally reflect the adequacy of Medicare's FFS SNF payments: Medicare remains a preferred payer in this sector.

All-payer total margins rose in 2024

In 2024, the estimated all-payer total margin for freestanding SNFs (reflecting all lines of business, all payers, and investment income) was 2.1 percent, up from 0.4 percent in 2023. In 2024, 40 percent of SNFs had negative all-payer total margins, down from 46 percent in 2023.

Because the all-payer total margin includes Medicaid-funded long-term care, state policies regarding the level of Medicaid payments, including base rates and supplemental payments, significantly affect the overall financial performance of this setting. A 2023 Medicaid and CHIP Payment and Access Commission study found that nursing facility profitability under Medicaid varies by facility and across and within states and that the 2019 median base payments (that exclude other supplemental payments from Medicaid) covered 86 percent of costs (Medicaid and CHIP Payment and Access Commission 2023). The continued growth of enrollment in MA, with its reportedly lower payment rates, also factors into the total margin.

Although related-party arrangements can help facilities streamline services and manage costs, the lack of transparency in reporting of third-party transactions and related entities makes it difficult to know whether we are accurately assessing the finances of nursing facilities. Nationally, over three-quarters of nursing

facilities reported making payments to related third parties (including real estate companies, management companies, pharmacies, and medical supply companies) in their cost reports (Harrington et al. 2024). One study of nursing facilities in Illinois (a state that requires detailed financial reporting) examined reported costs before and after nursing facilities entered into a related-party agreement (Gandhi and Olenski 2024). The study found that facilities' reported costs increased due to inflated sales-leaseback agreements and costly management fees owed to the related-party entity. After reestimating nursing home profits based on what costs would have been without the inflated costs, it found that the reported profits were only 32 percent of actual industry profits—that is, 68 percent of the actual profits were “hidden” in inflated costs.

High FFS Medicare rates improve the financial viability of nursing facilities by partially offsetting the lower profitability of patients with other payers with lower rates, such as Medicaid and possibly MA. Higher payments from FFS Medicare can be thought of as an implicit subsidy to nursing facilities. While some have argued that SNF PPS rates should remain high to subsidize lower rates from other payers, particularly Medicaid, the Commission has long held that subsidizing Medicaid or other payers with FFS Medicare payment rates that are far in excess of providers' costs is poor policy for several reasons:

Subsidization of other payers through Medicare's PPS payments creates undesirable incentives The differential between the profitability of FFS Medicare patients and that of other patients, such as those covered by Medicaid and MA, could encourage providers to select patients based on payer source. It also encourages providers to rehospitalize facility residents who are dually eligible (i.e., enrolled in both Medicare and Medicaid) to qualify them for a Medicare-covered SNF stay at a higher payment rate, and it encourages providers to extend the length of a Medicare-covered SNF stay to receive additional payment.

Subsidization of other payers through Medicare's PPS payments results in poorly targeted subsidies Facilities with high Medicare volume currently receive the most in “subsidies” through higher Medicare payments, while facilities with low Medicare volume—potentially the facilities with the greatest financial need—receive

the least. Thus, higher Medicare payments do not target assistance to those facilities with high Medicaid volumes. Furthermore, facilities located in states with relatively high Medicaid rates receive the same “subsidies” as those located in states with relatively low rates.

Maintaining or raising Medicare’s payments to subsidize other payers exerts pressure on an already fiscally challenged Medicare program If policymakers wish to provide additional support to certain SNFs, they could do so through a separate, targeted policy. It is important for providers that treat large shares of Medicaid patients to be supported, but that cost should be Medicaid’s responsibility and not be funded by the Medicare program. Medicare’s relatively high rates effectively subsidize long-term care, which is not a covered benefit.

Medicare payments and providers’ costs: FFS Medicare margins remained high in 2024

In 2024, the FFS Medicare margin for freestanding SNFs was 24 percent, an increase from 22 percent in 2023. FFS Medicare margins for individual facilities varied considerably across providers, as in prior years.

Trends in FFS spending and cost growth

In 2024, FFS Medicare spending on care in SNFs (excluding beneficiary spending and care in swing beds) was \$26 billion, an increase of 4 percent compared with 2023. This increase in overall spending is likely a function of total covered days holding steady and a CMS 4 percent payment update for FY 2024. Additionally, there is growing evidence that providers are adapting billing behavior to the incentives of the PDPM case-mix system, introduced in October 2019, in order to receive higher payments (Geng et al. 2025, Wang et al. 2025).

Between 2023 and 2024, the average FFS Medicare payment per day in freestanding SNFs increased 4.9 percent, while costs per day increased 2.3 percent. Changes in payments per day in 2024 reflect the combined effect of the market basket increase to the base rate, which included a payment adjustment for past overpayments under the PDPM. Payments also incorporate the forecast-error corrections made in both years (CMS makes these adjustments when its

historical estimate of the market basket differs from the actual market basket by at least 0.5 percentage points—either too high or too low).

Payment growth outpaced the growth in costs. Routine costs per day increased 2.9 percent in 2024, slowing down from previous years. The growth in routine costs reflects labor cost trends in 2024. Wage data for the SNF sector from the Bureau of Labor Statistics show that hourly wages in the sector grew 2.8 percent in 2024, down from the 3.3 percent growth in 2023 and much lower than the wage growth observed during the PHE. Preliminary data for the first six months of 2025 indicate wage growth was higher but relatively stable, with wages growing 2.6 percent (Bureau of Labor Statistics 2025, Bureau of Labor Statistics and Department of Labor 2024). Ancillary costs per day, which include therapy, fell year over year from 2019 through 2022 but rose by 4 percent from 2022 to 2023. These costs stabilized in 2024, growing only 1 percent.

Consistent with past years, cost growth and the level of costs varied by ownership. In 2024, for-profit providers reported larger increases in total cost per day than nonprofit providers did (2.5 percent vs. 1.8 percent). In 2024, nonprofit providers had 14 percent higher aggregate costs per day than for-profit providers, in part because they are smaller and have a lower average daily census, so they cannot achieve the same economies of scale as larger for-profit facilities. As discussed above, nonprofit SNFs also have higher average nurse HPRD than for-profit SNFs.

SNF FFS Medicare margins remain high

The FFS Medicare margin is a key measure of the adequacy of the program’s payments because it compares Medicare’s FFS payments with providers’ costs to treat FFS beneficiaries. In 2024, the FFS Medicare margin for freestanding SNFs was 24.4 percent (Table 7-4, p. 232). For the 25th consecutive year, the FFS Medicare margin for freestanding SNFs was 10 percent or higher (data not shown). The margin was higher than in 2023 (22.5 percent).

In 2024, hospital-based SNFs (which account for 2 percent of FFS Medicare program spending on SNFs) continued to have substantial negative FFS Medicare margins. The FFS Medicare margin for hospital-based

**TABLE
7-4****Freestanding SNF FFS Medicare margins, 2021–2024**

Category	2021	2022	2023	2024
All	22.8%	23.5%	22.5%	24.4%
For profit	25.5	26.1	25.5	27.2
Nonprofit	9.9	9.2	8.2	10.8
Urban	22.9	23.6	22.8	24.8
Rural	22.1	22.5	20.8	21.1
Frontier	18.9	18.2	16.1	17.4

Note: SNF (skilled nursing facility), FFS (fee-for-service). FFS Medicare margins exclude pandemic-related federal relief funds.

Source: MedPAC analysis of Medicare freestanding SNF cost reports and Minimum Data Set data.

SNFs was –38 percent, similar to –42 percent in 2023 (data not shown). Hospital administrators consider their SNF units in the context of the hospital's overall financial performance and mission. Hospitals with SNFs can lower their inpatient lengths of stay by transferring patients to their own SNF beds, thus making inpatient beds available to treat additional inpatients.

FFS Medicare margins varied widely in 2024

FFS Medicare margins for freestanding SNFs varied widely: One-quarter of SNFs had FFS Medicare margins that were almost 34 percent or higher, and one-quarter had margins that were 13 percent or lower (Table 7-5). The differences in FFS Medicare margins between for-profit and nonprofit facilities have persisted for years. The gap reflects differences in costs per day and, to a lesser extent, payments per day. Compared with for-profit facilities, nonprofit facilities were smaller (fewer beds and lower volume), and they had lower payments but higher costs per day (data not shown). The FFS Medicare margin for urban SNFs was about 3 percentage points higher than for rural SNFs in 2024, though this may be a function of size. Rural SNFs are smaller on average than urban SNFs, but small rural SNFs have, on average, higher margins than small urban SNFs. Differences in FFS Medicare margins partly reflect the economies of scale that larger SNFs achieve. Facilities with 20 to 50 beds had a lower FFS

Medicare margin than facilities with 100 to 199 beds. And low-volume facilities (bottom 25th percentile of total facility days) had a lower FFS Medicare margin than high-volume facilities (top 25th percentile of days). SNFs with the lowest cost per day (the bottom 25th percentile of the distribution of cost per day) had a FFS Medicare margin that was over 12 percentage points higher than SNFs with the highest (in the top 25th percentile) cost per day.

SNFs in the top quartile of the distribution of FFS Medicare margins appear to pursue cost strategies (such as staffing mix and levels) and revenue strategies (such as coding and documentation) that differentiate themselves from other SNFs. Compared with SNFs in the lowest FFS Medicare margin quartile, high-margin SNFs have lower costs per day and higher payments per day. High-margin SNFs also have lower total nursing and RN HPRD compared with low-margin SNFs, and this difference is reflected in their lower routine costs. High-margin SNFs may be more likely than low-margin SNFs to care for beneficiaries with low incomes: On average, high-margin SNFs in 2023 had a higher share of Medicare-covered SNF stays attributable to beneficiaries receiving the Part D low-income subsidy and higher shares of total Medicaid-covered facility days. Facilities with a higher Medicaid mix may keep their costs lower, in part through lower staffing,

contributing to their higher FFS Medicare margins. High-margin SNFs also have much longer lengths of stay, which yield additional revenue under the SNF per diem payment system, and a higher nursing case-mix index. Economies of scale also affect the difference in financial performance. In 2024, the median high-margin SNF had more beds and higher occupancy rates than the median low-margin SNF.

Projecting payments and costs for 2026

To project the FY 2026 FFS Medicare margin for freestanding SNFs, the Commission considered the relationship between SNF costs and Medicare payments in 2024 as a starting point. To estimate 2026 costs, we used CMS’s Office of the Actuary’s November 2025 estimates of the market baskets for 2025 (2.9 percent) and 2026 (3.2 percent) (Centers for Medicare & Medicaid Services 2025d). The annual market basket indicates how SNFs’ costs for a fixed basket of inputs will change, including estimates of the costs associated with higher wages and economy-wide inflation. The estimates of cost growth could be low or high depending on how actual costs differ from the projections. We adjusted facilities’ costs for the estimated cost and savings of complying with new policies, such as those associated with new MDS or quality-reporting-program requirements, or heightened civil monetary penalties. Our adjustments were based on CMS’s estimates (Centers for Medicare & Medicaid Services 2025f, Centers for Medicare & Medicaid Services 2024b).

To estimate payments in FY 2025 and FY 2026, we increased payment rates by the updates specified in the final rules for those years (Table 7-6, p. 234). The updates include the market basket with productivity adjustments and forecast-error corrections to market basket estimates made in earlier years. We did not consider additional changes in payments for potential changes in patient acuity or the recording of patient characteristics that would raise or lower payments.

The projected FFS Medicare margin for 2026 for freestanding SNFs is 25 percent. We expect the margin to increase in 2026 relative to 2024 because payment updates are projected to exceed cost growth in 2025 and 2026. Different assumptions about changes in costs, case mix, and revenues could raise or lower the projection.

TABLE 7-5 Variation in freestanding SNF FFS Medicare margins persisted in 2024

SNF group	FFS Medicare margin
All SNFs	24.4%
25th percentile of FFS Medicare margins	13.0
75th percentile of FFS Medicare margins	33.9
For profit	27.2
Nonprofit	10.8
Urban	24.8
Rural	21.1
Frontier	17.4
Cost per day: High	18.7
Cost per day: Low	31.1
Small (20–50 beds)	8.7
Large (100–199 beds)	26.5
Low-volume facility	11.1
High-volume facility	28.5

Note: SNF (skilled nursing facility), FFS (fee-for-service). Except for the margins at the 25th percentile and 75th percentile, the FFS Medicare margins in the table are aggregates for the facilities included in the group. FFS Medicare margins exclude pandemic-related federal relief funds. “Frontier” refers to counties with six or fewer people per square mile. “Cost per day: High” refers to the top quartile of total costs per day, and “Cost per day: Low” refers to the bottom quartile. Facility volume comprises all facility days. “High-volume facility” is the top quartile of total facility days, and “low-volume facility” is the bottom quartile of total facility days. Government-owned SNFs operate in a different financial context from other SNFs, so their margin is not necessarily comparable; therefore, data for government-owned SNFs are not reported separately or included in the ownership rows (but are included in other rows).

Source: MedPAC analysis of 2024 Medicare freestanding-SNF cost reports and SNF Medicare Provider Analysis and Review data.

How should FFS Medicare payments change in 2027?

In 2027, current law is expected to increase payment rates by 2.3 percent (an estimated market basket of 3.1 percent minus a productivity adjustment of 0.8 percent). CMS will revise its estimates before the publication of the FY 2027 final rule (which must be

**TABLE
7-6**

SNF current-law payment updates for fiscal years 2024–2026

	2024	2025	2026
Updates based on forecasts			
Market basket	3.0%	3.0%	3.3%
Productivity	–0.2	–0.5	–0.7
Forecast-error correction	3.6	1.7	0.6
Parity adjustment	–2.3	N/A	N/A
Total	4.0	4.2	3.2

Note: SNF (skilled nursing facility), N/A (not applicable). CMS makes forecast-error corrections when its estimate of the market basket differs from the actual market basket by at least 0.5 percentage points (either too high or too low). This correction is lagged two years. “Parity adjustment” is a payment-update adjustment that CMS implemented in fiscal year 2023 and fiscal year 2024 to correct for unintended overpayments after transitioning to the Patient-Driven Payment Model.

Source: CMS SNF final rules for fiscal years 2024–2026.

published before August 1, 2026). CMS also corrects for overestimates and underestimates of the SNF market basket two years prior to the rulemaking year (meaning the FY 2027 payment update will correct for under- or overestimates of the FY 2025 market basket). If CMS determines that it over- or underestimated the market basket by more than 0.5 percentage points in FY 2025, it will apply the correction in FY 2027. Currently, because the FY 2025 official market basket is within 0.5 percentage points of the actual FY 2025 market basket, there is no expected FY 2027 forecast-error adjustment. Routine forecast-error adjustments are unique to the SNF and Inpatient Capital payment updates.

The FFS Medicare margin in 2026 will depend on many factors. The update to the payment rate may not accurately capture any real changes in patient acuity or the recording of patient characteristics that raise payments (with no effect on costs). Costs may increase more or less than the market basket estimates. Under any plausible scenario, Medicare margins are likely to remain high, indicating that the SNF PPS exerts too little pressure on providers to control costs. Not surprisingly, FFS Medicare remains a preferred payer for SNFs.

RECOMMENDATION 7

For fiscal year 2027, the Congress should reduce the 2026 Medicare base payment rates for skilled nursing facilities by 4 percent.

RATIONALE 7

The level of Medicare’s payments indicates that a reduction is needed to better align aggregate payments to aggregate costs. The freestanding SNF FFS Medicare margin was 24 percent in 2024. With the market basket updates and the likely forecast-error adjustments, we project that the freestanding SNF FFS Medicare margin will be 25 percent in 2026. Thus, FFS payments will remain more than adequate to ensure beneficiary access to SNF care even if payments are lowered.

Although the overall FFS Medicare financial performance of SNFs is good and projected to remain so, the share of providers that operated at a loss in 2024—as well as the large difference in FFS Medicare margins between nonprofit and for-profit SNFs—indicates that not all providers do well financially under the SNF PPS. It is not sound policy to raise payments for all providers to address the poor financial performance of some. Nor does the Commission support differential updates for providers based on

ownership status or geographic location. Instead, the Congress could consider other approaches to redistribute FFS Medicare's payments. For example, as the Commission recommended in June 2021, the Congress should replace the VBP program with a program that includes larger incentive payments, which would direct funds to facilities that perform well on quality and resource-use measures (Medicare Payment Advisory Commission 2021a).

IMPLICATIONS 7

Spending

- Current law is expected to increase payment rates by 2.3 percent in FY 2027. This recommendation would lower spending relative to current law by between \$2 billion and \$5 billion over one year and between \$10 billion and \$25 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries' access to SNF care. Given the current level of payments, we do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries.

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. The ratings may also help managed care organizations, accountable care organizations, participants in CMS's bundled-payment initiatives, and hospital systems to select SNFs to include in their network of providers.

The current overall rating uses information from three separate ratings on three domains: inspection performance, staffing, and quality measures. Although there is a clear relationship between staffing and quality, the Commission noted that staffing does not play a prominent role in determining an NH's overall rating but that it could (Medicare Payment Advisory Commission 2025). At the same time, because the inspection ratings can be outdated or fail to identify

serious quality concerns, the weight of this domain could be lowered. Following up on our June 2025 report to the Congress, we explored alternative designs that would increase the weight of the staffing domain and include all staffing and quality ratings in calculating an overall rating. We present the results of two illustrative approaches. In one, the domains would be weighted equally; in the other, the staffing domain would be more heavily weighted than the quality and inspection ratings. Both designs would result in the majority of NHs gaining or losing a star. Those that currently have high ratings would see their ratings decline in large part due to the diminished role of their high inspection ratings. Those that currently have low ratings would see their ratings improve because the 2-, 3-, and 4-star staffing and quality ratings that currently do not affect their overall ratings would be counted. By considering all staffing and quality ratings and lowering the dominance of the inspection rating, the alternative designs would offer a more complete picture of an NH's overall performance.

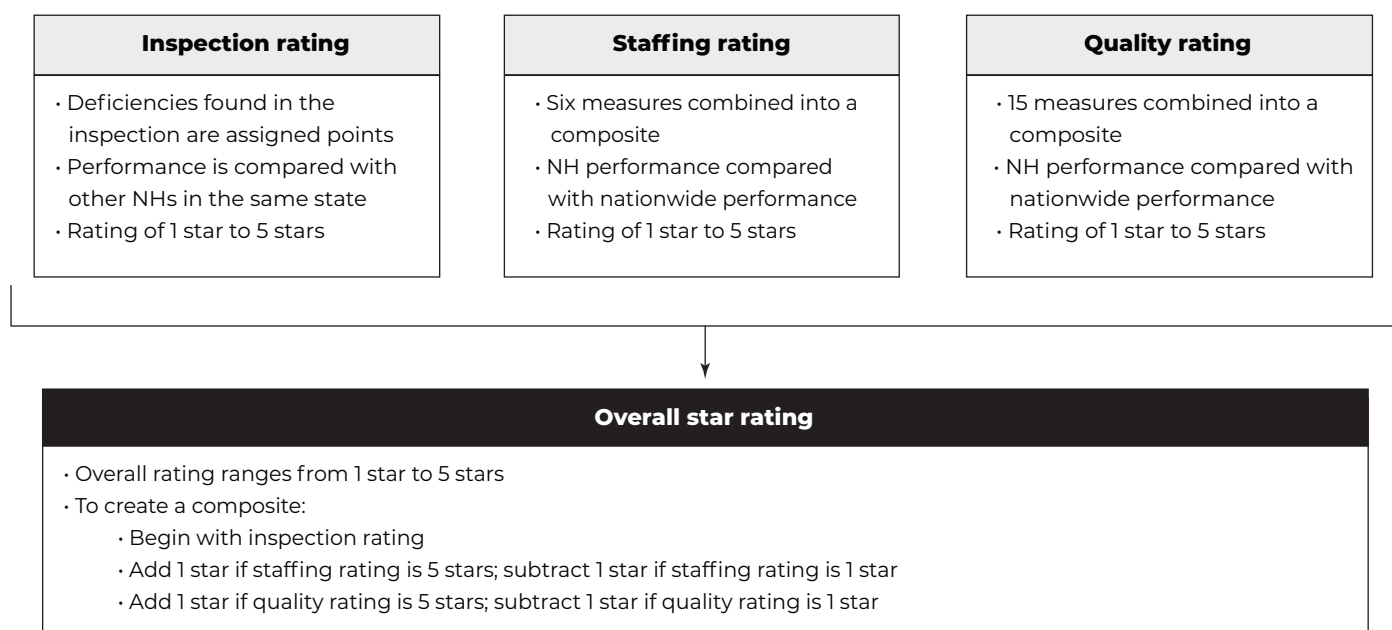
Current design of the star ratings

An NH's overall star rating is a composite of three separate ratings—one each for the NH's inspection, staffing levels, and quality measures. For each domain and the overall rating, NHs can receive 1 to 5 stars based on their performance. (A complete discussion of the star ratings can be found at Centers for Medicare & Medicaid Services 2025a.)

- *Inspection rating:* Each NH participating in the Medicaid or Medicare program has an on-site inspection every year, on average. Ratings are based on the number, scope, and severity of the deficiencies, with more serious and widespread deficiencies counting more than others.¹² Ratings consider the two most recent surveys, with the most recent one weighted 75 percent.¹³ Ratings are updated as survey results become available. The distribution of ratings is prescribed with a forced distribution of ratings within each state: 20 percent receive 1 star, 10 percent receive 5 stars, and the remaining 70 percent receive between 2 and 4 stars.
- *Quality rating:* The quality domain is a composite of 15 measures: 9 long-stay measures (e.g., the share of long-term nursing home residents whose need for help with activities of daily living increased) and

**FIGURE
7-5**

Nursing home overall star ratings are a composite of three ratings



Note: NH (nursing home).

Source: CMS Care Compare website, November 2024.

6 short-stay measures (e.g., the share of short-stay patients who were hospitalized).¹⁴ The majority of the measures are based on patient-assessment data, the accuracy of which the Commission and others have raised concerns about (see the PAC overview chapter, Chapter 6). Measures that experts determined gave NHs a greater opportunity to improve and measures with higher clinical significance count more than others. The quality ratings are updated quarterly.

- **Staffing rating:** The staffing domain is a composite of six staffing measures that are calculated from payroll-based data that NHs are required to report to CMS. Three are risk-adjusted measures of staffing levels (total nurse staffing across all days, registered nurse staffing across all days, and weekend total nurse staffing), and three are turnover rates over the entire year (total nursing staff, RNs, and administrators). Stars are assigned

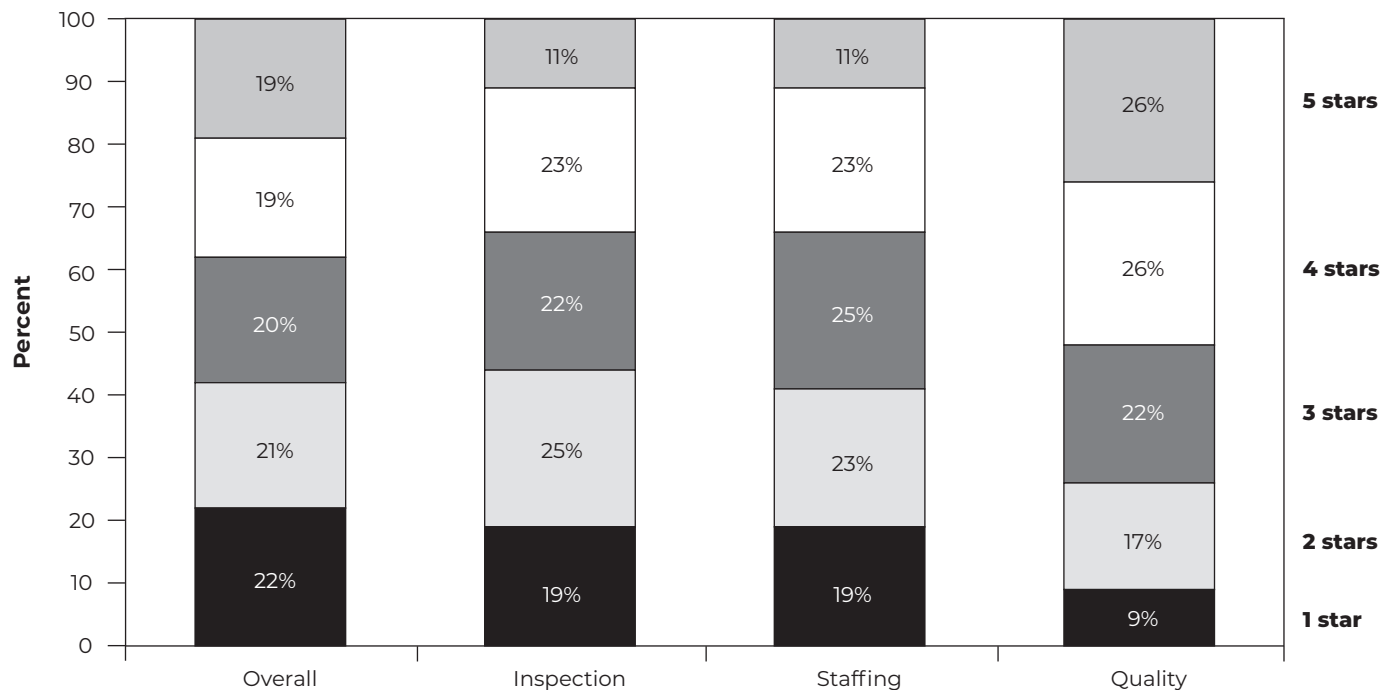
based on the total points earned across the six measures, with some measures counting more than others. Staffing measures are updated quarterly.

The overall rating utilizes the three domains' ratings. It first assigns a star rating based on the inspection star rating (Figure 7-5). Then, 1 star is added for a 5-star staffing rating, and 1 star is subtracted for a 1-star staffing rating. Last, 1 star is added to the overall rating for a 5-star quality rating, and 1 star is subtracted for a 1-star quality rating. For all other ratings (2, 3, or 4), there is no impact on the overall rating. For example, an NH with an inspection rating of 4 stars, a staffing rating of 4 stars, and a quality rating of 5 stars would receive an overall rating of 5 stars (4 stars for the inspection rating + 0 star for the staffing rating + 1 star for the quality rating).¹⁵

The design of the overall scoring is intended to have a more even distribution across the star ratings than

**FIGURE
7-6**

Current nursing home overall star ratings are fairly uniformly distributed but less so by domain, July 2025



Note: Percentages may not sum to 100 due to rounding.

Source: MedPAC analysis of July 2025 Care Compare data for nursing homes.

would have resulted if a weighting scheme had been used (White 2025). CMS explained that the inspection domain was given the most weight because it reflects an on-site inspection conducted by a trained surveyor (Centers for Medicare & Medicaid Services 2025a). Given that the most recent survey is more heavily weighted in the inspection rating, a facility with a 1-star inspection rating indicates very serious and relatively recent quality problems. The quality of the staffing data when CMS developed its methodology may also have contributed to its decision to give the rating for the staffing domain less weight.

Current ratings

The July 2025 Care Compare data show that the overall ratings were evenly distributed across the five levels of star ratings (Figure 7-6). The ratings varied for certain facility characteristics (data not shown). Nonprofit,

government, small, and hospital-based NHs were less likely to have an overall rating of 1 star and more likely to have 5-star ratings. For-profit and large facilities were more likely to have 1-star ratings and less likely to have 5-star ratings. Overall ratings did not differ between rural and urban facilities.

The staffing ratings were more unevenly distributed than the other domains: Only 11 percent of NHs had 5-star staffing ratings. Similar to the overall ratings, nonprofit, hospital-based, and small NHs were more likely to have 5-star staffing ratings and less likely to have 1-star ratings. For-profit SNFs were much less likely to have 5-star staffing ratings. The majority (71 percent) of NHs had 2-, 3- and 4-star staffing ratings that do not affect their overall ratings.

While the majority (52 percent) of NHs with 5-star staffing ratings also had 5-star overall ratings, the two

ratings did not go hand in hand for many facilities (data not shown). Thirty-nine percent of NHs with “high” overall ratings (defined as 4 or 5 stars) had “low” staffing ratings (defined as 1 or 2 stars). Beneficiaries in these NHs are likely to be affected by the poor staffing even though the facility had high inspection ratings. Forty-one percent of NHs had low inspection ratings but high staffing ratings. Beneficiaries in these NHs are likely to experience better care at facilities with higher staffing ratings, but the inspection ratings indicate other serious quality concerns. This mismatch reflects the dominance of the inspection ratings in calculating the overall scores and the fact that 2-, 3- and 4-star staffing ratings do not affect NHs’ overall ratings.

The quality domain ratings were the most variable: Only 9 percent of NHs had 1-star ratings, and more than half had either a 4-star or a 5-star rating. The high share of high star ratings may reflect the incentives providers have to improve care or to report information in ways to boost their ratings. In addition, the benchmarks used to establish the star ratings have been relatively stable, allowing providers to understand what is needed to increase their quality rating. Although the ratings did not vary much by ownership, a larger share of small NHs and hospital-based NHs and a smaller share of rural NHs had 5-star quality ratings. Similar to the mismatch between staffing and overall ratings, 60 percent of NHs had high quality ratings but low overall ratings, and one-third of NHs had high overall ratings but low quality ratings. The majority (65 percent) of NHs have 2-, 3-, or 4-star quality ratings that do not affect their overall ratings.

Rationales for modifying the overall rating’s design

The main reason to make staffing a more prominent feature of a facility’s overall star rating is that there is a clear relationship between staffing and quality. Using a variety of quality metrics, numerous studies have found that higher staffing levels, higher ratios of registered nurses to other nurse staffing, and lower staff turnover rates were associated with higher quality of care (Dellefield et al. 2015, Gandhi et al. 2021, Jutkowitz et al. 2023, Konetzka et al. 2021a, Loomer et al. 2022, Shen et al. 2023, Zheng et al. 2022). CMS noted that “staffing has the greatest impact on quality of care nursing homes deliver” (Centers for Medicare & Medicaid Services 2019). Yet, despite this evidence, only the best

and worst staffing ratings affect the overall rating. Increasing the weight of the staffing domain could incentivize providers to improve their staffing levels and turnover rates.

Another reason to increase the role of the staffing measures is that the quality of the staffing data has improved since the ratings were designed. The original design relied on OSCAR (the Online Survey, Certification, and Reporting system) data that were collected in the two weeks before a facility’s survey inspection, which did not provide an accurate picture of the staffing throughout the year or by day and created an incentive for NHs to temporarily increase staff. Concerned about the accuracy and completeness of the staffing data, in 2016 CMS introduced the Payroll Based Journal (PBJ) data-collection system and required NHs to submit quarterly payroll data. One study found that staffing levels were higher before and during the survey week compared with their annual averages (Geng et al. 2019). The data are updated quarterly (compared with the annual inspection-based data).

There are also grounds for decreasing the role inspections play in the overall rating. For a variety of reasons, NH inspections sometimes fail to identify serious quality problems and may not lead to effective and sustained corrections (Office of Inspector General 2022). In addition, due to the lack of funding, the required annual inspections are often delayed (U.S. Senate Special Committee on Aging 2023). As of December 2025, 44 percent of NHs had not been surveyed in the last 15 months, the required minimum survey frequency (Centers for Medicare & Medicaid Services 2025g). In its FY 2026 budget request, CMS estimated that it would have the resources to complete only 65 percent of the required inspections (Centers for Medicare & Medicaid Services 2025b). In addition, there is evidence that NHs alter their practices around inspection dates, including temporarily increasing staff, reducing admissions from and temporarily discharging residents to hospitals (both of which would increase an NH’s staffing-to-resident ratio), and increasing influenza and pneumonia vaccination rates (Chen and Dillender 2025).

Despite these shortcomings, the surveys can provide important information about NHs and should be

retained as a component of the overall rating. The inspection's on-site visits and interviews may uncover serious quality problems that may not be detected by the quality and staffing measures. In the July 2025 Care Compare data, we found that the inspection ratings are weakly correlated with the quality ratings (0.16 correlation) and with staffing star ratings (0.29 correlation), suggesting that the survey ratings capture a different dimension of quality.

Another problem with the overall design is that the quality ratings rely on patient-assessment data for 10 of the 15 measures. The Commission and others have raised concerns that data elements that are included in the risk adjustment for payment rates may not be accurate (Konetzka et al. 2021b, Medicare Payment Advisory Commission 2019, Sanghavi et al. 2020). (See the discussion of the patient-assessment data in the PAC overview chapter.) Studies have found that some providers underreport falls and the use of antipsychotic medications, both of which are quality measures in the ratings (Chen and Grabowski 2023, Office of Inspector General 2025). Finally, while likely to be more objective, the claims-based measures are calculated using only Medicare FFS claims and so they miss the experience of MA enrollees.

Illustrative alternative weightings of the three domains in calculating an overall rating

The alternative designs had two goals: raise the importance of the staffing rating and include all domain ratings in calculating the overall rating. Instead of starting with the inspection score and adding or subtracting stars, we evaluated three designs. One weighted the domains equally (that is, we averaged the three domain ratings), giving no preference to any of the individual ratings. The other two designs gave the staffing domain more prominence in calculating the overall rating, weighting it 50 percent or 60 percent, respectively. The evidence linking staffing to quality is strong, and the data are accurate and timely. The three alternatives are meant to be illustrative, and we acknowledge that other designs could achieve the same objectives.

We gave the quality and inspection ratings equal weights in models that weighted staffing at 50 percent or 60 percent because we did not have a basis to count one domain more than the other. Each method has

its shortcomings. On the one hand, old inspections or inspections that fail to identify and correct deficiencies would support lowering the role of this domain relative to the quality rating. On the other hand, the limited validation of the majority of the quality measures would support lowering the importance of this domain.

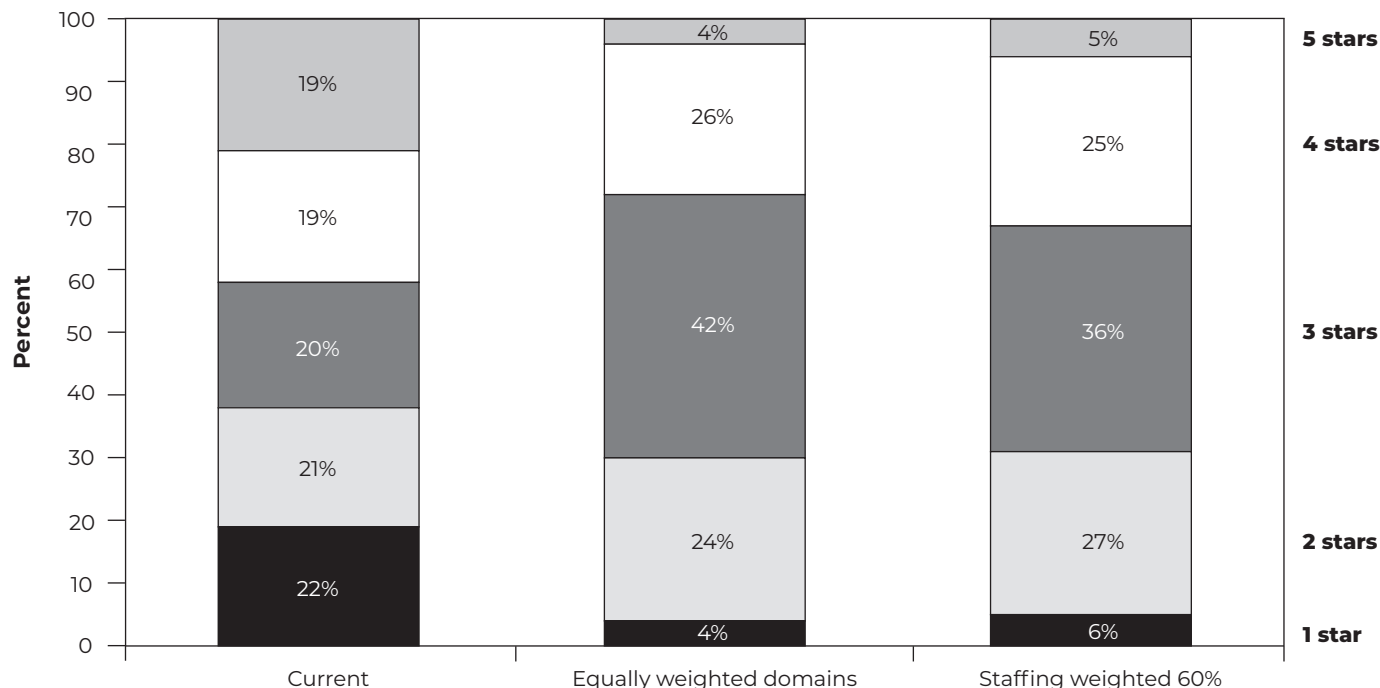
We did not change the domain ratings or their inputs (with minor changes to two caps that affect few NHs).¹⁶ Our modeling did not consider how providers might change their behavior in response to a different design of the overall ratings. We rounded all ratings, consistent with the current design. We discuss the results of the equally weighted model and the alternative that weighted the staffing domain 60 percent. The results of the design that weighted the staffing ratings 50 percent were similar to those for the 60 percent design.

The alternatives we modeled are intended only as illustrations of how the domain weightings could be revised, and we acknowledge there are many other possible designs. For example, instead of averaging the individual domain ratings, the points earned for each domain (before stars are assigned) could be pooled and the overall star rating could be assigned based on the distribution of the total scores. Policymakers could also consider a design that prescribes the shares of nursing homes that are assigned specific star ratings, such as 1 star or 5 stars.

Alternative illustrative design would change the distribution of overall ratings

Despite a higher weight for the staffing domain, the 60 percent alternative had results similar to the version that weighted the three domains equally at 33 percent. The differences between the alternative designs and the current design are largely driven by the use of a methodology that calculates an overall rating considering quality and staffing ratings for all facilities, rather than considering only the best and worst performances in quality and staffing.

Compared with the current design, the alternative weighting methodologies resulted in more uneven distributions of the overall star ratings across NHs, with far fewer NHs with 1- and 5-star ratings (Figure 7-7, p. 240). The share of NHs with 5-star ratings dropped from 19 percent to 4 percent for the equally weighted alternative and to 5 percent for the alternative that

**FIGURE
7-7****Comparison of current nursing home overall star ratings with illustrative designs, July 2025**

Note: The equally weighted design would count each domain 33.3 percent (i.e., averaging the inspection, staffing, and quality ratings). The alternative that weights staffing 60 percent counted the quality and inspection ratings evenly (20 percent each). The resulting overall ratings were rounded.

Source: MedPAC analysis, July 2025 Care Compare data for nursing homes.

weighted the staffing domain 60 percent. Without a high inspection rating to drive the overall ratings, many 5-star rated facilities' overall ratings would be lowered. The share of NHs with 1-star ratings would drop from 22 percent to 4 percent in the equally weighted alternative and to 6 percent when staffing is weighted 60 percent. These decreases reflect the consideration of the 2-, 3-, and 4-star staffing and quality ratings that pull up a facility's overall ratings. Reflecting a combination of those effects, the share of 3-star NHs would increase substantially.

Under the alternative designs, the overall ratings would more closely reflect the rating of an NH's staffing domain. With equally weighted domains, the share of NHs with high staffing ratings (4 or 5 stars) but low overall ratings (1- or 2-star ratings) would decline from

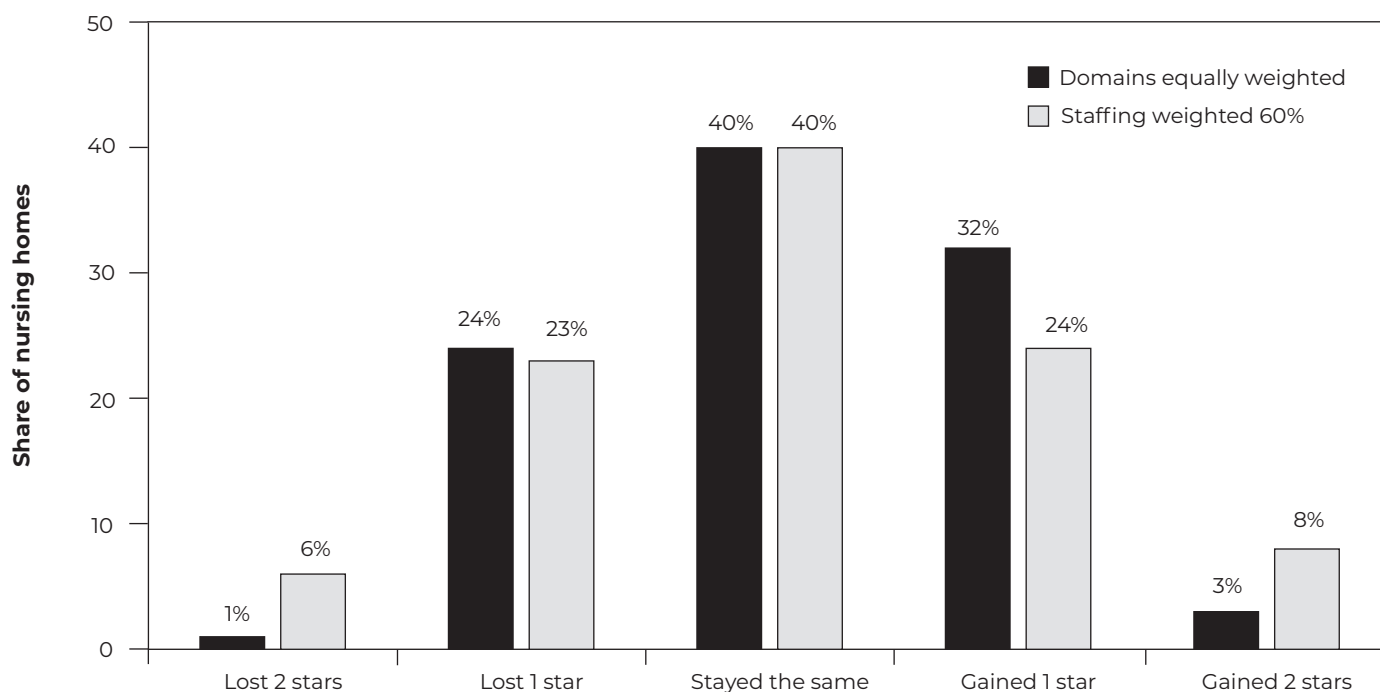
the current 39 percent to 5 percent, and the share of NHs with low staffing ratings but high overall ratings would decrease from the current 41 percent to 13 percent (data not shown). When staffing counts 60 percent in the overall rating, there would be no NHs with high staffing ratings but low overall ratings, or with low staffing ratings but high overall ratings. Under either approach, the reduced role of the inspection rating would yield a more complete picture of an NH's overall performance.

Assuming no behavioral responses, the ratings of the majority of nursing homes would change

Under either weighting approach, the overall ratings for 60 percent of facilities would change, assuming there were no behavioral responses to the new weighting schemes. Of those with changed ratings,

**FIGURE
7-8**

The majority of nursing homes would gain or lose a star in their overall rating under the illustrative alternative designs, July 2025



Note: The equally weighted-domain design would count each domain 33.3 percent (i.e., averaging the inspection, staffing, and quality ratings). The alternative that weights staffing 60 percent evenly weighted the quality and inspection ratings (20 percent each). The resulting overall ratings were rounded.

Source: MedPAC analysis, July 2025 Care Compare data for nursing homes.

most would gain or lose 1 star, but a small share would lose 2 stars (Figure 7-8). No NH would lose more than 2 stars. For many NHs, the reduced role of the inspection ratings would result in many facilities losing stars but would be offset (to varying degrees, depending on other domain ratings) by including the 2-, 3-, and 4-star quality and staffing ratings in the overall ratings. Though small in either design, the share of NHs that would change by 2 stars would be much higher if staffing was weighted 60 percent (4 percent would gain or lose 2 stars with equal weighting compared with 14 percent when staffing was weighted 60 percent).

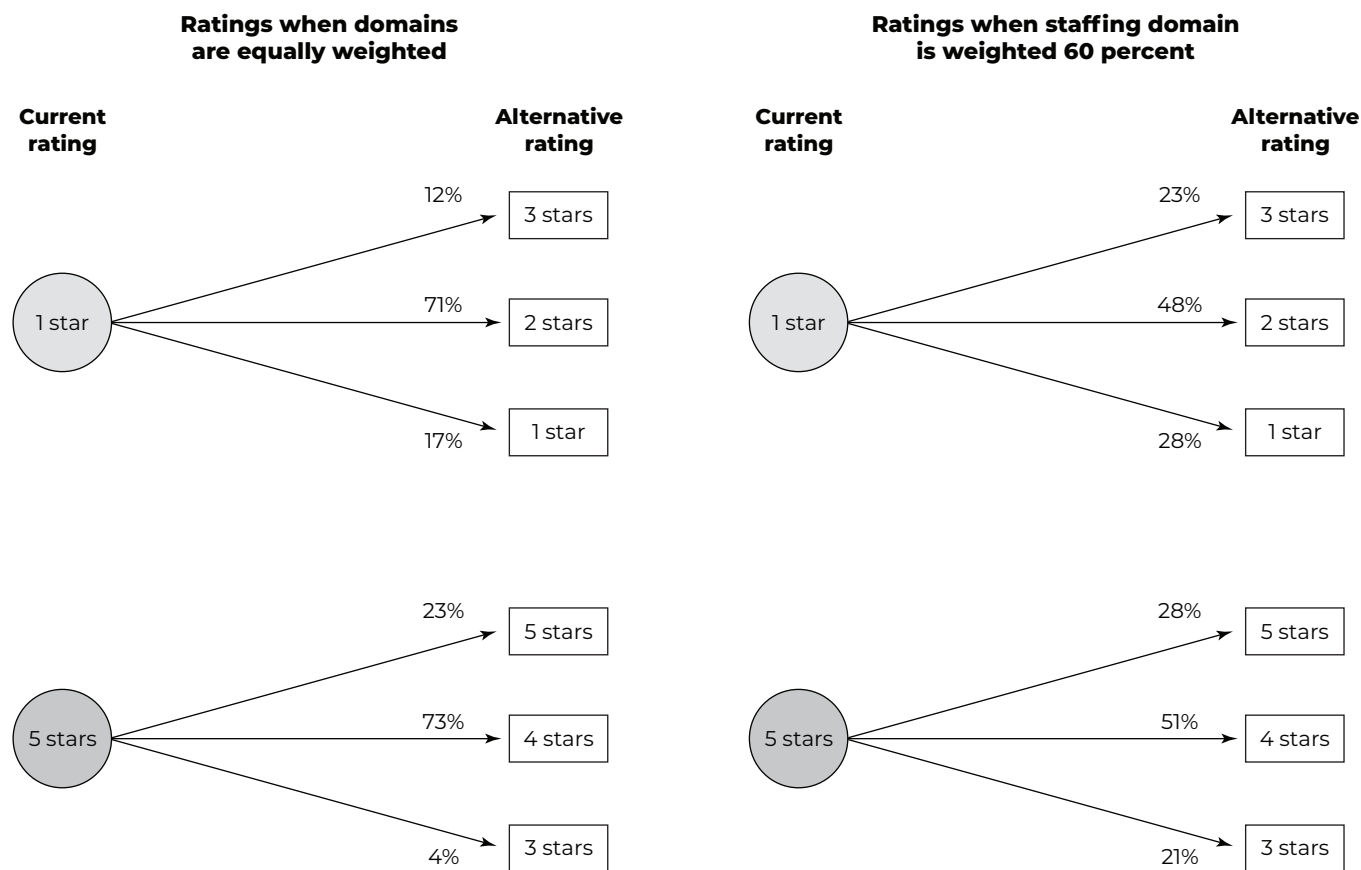
Of those NHs whose overall ratings would be raised, over three-quarters had 2-, 3-, or 4-star quality and staffing ratings that would pull up their overall ratings. Of those whose overall ratings would be lowered, over

three-quarters had high inspection ratings (4 or 5 stars). Figure 7-9 (p. 242) illustrates the changes to the current ratings for NHs with the highest and lowest ratings. When the domains were weighted equally, only 17 percent of 1-star facilities would remain at 1 star, 71 percent would become 2-star facilities, and 12 percent would become 3-star facilities. Almost three-quarters of the 5-star NHs would become 4-star rated. Similar shifts away from the current rating would occur if the staffing domain was weighted at 60 percent.

The alternative weighting approaches would give less weight to the inspection rating and count all staffing and quality ratings in calculating an overall score. As such, the overall rating could provide a more complete picture of an NH's performance across the three domains. An overall rating that includes an increased

**FIGURE
7-9**

Under alternative weightings, the ratings of the majority of 1-star nursing homes would increase and the ratings of 5-star nursing homes would decrease, July 2025



Note: The equally weighted-domain design would average the inspection, staffing, and quality ratings. In the alternative that weights the staffing domain 60 percent, the quality and inspection ratings would each be weighted 20 percent. The revised overall ratings were rounded and may not sum to 100 percent.

Source: MedPAC modeling of July 2025 Care Compare data for nursing homes.

role for staffing is likely to provide beneficiaries with a better indication of the care they would receive. We should note that increasing the importance of the quality rating could create incentives for providers to record patient-assessment information in ways that boost their ratings but would not represent real improvements in quality. It would be especially important that CMS effectively monitor the quality of this information. With that caution, NHs could respond to a revised design by increasing their staffing and making real improvements in their quality to raise

their overall ratings. Both changes would be good for beneficiaries.

Medicaid trends

Section 2801 of the Affordable Care Act of 2010 (ACA) requires the Commission to examine spending, use, and financial performance trends in the Medicaid program for providers that have a significant portion of revenues or services associated with Medicaid.

**TABLE
7-7**

The number of active nursing facilities certified as Medicaid providers declined slightly from 2024 to 2025

	2019	2020	2021	2022	2023	2024	2025	Average annual percent change 2019–2024	Percent change 2024–2025
Number of facilities	14,978	14,851	14,768	14,642	14,487	14,339	14,232	–1.0%	–0.7%

Note: The figure for 2025 was calculated through July 10, 2025; it does not include data from the full calendar year. Counts include dually certified skilled nursing facilities/nursing facilities, distinct-part skilled nursing facilities/nursing facilities, and nursing facilities. Counts are for Medicaid-certified nursing facilities in the 50 states and the District of Columbia. Percent changes were calculated on unrounded data.

Source: MedPAC analysis of active provider counts from CMS's Quality and Certification Oversight Reports online reporting system for 2022–2025.

We report on nursing facility (the term we use for Medicaid-certified facilities that provide long-term care, also commonly called “nursing homes”) spending trends for Medicaid and financial performance for non-Medicare payers. Medicaid revenues and costs are not reported separately in the Medicare cost reports. In a joint publication with the Medicaid and CHIP Payment and Access Commission, we report on characteristics, service use, and spending for dually eligible beneficiaries (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2025).

Medicaid covers long-term care and a portion of the skilled nursing care furnished to beneficiaries who are dually eligible for Medicaid and Medicare. Some state Medicaid programs pay dually eligible beneficiaries' Medicare copayments that begin on Day 21 of a SNF stay. Medicaid also pays for any skilled care for beneficiaries who exhaust their Part A coverage (that is, if their Part A stay exceeds 100 days). Medicaid also pays for long-term care services that Medicare does not cover. Similar to stays for non-dually eligible beneficiaries, discharges for dually eligible beneficiaries increase on Day 20. In addition, dually eligible beneficiaries are more likely to have stays past Day 20 or Day 100, possibly as a result of Medicaid coverage of cost sharing. For beneficiaries in long-term care stays who are enrolled in Part B or Part D, Medicare pays for covered Part B and Part D services.

Count of Medicaid-certified nursing homes

The number of Medicaid-certified nursing facilities has been declining steadily for years. Between 2016 and 2019, the number of active nursing facilities decreased on average 0.3 percent per year. Historically, factors contributing to closures include shifts away from institutional care toward home- and community-based care, overexpansion of supply in states with no certificate-of-need laws (such as Texas) and low Medicaid rates. Between 2019 and 2024, the average annual change was –1 percent. Between December 2024 and July 2025, the number of nursing facilities certified as Medicaid providers declined 0.7 percent from 14,339 to 14,232 (Table 7-7). This smaller decrease may reflect the shorter time period captured in 2025 (January through early July).

Of all Medicaid nursing homes active in January 2025, 54 had terminated as of July 2025, and the majority (43) were voluntary terminations. Providers that terminated participation in the Medicaid program may have remained open but no longer accepted Medicaid residents, may have closed, or may have been purchased by another entity and changed provider numbers. During the same time period, 24 providers opened.

Spending

FFS Medicaid spending on Medicaid-funded (combined state and federal funds) nursing home services totaled \$46.3 billion in 2024, a 9 percent increase from 2023.

**TABLE
7-8****Freestanding SNFs' all-payer total margin and non-FFS Medicare margins improved in 2024**

Type of margin	2019	2020	2021	2022	2023	2024
All-payer total margin	0.5%	3.0%	3.2%	-1.4%	0.4%	2.1%
Non-FFS Medicare margin	-3.5	-2.0	-1.5	-7.6	-4.3	-2.3

Note: SNF (skilled nursing facility), FFS (fee-for-service). "All-payer total margin" includes the revenues and costs associated with all payers and all lines of business and includes reported federal pandemic-related relief funds. "Non-FFS Medicare margin" includes the revenues and costs associated with Medicaid, Medicare Advantage, other private payers, FFS Medicare services not covered under the SNF prospective payment system, and self-pay for all lines of business. Margins shown are aggregates.

Source: MedPAC analysis of Medicare freestanding skilled nursing facility cost reports, 2019–2024.

This rise followed a 5.6 percent increase between 2022 and 2023. As of December 2024, 24 states operated Medicaid managed care for long-term services and supports (ADvancing States 2024). We do not currently have data on Medicaid managed care plans' payments to SNFs. Most states use provider taxes to fund the nonfederal share of Medicaid, and states reportedly use this revenue to increase FFS or managed care payment rates or to fund supplemental payments to providers (Burns et al. 2025).¹⁷

Freestanding SNFs' all-payer total and non-FFS Medicare margins improved in 2024

An all-payer margin is the percentage of revenue from all payers (including all FFS Medicare, Medicare Advantage, Medicaid, private insurers, and self-pay)

and sources (including all lines of business, including both post-acute and long-term care, plus investment income) after accounting for all costs. In 2024, the all-payer margin for freestanding SNFs was 2.1 percent, up from 0.4 percent in 2023 (Table 7-8). Forty percent of SNFs had negative total margins, a decrease from 46 percent in 2023 (data not shown). The non-FFS Medicare margin for freestanding SNFs in 2024 was -2.3 percent, an improvement from 2023. Non-FFS Medicare margins are the profitability of all lines of business and all payers exclusive of FFS Medicare-covered SNF PPS services. The improvement in the non-FFS Medicare margin likely reflects the increases in Medicaid payment rates made by 45 states in FY 2024 (Hinton et al. 2025, Hinton et al. 2023). ■

Endnotes

- 1 A “spell of illness” ends after a period of 60 consecutive days during which the beneficiary was not an inpatient in either a hospital or a SNF. Coverage for another 100 days does not begin until a beneficiary has not had hospital care or skilled care in a SNF for 60 consecutive days. Observation days and emergency department stays do not count toward the three-day hospital-stay requirement. CMS waived the three-day hospital-stay requirement during the coronavirus public health emergency, from January 2020 through May 2023. CMS may approve waivers of the three-day hospital-stay requirement for participants in certain demonstration models and accountable care organizations (ACOs), most notably within the Medicare Shared Savings Program (MSSP). As of January 1, 2025, 162 of the 476 MSSP ACOs were approved to use this waiver (Centers for Medicare & Medicaid Services 2025h). Medicare Advantage plans are not required to apply the three-day inpatient hospital stay requirement.
- 2 Throughout this chapter, “beneficiary” refers to an individual whose SNF stay is paid for by Medicare Part A. Except where specifically noted, this chapter examines FFS Medicare spending and service use and excludes services and spending for SNF services furnished to beneficiaries enrolled in Medicare Advantage plans.
- 3 Skilled services must be ordered by a physician, require the skills of technical or professional personnel, and be furnished directly by or under supervision of such personnel. Coverage ends when a skilled service is no longer needed (e.g., maintenance services can be performed by the patient alone or with assistance from an unskilled caregiver).
- 4 FFS Medicare pays separately for some services, including certain chemotherapy drugs, certain customized prosthetics, certain ambulance services, and radioisotope services. All physician services are paid separately under Part B.
- 5 Fully dual-eligible beneficiaries are not responsible for any cost sharing, and providers cannot bill beneficiaries for these amounts. States are not required to pay the full cost-sharing amount if the total provider payment from Medicare and Medicaid would exceed the state’s Medicaid rate. In 2025, 8 states paid the full Medicare cost-sharing amount; 37 states paid the lesser of the Medicare cost-sharing amount or the difference between the Medicare payment and the Medicaid payment; and 6 states paid another amount such as a set percentage of the Medicare cost sharing (Medicaid and CHIP Payment and Access Commission 2025).
- 6 Another study that made different assumptions in its estimates found higher shares of nursing homes with REITs and PE (16 percent and 13 percent, respectively) (Williams Jr. et al. 2024). Notably, these estimates do not consider divestments.
- 7 “Community,” for this measure, is defined as home/self-care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the FFS Medicare claim.
- 8 Patients who complete their SNF stay in a facility but remain afterwards in the facility as a long-term care resident are not considered discharged to the community.
- 9 We examined the all-cause readmissions within 30 days of admission to the SNF (referred to as the 30-day postadmission rate) and found that rates increased slightly between 2022 and 2023 and were more variable than postdischarge rates. Smaller hospital-based facilities, nonprofit facilities, and rural facilities tended to perform better than other SNFs. The 30-day postadmission and postdischarge rates were not strongly correlated. Because the 30-day postadmission measure could include a mix of days when the beneficiary is under the care of a facility and after discharge from the SNF, and includes only a portion of a stay if it is longer than 30 days, the Commission prefers a measure that gauges readmissions that occur only during the (entire) SNF stay (Medicare Payment Advisory Commission 2015).
- 10 Calculation of the annual turnover measures requires six consecutive quarters of Payroll Based Journal staffing data. Starting July 2024, employment is considered to end in turnover when the individual has at least 90 consecutive days without working, instead of 60 days. (For additional information, see the Centers for Medicare & Medicaid Services (2023a).) This year, we also simplified the methodology and used a calendar year to calculate the rate rather than the four-quarter rolling average.
- 11 The prices reported are based on arm’s-length transactions in which a willing buyer and a willing seller agree on a price with the property exposed to the market. Reported prices include the real estate and business operations, including any licenses. A sale by a provider to an REIT that then leases the property back to the same provider is not considered arm’s length. In contrast, a sale by a provider or owner to an REIT that then leases the property to an unrelated third party is considered an arm’s-length sale.
- 12 The inspection rating gauges safety, quality of life, medication management, resident assessment, NH administration, resident rights, the environment, and kitchen/food services

(with the most recent survey's results weighted more heavily than the earlier survey). The "scope" of a deficiency refers to whether it was isolated (a single instance) or widespread. The severity indicates whether the deficiency put residents at jeopardy of being harmed or were harmed (the highest severity) or there was no harm or the potential for only minimal harm (the lowest severity).

- 13 The inspection score also considers substantiated findings from the most recent 36 months of complaint investigations and focused infection-control surveys, as well as the number of revisits required to ensure that the deficiencies identified during the surveys have been corrected.
- 14 Of the 15 measures, 5 are based on Medicare FFS claims and 10 are based on patient-assessment information. The nine long-stay measures include the percentage of long-stay residents whose need for help with activities of daily living increased; whose ability to move independently worsened; who have or had a catheter inserted and left in their bladder; who had a urinary tract infection; who experienced one or more falls with major injury; who got an antipsychotic medication; the percentage of high-risk residents with pressure ulcers; the number of hospitalizations per 1,000 long-stay residents; and the number of outpatient emergency department visits per 1,000 long-stay resident days. There are six short-stay measures: the percentage of short-stay residents whose ability to move independently improved; who had new or worsened pressure ulcers; who got antipsychotic medication for the first time; who were rehospitalized; who had an emergency department visit; and the rate of successful discharge home. All of the claims-based measures and four of the Minimum Data Set-based measures (moving independently for long-stay residents, improvement in short-stay residents' ability to move around on their own, presence of a catheter, and pressure ulcers in short-stay

residents) are risk adjusted. See Chapter 6 of this report for a discussion of the potential inaccuracies of the patient-assessment information.

- 15 There are three exceptions to this scoring. First, a facility with a 1-star inspection rating cannot have its overall rating raised by more than 1 star based on its staffing and quality ratings. Second, an NH that was cited for abuse cannot have an inspection rating higher than 2 stars. Third, a facility participating in the Special Focus Facility (SFF) program is not rated and instead has a warning sign on its overall rating on the Care Compare website. The SFF program targets the lowest-performing NHs—those with a sustained pattern of numerous and serious survey deficiencies—for more frequent surveys. Due to the lack of resources, CMS can include only a fraction of the poorest-performing homes in the program.
- 16 We did not change the domain ratings except to lift two current caps on ratings. One cap limits the upgrade of the overall rating for NHs that have a 1-star inspection rating. In a design that weights domains, adding or subtracting stars from the inspection rating did not fit the approach. In the July 2025 Care Compare data, only a handful of NHs were affected by this cap. Another cap limits the inspection rating to 2 stars for NHs that were cited for patient abuse. Lifting this cap would not affect our results because there were no NHs with an abuse icon that had an inspection rating greater than 2 stars.
- 17 Under a nursing home provider tax, states tax all facilities and use the collected amount to help finance the state's share of Medicaid funds. The provider tax increases the state's contribution, which in turn raises the federal matching funds. The augmented federal funds more than cover the cost of the provider-tax revenue, which is returned to providers in the form of Medicaid payments to providers.

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CHAPTER

8

Home health care services

R E C O M M E N D A T I O N

- 8** For calendar year 2027, the Congress should reduce the 2026 Medicare base payment rate for home health agencies by 7 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Home health care services

Chapter summary

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2024, about 2.7 million fee-for-service (FFS) Medicare beneficiaries received home health care, and the program spent \$16.0 billion on those services. In that year, there were over 12,000 HHAs certified to participate in Medicare.

Assessment of payment adequacy

The indicators of FFS Medicare payment adequacy for home health care were positive in 2024.

Beneficiaries' access to care—Supply and volume indicators show that FFS Medicare beneficiaries have good access to home health care.

- **Capacity and supply of providers**—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

In this chapter

- Are FFS Medicare payments adequate in 2026?
- How should FFS Medicare payments change in 2027?

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 pattern of HHA supply and utilization in Los Angeles County raises program-integrity concerns. Excluding California, the number of participating HHAs declined by 1.0 percent in 2024.

- **Volume of services**—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—The FFS Medicare margin for freestanding HHAs averaged 21.2 percent in 2024. This margin indicates 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.

How should payments change in 2027?

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 2027, the Congress reduce the 2026 Medicare base payment rate for home health agencies by 7 percent. ■

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. Such providers include home health agencies (HHAs) that furnish skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work to beneficiaries in their homes.

Background

To be eligible for Medicare's home health benefit, beneficiaries must need part-time (fewer than eight hours per day) or intermittent skilled care to treat their illnesses or injuries and must be unable to leave their homes without considerable effort. In contrast to coverage for skilled nursing facility (SNF) services, Medicare does not require a preceding hospital stay to qualify for home health care. Also, unlike for most services, Medicare does not require copayments or a deductible for home health services. In 2024, about 2.7 million FFS Medicare beneficiaries received home care, and the program spent \$16.0 billion on home health care services under the home health prospective payment system (PPS).

FFS Medicare requires that a physician, nurse practitioner, clinical nurse specialist, or physician assistant certify a patient's eligibility for home health care.¹ FFS Medicare also requires that a beneficiary have a face-to-face encounter with a doctor or other allowed practitioner that is related to the primary reason for home health care. The encounter must take place in the 90 days preceding or 30 days following the initiation of home health care. An encounter through telehealth services may satisfy the requirement.

In 2020, CMS implemented major changes required by the Bipartisan Budget Act (BBA) of 2018: a new 30-day unit of payment and elimination of the number of in-person therapy visits as a factor in the case-mix system. CMS implemented the BBA of 2018 policies through a new case-mix system, the Patient-Driven Groupings Model (PDGM). Payments for a 30-day period are adjusted by the case-mix system to account for differences in patient severity. If beneficiaries need additional home health services at the end of the initial 30-day period, another period commences, and

Medicare makes an additional payment. Coverage for additional periods generally has the same requirements as the initial period (i.e., the beneficiary must be homebound and need skilled care).² Thirty-day periods with relatively few visits are paid on a per visit basis through a low-use payment adjustment (LUPA); the threshold for the LUPA varies from two to five in-person visits, depending on the payment group to which a 30-day period has been assigned. Full 30-day periods—periods that meet or exceed the LUPA threshold—receive the full case-mix-adjusted 30-day payment under the PDGM. These periods accounted for about 93 percent of volume in 2024 (about 7 percent of 30-day periods were subject to the LUPA).

The BBA of 2018 requires that the Commission assess the impact of the changes to the home health PPS on agency payments and costs and on the delivery and quality of care. The Act also requires the Commission to provide interim and final reports to the Congress. In March 2022, the Commission submitted its interim report, which described recent changes in use and costs of care that occurred in 2020 but noted that any observed initial impact of the new payment system was confounded by the disruptions associated with the coronavirus public health emergency (Medicare Payment Advisory Commission 2022). The Commission's final report examining the impact of the BBA of 2018 changes is in Chapter 14 of this report to the Congress.

Home health payments have historically been high relative to costs

Since the implementation of the home health PPS, FFS Medicare payments for home health care have consistently exceeded costs. In 2001—the first year of the PPS—freestanding HHAs reported an average FFS Medicare margin of 23 percent.³ (The FFS Medicare margin measures how an agency's revenue from FFS Medicare patients compares with the cost of providing their care.) Although the PPS payment update has been reduced multiple times since 2001, these adjustments have not fully addressed the excess payment levels. In addition, HHAs have been able to mitigate cost increases by reducing the number of in-person visits provided. From 2001 through 2023, the average FFS Medicare margin remained high at 17.2 percent.

While the changes required by the BBA of 2018 substantially altered the home health PPS, they

were not designed to change the overall level of FFS Medicare's payments for home health care services. The Act requires CMS to set the base rate for the PDGM at a level that is budget neutral relative to 2019, when the FFS Medicare margin for freestanding agencies was 15.4 percent.

Are FFS Medicare payments adequate in 2026?

To examine the adequacy of FFS Medicare's payments for home health care, we assess beneficiary access to care (by examining the supply of home health providers and annual changes in the volume of services); quality of care; access to capital; and the relationship between Medicare's payments and providers' costs. Overall, the payment-adequacy indicators for home health care are positive.

Beneficiaries' access to care: Supply of agencies and utilization did not change substantially in 2024

The number of HHAs is one indicator of the overall size of the industry, but it is a limited measure of capacity. HHAs can vary in size and the services they provide. Also, because home health care is not provided in a medical facility, HHAs can adjust their service areas and capacity as local conditions change. Even the number of staff directly employed by an HHA may not be an effective measure of the supply of home health care because HHAs can use contract staff to meet their patients' needs. The presence of a provider also does not measure an HHA's ability to take additional patients. For other Medicare providers, such as inpatient hospitals and skilled nursing facilities (SNFs), administrative data are available to measure occupancy, such as the share of their beds that are occupied for a given period, to assess their available capacity. However, a similar measure is not available for home health care.

Supply of HHAs did not change substantially, and almost all beneficiaries live in an area served by at least one home health agency

In 2024, 97 percent of FFS beneficiaries lived in a ZIP code served by two or more HHAs, and 86 percent lived in a ZIP code served by five or more agencies.

The number of HHAs active in a ZIP code may not be a complete measure of access, but it does provide a baseline of how the supply of providers is distributed relative to the FFS Medicare population. This definition may overestimate the local supply of agencies because HHAs need not serve the entire ZIP code to be counted as serving it, and this measure does not assess the capacity of agencies relative to beneficiary demand (i.e., agencies may not have capacity to serve additional beneficiaries who require home health care).⁴ At the same time, the definition may understate local supply if HHAs are willing to serve a ZIP code but did not receive a request to do so in the previous 12 months. The analysis excludes beneficiaries with unknown ZIP codes.

From 2019 to 2024, the number of HHAs certified to participate in Medicare increased by over 870 HHAs, or almost 8 percent, climbing about 1.5 percent per year, on average; but this increase was driven entirely by growth in the number of HHAs in California, which nearly doubled over the time period (Table 8-1). The number of HHAs in California climbed 14.6 percent per year, on average, from 2019 to 2023, and an additional 269 HHAs were certified to participate in Medicare in 2024. Meanwhile, HHA supply for states and territories excluding California declined by about 1 percent per year, on average, from 2019 to 2024.

The Commission's examination of HHAs includes all providers approved by CMS to participate in Medicare, but not all approved HHAs necessarily serve FFS Medicare beneficiaries. Approval means the HHA meets federal requirements and is eligible to bill FFS Medicare, yet participation depends on the agency's business model and patient mix. Certain agencies may focus on private-pay clients or those covered by other insurance plans, even though they hold Medicare certification. As a result, some of the HHAs included in our counts do not serve FFS Medicare beneficiaries.

Most of the growth in HHAs in California has been concentrated in Los Angeles County—an area previously identified as a major hotspot for fraud, waste, and abuse in hospice services under Medicare. A 2022 report by the California State Auditor found that “growth in the number of hospice agencies in Los Angeles County has vastly outpaced the need for

**TABLE
8-1**

Recent increase in home health agencies reflects significant growth in California

							Average annual percent change	Percent change
	2019	2020	2021	2022	2023	2024	2019– 2023	2023– 2024
Participating home health agencies								
Nation (all states and territories)	11,356	11,386	11,506	11,657	12,057	12,234	1.5%	1.5%
States and territories excluding California	9,823	9,691	9,665	9,257	9,412	9,320	–1.1	–1.0
California only	1,533	1,695	1,841	2,400	2,645	2,914	14.6	10.2

Source: MedPAC analysis of the CMS Provider of Services file.

hospice services” (Auditor of the State of California 2022, Centers for Medicare & Medicaid Services 2023). The sustained, multiyear increase in HHAs in the same county may raise similar concerns.

The California state auditor’s report on hospice noted that home health agencies were operating in the same areas of Los Angeles County that were identified as having a “suspiciously high number of hospice agencies” (Auditor of the State of California 2022). For example, the report highlighted a 22,500-square-foot office building that housed the corporate offices of 112 hospice agencies and 49 HHAs. The auditor concluded that “based on the size of the building and our observations from visiting the building, there does not appear to be space for more than a total of 150 hospice agencies, home health agencies, and other businesses in the building.” The report also flagged irregularities in inspections of HHAs conducted by the California Department of Public Health in Los Angeles County. These inspections revealed issues such as HHA staff being unavailable and patients being admitted without their knowledge or without meeting eligibility requirements for services. Industry stakeholders have also expressed concern about potential home health fraud in Los Angeles County and have urged CMS to investigate aberrant trends and take appropriate action to address program-integrity issues (Berger 2025, LeadingAge 2025, National Alliance for Care at Home 2025).

Home health care spending in Los Angeles County has risen alongside rapid HHA growth. In 2024, the county accounted for \$1.4 billion—about 9 percent of total FFS home health care expenditures—even though it represents only about 2 percent of FFS Medicare beneficiaries. That year, approximately 16 percent of FFS Medicare beneficiaries in Los Angeles County received home health services—more than double the national average. It is unclear whether higher FFS Medicare home health spending reflects substitution for more costly care. For example, SNF care may be an alternative for some posthospital home health users, yet the share of FFS Medicare beneficiaries with a SNF stay in Los Angeles County was 4.9 percent in 2023, compared with a national average of 4.0 percent.

Another unusual trend in Los Angeles County is the significant number of HHAs that serve only FFS Medicare beneficiaries. Typically, HHAs serve a mix of Medicare Advantage (MA) and FFS Medicare beneficiaries, reflecting local enrollment patterns. But in Los Angeles County, more than 400 HHAs in 2022 served only FFS Medicare beneficiaries—about 38 percent of HHAs in the county (the remaining 62 percent served a mix of FFS and MA beneficiaries).⁵ Nationwide, HHAs serving only FFS Medicare beneficiaries accounted for just 8 percent of agencies. This finding is particularly striking because the share of beneficiaries enrolled in MA in Los Angeles County was 61.5 percent in 2023, higher than the national average.

**TABLE
8-2**

In 2024, the share of FFS Medicare beneficiaries receiving home health care was steady

FFS Medicare volume	2019	2020	2021	2022	2023	2024	Average annual percent change	Percent change
							2019–2023	2023–2024
FFS users of home health (in millions)	3.3	3.1	3.0	2.8	2.7	2.7	–4.7%	–2.1%
Share of FFS Medicare beneficiaries using home health care	8.5%	8.1%	8.3%	8.0%	7.9%	7.9%	–2.1	1.0
30-day periods (in millions)	N/A	N/A	9.3	8.6	8.3	8.3	N/A	–0.5
30-day periods per 100 FFS Medicare beneficiaries	N/A	N/A	25.5	24.3	24.1	24.7	N/A	2.6
30-day periods per FFS Medicare beneficiary who received home health care	N/A	N/A	3.1	3.0	3.1	3.1	N/A	1.6

Note: FFS (fee-for-service), N/A (not applicable). CMS implemented a 30-day period as the unit of payment in 2020, so no data on 30-day periods are available for 2019. Not all claims in January and February of 2020 were paid under the new Patient-Driven Groupings Model, so we do not have a full year of data on 30-day periods for 2020. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of home health standard analytic files and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

While many factors can affect the mix of beneficiaries an HHA serves, it is unclear why the rate of FFS-only HHAs is so high in this county.

The substantial growth in HHAs within an area associated with hospice-related fraud, the higher-than-average home health utilization and spending, findings from the California State Auditor and the Department of Public Health, and concerns raised by industry stakeholders all indicate an aberrant pattern of home health care supply and utilization in Los Angeles County. Further investigation may be warranted to determine whether these trends stem from program-integrity issues.

In prior years, CMS has addressed rapid growth in HHAs by establishing a moratorium on enrollment of new HHAs, but no moratoriums are in effect in Los Angeles County or other areas. In addition, a moratorium does not address activities by HHAs that

have already begun operation, but another program—the Review Choice Demonstration (RCD)—may offer an alternative. Under the RCD, HHAs are subject to a review of their claims and can select either prepayment or postpayment review. Agencies that maintain high compliance can transition to less frequent reviews. The RCD currently applies to HHAs operating in Florida, Illinois, North Carolina, Ohio, Oklahoma, and Texas through 2029.

Utilization of home health care did not change substantially in 2024

Between 2019 and 2023, the number of FFS users of home health declined almost 5 percent per year, on average, as enrollment shifted from FFS to MA and fewer FFS beneficiaries used home health services (Table 8-2). However, in 2024, the share of FFS beneficiaries using home health increased slightly, rising 1.0 percent. Accounting for changes in FFS enrollment, the average number of thirty-day periods

**TABLE
8-3**

In 2024, use of home health by FFS Medicare beneficiaries was higher in urban counties

	30-day periods per 100 FFS Medicare beneficiaries
Urban counties	24.8
Rural counties	
All rural counties	21.7
In micropolitan statistical areas	22.1
Not in micropolitan statistical areas	23.1
Frontier (population density less than 6 people per square mile)	11.7

Note: FFS (fee-for-service). Rural counties are classified based on the boundaries of micropolitan statistical areas established by the U.S. Census Bureau. Under the Census Bureau's definition, micropolitan statistical areas are labor-market and statistical areas in the U.S. centered on an urban cluster (urban area) with a population of at least 10,000 but fewer than 50,000 people. Micropolitan statistical areas consist of the county or counties containing the core plus any other counties with strong commuting ties to the core counties.

Source: MedPAC analysis of home health standard analytic files and Common Medicare Environment file.

also increased slightly in 2024 to 24.7 thirty-day periods per 100 FFS Medicare beneficiaries. The intensity of use among those who received home health care remained relatively stable, with each user receiving approximately 3.1 thirty-day periods of care annually from 2021 to 2024 (Table 8-2). Understanding the trends in timely access to home health care after hospitalization is important, as some studies have demonstrated that delays in the initiation of home health care can lead to adverse outcomes (Smith et al. 2021, Topaz et al. 2022). The Commission plans to analyze these trends in future analyses.

Home health utilization was lower on a per capita basis in rural areas, averaging 21.7 thirty-day periods per 100 FFS Medicare beneficiaries in rural counties compared with 24.8 thirty-day periods per 100 FFS Medicare beneficiaries for urban counties in 2023 (Table 8-3). The average use in rural counties in micropolitan statistical areas was comparable with nonmicropolitan rural counties outside these areas. While rural frontier counties had the lowest use rate compared with other areas, it is notable that rural areas also include some of the highest-utilization counties in the country. For example in 2024, 22 of the 25 counties with the highest

frequency of 30-day periods per 100 FFS beneficiaries were classified as rural, demonstrating that rural areas, like urban areas, are a mix of high-utilization and low-utilization counties (data not shown).

In-person visits during a full 30-day period have declined since 2019 In 2024, there were 0.1 fewer visits per full 30-day period, or 1.6 percent fewer, relative to 2023 (Table 8-4, p. 262).⁶ Since 2019, the number of visits per full 30-day period declined 18.0 percent, or 1.8 visits. The decline occurred in two phases: In 2020, the first year of the PDGM, the number of in-person therapy (physical, occupational, and speech-language pathology) visits per full 30-day period declined by 1.0 visit (almost 20 percent). A decline in therapy visits was expected following the implementation of the new PDGM, which eliminated the number of therapy visits as a factor in payment, but utilization in this year was also disrupted by the coronavirus pandemic. After this initial decline, the number of in-person therapy visits per full 30-day period remained relatively steady through 2024. By contrast, there was little change in the number of skilled nursing visits per full 30-day period in 2020 relative to the prior year, but the number of these visits per 30-day period decreased by 0.5 visits from 2020 to 2024. (The number of medical

**TABLE
8-4**

Since 2020, the number of FFS home health in-person visits per full 30-day period has declined

Volume measure	2019	2020	2021	2022	2023	2024	Cumulative percent change 2019–2024	Percent change 2023–2024
Total in-person visits (in millions)	99.7	81.1	76.8	69.5	66.8	65.4	–34.4%	–2.1%
Total in-person visits per full 30-day period	10.2	9.2	8.8	8.6	8.5	8.4	–18.0	–1.6
In-person visits per full 30-day period by discipline:								
Physical therapy, occupational therapy, and speech–language pathology	4.9	3.9	3.9	4.0	3.9	3.8	–21.5	–2.2
Skilled nursing	4.6	4.6	4.3	4.1	4.1	4.1	–11.8	–0.6
Medical social services and home health aide	0.8	0.7	0.6	0.5	0.5	0.5	–41.6	–5.9

Note: FFS (fee for service). Home health services initiated in 2019 were paid under 60-day episodes. For this table, home health care services initiated in 2019 were recalculated as 30-day periods to provide comparable units of service in the later years. Thirty-day periods are included in the year that the period ended. A 30-day period is classified as “full” when the number of in-person visits meets or exceeds the threshold established for the payment group to which the 30-day period has been assigned (a number that ranges from two to five in-person visits). Visit counts have been rounded. Percentages were calculated on unrounded data.

Source: MedPAC analysis of 2019 home health Limited Data Set file and standard analytic files, 2019–2024.

social services and home health aide services per 30-day period, which make up a small fraction of total visits, declined by 0.3 between 2019 and 2024.)

Share of beneficiaries receiving home health care after hospitalization declined in the first 10 months of 2024

The share of hospital discharges to HHAs decreased to 18.0 percent in the first 10 months of 2024, but home health care remained the most frequent formal post-acute care (PAC) site used after discharge (Table 8-5). Before the coronavirus pandemic, SNFs were the most frequent first PAC destination among beneficiaries receiving formal PAC, with home health care services being the second-most frequent. In 2020, the two sites of care switched ranks in their share of use after an inpatient hospital stay: Use of SNF services after hospitalization fell, and use of home health care after hospitalization climbed. Since then, the share of inpatient prospective payment systems (IPPS) discharges to SNFs has increased, and the share discharged to home health care has decreased. Even so, the share of FFS Medicare beneficiaries receiving home

health care after IPPS discharge in the first 10 months of 2024 was 2.2 percentage points higher than the 2019 rate (Table 8-5).

Telehealth and remote patient-monitoring services are covered under the home health care benefit but were not used by many FFS Medicare beneficiaries in 2024

Under the Medicare home health benefit, HHAs are permitted to provide two types of digital services: audio or video telehealth visits and remote patient monitoring. Though these services have been covered for several years, HHAs began mandatory reporting for digital services initiated on or after July 1, 2023.

The claims data for 2024 indicate that 2.2 percent of 30-day periods included a telehealth visit or remote patient monitoring. About 12 percent of HHAs reported providing at least one telehealth visit to a FFS Medicare beneficiary.⁷ There were about 375,000 telehealth visits in 2024, with skilled nursing care accounting for about 80 percent of the visits. The small number of telehealth services furnished (less than 1 percent of all visits), and

**TABLE
8-5**

FFS Medicare beneficiaries' first post-acute site after an IPPS hospital stay, 2019–2024

	2019	2020	2021	2022	2023	First 10 months of 2024
Total IPPS discharges (in millions)	9.0	7.5	7.1	6.8	6.8	5.6
Share of discharges with:						
No PAC service after discharge	60.8%	59.0%	58.6%	58.4%	58.8%	58.7%
At least one PAC service (skilled nursing facility, home health care, inpatient rehabilitation facility, or long-term acute care hospital)	39.1	41.0	41.4	41.6	41.2	41.3
First PAC site following IPPS discharge (as share of total discharges):						
Skilled nursing facility	18.7	15.9	16.6	17.4	17.3	17.3
Home health agency	15.8	20.1	19.6	18.6	18.1	18.0
Inpatient rehabilitation facility	3.7	4.1	4.4	4.7	5.0	5.3
Long-term acute care hospital	0.9	1.0	0.8	0.8	0.8	0.7

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), PAC (post-acute care). MedPAC reports the first 10 months of 2024 because some home health claims that followed the IPPS discharges in the last two months of that year are not available for analysis.

Source: MedPAC analysis of Medicare Provider Analysis and Review and home health standard analytic file.

the limited number of HHAs providing them, indicates that most clinical care in the home health benefit is still provided in person.

Quality of care: Discharge to the community and potentially preventable readmissions

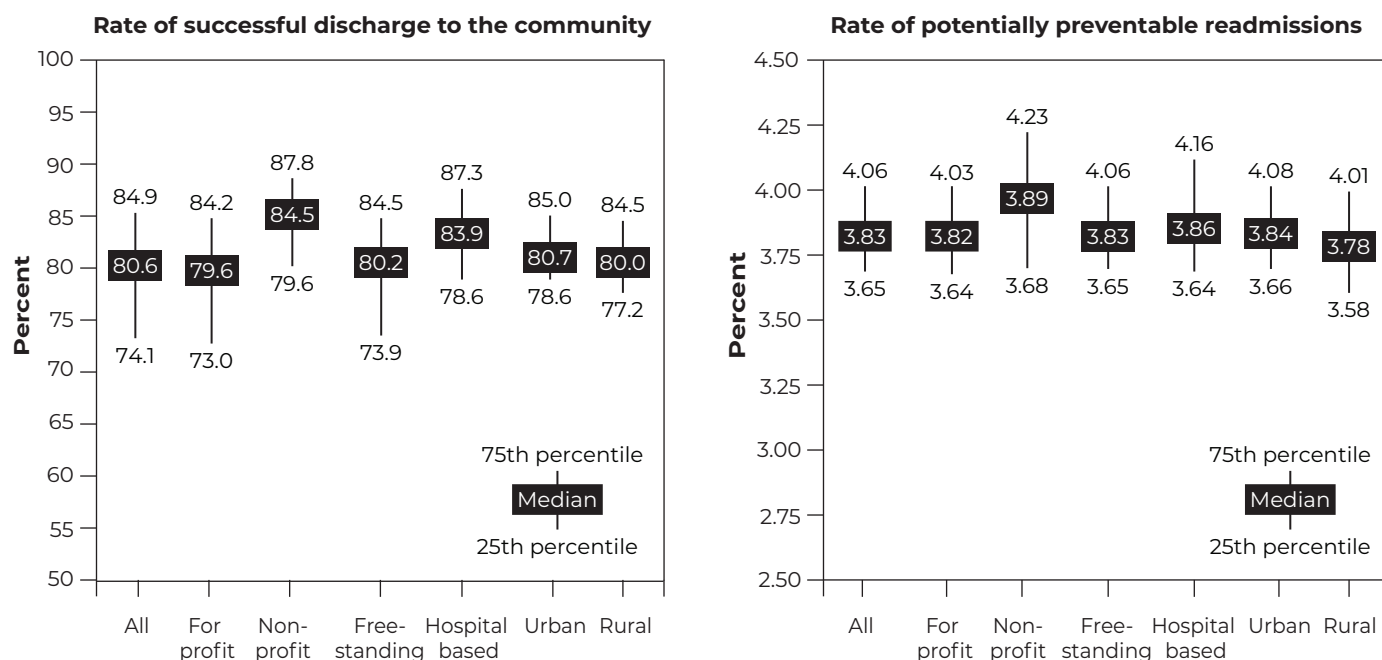
The Commission prioritizes quality measures tied to clinical outcomes in our assessment of payment adequacy. We report two outcome measures for HHAs: risk-adjusted potentially preventable hospital readmissions after discharge and risk-adjusted discharge to the community. The quality measure of the return to home or community shows the rate at which patients stay home and remain alive without any unplanned hospitalizations in the 31 days following discharge from the HHA (higher rates are better). This rate includes both community-admitted and posthospital home health beneficiaries. The median rate of discharge to the community increased from

79.3 percent in the period from January 1, 2021, to December 31, 2022 (data not shown), to 80.6 percent in the period from January 1, 2022, to December 31, 2023 (Figure 8-1, p. 264). The interquartile range varied more than 10 percentage points: HHAs at the 25th percentile and 75th percentile had rates of 74.1 percent and 84.9 percent, respectively (Figure 8-1, first graph). For-profit HHAs had a lower median rate of discharge to the community in 2023 compared with nonprofit HHAs.

Potentially preventable readmissions after discharge are calculated as the percentage of patients discharged from home health care services who were readmitted to a hospital for a medical condition that might have been prevented in the 30-day period beginning 2 days after the end of home health care services (lower percentages are better; a home health stay had to be preceded by a hospital stay to be included in this measure). From January 1, 2021, to December 31, 2023, the median rate of home health stays with a potentially

FIGURE 8-1

Median and interquartile ranges of HHAs' risk-standardized rates of successful discharge to community and potentially preventable readmissions



Note: HHA (home health agency). The measure of “successful discharge to the community” is an HHA’s risk-adjusted rate of fee-for-service (FFS) patients who were discharged to the community after a home health stay, did not have an unplanned admission to an acute care or long-term care hospital in the 31 days following discharge, and remained alive during those 31 days. All FFS Medicare patients, regardless of whether the home health stay was preceded by a hospitalization, are included in the calculation of the measure. Higher rates are better. The measure of “potentially preventable readmission” is calculated only for FFS home health patients who had an acute inpatient discharge within the five days before the start of their home health stay. The measure is calculated as the risk-adjusted percentage of those patients who were readmitted to an acute care hospital for a medical condition that might have been prevented in the 30-day period that begins 2 days after the end of the home health stay. Lower rates are better. Data for “successful discharge” cover the two-year period from January 1, 2022, to December 31, 2023; data for potentially preventable readmissions cover the 36-month period from January 1, 2021, to December 31, 2023.

Source: MedPAC analysis of claims-based outcome measures from the Provider Data Catalog.

preventable readmission was 3.83 percent. The median rates of potentially preventable rehospitalization did not differ substantially across ownership categories or facility type. In the January 1, 2021, to December 31, 2023, period, potentially preventable rehospitalization rates varied across the 25th and 75th percentiles with rates of 3.65 percent and 4.06 percent, respectively (Figure 8-1, right figure).

Maintaining and improving patients’ function is a key outcome of post-acute care. HHAs assess and record information on each beneficiary’s level of function at

admission to and discharge from an HHA using the Outcome and Assessment Information Set (OASIS) patient-assessment instrument. However, because provider-reported function data are used to assign patients to case-mix groups to adjust payment, the Commission and others have raised concerns about the validity of the provider-reported patient-assessment information (see discussion in Chapter 6 of this report).

Patient-experience measures remained stable

HHAs collect Home Health Care Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS)

**TABLE
8-6**

Most patient-experience measures did not change in 2024

HH-CAHPS measure	2019	2020	2021	2022	2023	2024	Percentage point change	
							2019–2023	2023–2024
Share of patients rating the HHA a 9 or 10 out of 10	84%	N/A	84%	84%	85%	85%	1	0
Share of patients who would definitely recommend the home health agency to friends or family	78	N/A	77	78	78	79	0	1
Share of patients who reported that their home health provider:								
Gave care in a professional way	88	N/A	88	88	88	89	0	1
Communicated well with them	85	N/A	85	85	86	86	1	0
Discussed medicines, pain, and home safety with them	83	N/A	81	82	82	82	–1	0

Note: HH-CAHPS (Home Health Consumer Assessment of Healthcare Providers and Systems), HHA (home health agency), N/A (not applicable). HH-CAHPS is a standardized survey of patients' evaluations of home health. The survey items are combined to calculate measures of patient experience for each HHA. Each year's results are based on a sample of surveys of HHAs' patients from January to December. CMS did not collect HH-CAHPS data for the first six months of 2020 due to the coronavirus public health emergency. Data include fee-for-service Medicare, Medicare Advantage, and Medicaid beneficiaries.

Source: CMS summary of HH-CAHPS public report of survey results tables.

surveys from a sample that includes FFS Medicare, MA, and Medicaid patients served by HHAs. The HH-CAHPS measures key components of quality by assessing whether something that should happen during a stay (such as clear communication) actually happened. These data include both posthospital and community-admitted home health beneficiaries.

HH-CAHPS ratings in 2024 were relatively stable compared with prior years, and most patients reported high rates of positive responses.⁸ (Data for 2020 are unavailable because CMS waived the requirement to collect HH-CAHPS data for the first six months of 2020 due to the coronavirus public health emergency.) The share of patients reporting (1) that they would definitely recommend their HHA to friends or family and (2) that their HHA provided care in a professional way increased by 1 percentage point in 2024 (Table 8-6).

Providers' access to capital is adequate

HHAs are not as capital intensive as other providers because they do not require extensive physical infrastructure, and many are too small to attract interest from capital markets. Yet indicators suggest that HHAs have adequate access to capital. One measure the Commission assesses is the overall profitability of HHAs, which examines the profitability for all health care payers that HHAs serve (including FFS Medicare, MA, and other payers). In 2024, the all-payer margin for freestanding HHAs was 5.0 percent, indicating that many HHAs yield positive financial results that should appeal to capital markets. Few HHAs access capital through publicly traded shares or through public debt such as issuance of bonds.

While there has been significant acquisition activity by the larger for-profit firms in recent years, there

TABLE
8-7

FFS Medicare spending for home health care was steady in 2024

							Average annual percent change	Percent change
FFS Medicare volume	2019	2020	2021	2022	2023	2024	2019–2023	2023–2024
Total payments (in billions)	\$17.9	\$17.1	\$16.9	\$16.2	\$15.9	\$16.0	–3.0%	1.1%
Payment per FFS Medicare user of home health care	5,437	5,591	5,587	5,703	5,839	6,031	1.8	3.3
Average payment per full 30-day period	N/A	N/A	1,945	2,010	2,024	2,057	N/A	1.6
Medicare payment per in-person visit	180	211	220	232	237	245	7.2	3.3

Note: FFS (fee-for-service), N/A (not applicable). CMS implemented a 30-day period as the unit of payment in 2020, so no data on 30-day periods are available for 2019. Not all claims in January and February of 2020 were paid under the new Patient-Driven Groupings Model, so we do not have a full year of data on 30-day periods for 2020. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of home health standard analytic files

have been notable swings in the number of HHAs purchased by investors since 2020. In 2021 and 2022, the reported number of investor purchases increased relative to prior years, with the number of transactions lower in 2023 and 2024 (Braff Group 2024). This change may reflect several factors, such as (1) higher interest rates reducing demand from investors for acquisition, (2) large insurers having completed substantial acquisitions that met their needs for capacity in this sector, and (3) changes in the home health market such as increasing MA enrollment or the BBA of 2018 budget-neutrality adjustments to FFS Medicare payments.

Even with the decrease in interest since 2023, some firms continue to expand their operations. For example, in 2025, Addus Homecare completed a \$21.3 million acquisition of home health and hospice agencies in Pennsylvania (Mertz-Taggart 2025). The Pennant Group also acquired several new agencies in California and completed a \$146.5 million acquisition of HHAs from UnitedHealth Group (Marselas 2025). These acquisitions suggest that, while the overall volume of acquisitions has declined, access to capital is adequate for companies that seek to expand.

Some of the largest publicly traded HHA companies have been acquired in recent years. In 2021, Humana completed its purchase of Kindred at Home (Waddill 2021). In 2023, Optum Health Care, a subsidiary of UnitedHealth Group, completed its purchase of LHC Group, and in 2025, Optum Health Care finalized its purchase of Amedisys (Emerson 2025). According to industry analysts, these acquisitions reflect several trends, including efforts to expand population-based health care services, better management of spending and utilization of home health care services, and capturing revenues that are paid to providers for services to plan beneficiaries (Irving Levin Associates LLC 2023, Pifer 2023). The acquisitions suggest that large investors viewed the publicly traded for-profit HHAs, which receive a significant share of their revenues from FFS Medicare, as attractive investments.

Medicare payments and providers' costs: FFS Medicare margins remain historically high

The FFS Medicare margin for freestanding HHAs rose to 21.2 percent in 2024, up 1.4 percentage points since 2023. This increase reflects growth in the average

**TABLE
8-8****FFS Medicare margins for freestanding home health agencies, 2019–2024**

	2019	2020	2021	2022	2023	2024	Share of home health agencies, 2024	Share of 30-day periods, 2024
All	15.4%	20.2%	24.9%	22.2%	19.8%	21.2%	100%	100%
Geography								
Majority urban	16.1	20.0	24.8	22.3	20.0	21.3	86	87
Majority rural	14.2	21.6	25.2	22.0	18.6	20.5	14	13
Type of ownership								
For profit	17.4	22.7	26.1	23.6	21.2	23.1	93	86
Nonprofit	11.4	12.4	20.2	16.4	13.3	12.2	7	14
Volume quintile								
First (smallest)	9.7	11.6	14.0	13.7	12.5	14.4	20	3
Second	11.4	14.0	15.9	14.5	13.7	15.1	20	7
Third	13.3	17.0	19.3	17.0	14.5	17.6	20	11
Fourth	14.1	18.8	22.8	21.0	19.0	20.3	20	19
Fifth (largest)	17.5	22.4	28.3	24.8	22.1	23.2	20	60

Note: FFS (fee-for service). Home health agencies (HHAs) were classified as “majority urban” if they provided more than 50 percent of episodes to beneficiaries in urban counties, and they were classified as “majority rural” if they provided more than 50 percent of episodes to beneficiaries in rural counties. These data do not include federal provider relief funds that HHAs received due to the coronavirus pandemic. Percentage changes were calculated on unrounded data. Percentages may not sum to 100 due to rounding.

Source: MedPAC analysis of Medicare home health cost report files from CMS.

payment per 30-day period since costs remained relatively stable. These margins indicate that FFS Medicare payments in 2024 far exceeded costs, as they have for more than 20 years.

Trends in FFS spending and cost growth

In 2024, aggregate FFS Medicare payments for home health care totaled \$16.0 billion, remaining essentially unchanged from the previous year (Table 8-7). This stability marks a shift from 2019 to 2023, when total FFS Medicare payments declined. However, when adjusting for changes in FFS enrollment and the number of beneficiaries receiving home health care, payments have generally increased since 2019, with the average payment per full 30-day period increasing by 1.6 percent in 2024. As the number of in-person visits per 30-day period has declined, the average Medicare FFS

payment per in-person home health visit has grown substantially, rising from \$180 per visit in 2019 to \$245 per visit in 2024.

Cost per full 30-day period increased by just 0.2 percent in 2024, lower growth than in previous years, as higher average costs per visit were largely offset by the reduction in the number of visits per 30-day period (data not shown).

The FFS Medicare margin for freestanding HHAs was over 20 percent in 2024

In 2024, the FFS Medicare margin for freestanding HHAs was 21.2 percent, with wide variation across HHAs (Table 8-8). The margin ranged from 5.7 percent for the HHA at the 25th percentile to 31.0 percent for the HHA at the 75th percentile of the

**TABLE
8–9****Home health PPS payment policy changes in 2025 and 2026**

	2025	2026
Home health PPS policy changes:		
Home health market basket	3.2%	3.2%
Productivity	–0.5	–0.8
Budget-neutrality adjustment under BBA of 2018	–1.975	–3.6
Outlier threshold adjustment	–0.4	–0.5
Total	0.4	–1.4

Note: PPS (prospective payment system), BBA (Bipartisan Budget Act). The impact of the budget-neutrality adjustment applies to all 30-day periods without the low-use payment adjustment (LUPA), and so the net reduction on aggregate payments (which include both LUPA and non-LUPA periods) for 2025 and 2026 is less than the reduction to the base rate.

Source: MedPAC analysis of home health final rule for 2025 and final rule for 2026.

margin distribution (data not shown). Agencies with higher volume had better financial results, likely reflecting the economies of scale possible for larger operations. For example, the FFS Medicare margin for HHAs in the bottom quintile of volume averaged 14.4 percent, compared with 23.2 percent for HHAs in the top quintile of volume. While agencies' financial performance varies, FFS Medicare payments are generally well in excess of HHA costs. While home health care is a valuable service when provided appropriately and efficiently, these overpayments have consequences for the Medicare program since they increase the financial pressure on the Medicare trust funds and raise Part B premiums paid by Medicare beneficiaries.

In 2024, the average FFS Medicare margin for hospital-based HHAs was –15.2 percent. The lower FFS Medicare margins of hospital-based HHAs are attributable chiefly to their higher costs, some of which are a result of overhead costs allocated to the HHA from its parent hospital. Hospital-based HHAs help their parent institutions financially if they can shorten inpatient stays, lowering costs in the inpatient hospital setting.

FFS Medicare margin for 2026 projected to decline relative to 2024 but remain high

In projecting 2026 FFS Medicare margins, we incorporate policy changes that will go into effect between the year of our most recent data, 2024, and the year for which we are making the margin

projection, 2026. Table 8–9 shows the major payment-policy changes finalized in 2025 and 2026, including the reductions mandated by the BBA of 2018.

Under the BBA of 2018, CMS is required to make permanent adjustments (increases or decreases) when it estimates that home health care spending will deviate from the level expected absent changes made by the BBA of 2018. The statute requires temporary (one-year) adjustments when CMS identifies overpayments or underpayments that occurred in a prior year. In the 2026 home health final rule, CMS implemented a permanent 1.023 percent reduction to the base rate to align with the BBA of 2018 budget-neutrality target for 2026 and future years, and a temporary 3 percent reduction for the 2026 rate year to address spending above the target from 2020 to 2024.

In projecting the 2026 FFS Medicare margin, we also make an estimate of cost growth between 2024 and 2026. The annual increase in cost per 30-day period has fluctuated significantly since the PDGM was implemented. In 2021, the cost per 30-day period declined by 2.9 percent, while in 2022 and 2023, the cost per 30-day period increased by about 3.4 percent each year. As noted earlier, the cost per full 30-day period increased by just 0.2 percent in 2024.

We project that the FFS Medicare margin for freestanding HHAs in 2026 will be 19 percent.

How should FFS Medicare payments change in 2027?

Under current law, FFS Medicare's payment rates to HHAs are increased annually based on the projected increase in the HHA market basket, less an amount for productivity improvement. CMS will revise its estimates before setting rates for 2027; however, CMS's third-quarter 2025 projections indicate a 2.3 percent payment update in 2027 (an estimated market basket increase of 3.1 percent minus a productivity adjustment of 0.8 percent). The payment-adequacy indicators for Medicare home health services are positive and show that FFS Medicare payments continue to substantially exceed costs, as they have for many years. These excess payments do not accrue to the advantage of beneficiaries or the FFS Medicare program. Further, excessive FFS Medicare payments reduce the incentives for HHAs to furnish care efficiently.

As discussed above, for 2026 CMS implemented the BBA of 2018–required reduction to the 30-day period base rate to maintain budget neutrality after implementation of the PDGM classification system and associated changes to the PPS required by the BBA of 2018. Our margin estimate for 2026 includes the effects of this policy; even after this reduction, FFS Medicare payments to HHAs would remain far above costs.

RECOMMENDATION 8

For calendar year 2027, the Congress should reduce the 2026 Medicare base payment rate for home health agencies by 7 percent.

RATIONALE 8

Home health care can be a high-value benefit when it is appropriately and efficiently delivered. Home health care can be provided at lower costs than institutional care, and Medicare beneficiaries often prefer to receive care at home. However, FFS Medicare's payments for home health services are too high, and payments need to be reduced to align aggregate payments more closely with aggregate costs. FFS Medicare has overpaid for home health care since the inception of the prospective payment system in 2000, and these overpayments create higher expenditures for the taxpayers and the Medicare program. The FFS Medicare margin was 21.2 percent in 2024. We project

that, after CMS implements the BBA of 2018–required adjustments to the base payment rate, the FFS Medicare margin will be 19 percent in 2026.

This recommendation is not intended to be additive to the BBA of 2018 adjustments. Under this recommendation, the base rate for 2027, net of all payment changes, would be 7 percent lower than the 2026 base rate.

IMPLICATIONS 8

Spending

- Current law is expected to increase payment rates by 2.3 percent in 2027. This recommendation would decrease federal program spending by \$750 million to \$2 billion over one year and by \$10 billion to \$25 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries' access to home health care. Given the current level of payments, we do not expect the recommendation to affect providers' willingness or ability to care for FFS Medicare beneficiaries. ■

Endnotes

- 1 The Medicare statute permits nurse practitioners, clinical nurse specialists, and physician assistants to order and supervise home health care services. State laws on medical scope of practice also govern the services these practitioners are permitted to deliver and may limit the ability of some nonphysician practitioners to order home health care.
- 2 An overview of the home health PPS is available at https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_HHA_FINAL_SEC.pdf.
- 3 Freestanding HHAs, which constituted about 95 percent of HHAs in 2024, are not owned or operated by a hospital or other health care facility. The Commission's analysis of financial performance focuses on freestanding agencies because the cost structure of facility-based HHAs may include overhead costs from parent facilities that do not reflect the cost of providing care.
- 4 As of November 2025, this measure of access is based on data collected and maintained as part of CMS's Home Health Compare database. The service areas listed are ZIP codes in which an HHA has provided services in the past 12 months.
- 5 MedPAC assessed the trends in volume by analyzing the Outcome and Assessment Information Set, Medicare Advantage, and FFS Medicare data for each provider, similar to the approach in our June 2024 report to the Congress (Medicare Payment Advisory Commission 2024).
- 6 A 30-day period is classified as "full" when the number of in-person visits meets or exceeds the threshold established for the payment group to which the 30-day period has been assigned (a number that ranges from two to five in-person visits).
- 7 Remote patient monitoring is also covered under the FFS Medicare home health benefit, though these services were provided in only 0.1 percent of 30-day periods in 2024.
- 8 CMS reported a 23 percent response rate for the HH-CAHPS in 2024.

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C H A P T E R

9

Inpatient rehabilitation facility services

R E C O M M E N D A T I O N

- 9** For fiscal year 2027, the Congress should reduce the 2026 Medicare base payment rate for inpatient rehabilitation facilities by 7 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Inpatient rehabilitation facility services

Chapter summary

Inpatient rehabilitation facilities (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 fiscal year (FY) 2024, the fee-for-service (FFS) Medicare program and its beneficiaries spent \$11.0 billion on about 435,000 IRF stays in about 1,170 IRFs nationwide. FFS Medicare beneficiaries accounted for about 51 percent of IRF stays.

Assessment of payment adequacy

The indicators of FFS Medicare payment adequacy for IRFs were generally positive.

Beneficiaries’ access to care—Indicators of IRF capacity and supply and FFS Medicare beneficiaries’ volume of IRF stays show that access remains adequate.

- **Capacity and supply of providers**—Between FY 2023 and FY 2024, IRFs’ available capacity and supply of IRFs remained relatively stable. IRFs’ occupancy rate remained below capacity (71 percent), indicating

In this chapter

- Are FFS Medicare payments adequate in 2026?
- How should FFS Medicare payments change in 2027?

capacity was more than adequate to meet demand. The number of IRFs increased slightly, driven by growth in freestanding and for-profit IRFs.

- **Volume of services**—FFS beneficiaries used notably more IRF services in FY 2024. From 2023 to 2024, the total number of FFS Medicare stays in IRFs increased by about 8 percent, and stays per FFS beneficiary increased by about 10 percent. In 2024, the average length of stay was 12.4 days, similar to the level in 2023.

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 FY 2026, we project that IRFs' FFS Medicare margin will increase to about 18 percent.

How should payment rates change in 2027?

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 prospective payment system payment rates closer to the cost of efficiently delivering high-quality care. ■

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. Such providers include inpatient rehabilitation facilities (IRFs), which provide intensive rehabilitation care after illness, injury, or surgery, including services such as physical and occupational therapy, rehabilitation nursing, and speech-language pathology.¹

Background

IRFs must be focused primarily on treating conditions that typically require intensive rehabilitation, among other requirements. IRFs can be fully licensed freestanding hospitals or hospital-based units within general or other hospitals. To qualify for a covered IRF stay, a FFS Medicare beneficiary must, among other criteria, be able to tolerate and benefit from intensive therapy and must have a condition that requires frequent, face-to-face supervision by a rehabilitation physician. FFS Medicare makes payments for inpatient IRF services under the IRF prospective payment system (PPS).² In fiscal year (FY) 2024, about 1,170 IRFs furnished about 435,000 FFS Medicare-covered stays. FFS Medicare spending on IRF services was \$11.0 billion (\$10.8 billion in program spending and \$0.2 billion in beneficiary cost-sharing liability). FFS Medicare beneficiaries accounted for about 51 percent of IRF stays.³

Medicare facility requirements for IRFs

IRFs must meet the requirements to be a hospital or be a unit within a hospital meeting the hospital requirements, but IRFs have additional requirements for payment. They must:

- have a preadmission screening process to determine that each prospective patient is likely to benefit significantly from an intensive inpatient rehabilitation program;
- ensure that the patient receives close medical supervision and provide—through qualified personnel—rehabilitation nursing; physical therapy, occupational therapy, and, as needed, speech-language pathology services; psychological (including neuropsychological) services; social services; and orthotic and prosthetic services;

- have a medical director of rehabilitation with training or experience in rehabilitation who provides services in the facility on a full-time basis for freestanding IRFs or at least 20 hours per week for hospital-based IRF units;
- use a coordinated interdisciplinary team led by a rehabilitation physician that includes a rehabilitation nurse, a social worker or case manager, and a licensed therapist from each therapy discipline involved in the patient's treatment;
- have a plan of care for each patient, which is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; and
- meet the compliance threshold, which requires that no less than 60 percent of patients admitted to an IRF required intensive rehabilitation services for treatment of one or more of the 13 conditions, either as a principal diagnosis or comorbidity, specified by CMS.⁴ The intent of the compliance threshold is to distinguish IRFs from acute care hospitals (ACHs). If an IRF does not meet the compliance threshold, Medicare pays for all its patients' stays based on the inpatient hospital PPS rather than the IRF PPS.

Medicare coverage criteria for IRF PPS stays

Medicare applies additional criteria to specify whether IRF services are covered for an individual FFS Medicare beneficiary. For an IRF claim to be considered reasonable and necessary, the patient must be reasonably expected to meet the following requirements at admission:

- The patient requires active and ongoing therapy in at least two modalities, one of which must be physical or occupational therapy. The patient can actively participate in and benefit from intensive therapy that most typically consists of three hours of therapy a day at least five days a week.
- The patient is sufficiently stable at the time of admission to actively participate in the intensive rehabilitation program.
- The patient requires supervision by a rehabilitation physician. This requirement is satisfied by face-to-face physician visits with a patient at least three

days a week. Beginning with the second week of the IRF stay, a nonphysician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct one of the three required face-to-face visits with the patient per week, provided that such duties are within the nonphysician practitioner's scope of practice under applicable state law.

- The patient requires an intensive and coordinated interdisciplinary team approach to the delivery of rehabilitative care.

Are FFS Medicare payments adequate in 2026?

Based on the most recent available data, indicators of the adequacy of IRF PPS payments are generally positive. IRFs continued to have available capacity in aggregate, and the number of IRFs was relatively stable. Notably, the number of IRF stays per FFS Medicare beneficiary increased substantially in FY 2024. Our measures of quality of care were relatively stable. IRFs' access to capital improved: Freestanding IRFs' all-payer total margin increased, as did the all-payer margin of hospital-based IRFs' parent hospitals. IRFs' FFS Medicare margin rose more than 2 percentage points to 17.1 percent in FY 2024, and we project that it will increase to about 18 percent in FY 2026.

Beneficiaries' access to care: Beneficiaries maintained good access to IRF inpatient services in 2024

Relatively stable IRF capacity and supply and the growth in FFS Medicare beneficiaries' volume of services suggest that capacity in FY 2024 remained adequate to meet demand.

Occupancy rate and number of IRFs suggest adequate capacity and supply

IRFs' capacity increased in FY 2024, and IRFs maintained adequate available capacity. Nationwide, the number of IRF beds grew by about 3.5 percent in 2024. This increase was driven by an increase in beds in freestanding for-profit IRFs. Beds in hospital-based nonprofit IRFs were stable.⁵ Prior interviews with a small set of ACH discharge planners and executives regarding discharges to IRFs or skilled nursing facilities

(SNFs), interviewees did not distinguish between IRF services received in hospital-based or freestanding IRFs (L & M Policy Research 2023). Over this same period, the number of all-payer IRF stays grew slightly faster, resulting in IRFs' occupancy rate increasing slightly to 71 percent (compared with 69 percent in the prior year). The occupancy rate among freestanding IRFs rose from 73 percent to 74 percent, and among hospital-based IRFs, the aggregate occupancy rate rose from 65 percent to 67 percent. In general, larger IRFs had higher occupancy rates than smaller IRFs. These occupancy rates continue to indicate that capacity is adequate to meet demand for IRF services.

The supply of IRFs was relatively stable, increasing by less than 1 percent in FY 2024, to 1,169 (Table 9-1), consistent with the average annual change from 2019 through 2023. The vast majority of IRFs (88 percent) were located in urban areas, and the majority of IRFs (66 percent) were hospital based. Over 60 percent of IRFs in urban areas were hospital-based facilities compared with 90 percent of IRFs in rural areas (data not shown). Freestanding IRFs tended to be larger facilities compared with hospital-based IRFs: In FY 2024, 95 percent of freestanding IRFs had 25 or more beds, while most hospital-based IRFs (67 percent) had fewer than 25 beds (data not shown).

The growth in the number of IRFs in FY 2024 was driven by a 4.3 percent increase in both freestanding and for-profit IRFs (Table 9-1). In contrast, the number of hospital-based and nonprofit IRFs continued to decline, falling by 0.9 percent and 2.8 percent, respectively. The majority of new IRFs were freestanding for-profit facilities and opened in markets in which another IRF was already serving beneficiaries (data not shown). Half of the closures were nonprofit hospital-based facilities in areas with another IRF.

In a prior analysis the Commission found that, in 2022, less than 30 percent of hospital service areas (HSAs) had one or more IRFs (Medicare Payment Advisory Commission 2024).⁶ (By comparison, 97 percent of HSAs contained at least one SNF.) Of markets with IRFs, most had only hospital-based IRFs (67 percent) or only freestanding IRFs (18 percent), and about 15 percent had both types. Seventy percent of Medicare beneficiaries (including those in FFS and Medicare Advantage) lived in HSAs with IRFs; only about 30 percent of FFS Medicare beneficiaries lived in an HSA

**TABLE
9-1**

The supply of IRFs was relatively stable in FY 2024, but the number of for-profit and freestanding IRFs continued to grow

Type of IRF	Share of FFS Medicare stays, 2024	Number of IRFs						Average annual percent change 2019–2023	Percent change 2023–2024
		2019	2020	2021	2022	2023	2024		
All	100%	1,119	1,114	1,118	1,132	1,160	1,169	0.9%	0.8%
Type									
Freestanding	64	302	316	330	350	376	392	5.6	4.3
Hospital based	36	817	798	788	782	784	777	–1.0	–0.9
Ownership									
For profit	68	431	439	467	479	529	552	5.3	4.3
Nonprofit	27	575	562	544	542	531	516	–2.0	–2.8
Government	5	113	113	107	102	100	101	–3.0	1.0
Geography									
Urban	94	976	970	973	987	1,016	1,025	1.0	0.9
Rural	6	143	144	145	145	144	144	0.2	0

Note: IRF (inpatient rehabilitation facility), FY (fiscal year), FFS (fee-for-service). "Number of IRFs" refers to the count of IRF provider numbers that provided at least one inpatient service to a FFS Medicare beneficiary in that fiscal year. IRFs in Maryland that are paid under CMS's Maryland All-Payer Model are excluded. "Freestanding" and "hospital-based" designations reflect the IRF's Medicare provider number, with "hospital based" indicating a separately certified unit of another hospital. "Urban" refers to metropolitan counties, which contain an urban cluster of 50,000 or more people; all other counties are classified as "rural." Results differ from those published in prior years because of methodological updates, such as including IRFs that did not submit FFS Medicare claims. Components may not sum to totals due to missing data.

Source: MedPAC analysis of Medicare Provider Analysis and Review, hospital cost-report, Provider of Services, and census geographic data.

without an IRF. Some beneficiaries who lived in these HSAs traveled to other areas to receive IRF care or received rehabilitative care from other post-acute care (PAC) providers.

IRFs are intended to provide a more intense level of therapy under direct medical supervision, but other providers also furnish PAC services in communities with and without IRFs. SNFs provide PAC in an institutional setting, and home health agencies, hospital outpatient departments, comprehensive outpatient rehabilitation facilities, and independent therapy providers furnish such care at a beneficiary's home or on an outpatient basis. Given the number and distribution of these other providers, it is unlikely that IRFs are the only provider of PAC services available to Medicare beneficiaries in any given area.

Many providers and caregivers (such as therapists) use guidelines to make placement recommendations for beneficiaries needing rehabilitative care, but these are often based on Medicare coverage rules rather than on evidence of what practices result in the best outcomes for a given clinical condition. Few evidence-based guidelines exist to help beneficiaries and their clinicians choose the PAC setting that is best suited to their needs. For example, one study of patients treated for debility in IRFs concluded that more research was needed to identify the most appropriate rehabilitation setting for debility patients to achieve functional improvement (Kortebein et al. 2008). One exception is for stroke: Guidelines established by the American Heart Association/American Stroke Association outline

**TABLE
9-2****FFS Medicare beneficiaries' IRF stays per capita increased substantially in FY 2024**

	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
IRF inpatient stays (thousands)	404	374	373	376	404	435	0.0%	7.6%
IRF inpatient stays per 10,000 beneficiaries	107	101	104	109	120	132	2.8	9.7
Average length of stay (days)	12.6	12.9	12.9	12.8	12.5	12.4	–0.2	–0.7

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), FY (fiscal year). "Inpatient stays per 10,000 beneficiaries" refers to FFS Medicare inpatient stays divided by all FFS Medicare beneficiaries who resided in the U.S. and had Part A. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of Medicare Provider Analysis and Review and Common Medicare Environment data.

best practices in rehabilitation care for stroke patients (e.g., prevention of falls and skin breakdown and pain management) and recommend placement in IRFs over SNFs for patients who qualify for IRF services (Winstein et al. 2016).

Notable increase in FFS Medicare beneficiaries' IRF stays per capita

The number of FFS IRF stays, both in aggregate and per capita, increased substantially in FY 2024, for the second straight year (Table 9-2). In 2024, the aggregate number of stays rose by 7.6 percent to 435,000 inpatient stays, and the number of stays per 10,000 FFS beneficiaries rose by 9.7 percent to 132. Both were well above prepandemic levels. The average length of stay was 12.4 days, similar to the level in 2023.

Most of the growth in the number of stays per FFS Medicare beneficiaries was from growth in freestanding and for-profit IRFs. In FY 2024, IRF stays per capita increased 14 percent at freestanding IRFs, compared with only 3 percent at hospital-based IRFs. Similarly, IRF stays per capita increased 13 percent at for-profit IRFs, compared with 3 percent at nonprofit IRFs and 4 percent at government IRFs. High growth in the number of stays per FFS beneficiary occurred

across many of the most common rehabilitation impairment categories (RICs) of IRF stays, such as over 12 percent growth in other neurological rehabilitation and nontraumatic brain injury. Stroke stays per beneficiary grew by 4 percent compared to the prior year. The Commission continues to examine the drivers of the growing use of IRFs by FFS beneficiaries.

Patterns of use in IRFs

In FY 2024, the three most common conditions among FFS Medicare beneficiaries treated by IRFs nationwide, as reported on the IRF Patient Assessment Instrument (IRF-PAI) at admission, were stroke (15.1 percent of stays), "other neurological conditions" (15.0 percent of stays), and debility (14.7 percent of stays).

The distribution of FFS Medicare stay types differs by type of IRF and ownership (Table 9-3). For example, in FY 2024, only 13 percent of stays in freestanding for-profit IRFs were admitted for rehabilitation following a stroke, compared with 20 percent of stays in hospital-based nonprofit IRFs. By contrast, 20 percent of stays in freestanding for-profit IRFs were admitted with other neurological conditions, more than twice the share admitted to hospital-based nonprofit IRFs. Stays for fracture of the lower extremity made up a slightly

**TABLE
9-3**

Mix of FFS Medicare IRF stays differed by provider type and ownership, FY 2024

Condition	Freestanding		Hospital based	
	For profit	Nonprofit	For profit	Nonprofit
All (share of stays)	55%	9%	9%	27%
Percent of total				
Stroke	13	17	14	20
Other neurological conditions	20	11	11	8
Fracture of the lower extremity	13	12	16	15
Debility	15	15	17	14
Brain injury	12	12	13	12
Other orthopedic conditions	9	8	8	7
All other conditions	19	24	22	24

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), FY (fiscal year). "Nonprofit" columns include government-owned IRFs. "Condition" based on impairment group at admission recorded on the IRF Patient Assessment Instrument. "Other neurological conditions" includes neuromuscular disorders, multiple sclerosis, Parkinson's disease, and polyneuropathy included in the neurological impairment group. "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. Patients with "debility" have generalized deconditioning not attributable to other conditions. "Other orthopedic conditions" excludes fractures of the hip, pelvis, and femur, as well as hip and knee replacements. "Brain injury" includes both traumatic and nontraumatic injuries. Freestanding for-profit IRFs are more likely to have stays in certain subcategories of the "other neurological conditions": neuromuscular conditions (such as myasthenia gravis, motor neuron disease, post-polio syndrome, muscular dystrophy, and other myopathies) and "other neurological disorders" (such as other extrapyramidal disease, abnormal movement disorders, and hereditary ataxia). Column components may not sum to 100 percent due to rounding.

Source: Inpatient Rehabilitation Facility Patient Assessment Instrument data from CMS.

larger share of stays in hospital-based facilities than in freestanding facilities. Other orthopedic conditions were similar across IRF types. The distribution of stay types was relatively stable between 2019 and 2024 (data not shown). The Commission has previously reported that some stay types, especially those for other neurological conditions, are more profitable than others under the IRF PPS (for more details, see the IRF chapter (Chapter 8) of our March 2024 report to the Congress (Medicare Payment Advisory Commission 2024)).

Quality of care: Discharge to the community and potentially preventable readmissions were relatively stable

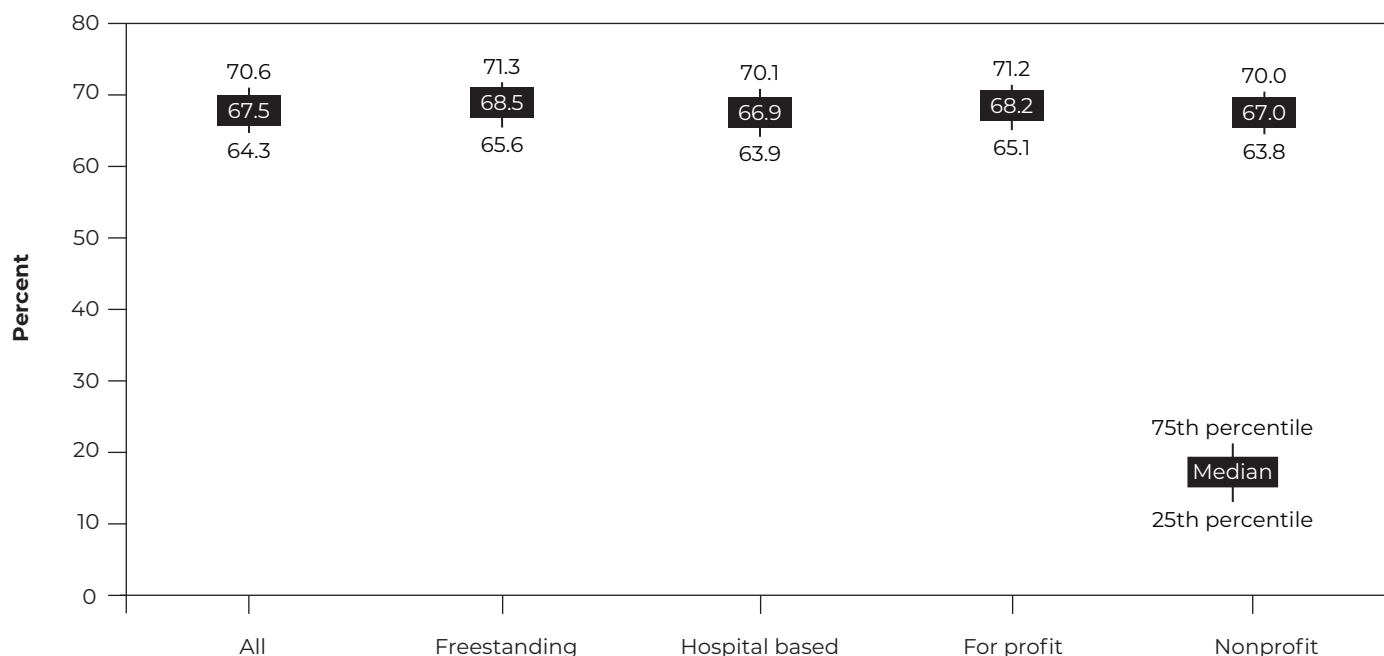
In our assessment of payment adequacy, the Commission prioritizes quality measures tied to clinical outcomes. We report two outcome measures for FFS Medicare beneficiaries in IRFs: risk-adjusted potentially

preventable hospital readmissions after discharge and risk-adjusted discharge to the community, which are claims-based outcome measures developed by CMS. CMS publicly reports facility-level measures after providers are given an opportunity to review the data. The measures are updated annually and cover a 24-month period. The most recent available data, released in October 2025, cover FY 2023 through FY 2024. Data from this period indicate that, in aggregate, rates of successful discharge to the community and potentially preventable readmissions were relatively stable compared with the previous 24-month period.

Readmissions and community-discharge measures assess key outcomes of IRF care, but they do not capture all aspects of quality in IRFs. Ideally, we could measure other outcomes and the experience of IRF care for Medicare beneficiaries in a stay. However, lack of data on patient experience and concerns about the

**FIGURE
9-1**

Median and interquartile range of IRFs' risk-adjusted FFS Medicare rates of successful discharge to the community in FY 2023–2024



Note: IRF (inpatient rehabilitation facility), FY (fiscal year), FFS (fee-for-service). "Successful discharge to the community" is an IRF's risk-adjusted rate of FFS Medicare patients who were discharged to the community after an IRF stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. "Freestanding" and "hospital-based" designations reflect the IRF's Medicare provider number, with "hospital based" indicating a separately certified unit of another hospital. Higher rates of successful discharge to the community are better. The measure is calculated uniformly across post-acute care settings; providers with fewer than 25 stays or missing data were excluded, as were swing beds. Data cover 24 months (FY 2023 and FY 2024 combined).

Source: MedPAC analysis of claims-based outcome measures from CMS's Provider Data Catalog.

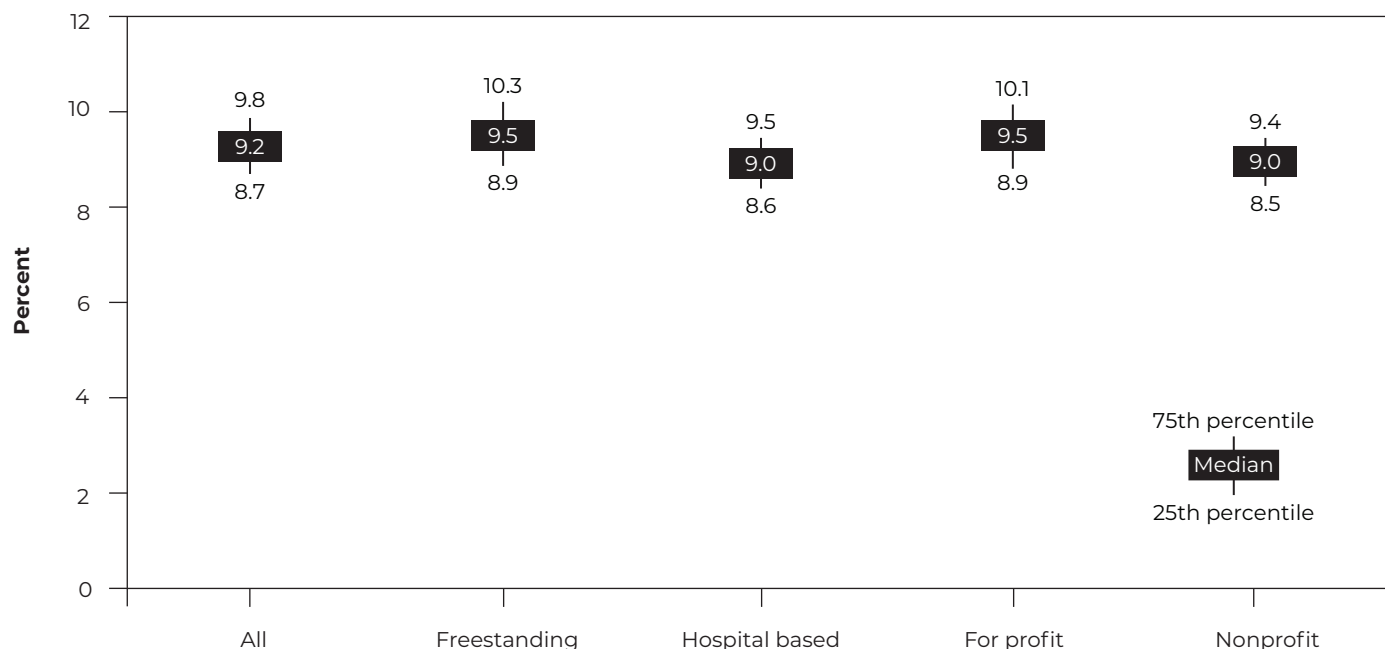
validity of function data limit our ability to assess the quality of IRF care.

Successful discharge to the community

The measure of successful discharge to the community is the rate at which patients returned home or to the community from the IRF and remained alive without any unplanned hospitalizations in the 31 days following discharge (higher rates are better) (Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2015).⁷ IRFs can improve their rate of successful discharge to the

community by providing rehabilitation strategies to improve functional ability, discharge planning and care coordination, patient and family education, and solutions to barriers a patient may face in the community.

During the FY 2023 through FY 2024 period, the median facility risk-adjusted rate of successful discharge to the community was 67.5 percent, similar to the rate for FY 2022 and FY 2023, which was 67.2 percent (Figure 9-1; latter figure not shown). About one-quarter of facilities had a risk-adjusted rate below 64.3 percent, and one-quarter had a rate above 70.6 percent.

**FIGURE
9-2****Median and interquartile range of IRFs' risk-adjusted FFS Medicare rates of potentially preventable readmissions in FY 2023-2024**

Note: IRF (inpatient rehabilitation facility), FY (fiscal year), FFS (fee-for-service). "Potentially preventable readmissions" is an IRF's risk-adjusted rate of FFS Medicare patients who were readmitted to a hospital within 30 days of discharge from the IRF stay for a medical condition that might have been prevented. "Freestanding" and "hospital-based" designations reflect the IRF's Medicare provider number, with "hospital based" indicating a separately certified unit of another hospital. Lower rates of potentially preventable readmissions are better. The measure is calculated uniformly across post-acute care settings; providers with fewer than 25 stays or missing data were excluded, as were swing beds. Data cover 24 months (FY 2023 and FY 2024 combined).

Source: MedPAC analysis of claims-based outcome measures from CMS's Provider Data Catalog.

Potentially preventable readmissions

Readmissions expose beneficiaries to hospital-acquired infections, increase the number of transitions between settings (which is disruptive to patient care), and can result in medical error (Centers for Medicare & Medicaid Services 2016). In addition, they unnecessarily increase Medicare spending (Centers for Medicare & Medicaid Services 2023). IRFs can reduce the number of potentially preventable hospital readmissions by preventing complications, providing clear discharge instructions to patients and families, and ensuring a safe discharge plan. Potentially preventable readmissions after discharge are calculated as the

percentage of patients discharged from an IRF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented (lower percentages are better).

During the FY 2023 and FY 2024 period, the median facility-level risk-adjusted rate of potentially preventable readmissions was 9.2 percent, similar to the rate for FY 2022 and FY 2023, which was 8.8 percent (Figure 9-2; latter figure not shown). In the FY 2023 to FY 2024 period, about one-quarter of facilities had a risk-adjusted rate below 8.7 percent and one-quarter had a rate above 9.8 percent. The rate was higher (worse) among freestanding and for-

profit providers than for hospital-based and nonprofit providers, with the highest 25 percent of freestanding or for-profit providers having rates above 10 percent. The rate of potentially preventable readmissions was the same for urban and rural IRFs (data not shown).

Patient-experience data are not collected for IRF patients

Patient experience is an important measure of quality. Research finds that, across the health care system, improving patient experience correlates with better health outcomes and adherence to treatment plans (Boulding et al. 2011, Navarro et al. 2021).

CMS has developed a survey of patients' experience of IRF care for public use but is not requiring or collecting results through the Quality Reporting Program (Centers for Medicare & Medicaid Services 2025).⁸ The Commission has recommended the general use of patient-experience surveys for PAC beneficiaries (Medicare Payment Advisory Commission 2022, Medicare Payment Advisory Commission 2018). Discussion in Chapter 14 of our March 2022 report to the Congress stated that CMS could explore using the IRF survey as a basis for uniform PAC patient-experience data (Medicare Payment Advisory Commission 2022). To implement the survey, CMS would need to develop patient-experience measures based on the survey responses and develop a process for third-party vendors to collect survey results.

Our set of IRF quality measures is limited by concerns about the validity of function data

Maintaining and improving functional status is a key outcome of PAC. IRFs assess and record information on each beneficiary's level of function at admission to and discharge from the IRF using the IRF-PAI. However, because provider-reported function data are used to assign stays to case-mix groups to adjust payment, the Commission and others have raised concerns about the validity of the provider-reported function data (see discussion in Chapter 6 of this report). In our June 2019 report to the Congress, the Commission discussed strategies to improve the functional-assessment data, the importance of monitoring the data reporting, and alternative measures of function (such as patient-reported surveys) that do not rely on provider-

completed assessments (Medicare Payment Advisory Commission 2019). Options to improve the data could include conducting on-site or medical-record audits of providers with aberrant-appearing function data, requiring transferring hospitals to provide function data for patients at the time of transfer, or collecting patient-reported functional outcomes.

Freestanding IRFs' access to capital remained strong in 2024

In FY 2024, the all-payer total margin for freestanding IRFs increased to 11.6 percent, up from 10.4 percent in FY 2023.⁹ However, the all-payer margin varied substantially by ownership. For-profit freestanding IRFs' all-payer total margin was about 14 percent in 2024, remaining steady over the last few years. In contrast, the all-payer margin for the small number of nonprofit freestanding IRFs continued to be much lower at 4 percent, an increase from 2 percent in 2023.

For-profit corporations continued to have sufficient access to capital to open new IRFs and expand existing IRFs. Almost all of the new IRFs that opened in FY 2024 were for profit. In calendar year (CY) 2024, the IRF industry's largest corporation, Encompass Health, which owned or operated about 42 percent of freestanding IRFs and accounted for about 34 percent of all FFS Medicare IRF stays, opened six new IRFs and one satellite with a combined total of 320 beds and added 107 beds to its existing IRFs (Encompass Health 2025a). Encompass Health's growth continued in 2025 when it added seven new hospitals with a combined total of 290 beds and a 50-bed satellite plus 190 beds to existing facilities. According to its latest investor report, the company has 12 additional IRFs under development (Encompass Health 2025b).

Two-thirds of IRFs are hospital-based units that access any necessary capital through their parent hospitals to maintain, modernize, or expand. Overall, as detailed in the hospital chapter of this report (Chapter 3), ACHs' access to capital generally improved in FY 2024. The all-payer operating margin for hospitals paid under the inpatient prospective payment systems increased to 6.5 percent in 2024, up from 5.2 percent in 2023, despite a decline in coronavirus relief funds. (See the text box in Chapter 2 on the different margin measures that MedPAC uses to assess provider profitability.) In addition, investment income for these hospitals

increased. Hospitals' borrowing costs held stable in 2024, and investors' risk premium on hospitals decreased slightly.

Medicare payments and providers' costs: IRFs' FFS Medicare margin increased in 2024

In FY 2024, IRFs' FFS Medicare payments per stay grew faster than IRFs' costs per stay. As a result, IRFs' FFS Medicare margin increased to 17.1 percent (Table 9-4, p. 286). Margins continued to vary widely across categories of IRFs, with higher margins for IRFs that were freestanding, for profit, urban, larger, or that had a higher FFS Medicare share of days. (See the text box in Chapter 2 on the different margin measures that MedPAC uses to assess provider profitability.)

In 2024, FFS Medicare payments per stay increased more than IRFs' costs per stay

Among IRFs delivering care in cost-reporting periods FY 2023 and FY 2024, FFS Medicare payments per stay increased more than IRFs' costs per stay, with IRF PPS payments per stay rising 3.4 percent in FY 2024, while IRFs' costs per stay rose just 0.6 percent. Growth in cost per stay was higher among freestanding IRFs (2.1 percent) compared to hospital-based IRFs (1.1 percent). At the same time, growth in payments per stay was lower among freestanding IRFs (3.0 percent) compared with hospital-based IRFs (4.7 percent).

IRFs' FFS Medicare margin increased but continued to vary widely

In FY 2024, IRFs' FFS Medicare margin increased to 17.1 percent, up from 14.8 percent in FY 2023 (Table 9-4, p. 286). The FFS Medicare margin varied widely across IRFs, with the facility at the 25th percentile having a margin of -6.3 percent and the facility at the 75th percentile having a margin of 24.9 percent (data not shown).

The FFS Medicare margin increased for nearly all categories of IRFs we examined, though significant variation in margins persisted (Table 9-4, p. 286):

- *Freestanding IRFs continued to have a higher FFS Medicare margin than hospital-based IRFs.* Freestanding IRFs' FFS Medicare margin was 25.0 percent in FY 2024, slightly above the level in FY 2023 and FY 2019. In comparison, hospital-based IRFs' FFS Medicare margin was 4.1 percent, much lower than the margin among freestanding IRFs but a notable increase from 0.6 percent in 2023 and 1.3 percent in 2019. As discussed above, this increase was driven by low growth in costs per stay and higher growth in payments per stay. As discussed below, numerous factors contribute to the lower FFS Medicare margin among hospital-based IRFs than among freestanding IRFs.
- *For-profit IRFs continued to have a higher FFS Medicare margin than nonprofit IRFs.* In FY 2024, the FFS Medicare margin continued to be higher for IRFs that were for profit (24.6 percent) than for IRFs that were nonprofit (2.9 percent). This spread in margin across ownership is similar to the margins of freestanding versus hospital-based facilities, reflecting that for-profit IRFs are more likely to be freestanding while nonprofit IRFs are more likely to be hospital based.
- *Larger IRFs continued to have higher FFS Medicare margins.* The FFS Medicare margin continued to be higher for IRFs with more beds, indicating economies of scale. Notably, in FY 2024, the FFS Medicare margin among IRFs with less than 10 beds was -4.9 percent, negative but higher than in FY 2019. These IRFs tended to be hospital-based with low occupancy rates (about 57 percent compared to the overall average occupancy rate of 71 percent in FY 2024).
- *More FFS Medicare-dependent IRFs continued to have higher FFS Medicare margins.* In FY 2024, the FFS Medicare margin was higher among IRFs for which FFS Medicare beneficiaries constituted over three-quarters of their inpatient days (22.1 percent) than among IRFs for which FFS Medicare beneficiaries constituted less than half of their inpatient days (10.2 percent).
- *IRFs that treated a smaller share of beneficiaries with low income continued to have higher FFS Medicare margins.* Like the disproportionate-share-hospital adjustment for acute care hospitals paid under the inpatient PPS, IRFs receive low-income-patient (LIP) payments that are intended to offset costs incurred by treating a large or disproportionate share of low-income patients. Nevertheless, in FY 2024, the FFS Medicare margin was substantially

**TABLE
9-4****IRFs' FFS Medicare margin increased in FY 2024,
and substantial variation across IRFs persisted**

IRF category	2019	2020	2021	2022	2023	2024
All	14.1%	13.5%	16.7%	13.7%	14.8%	17.1%
Type						
Freestanding	24.7	23.6	25.7	23.0	24.3	25.0
Hospital based	1.3	1.5	5.2	0.9	0.6	4.1
Ownership						
For profit	24.2	23.6	25.2	22.4	23.5	24.6
Nonprofit	0.7	-0.3	4.6	-0.1	-0.2	2.9
Geography						
Urban	14.5	13.8	17.0	14.1	15.0	17.3
Rural	7.3	8.5	11.7	7.7	10.6	12.5
Number of beds						
1 to 10	-9.6	-6.2	-3.3	-7.0	-6.4	-4.9
11 to 24	1.3	2.0	5.0	0.8	1.1	5.1
25 to 64	15.9	15.6	18.6	15.3	16.4	18.6
65 or more	21.0	18.6	21.9	19.4	20.5	22.0
FFS Medicare share of days						
<50%	4.0	6.3	11.4	7.0	7.0	10.2
50% to 75%	16.2	16.5	20.0	17.6	19.1	20.8
>75%	22.4	20.3	20.5	21.7	21.8	22.1
Low-income patient share						
0% to 5%	18.2	15.7	20.0	16.8	18.4	21.3
5% to 10%	18.3	18.8	20.1	18.1	18.3	22.2
10% to 15%	13.7	12.6	16.9	13.8	14.5	14.3
15% to 20%	15.3	14.9	16.6	12.6	14.7	15.0
20% to 25%	2.3	8.3	14.1	6.6	12.5	12.7
25% or more	5.9	5.0	9.6	10.0	5.5	5.4

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service), FY (fiscal year). "FFS Medicare margin" is calculated based on revenue and costs for services included under the IRF prospective payment system. Government-owned IRFs operate in a different financial context from other IRFs, so their margin is not necessarily comparable; therefore, data for government-owned IRFs are not reported separately or included in the ownership rows (but are included in other rows). "Freestanding" and "hospital based" designations reflect the IRF's Medicare provider number, with "hospital based" indicating a separately certified unit of another hospital. "Urban" refers to metropolitan counties, which contain an urban cluster of 50,000 or more people; all other counties are classified as "rural." "Low-income patient share" was calculated as the sum of two ratios: the share of all Medicare days devoted to patients on Supplemental Security Income plus the share of Medicaid days out of all inpatient days.

Source: MedPAC analysis of IRF cost-report data.

higher among IRFs with an LIP share of less than 5 percent (21.3 percent) than among IRFs with an LIP share of 25 percent or more (5.4 percent).

Numerous factors contribute to lower margins in hospital-based IRFs

The Commission has long noted the substantial difference between freestanding and hospital-based

IRFs' FFS Medicare margins. Several factors are likely to contribute to this difference:

- *Higher costs per stay in hospital-based IRFs:* In FY 2024, average cost per stay was \$25,000 for hospital-based IRFs compared with \$18,000 for freestanding IRFs. Although, on average, both routine and ancillary costs per stay were higher among hospital-based IRFs, routine costs per stay were substantially higher among hospital-based IRFs than freestanding IRFs. The amount of hospital-based IRFs routine costs per stay (such as room and board) may depend, to some extent, on how parent hospitals allocate their overall routine costs to their IRF subunits; on the other hand, routine costs at freestanding IRFs would be directly related to IRF services rather than including costs allocated from the parent hospital. In addition, higher costs at hospital-based IRFs can result, in part, from a relative lack of economies of scale because these facilities tend to be smaller (67 percent had fewer than 25 beds compared to 5 percent for freestanding IRFs) and have a lower occupancy rate (67 percent compared to 74 percent for freestanding IRFs).
- *Differences in patient mix not accounted for by the payment system:* As noted previously, there are also marked differences in hospital-based and freestanding IRFs' mix of stays. In FY 2024, compared with freestanding IRFs, hospital-based IRFs admitted a smaller share of patients with a diagnosis in the other neurological conditions category and a larger share of patients with stroke as the primary reason for rehabilitation (Table 9-3, p. 281). The Commission previously reported on profitability differences among different types of stays: Notably, stays for beneficiaries diagnosed with other neurological conditions were among the most profitable, with payments in aggregate exceeding costs by 26 percent in 2019 (Medicare Payment Advisory Commission 2024). By contrast, stays for beneficiaries diagnosed with a stroke were among the least profitable case types in IRFs. As we noted in our March 2024 report, using an alternative method to set payment weights in the IRF PPS would yield more uniform profitability across case-mix groups (Medicare Payment Advisory Commission 2024). This change could also help to reduce providers' incentives to code

patients as more functionally impaired (thereby increasing case-mix severity and payment rates). The Commission has previously reported findings that were suggestive of such differential coding between freestanding and hospital-based IRFs (Medicare Payment Advisory Commission 2016). We will continue to monitor the variation in performance.

- *Differential prevalence of outlier stays:* Hospital-based IRFs' higher costs and patient mix may contribute to their increased likelihood of outlier stays, which are stays with extraordinarily high costs. In FY 2024, hospital-based IRFs accounted for about 36 percent of FFS stays but 78 percent of high-cost outlier stays. Although outlier payments diminish the financial loss per outlier stay, by design, outlier payments do not completely cover facilities' costs. Since outlier payments cover only a portion of the excess costs, having more outliers has the potential to lower margins.

In FY 2024, the FFS Medicare margin among hospital-based IRFs was about 4 percent, which is substantially higher than the FFS Medicare margin we report for ACHs (-12.1 percent, as reported in Chapter 3). ACHs can discharge eligible patients to their hospital-based IRF subunits, enabling the hospital to open beds to additional acute care patients. Indeed, the FFS margin among ACHs with IRF subunits is slightly higher than the margin among ACHs without IRF subunits.

IRFs' FFS Medicare margin is projected to increase slightly in 2026

We estimate that IRFs' FFS Medicare margin in FY 2026 will be about 18 percent, a slight increase from 17.1 percent in FY 2024. To make this projection, the Commission considered the relationship between FFS Medicare payments and IRFs' costs in 2024 as a starting point and then applied policy changes effective in 2025 and 2026 and estimated changes in costs.

In FY 2025 and FY 2026, IRF payment-rate changes included:

- a regulatory update of 3.0 percent in FY 2025, based on an IRF market basket increase of 3.5 percent and an offsetting total productivity adjustment of 0.5 percentage points; and

- a regulatory update of 2.6 percent in FY 2026, based on an IRF market basket increase of 3.3 percent and an offsetting total productivity adjustment of 0.7 percentage points.

Based on recent cost patterns, we estimate slightly lower increases in IRFs' cost per stay. Specifically, because the industry's costs have continued to normalize after the faster cost growth during the coronavirus pandemic, we used a three-year historical average of cost growth equal to about 2 percent.

Like all projections, ours is subject to uncertainty. The projection is especially sensitive to the uncertainties of estimating costs, whereas the payment updates have been set.

How should FFS Medicare payments change in 2027?

Under current law, Medicare's IRF PPS base payment rate is increased annually based on the projected increase in the IRF market basket, less an amount for productivity improvement. The final update for FY 2027 will not be set until summer 2026; however, using CMS's third-quarter 2025 projections of the market basket and productivity, the update would increase the IRF PPS base payment rate by 2.3 percentage points.

RECOMMENDATION 9

For fiscal year 2027, the Congress should reduce the 2026 Medicare base payment rate for inpatient rehabilitation facilities by 7 percent.

RATIONALE 9

The payment-adequacy indicators for Medicare IRF services were generally positive and show that FFS Medicare payments continue to substantially exceed costs, as they have for many years. IRFs continued to have available capacity in aggregate, and the number of IRFs was relatively stable. Notably, the number of IRF stays per FFS Medicare beneficiary increased substantially in FY 2024. Our measures of quality of care were relatively stable. IRFs' access to capital improved: Freestanding IRFs' all-payer total margin increased, as did the all-payer margin of hospital-based IRFs' parent hospitals. IRFs' FFS Medicare margin rose more than 2 percentage points to 17.1 percent in FY 2024, and we project that it will increase to about

18 percent in FY 2026. The high FFS Medicare margin indicates that the IRF PPS exerts too little pressure on providers to control costs. A 7 percent reduction to 2026 IRF PPS payment rates—the same reduction we recommended last year—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.

IMPLICATIONS 9

Spending

- This recommendation would lower spending relative to current law by between \$2 billion and \$5 billion in one year and by between \$10 billion and \$25 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have an adverse effect on Medicare beneficiaries' access to care or out-of-pocket spending. Given the current level of payments, we do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries, though financial pressure may increase for some providers. ■

Endnotes

- 1 In markets without IRFs, beneficiaries who need skilled nursing care or therapy services on an inpatient basis can be admitted to skilled nursing facilities, which have less extensive requirements regarding the amount of therapy and the frequency and level of medical supervision that their patients must receive.
- 2 A more detailed description of FFS Medicare's IRF PPS can be found in our *Payment Basics* series at <https://www.medpac.gov/document-type/payment-basic/page/2/>.
- 3 Among freestanding IRFs in FY 2024, about 49 percent of all payments were for FFS Medicare patients. The FFS Medicare share of total IRF payments could not be calculated for hospital-based IRFs due to data limitations on the cost reports.
- 4 The 13 conditions are stroke; spinal cord injury; congenital deformity; amputation; major multiple trauma; hip fracture; brain injury; certain other neurological conditions (including multiple sclerosis, Parkinson's disease, cerebral palsy, and neuromuscular disorders); burns; three arthritis conditions that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings but have the potential to improve with more intensive rehabilitation; and hip or knee replacement when it is bilateral, the patient's body mass index is greater than or equal to 50, or the patient is age 85 or older. In fiscal years 2014, 2015, and 2018, CMS updated its lists of codes from the International Classification of Diseases, 10th Revision, Clinical Modification, replacing certain general codes (such as the arthritis codes) with more specific ones for patients who would be likely to require intensive rehabilitation therapy. The updated diagnosis codes are listed in <https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/rules-related-files/cms-1781-f> and open Presumptive Compliance-3_FY 2024-ICD-10code update_final_09062023.
- 5 In FY 2024, there were about 23,000 beds in freestanding IRFs and about 19,000 beds in hospital-based IRFs.
- 6 HSAs are local health care markets for hospital care. An HSA is a collection of ZIP codes in which Medicare residents receive most of their hospitalizations from hospitals in that area. See <https://www.dartmouthatlas.org>.
- 7 For this measure, "community" is defined as home/self-care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the FFS Medicare claim.
- 8 As discussed in Chapter 6 of this report, CMS has solicited comments on IRF patient-experience/patient-satisfaction measures and received mixed support, including concerns about the administrative and financial costs associated with data collection (Centers for Medicare & Medicaid Services 2023b). An industry stakeholder commented that the number of survey responses required for reliable results would be problematic for most IRFs (Encompass Health 2024).
- 9 Hospital cost reports do not require hospitals to report the components needed to calculate an all-payer margin specifically for their IRFs or other hospital-based units.

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CHAPTER 10

Hospice services

R E C O M M E N D A T I O N

- 10** For fiscal year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rates for hospice.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Hospice services

Chapter summary

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. Fee-for-service (FFS) Medicare pays for hospice care for beneficiaries enrolled in either traditional FFS Medicare or Medicare Advantage (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.

Assessment of payment adequacy

The indicators of FFS Medicare payment adequacy for hospices were positive.

Beneficiaries' access to care—In 2024, indicators of beneficiaries' access to care were positive. The number of hospice providers and measures of hospice utilization increased.

In this chapter

- Are FFS Medicare payments adequate in 2026?
- How should FFS Medicare payments change in 2027?

- **Capacity and supply of providers**—In 2024, 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.
- **Volume of services**—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 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 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 are 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 Medicare margins are presented through 2023 because of the standard data lag required to calculate cap-overpayment amounts. Between 2022 and 2023, average costs 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.

How should FFS Medicare payments change in 2027?

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. ■

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. Such providers include hospices that furnish palliative and supportive services to Medicare beneficiaries who are terminally ill and whose prognosis indicates that the individual's life expectancy is six months or less if the illness runs its normal course.

Background

The hospice benefit covers services that are reasonable and necessary for palliation of the terminal illness and related conditions. The hospice benefit covers a broad set of palliative services (e.g., visits by nurses, aides, social workers, physicians, and therapists; drugs, durable medical equipment, and supplies; short-term inpatient care and respite care; bereavement services for the family; and other services for palliation of the terminal illness and related conditions). To receive hospice services, a beneficiary must elect the hospice benefit. 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. Medicare continues to cover items and services unrelated to the terminal illness outside of hospice. Most commonly, hospice care is provided in patients' homes, but hospice services may also be provided in nursing facilities, assisted-living facilities, hospice facilities, and other inpatient settings. In 2024, Medicare's hospice prospective payment system (PPS) paid about \$28.3 billion for hospice services for more than 1.8 million Medicare beneficiaries.

Beneficiaries elect hospice for defined benefit periods. When a beneficiary first elects hospice, two physicians—a hospice physician and the beneficiary's attending physician—are required to certify that the beneficiary has a life expectancy of six months or less if the illness runs its normal course.¹ The first hospice benefit period spans up to 90 days. After the first period, the hospice physician can recertify the patient for a second 90-day period and for an unlimited number of 60-day periods after that, as long as the patient's terminal illness continues to engender a life expectancy

of six months or less. Beneficiaries can disenroll from hospice at any time (referred to as "revoking hospice") and can reelect hospice for a subsequent period as long as they meet the eligibility criteria.

Enrollment in the hospice benefit is voluntary; it is a choice made by individual beneficiaries and their families. Patient autonomy and care according to a patient's preferences are important principles in end-of-life care. The decision of whether to elect hospice is a deeply personal one for a beneficiary and their family, influenced by their preferences and beliefs and informed by discussions with their physician and health care providers about disease progression, prognosis, and options for care. While it is important that eligible beneficiaries have the option to elect hospice, it is also important that beneficiaries can choose not to enroll in hospice care and remain with conventional care throughout the end of life.

The most important benefit of hospice is its effect on patient care. The Medicare hospice benefit offers beneficiaries the option to receive end-of-life care focused on symptom management and quality of life and can enable some beneficiaries to die at home (rather than in the hospital) if they wish to do so. When the Congress expanded the Medicare benefit to include hospice care in 1983, it was thought that the new benefit would be a less costly alternative to conventional end-of-life care (Government Accountability Office 2004, Hoyer 2007). The literature is mixed on whether hospice has reduced Medicare spending compared with conventional care, with findings varying in part depending on the methodology used.² The Commission has additional research underway in this area.

Medicare payment for hospice services

The FFS Medicare program pays a daily rate to hospice providers. The hospice provider assumes all financial risk for costs and services associated with care for the patient's terminal illness and related conditions. The hospice provider receives payment for every day that a patient is enrolled, regardless of whether the hospice staff visits the patient or otherwise provides a service each day. This payment design is intended to encompass not only the cost of visits but also other costs that a hospice incurs for palliation and management of the terminal illness and related

conditions (e.g., on-call services, care planning, and nonvisit services like drugs and medical equipment).

Payments are made according to a fee schedule that has four levels of care. Routine home care (RHC) is the most common level of care, accounting for 98.8 percent of Medicare-covered hospice days in 2024. There are three other specialized levels of care: continuous home care (CHC), which is provided in the home during periods of patient crisis; general inpatient care (GIP), which is provided when symptoms require management in an inpatient setting; and inpatient respite care (IRC), which is provided to enable a short respite for a patient's primary caregiver. In both 2023 and 2024, 89 percent of Medicare hospice patients received at least one day of RHC, 16 percent received at least one day of GIP, 4 percent received at least one day of IRC, and 2 percent received at least one day of CHC (with some patients receiving more than one level of hospice care over the course of their hospice stay). The per diem payment for RHC is higher during the first 60 days of a hospice episode and reduced for days 61 and beyond. For the other three levels of care, the daily payment rate is higher than for RHC. Medicare makes additional payments for registered nurse and social worker visits that occur during the last seven days of life for patients receiving RHC.

When the Congress established the hospice benefit, it included a “cap” limiting the aggregate Medicare payments that an individual hospice can receive.³ The cap is not applied individually to the payments received for each beneficiary, but rather to the total payments across all Medicare patients served by the hospice in the cap year. Each hospice's aggregate payments are capped at a level equal to their number of patients in the year multiplied by the aggregate cap amount. If a hospice's total Medicare payments exceed that amount, it must repay the excess to the program. Unlike the daily hospice payments, the cap is not adjusted for geographic differences in costs. The hospice aggregate cap in 2026 (\$35,361) is equivalent to the amount that Medicare pays for an RHC hospice stay of about 178 days (assuming a wage index of 1.0). Because the cap is applied in the aggregate across the provider's entire patient population (including both short and long stays) and not at the stay level, a hospice provider can furnish a substantial number of long stays and remain under the cap.⁴ In 2023, we estimate that nationally about 28 percent of hospices, which provided care to about 8

percent of hospice patients, exceeded the cap and were required to return payments to the program. Above-cap hospices are disproportionately concentrated in four states that have been subject to enhanced program-integrity efforts by CMS. The Commission first recommended in March 2020 that the hospice cap be wage adjusted and reduced by 20 percent to make the cap more equitable across providers and focus payment reductions on providers with long stays and high margins (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2020).

FFS Medicare pays for hospice care for beneficiaries enrolled in either traditional FFS Medicare or Medicare Advantage (MA).⁵ Once a beneficiary in an MA plan elects hospice care, the beneficiary receives hospice services through a provider paid by FFS Medicare (while Medicare continues to pay the MA plan for Part D services and Part C rebates, but not Part A and Part B services).⁶ In March 2014, the Commission urged that this policy be changed, recommending that hospice be included in the MA benefit package (Medicare Payment Advisory Commission 2014). In making this recommendation, the Commission expressed concern that the carve-out of hospice from the MA benefit package fragments financial responsibility and accountability for care. The Commission stated that including hospice in the MA benefit package could have a number of potential benefits: It would give plans responsibility for the full continuum of care and promote integrated, coordinated care; it would give MA plans greater incentive to develop and test innovative programs to improve end-of-life care; and it would be a step toward synchronizing accountability for hospice across Medicare platforms (MA, accountable care organizations, and FFS) (Medicare Payment Advisory Commission 2014). From 2021 to 2024, as part of its value-based insurance design (VBID) models in MA, CMS's Innovation Center implemented a voluntary demonstration permitting MA organizations to provide hospice and palliative care services for their enrollees to test the effects of adding the hospice benefit to MA (Centers for Medicare & Medicaid Services 2020). In 2023, the last year for which data are currently available from a CMS contractor report, 23,828 beneficiaries who were enrolled in MA plans participating in the hospice VBID model started hospice that year paid for by the MA plan. CMS ended the hospice component of the MA-VBID model in December 2024, citing plan-

**TABLE
10-1**

Increase in total number of hospices driven by entry of for-profit providers

Category	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
All hospices	4,840	5,058	5,358	5,899	6,535	6,706	7.8%	2.6%
For profit	3,435	3,694	4,024	4,581	5,243	5,497	11.2	4.8
Nonprofit	1,254	1,217	1,190	1,172	1,155	1,070	–2.0	–7.4
Government	149	145	141	138	136	130	–2.3	–4.4
Freestanding	3,942	4,190	4,515	5,074	5,695	5,740	9.6	0.8
Hospital based	430	413	394	383	365	350	–4.0	–4.1
Home health based	449	436	432	421	415	415	–1.9	0.0
SNF based	19	19	17	17	17	16	–2.7	–5.9
Urban	3,973	4,193	4,501	5,051	5,701	5,877	9.4	3.1
Rural	861	856	849	834	833	829	–0.8	–0.5

Note: SNF (skilled nursing facility). The providers included in this analysis submitted at least one paid hospice claim in a given year. The rural and urban definitions used in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census) and reflect the hospice's office location. Type of hospice reflects the type of cost report filed (a hospice files a freestanding hospice cost report, or the hospice is included in the cost report of a hospital, home health agency, or SNF). Some categories do not sum to totals because of missing data for some providers. Missing data on hospice type particularly affect the most recent year (2024), for which we lack data on this characteristic for 185 providers. Numbers for 2023 and earlier years in certain categories may differ from those in our prior reports due to refinements in methodology and/or use of updated data.

Source: MedPAC analysis of Medicare cost reports, Provider of Services file, Hospice Enrollments dataset, and Medicare hospice claims data from CMS.

implementation challenges and declining numbers of participating plans as reasons for the decision (Centers for Medicare & Medicaid Services 2024).⁷

Are FFS Medicare payments adequate in 2026?

To address whether payments in 2026 are adequate to cover the costs of efficient delivery of care and how much providers' payments should change in the coming year (2027), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries' access to care by examining the capacity and supply of hospice providers, changes over time in the volume of services provided, quality of care, providers' access to capital, and the relationship between Medicare's payments and providers' costs.

Overall, our indicators of FFS Medicare payment adequacy for hospice care are positive.

Beneficiaries' access to care: Hospice supply grew substantially, and use increased

Our analysis of access indicators—including trends in the supply of providers and use of hospice services—shows that beneficiaries' access to care in 2024 was favorable.

Supply of hospices continued to grow in 2024, driven by an increase in for-profit providers

In 2024, 6,706 hospices provided care to Medicare beneficiaries, a 2.6 percent increase from the prior year (Table 10-1). Market entry of for-profit providers drove the growth in supply. We report on changes in the supply of hospice providers but caution that the number of hospice providers is not necessarily

an indicator of beneficiary access to hospice care because the number does not capture the size of providers, their capacity to serve patients, or the size of their service areas. Commission analyses of data from 2008 and 2019 found that hospice-use rates across states appear unrelated to a state's number of hospice providers per 10,000 beneficiaries (data not shown) (Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2010).

In 2024, the number of for-profit hospices grew about 5 percent (Table 10-1, p. 299). Between 2023 and 2024, the number of hospices with nonprofit ownership or government ownership declined, continuing the downward trend observed over a number of years. In 2024, among the hospices for which we have data, about 82 percent of providers were for profit; however, they furnished care to 60 percent of Medicare hospice patients because, on average, for-profit providers had smaller patient censuses than nonprofit providers (latter data not shown). The number of freestanding providers increased, while the number of home health-based hospices was unchanged and the number of hospital-based and skilled nursing facility (SNF)-based hospices declined in 2024.^{8,9} In 2024, we found, based on only hospices without missing data, that about 88 percent of hospices were freestanding, and these hospices furnished care to 84 percent of Medicare hospice patients (latter data not shown).

The number of rural hospices declined just under 1 percent in 2024, continuing the trend observed from 2019 to 2023 of rural providers declining about 1 percent per year on average (Table 10-1, p. 299). As of 2024, we estimate that 88 percent of hospices were located in urban areas and 12 percent were in rural areas. As noted above, the number of hospices located in rural areas is not reflective of hospice access for rural beneficiaries because it does not capture the size of those hospice providers, their capacity to serve patients, or the size of their service areas. Further, some urban hospices provide services in rural areas. Indeed, as discussed below, the share of rural decedents using hospice grew in 2024 (Table 10-2).

The moderate growth in the number of hospices in 2024 follows a period of substantial growth in provider supply driven by rapid provider entry in a few states. Between 2019 and 2023, the number of hospice providers grew an average of 7.8 percent per year

nationally (Table 10-1, p. 299). Over that period, four states had above-average growth in the number of hospices: California (gain of 1,046 hospices, a 19 percent per year increase), Texas (gain of 257 hospices, a 9 percent per year increase), Arizona (gain of 96 hospices, a 14 percent per year increase), and Nevada (gain of 60 hospices, a 21 percent per year increase) (data not shown). In 2024, growth in the number of hospices slowed in three of the four states (California, Texas, and Arizona), contributing to the more moderate growth in the overall number of providers observed in 2024. Between 2023 and 2024, Arizona gained 1 hospice (a less than 1 percent increase); California gained 38 hospices (a 2 percent increase); Texas gained 44 hospices (a 5 percent increase); and Nevada gained 23 hospices (a 20 percent increase). In addition, beyond the four states, other states and the District of Columbia had generally modest changes in the number of providers in 2024 relative to 2023, with 24 additional states experiencing an increase in the number of providers, 15 experiencing no change, and 8 experiencing a decrease. The two states with the biggest decline in the number of hospices were Louisiana (four hospices) and Mississippi (two hospices); hospice use among decedents in these states increased between 2023 and 2024 despite the decline in the number of providers.

The rapid entry of providers in Arizona, California, Nevada, and Texas in recent years has spurred program-integrity efforts by the State of California and CMS, which may partly account for the slowdown in provider entry observed in some of these states in 2024. California placed a moratorium on new hospice licenses in 2022 and bolstered its state laws governing hospice referral and patient-enrollment practices (California Legislature 2021). The California state auditor issued a report on hospice care in Los Angeles County, stating that “growth in the number of hospice agencies in Los Angeles County has vastly outpaced the need for hospice services” and identifying “numerous indicators of fraud and abuse” (Tilden 2022). Further, the California auditor’s report stated that “the fraud indicators we found particularly in Los Angeles County include the following: A rapid increase in the number of hospice agencies with no clear correlation to increased need. Excessive geographic clustering of hospices with sometimes dozens of separately licensed agencies located in the same building. Unusually long durations of hospice services provided to individual patients. Abnormally high rates

**TABLE
10-2****In 2024, the share of decedents using hospice increased overall
and across all beneficiary subgroups****Share of Medicare decedents who used hospice**

	2010	2019	2022	2023	2024	Average annual percentage point change 2010–2023	Percentage point change 2023–2024
All decedent beneficiaries	43.8%	51.6%	49.1%	51.7%	52.9%	0.6	1.2
FFS beneficiaries	42.8	50.7	49.1	51.7	52.9	0.7	1.2
MA beneficiaries	47.2	53.2	49.2	51.7	52.9	0.3	1.2
Dually eligible for Medicaid	41.5	49.3	43.9	46.7	48.1	0.4	1.4
Not Medicaid eligible	44.5	52.4	51.1	53.6	54.6	0.7	1.0
Age							
< 65	25.7	29.5	26.6	28.6	29.8	0.2	1.2
65–74	38.0	41.0	37.7	40.3	41.1	0.2	0.8
75–84	44.8	52.2	49.4	51.9	52.9	0.5	1.0
85+	50.2	62.7	61.8	64.1	65.2	1.1	1.1
Race/ethnicity							
White	45.5	53.8	51.7	54.3	55.6	0.7	1.3
Black	34.2	40.8	37.4	39.7	40.9	0.4	1.2
Hispanic	36.7	42.7	38.2	40.0	40.4	0.3	0.4
Asian American	30.0	39.8	38.0	39.0	39.7	0.7	0.7
North American Native	31.0	38.5	37.2	39.3	41.0	0.6	1.7
Sex							
Male	40.1	46.7	43.9	46.4	47.6	0.5	1.2
Female	47.0	56.3	54.4	56.9	58.1	0.8	1.2
Beneficiary location							
Urban	45.6	52.8	50.2	52.7	53.8	0.5	1.1
Micropolitan	39.2	49.7	47.3	50.2	51.6	0.8	1.4
Rural, adjacent to urban	39.0	49.5	47.9	50.9	52.6	0.9	1.7
Rural, nonadjacent to urban	33.8	43.8	42.1	44.9	46.5	0.9	1.6
Frontier	29.2	36.2	35.3	37.1	38.8	0.6	1.7

Note: FFS (fee-for-service), MA (Medicare Advantage). For each demographic group, the share of decedents who used hospice is calculated as follows: The number of beneficiaries in the group who both died and received hospice in a given year is divided by the total number of beneficiaries in the group who died in that year. “Beneficiary location” refers to the beneficiary’s county of residence in one of four categories (urban, micropolitan, rural adjacent to urban, or rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes (UICs). This chart uses the 2013 UIC definitions. The “frontier” category is defined as population density equal to or less than six people per square mile and overlaps the categories of residence. Yearly figures presented in the table are rounded, but figures in the columns for percentage-point change were calculated on unrounded data. Analysis excludes beneficiaries without Medicare Part A because hospice is a Part A benefit.

Source: MedPAC analysis of data from the Common Medicare Environment and hospice claims data from CMS.

of still-living patients discharged from hospice care. Hospice agencies using possibly stolen identities of medical personnel” (Tilden 2022).

In recent years, CMS has reported taking a number of steps to increase program-integrity efforts for hospice providers overall and specifically in four states. Beginning July 2023, for newly enrolled hospices in Arizona, California, Nevada, and Texas, CMS has implemented a provisional period of enhanced oversight (PPEO) that involves conducting medical review before making payments on these providers’ claims (Centers for Medicare & Medicaid Services 2025a). CMS reports that under the PPEO initiative, the agency reviewed claims for 668 hospices in the four states and revoked Medicare enrollment of 122 of these providers as of June 2025. In addition, CMS reported expanding prepayment review to existing hospices in the four states as of September 2024. Beyond these efforts focused specifically on these states, CMS has reported undertaking broader initiatives including a nationwide hospice site-visit project, streamlining the beneficiary disenrollment process (for beneficiaries wishing to disenroll from hospice), establishment of a rapid response team to resolve beneficiary complaints about inappropriate hospice enrollment, and a pilot project to review hospice claims following an individual’s first 90 days of hospice care (Centers for Medicare & Medicaid Services 2025a, Centers for Medicare & Medicaid Services 2023a). CMS has also undertaken several other types of measures to enhance aspects of program integrity for hospice providers (e.g., requiring physicians certifying hospice eligibility to be enrolled in Medicare or have officially opted out, categorizing hospice as “high risk” for Medicare enrollment screening purposes, and requiring hospices to reapply for enrollment if there is a majority ownership change within 36 months of enrollment or a prior majority ownership change) (Centers for Medicare & Medicaid Services 2023b, Centers for Medicare & Medicaid Services 2023c).

Volume of services: Measures of hospice use increased in 2024

Nationally, the share of Medicare decedents using hospice increased in 2024. In that year, 52.9 percent of Medicare decedents received hospice services, up from 51.7 percent in 2023, reaching a new high (Table 10-2, p. 301). The hospice-use rate, which had increased in the prior decade from 2010 to 2019, declined in the

first two years of the pandemic to 47.3 percent in 2021 as beneficiary deaths outpaced growth in the number of hospice users (2021 data not shown) (Medicare Payment Advisory Commission 2023). The hospice-use rate began increasing in 2022 and increased again in both 2023 and 2024.

In 2024, the share of decedents using hospice increased across all subgroups examined (Table 10-2, p. 301). However, hospice use remained more common among decedents who were older, female, White, residents of urban areas, and not eligible for Medicaid (i.e., not dually eligible for Medicare and Medicaid). Hospice use among beneficiaries with end-stage renal disease (who used dialysis at some time during the last year of life), a group that has lower-than-average hospice use, increased to 31.4 percent in 2024, up from 31.0 percent in 2023 (data not shown). In 2024, hospice-use rates were similar for FFS and MA decedents.

Although overall between 2010 and 2024 hospice-use rates increased among all racial and ethnic groups examined, rates continued to be higher for White decedents (Table 10-2, p. 301). The reasons for these differences are not fully understood. Researchers have cited a number of possible factors, such as cultural or religious beliefs, preferences for end-of-life care and advance care planning, disparities in access to care or information about hospice, socioeconomic factors, and mistrust of the medical system (Barnato et al. 2009, Cohen 2008, Crawley et al. 2000, LoPresti et al. 2016, Martin et al. 2011).

In 2024, decedents’ hospice-use rates increased across all categories of rural and urban counties (Table 10-2, p. 301). Historically, a greater share of urban decedents than rural decedents have used hospice. However, the difference in hospice-use rates between decedents in urban and rural counties has lessened over time as hospice-use rates grew more in rural counties than urban counties between 2010 and 2024 (Table 10-2). Hospice use is lowest among beneficiaries in frontier counties, although hospice use in these areas has also grown.

In 2024, measures of hospice use for all hospice enrollees (not just decedents) increased. That year, 1.82 million Medicare beneficiaries received hospice services, a 4.6 percent increase from 2023. The number of hospice days furnished increased substantially, 7.7 percent, to about 148 million days (Table 10-3).¹⁰

**TABLE
10-3**

Hospice use increased in 2024

						Average annual percent change	Percent change	
	2010	2019	2022	2023	2024	2010– 2019	2019– 2023	2023– 2024
Hospice use among Medicare decedents								
Number of Medicare decedents (in millions)	1.99	2.32	2.64	2.50	2.52	1.7%	1.8%	0.7%
Number of Medicare decedents who used hospice (in millions)	0.87	1.20	1.30	1.29	1.33	3.6	1.9	3.0
Average lifetime length of stay among decedents (in days)	87.0	92.5	95.3	96.2	99.6	0.7	1.0	3.5
Median lifetime length of stay among decedents (in days)	18	18	18	18	19	0 days	0 days	1 day
Medicare use and spending for all hospice users (not limited to decedents)*								
Total spending (in billions)	\$12.9	\$20.9	\$23.7*	\$25.7*	28.3*	5.5%	5.3%*	10.4%*
Number of Medicare hospice users (in millions)	1.15	1.61	1.72*	1.74*	1.82*	3.8	2.0*	4.6*
Number of hospice days for all hospice beneficiaries (in millions)	81.6	121.8	130.2*	137.7*	148.2*	4.6	3.1*	7.7*

Note: “Lifetime length of stay” is calculated for decedents who were using hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during their lifetime. Total spending, number of hospice users, number of hospice days, and average length of stay displayed in the table are rounded; the percentage-change columns for the number of hospice users and total spending are calculated using unrounded data.

* These estimates are based on Medicare-paid hospice claims, which exclude hospice care paid for by Medicare Advantage (MA) plans participating in the Center for Medicare & Medicaid Innovation hospice model of MA value-based insurance design (VBID) from 2021 to 2024. According to a CMS contractor evaluation report, 19,065 MA beneficiaries in 2022 and 23,828 MA beneficiaries in VBID-participating MA plans in 2023 started hospice that year under the model (Eibner et al. 2025). An evaluation report with data on experience in the fourth year of the model (2024) is not available yet.

Source: MedPAC analysis of data from the Common Medicare Environment and hospice claims data from CMS.

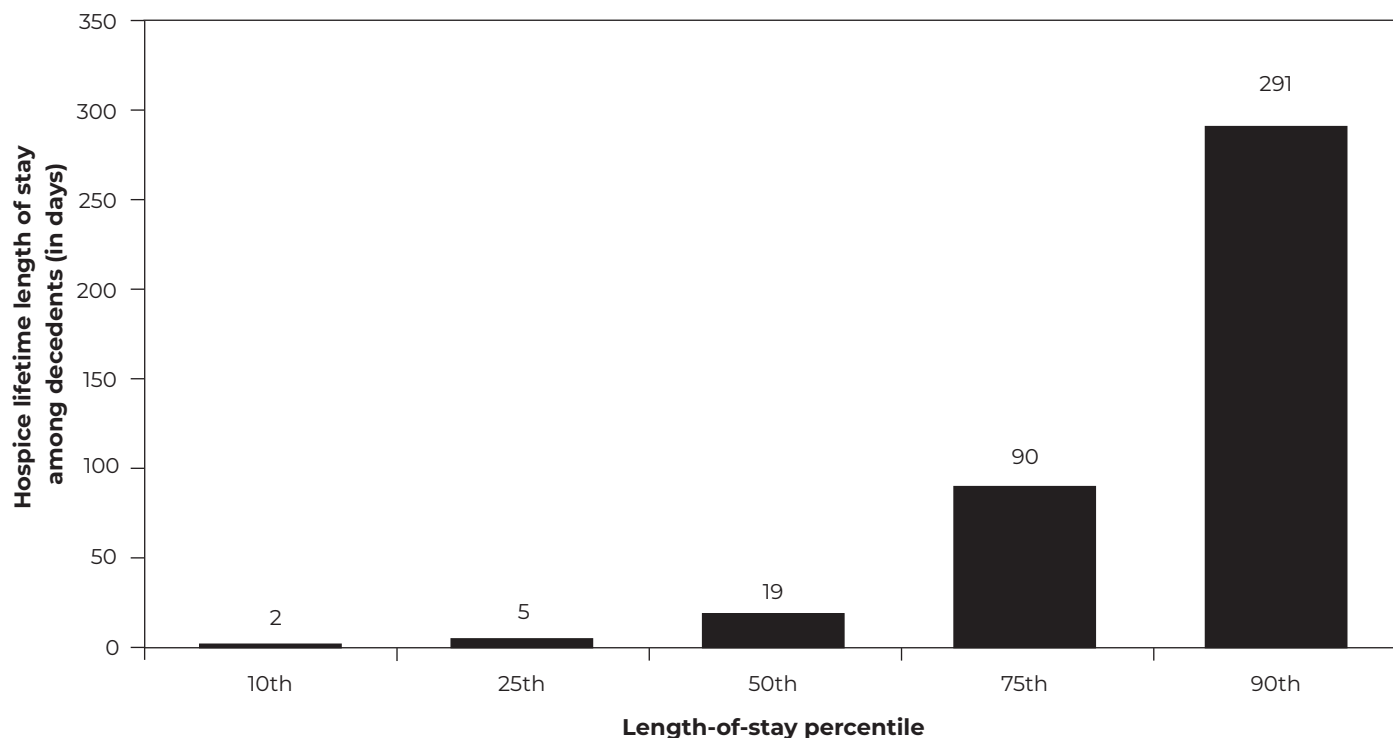
Hospice length of stay increased in 2024 Average lifetime length of stay among decedents was 99.6 days in 2024, up from 96.2 days in 2023 (Table 10-3). Median length of stay increased by 1 day to 19 days in 2024. Most hospice decedents have short stays, but some have very long stays (Figure 10-1, p. 304). Between 2023 and 2024, length of stay among decedents with the shortest stays remained the same (2 days at the 10th percentile and 5 days at the 25th percentile), and it increased among those with longer stays (from 86 days

to 90 days at the 75th percentile and from 278 days to 291 days at the 90th percentile) (Figure 10-1; 2023 data not shown).

Length of stay has implications for our broader assessment of payment adequacy because patients’ length of stay affects provider profitability. Hospices furnish more services at the beginning and end of a hospice episode and fewer services in the middle, making long stays more profitable for providers than

**FIGURE
10-1**

Most hospice decedents had relatively short stays, but some had very long stays, 2024



Note: Lifetime length of stay is calculated for decedents who were using hospice at the time of death or before death; it reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during their lifetime.

Source: MedPAC analysis of the Common Medicare Environment and the Medicare Beneficiary Database from CMS.

short stays (Medicare Payment Advisory Commission 2013). Hospice lengths of stay vary by observable patient characteristics—such as patient diagnosis and location—so hospice providers can identify and enroll patients who are likely to have long (more profitable) stays if they so choose. For example, in 2024, average lifetime length of stay was longer among decedents admitted to hospice for neurological conditions and chronic obstructive pulmonary disease (169 days and 133 days, respectively) than among decedents with cancer (51 days). Length of stay was also longer among patients in assisted-living facilities (174 days) or nursing facilities (120 days) compared with patients at home (100 days).

For-profit hospices have substantially longer average lengths of stay than nonprofit hospices (120 days compared with 71 days, respectively, in 2024). For-

profit hospices have more patients admitted for diagnoses that tend to have longer stays, but they also have patients with longer stays than nonprofit hospices for all types of diagnoses. For example, among hospice decedents admitted for neurological conditions, average length of stay was 194 days for for-profit hospices and 129 days for nonprofit hospices.¹¹ These differences in patient mix and length of stay contribute to the variation observed among providers' profit margins, discussed below. (See our March 2021 report to the Congress for a text box discussing approaches that could be explored to modify the hospice payment system to reduce variation in profitability by length of stay and address aberrant utilization patterns by some providers (Medicare Payment Advisory Commission 2021).)

**TABLE
10-4****Over 60 percent of Medicare hospice spending was for patients with stays exceeding 180 days, 2024****Medicare hospice spending, 2024 (in billions)**

All hospice users in 2024	\$28.3
Beneficiaries with LOS > 180 days	17.5
Days 1-180	5.6
Days 181-365	5.3
Days 366+	6.6
Beneficiaries with LOS ≤ 180 days	10.9

Note: LOS (length of stay). "LOS" reflects the beneficiary's lifetime days with hospice as of the end of 2024 (or at the time of discharge in 2024 if the beneficiary was not enrolled in hospice at the end of 2024). All spending reflected in the chart occurred only in 2024. Components do not sum to totals because of rounding.

Source: MedPAC analysis of Medicare hospice claims data and an Acumen data file on hospice lifetime length of stay (which is based on an analysis of historical claims data).

Although most patients have short hospice stays, long stays account for the majority of Medicare spending on hospice. In 2024, Medicare spent more than \$17 billion, just over 60 percent of hospice spending that year, for patients with stays exceeding 180 days (Table 10-4). About \$6.6 billion of that spending was for hospice care for patients who had already received at least one year of hospice services (which is already

twice the presumptive eligibility period for the hospice benefit).

Among the hospices with very long stays are those that exceed the hospice aggregate cap. We estimate that in 2023, about 28 percent of hospices (which furnished care to about 8 percent of hospice beneficiaries in 2023) exceeded the aggregate payment cap, up from about 23 percent in 2022 (Table 10-5).¹² On average,

**TABLE
10-5****Hospices that exceeded Medicare's annual payment cap, 2019-2023**

	2019	2020	2021	2022	2023
Estimated share of hospices exceeding the cap	19%	19%	19%	23%	28%
Average payments over the cap per hospice exceeding it (in thousands)	\$384	\$422	\$451	\$419	\$410
Payments over the cap as a share of overall Medicare hospice spending	1.7%	1.8%	2.0%	2.3%	2.9%

Note: The aggregate cap statistics reflect the Commission's estimates and may differ from CMS claims-processing contractors' estimates. Our estimates assume all hospices use the proportional methodology and rely on claims data through 15 months after the end of each cap year. The claims-processing contractors may reopen the hospice cap calculation for up to three years; the reopening process and timing vary across contractors. The cap years for 2019 through 2023 are aligned with the federal fiscal year (October 1 to September 30 of the following year).

Source: MedPAC analysis of Medicare hospice claims data, Medicare hospice cost reports, and Medicare Provider of Services file from CMS.

each above-cap hospice exceeded the cap by about \$410,000 in 2023. Hospices that exceed the cap are disproportionately located in four states—Arizona, California, Nevada, and Texas. Excluding these four states, we estimate that the share of hospices exceeding the cap in 2023 was about 6 percent, up slightly from 5 percent in 2022. In contrast, we estimate that more than half of hospices in California exceeded the cap in 2023 and approximately 30 percent to 40 percent of hospices in Texas, Nevada, and Arizona. These four states have experienced rapid entry of new providers in recent years, particularly through 2023. In mid-2023, CMS began a program of enhanced oversight for newly enrolling hospices in these states, motivated by concerns about rapid entry of providers, market saturation, and fraud, waste, and abuse (Centers for Medicare & Medicaid Services 2025b). As we have discussed in past reports, above-cap hospices have substantially longer stays and higher live-discharge rates than below-cap hospices (even for patients with similar diagnoses), and they tend to treat fewer patients per year and are more likely to be for profit, freestanding, recent entrants to the Medicare program, and located in urban areas (Medicare Payment Advisory Commission 2022). As the Commission has noted in past reports, these length-of-stay and live-discharge patterns suggest that above-cap hospices are admitting patients who do not meet the hospice eligibility criteria, which merits further investigation by the Office of Inspector General and CMS (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2012). Recent studies have raised questions about the effect of the cap on beneficiary outcomes and Medicare spending (Coe and Rosenkranz 2025, Gruber et al. 2025).¹³ The Commission has further research underway concerning the cap.

In-person hospice visits were stable between 2023 and 2024 In 2024, the average number and length of hospice in-person visits was generally stable compared with the prior year (Table 10-6). In 2024, beneficiaries who were enrolled in hospice received on average 3.9 visits per week, with nurse, aide, and social worker visits accounting for 1.8, 1.9, and 0.3 visits, respectively, per week on average (Table 10-6). The number of in-person nurse visits, which declined slightly during the pandemic, has rebounded. The average number of aide visits per week was stable in 2024 compared with 2023

but remained below the 2019 level. Each hospice visit in 2024 averaged just under an hour long, similar to 2023, and aide visits were slightly longer on average than nurse and social worker visits. Overall, the average total visit time per week was stable between 2023 and 2024 but remained below the prepandemic level.

From 2020 through mid-2023 (i.e., through the end of the public health emergency on May 11, 2023), hospices were given the flexibility to provide RHC visits via telecommunications technology as a substitute for in-person visits if it was feasible and appropriate to do so. However, hospices were not required to report data on the telehealth visits they furnished (except for social worker phone calls) during that period. Therefore, we lack data to determine whether telehealth visits were used to substitute for in-person visits from 2020 to 2023.

Quality of care is difficult to assess, but available indicators appear stable

Scores on available quality metrics, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) hospice survey were stable in the most recent period. Scores on a composite of seven processes of care at admission increased slightly but were very high in the most recent period and topped out for most providers. Measures of the provision of in-person nurse and social worker visits at the end of life increased in the most recent period.

Consumer Assessment of Healthcare Providers and Systems

The Hospice Quality Reporting Program requires hospice providers to participate in a CAHPS hospice survey.¹⁴ The survey gathers information from the patient's informal caregiver (typically a family member) after the patient's death.¹⁵ Areas of focus include how the hospice performed on the following measures: communicating, providing timely care, treating patients with respect, providing emotional support, providing help for symptom management, and training family or other informal caregivers in the home setting. Respondents are also asked to rate the hospice on a scale of 1 to 10 and to say whether they would recommend the hospice.

All hospice providers are required to report CAHPS data, except those that are exempt due to being too small or too new (i.e., having an eligible patient population

**TABLE
10-6****In-person hospice visits were generally stable between 2023 and 2024**

	2019	2021	2022	2023	2024	Percent change 2023–2024
Average number of visits per week						
All visits	4.3	3.8	3.9	3.9	3.9	1%
Nurse visits	1.8	1.7	1.7	1.8	1.8	1
Aide visits	2.2	1.8	1.8	1.9	1.9	1
Social worker visits	0.3	0.3	0.3	0.3	0.3	–1
Average length per visit (in minutes)						
All visits	58	57	56	56	55	0
Nurse visits	56	54	53	52	52	–1
Aide visits	62	60	60	60	60	0
Social worker visits	50	49	48	47	47	–1
Average visit time per week (in minutes)						
All visits	252	215	215	217	218	0
Nurse visits	103	92	91	92	92	0
Aide visits	136	109	110	111	112	1
Social worker visits	16	13	13	13	13	–2

Note: Analysis includes only routine home care days and visits. “Visits” refers to in-person visits only and excludes postmortem visits. “Nurse visits” includes both registered nurse and licensed practical nurse visits. “Visit length” is reported by providers in the number of 15-minute increments, rounded to the nearest increment. We calculate minutes per visit by multiplying the number of 15-minute increments by 15. Components may not sum to totals due to rounding. Data displayed in table on visit frequency and time are rounded; percent change was calculated using unrounded numbers. Estimates of length of visits and total visit time for 2023 and earlier years differ from those in our prior reports due to refinements in methodology.

Source: MedPAC analysis of Medicare hospice claims data from CMS.

of fewer than 50 patients in a reference year or being in their first year of furnishing hospice services). For those hospices that participate in CAHPS, CMS does not publicly report the data if there were fewer than 30 completed surveys for the hospice for the reporting period or there were fewer than 11 answers for a specific CAHPS measure. In the most recent reporting period (January 2023 to December 2024), just over 3,100 hospice providers had hospice CAHPS scores publicly reported on each measure, which represents less than half of all hospice providers in 2023.

Sector-wide CAHPS scores—as measured by the median hospice’s share of caregivers who reported the “top box,” meaning the most positive, survey

response in eight domains—were generally stable in the most recent period (January 2023 to December 2024) compared with the prior period (January 2022 to December 2023) (Table 10-7, p. 308). Specifically, scores for the median hospice on seven of the measures were unchanged in the most recent period, while the score increased 1 percentage point for a measure of hospice communication. Similar to the prior period, for the median hospice, 82 percent of caregivers in the most recent period rated the hospice a 9 or 10, and 85 percent would definitely recommend the hospice. Caregivers most frequently gave top ratings on measures of providing emotional support and treating patients with respect (91 percent of caregivers chose

**TABLE
10-7**

Scores on hospice CAHPS quality measures

	Median performance across hospice providers	
	Previous period (January 2022 to December 2023)	Most recent period (January 2023 to December 2024)
Share of caregivers rating the hospice a 9 or 10	82%	82%
Share of caregivers who would definitely recommend the hospice	85	85
Share of caregivers who give top ratings on:		
Providing emotional support	91	91
Treating patients with respect	91	91
Help for pain and symptoms	75	75
Hospice team communication	81	82
Providing timely help	78	78
Caregiver training	76	76

Note: CAHPS (Consumer Assessment of Healthcare Providers and Systems). The CAHPS scores in the eight listed domains reflect the share of respondents who reported the “top box” (the most positive survey response) across all providers. In the most recent period, between 3,120 and 3,134 hospice providers had publicly reported CAHPS scores for these measures. These hospices accounted for less than half of all hospices in 2023.

Source: CAHPS hospice survey data from CMS.

the most positive response in those areas in the most recent period). Roughly three-quarters of caregivers gave hospices top ratings for providing help for pain and symptoms, providing timely care, and training caregivers (Table 10-7).

Recent studies have also indicated that CAHPS scores vary by ownership status. In an analysis of CAHPS data from the second quarter of 2017 to the first quarter of 2019, Anhang Price and colleagues found that nonprofit providers were more likely to be high performers and less likely to be low performers (as measured by being 3 percentage points above or below the national average CAHPS score in a domain on the CAHPS survey) than for-profit providers (Anhang Price et al. 2023). Analysis of hospice CAHPS data from January 2021 to December 2022 by Soltoff and colleagues found that nonprofit hospices had higher average scores on CAHPS measures than two types of for-profit providers (those owned by chains or private equity firms and those with other types of for-profit ownership) (Soltsoff et al. 2024).¹⁶

Another way to consider quality performance is to examine the frequency with which caregivers report poor experiences. Two fundamental purposes of hospice are to manage a patient’s symptoms in accord with the patient’s preferences and to provide timely help; thus, it could be informative to examine how frequently poor performance occurs in these areas. Looking at the distribution of caregiver responses across providers on the CAHPS survey in the most recent period, for the median hospice, 10 percent of patients’ informal caregivers gave the bottom rating on help for pain and symptoms (i.e., reported that the patient sometimes or never got the help they needed for pain or symptoms) and 9 percent gave the bottom rating on providing timely help (i.e., reported that the hospice team sometimes or never provided timely help). Across providers, the share of caregivers choosing the bottom rating on these two measures ranged from 5 percent or 6 percent at the 10th percentile to 15 percent at the 90th percentile in the most recent period, and those figures were similar to the prior period.

Process measures

Hospices are required to report data on seven processes of care that are important for patients newly admitted to hospice. These processes include pain screening, pain assessment, dyspnea (shortness of breath) screening, dyspnea treatment, documentation of treatment preferences, addressing beliefs and values if desired by the patient, and provision of a bowel regimen for patients treated with an opioid. CMS has a composite measure that reflects the share of admitted patients for whom the hospice performed all seven activities appropriately (or appropriately performed all the activities relevant to the patient). Hospice providers' scores on the composite measure are very high and increased slightly in the most recent period. The provider-level median score was 96.8 percent, up slightly from 96.6 percent in the previous period. The consistently high scores on the composite measure suggest that it has topped out in its ability to distinguish meaningful differences in quality for most hospices.

In addition, the Hospice Quality Reporting Program includes two claims-based process measures.¹⁷ One is the Hospice Care Index, which identifies providers with outlier patterns of care based on hospice providers' performance across 10 indicators. These indicators include four related to the provision of visits to hospice patients, four related to aspects of live discharge, one that reflects Medicare hospice spending per beneficiary, and one that gauges whether the provider furnished any high-intensity care (CHC or GIP).¹⁸ In the most recent reporting period, from January 2023 to December 2024, 15 percent of providers with data were outliers (with "outlier" defined as performance being among the worst 10 percent) on at least 3 of 10 measures, and 2 percent were outliers on at least half of the measures.

The second claims-based process measure focuses on visits by hospice nurses and social workers at the end of life. Measures of these visits are thought to be indicators of quality because patients' and caregivers' need for symptom management and support tends to increase in the last week of life. The measure calculates the share of hospice decedents who received in-person nurse or social worker visits on at least two of the last three days of life. In the most recent period (January 2023 to December 2024), the median hospice

furnished visits on at least two of the last three days of life for 61 percent of patients, a 2 percentage point increase from 59 percent in the prior period (January 2022 to December 2023). Performance on this measure varied substantially across providers, ranging from 43 percent at the 25th percentile to 73 percent at the 75th percentile in the most recent period, up 2 percentage points from the prior reporting period (which were 41 percent and 71 percent, respectively).

Future quality measures

The Commission consistently maintains that, with quality measurement in general, outcome measures are preferable to process measures. Although outcome measures for hospice are particularly challenging, the Commission contends that outcome measures such as patient-reported pain and other symptom-management measures warrant further exploration.

As of October 2025, hospices have begun reporting patient data using a new hospice data-collection instrument (referred to as the Hospice Outcomes & Patient Evaluation (HOPE) instrument). The new instrument collects information at additional times during the hospice episode (not just at admission and discharge) and additional types of data about patient characteristics and symptoms, which may offer the opportunity for new types of quality measures. CMS has finalized two new process quality measures that will be collected via the HOPE instrument: timely reassessment of pain impact and timely reassessment of nonpain-symptom impact.

High rates of live discharge from hospice could signal problems

As the Commission has noted over the years, high rates of live discharge may signal poor quality or program-integrity issues. Hospice providers are expected to have some live discharges because patients may change their mind about using the hospice benefit and disenroll from hospice or their condition may improve such that they no longer meet the hospice-eligibility criteria. However, high rates of live discharge relative to other hospices could indicate a problem, such as a hospice provider not meeting the needs of patients and families or admitting patients who do not meet the eligibility criteria. In 2024, the aggregate rate of live discharge (that is, live discharges as a share of all discharges) was 19.1 percent, up slightly from

18.5 percent in 2023.¹⁹ Analysis of prior year (2023) data provides more details on live discharges. Some providers have disproportionately high live-discharge rates. Among providers with more than 30 discharges, the median live-discharge rate in 2023 was about 21 percent, but 10 percent of those providers had live-discharge rates of 56 percent or more in 2023 (Medicare Payment Advisory Commission 2025).

Very short hospice stays signal opportunities for quality improvement

For many years, a significant share of hospice stays have been very short. More than one-quarter of hospice decedents enroll in hospice only in the last week of life, a length of stay that is commonly thought to be less beneficial to patients and families than enrolling earlier. These short stays are generally unrelated to the adequacy of Medicare's hospice payment rates. Very short hospice stays occur across a wide range of diagnoses. In some cases, short stays may be the result of a rapid change in a patient's health condition. Broader issues in the health care delivery system that precede the hospice referral also likely contribute to short stays (Medicare Payment Advisory Commission 2022). For example, some physicians are reluctant to have conversations about hospice or tend to delay such discussions until death is imminent; some patients or families may prefer conventional care to palliative care or may prefer exhausting all treatment options before enrolling in hospice; and financial incentives in the FFS system may encourage increased volume of clinical services (compared with palliative care furnished by hospice providers) (Medicare Payment Advisory Commission 2009). The requirement that beneficiaries forgo intensive conventional care to enroll in hospice, some analysts point out, may also contribute to beneficiaries deferring hospice care, resulting in short hospice stays (Medicare Payment Advisory Commission 2009).

Multiple factors influence the decision to enroll in hospice. One such factor is the interactions that beneficiaries and their families have with clinicians upstream in the health care delivery system before hospice enrollment. Broader health care delivery-system services or initiatives may offer the potential to improve end-of-life care quality, such as advance care-planning visits (which have been covered by Medicare since 2016), or new payment models CMS

is testing such as accountable care organizations and the Guiding an Improved Dementia Experience (GUIDE) Model, as well as the recent MA-VBID model and Medicare Care Choices Model (Medicare Payment Advisory Commission 2024).²⁰

Hospices have good access to capital

Hospices in general require less capital than many other provider types because they do not need extensive physical infrastructure (although some hospices have built their own inpatient units, requiring significant capital). Overall, access to capital for hospices appears adequate, given the continued entry of for-profit providers in the Medicare program.

In 2024, the number of for-profit providers grew by 5 percent, indicating that these providers have been able to access capital. The most recent available financial reports for five publicly traded hospice companies generally indicate strong financial performance through the second or third quarter of calendar year 2025 (Addus 2025, Amedisys 2025, Chemed 2025, Enhabit 2025b, Pennant Group 2025).²¹ Admissions and average daily census grew for all five companies in the first nine months (or first six months for Amedisys) of 2025 compared with the same period in 2024. Trends in average length of stay among discharged patients varied across companies, ranging from a modest decrease to a substantial increase. Among the four publicly traded companies that report hospice-specific margins, margins increased for three companies and decreased for one company (Addus 2025, Amedisys 2025, Chemed 2025, Enhabit 2025a). In 2025, two publicly traded hospice companies expanded by acquiring other hospice providers, and one company closed or consolidated some hospice branches (Addus 2025, Enhabit 2025b, Pennant Group 2025).

The hospice sector continues to garner investment interest from other health care companies and private equity firms and investors. For example, in 2025, an insurer, UnitedHealth Group, acquired Amedisys (a large home health and hospice company) (Parker 2025b). Over a longer time horizon from 2010 to 2021, a study by Braun and colleagues found that private equity firms and publicly traded companies have been involved in the acquisition of numerous hospice agencies (over 1,200 hospice agencies over that period), with private equity and publicly traded firms caring

for an increasing share of Medicare hospice patients (25 percent in 2021 according to the study) (Braun et al. 2023). However, merger-and-acquisition activity slowed over the period from 2022 to 2025, following several years of increased activity (Braff Group 2025, Mertz-Taggart 2025). Some analysts attribute the slowdown in mergers and acquisitions to high interest rates (which increased substantially in 2022 and 2023 and began to decline in 2024 and 2025) and uncertainty over future interest rates and inflation (Parker 2025a, Vossel 2025). In addition, some analysts indicate that the heightened program-integrity environment, particularly in four states, has slowed some merger-and-acquisition activity (Mertz-Taggart 2025).

Less is known about access to capital for nonprofit freestanding providers. Hospital-based and home health-based nonprofit hospices have access to capital through their parent providers. Our analysis of access to capital for these types of providers found that in 2024 hospitals' access to capital improved (see Chapter 3) and home health agencies' access to capital was adequate (see Chapter 8).

A provider's all-payer total margin—which reflects how its total revenues compare with its total costs for all lines of business and all payers—can influence a provider's ability to obtain capital. Irregularities in the way some hospices report their total revenue and total expense data on cost reports prevent us from calculating a reliable estimate of all-payer total margins for hospices. Among hospice payers, however, Medicare accounted for about 91 percent of hospice days in 2023, and hospices' FFS Medicare margins are strong.

Medicare payments and costs: Aggregate payments exceed costs

In 2023, the FFS Medicare margin was 8.0 percent, down from 9.8 percent in 2022, as per day cost growth outpaced growth in per day payments. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability and how MedPAC utilizes margins and other types of data to make a judgment about payment adequacy. Hospice margins are presented through 2023 because of the data lag required to calculate cap-overpayment amounts.) Hospice costs per day increased 3.0 percent between 2022 and 2023; cost growth slowed considerably in

2024. Hospice costs vary substantially by providers' average length of stay: Hospices with longer stays have lower costs per day, on average, resulting in higher margins. Hospices with a large share of patients in nursing facilities and assisted-living facilities also have higher FFS Medicare margins.

Medicare's payments to hospice providers

Between 2010 and 2023, Medicare's spending for hospice grew substantially, increasing 5.4 percent per year on average, from \$12.9 billion to \$25.7 billion. Between 2023 and 2024, Medicare hospice spending increased 10.4 percent to \$28.3 billion, largely reflecting a 3.1 percent update to hospice base payment rates in fiscal year 2024 and a 7.7 percent increase in total days of care in 2024. On a per day basis, Medicare's average payment to hospice providers was about \$191 in 2024, up 2.6 percent from 2023.

Hospice costs

In 2024, hospice costs per day across all levels of care for hospice providers with cost-report data averaged about \$168, rising 1.1 percent from 2023.

Hospice costs per day vary substantially by type of provider, which is one reason for differences in hospice margins across provider types (Table 10-8, p. 312). In 2024, freestanding hospices had lower average costs per day than provider-based hospices (i.e., home health-based and hospital-based hospices). For-profit and rural hospices also had lower average costs per day than their respective counterparts.²² Many factors contribute to variation in hospice costs across providers. One factor is length of stay. Hospices with longer stays have lower costs per day on average, and freestanding and for-profit hospices have substantially longer stays than other hospices (Medicare Payment Advisory Commission 2022). Another factor is overhead costs. Included in the costs of provider-based hospices are overhead costs allocated from the parent provider, which likely contribute to these hospices' higher costs.²³ The Commission maintains that payment policy should focus on the efficient delivery of services and that if freestanding hospices are able to provide high-quality care at a lower cost than provider-based hospices, payment rates should be set accordingly; the higher costs of provider-based hospices should not be a reason for increasing Medicare payment rates.

**TABLE
10-8****Total hospice costs per day varied
by type of provider, 2024**

Average total cost per day	
All	\$168
Freestanding	162
Home health based	186
Hospital based	275
For profit	147
Nonprofit	214
Urban	170
Rural	156

Note: "Cost per day" reflects aggregate costs per day for all types of hospice care combined (routine home care, continuous home care, general inpatient care, and inpatient respite care) divided by the total number of days of hospice care for all payers. "Day" reflects the total number of days for which the hospice is responsible for care of its patients, regardless of whether the patient received a visit on a particular day. Data are not adjusted for differences in case mix or wages across hospices.

Source: MedPAC analysis of Medicare hospice cost reports and Medicare Provider of Services file from CMS.

Hospice margins

Between 2022 and 2023 (the year of our margin estimate), hospice costs per day grew 3.0 percent. Cost growth outpaced growth in per day payments (which is the result of a combination of factors, including the annual payment update of 3.8 percent in 2023, full reinstatement of the sequester in 2023 (which was reinstated for only a portion of cost-report year 2022), shifts in the mix of days, and the effects of the aggregate cap). As a result, the aggregate FFS Medicare margin for hospice providers in 2023 was 8.0 percent, down from 9.8 percent in 2022 (Table 10-9).²⁴ FFS Medicare margins varied widely across individual hospice providers: -16 percent at the 25th percentile, 6 percent at the 50th percentile, and 21 percent at the 75th percentile (data not shown). Our estimates of FFS Medicare margins exclude overpayments to above-cap hospices and are calculated based on Medicare-allowable, reimbursable costs, consistent with our approach used in other Medicare sectors.²⁵

In addition, these margin estimates do not include federal pandemic relief funds that were received by hospice providers.

Hospice margins vary by provider characteristics, such as type of hospice (freestanding or provider based), type of ownership (for profit or nonprofit), patient volume, and urban or rural location (Table 10-9). In 2023, freestanding hospices had a higher aggregate FFS Medicare margin (10.2 percent) than home health-based (4.4 percent) or hospital-based hospices (-25.6 percent) (Table 10-9). Provider-based hospices typically have lower FFS Medicare margins than freestanding hospices for several reasons, including their shorter stays and the allocation of overhead costs from the parent provider to the provider-based hospice. In 2023, the aggregate FFS Medicare margin of for-profit hospices was strong, at 13.7 percent. Overall, nonprofit hospices had a slightly negative margin (-1.3 percent), but the margin was positive among freestanding nonprofit hospices (2.6 percent; data not shown). Generally, hospices' FFS Medicare margins vary by the provider's volume: Hospices with more patients have higher margins on average. Hospices in urban areas had a slightly higher aggregate FFS Medicare margin (8.3 percent) than those in rural areas (5.3 percent).

Margins also vary by whether a hospice exceeds the aggregate cap. In 2023, below-cap hospices had an aggregate FFS Medicare margin of 9.0 percent. Above-cap hospices had a high FFS Medicare margin in 2023 before the return of overpayments (17.8 percent) and a slightly negative estimated margin after the return of overpayments (-1.4 percent) that year (Table 10-9). Although our estimate of above-cap hospices' "margin after the return of overpayments" assumes that 100 percent of cap overpayments are returned to the government, the Office of Inspector General (OIG) audits suggest that some portion of cap overpayments may be uncollectible. For example, OIG audits of three Medicare claims-processing contractors found that the share of cap overpayments that were classified as uncollectible (meaning at least 180 days delinquent and unlikely to be collected) varied, ranging from 4 percent to 20 percent to 27 percent across the three contractors (Office of Inspector General 2024, Office of Inspector General 2022, Office of Inspector General 2021).

Hospice profitability is closely related to length of stay. Hospices with longer stays have higher margins. For

**TABLE
10-9****Hospice providers' FFS Medicare margins
by selected characteristics, 2019-2023**

Category	Share of		FFS Medicare margin				
	Hospice providers, 2023	Hospice patients, 2023	2019	2020	2021	2022	2023
All	100%	100%	13.4%	14.2%	13.3%	9.8%	8.0%
Freestanding	88	84	16.2	16.7	15.5	12.4	10.2
Home health based	6	9	9.7	11.2	10.9	3.8	4.4
Hospital based	6	7	-18.4	-18.2	-15.6	-23.5	-25.6
For profit	80	57	19.2	20.5	19.2	16.1	13.7
Nonprofit	18	42	6.1	5.8	5.2	0.3	-1.3
Urban	87	90	13.6	14.3	13.4	10.0	8.3
Rural	13	10	11.5	13.5	12.3	8.1	5.3
Patient volume (quintile)							
Lowest	20	2	-4.5	-2.1	-4.4	-12.3	-20.2
Second	20	4	6.2	4.9	3.1	-6.4	-6.8
Third	20	9	13.5	14.2	13.3	5.5	5.9
Fourth	20	18	15.8	17.9	15.5	12.2	10.6
Highest	20	67	13.9	14.4	14.0	11.7	9.5
Below cap	72	92	13.8	14.8	14.0	10.8	9.0
Above cap (excluding cap overpayments)	28	8	10.0	7.7	2.5	-1.6	-1.4
Above cap (including cap overpayments)	28	8	22.5	22.8	21.8	18.5	17.8
Share of stays > 180 days							
Lowest quintile	20	31	-2.5	-0.4	0.0	-4.1	-4.8
Second quintile	20	28	10.3	11.8	11.1	8.2	7.6
Third quintile	20	19	19.9	20.0	20.5	17.8	16.7
Fourth quintile	20	17	22.8	24.1	22.2	18.6	15.9
Highest quintile	20	6	13.4	13.4	9.7	2.7	-1.1
Share of patients in nursing facilities and assisted-living facilities							
Lowest half	50	45	6.6	7.5	7.1	1.8	0.2
Highest half	50	55	18.7	18.9	17.6	15.1	13.3

Note: FFS (fee-for-service). Margins for all provider categories exclude overpayments to above-cap hospices, except where specifically indicated. Medicare aggregate margins are calculated based on Medicare-allowable, reimbursable costs. Margin by hospice ownership status is based on hospices' ownership designation from the Medicare cost report. The rural and urban definitions used in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census). Government-owned hospices operate in a different financial context from other hospices, so their margin is not necessarily comparable; therefore, data for government-owned hospices are not reported separately or included in the ownership rows (but are included in other rows).

Source: MedPAC analysis of Medicare hospice cost reports, Medicare hospice claims data, and Medicare Provider of Services file from CMS.

example, in an analysis of hospice providers based on the share of their patients' stays exceeding 180 days, we found that the 2023 aggregate FFS Medicare margin ranged from about -5 percent for hospices in the lowest quintile to 17 percent in the third-highest and 16 percent in the second-highest quintile (Table 10-9, p. 313). Hospices in the quintile with the greatest share of patients exceeding 180 days had an aggregate FFS Medicare margin of about -1 percent after the return of cap overpayments, but without the hospice aggregate cap, these providers' aggregate FFS Medicare margin would have been nearly 18 percent (latter figure not shown in table).

Hospices with a large share of patients in nursing facilities and assisted-living facilities have higher FFS Medicare margins than other hospices (Table 10-9, p. 313). For example, in 2023, the 50 percent of hospices with the highest share of patients residing in nursing facilities and assisted-living facilities had an aggregate FFS Medicare margin of 13.3 percent compared with a margin of 0.2 percent for providers with fewer patients residing in facilities. The higher aggregate FFS Medicare margin among hospices treating more facility-based patients is driven in part by the diagnosis profile and length of stay of patients residing in facilities. In addition, treating hospice patients in a centralized location likely creates efficiencies in terms of mileage costs and staff travel time, as well as facilities serving as referral sources for new patients. Nursing facilities can also be a lower-cost setting for hospices to provide care because of the overlap in responsibilities between the hospice and the nursing facility.

Projected 2026 aggregate FFS Medicare margin

To project the 2026 aggregate FFS Medicare margin, we model the policy changes that went into effect between 2023 (the year of our most recent margin estimates) and 2026. For 2024, we assume rates of payment and cost growth based on preliminary data for that year. For 2025 and 2026, we assume revenue growth based on the annual payment updates in 2025 (2.9 percent) and 2026 (2.6 percent). The updates for these years reflect the statutorily required market basket update and productivity adjustment. In addition, our margin reflects the payment-rate penalty that providers face for not reporting quality data, which increased in 2024

from 2 percent to 4 percent. In addition, we assume a rate of cost growth similar to historical trends for 2025 and 2026. We also assume additional administrative costs associated with implementation of the new HOPE data collection instrument beginning in fiscal year 2026. Taking these factors into account, we project an aggregate FFS Medicare margin of about 9 percent for hospices in 2026.

How should FFS Medicare payments change in 2027?

Under current law, Medicare's base payment rates for hospice care are updated annually based on the projected increase in the hospice market basket, less an amount for productivity improvement. The final update for 2027 will not be set until summer 2026; however, using CMS's third-quarter 2025 projections of the 2027 market basket (3.1 percent) and productivity adjustment (0.8 percent) would increase hospice payment rates by 2.3 percent.

Our indicators of payment adequacy for hospices—beneficiary access to care, quality of care, provider access to capital, and Medicare payments relative to providers' costs—are positive. Current payment rates appear sufficient to support the provision of high-quality care without an increase to the base payment rates in 2027.

RECOMMENDATION 10

For fiscal year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rates for hospice.

RATIONALE 10

Our indicators of access to care are positive, and there are signs that the aggregate level of payment for hospice care exceeds the level needed to furnish high-quality care to beneficiaries. In 2024, the number of providers increased by 2.6 percent. The share of Medicare decedents using hospice, the total number of beneficiaries receiving hospice care, and the total days of hospice care also increased. Among decedents, median and average length of stay increased. Access to capital remains adequate: The number of for-profit

providers increased by about 5 percent, and financial reports suggest that the sector continues to be viewed favorably by investors. The 2023 aggregate FFS Medicare margin was 8.0 percent. The projected 2026 aggregate FFS Medicare margin is about 9 percent.

IMPLICATIONS 10

Spending

- This recommendation would decrease federal program spending relative to current law by \$250 million to \$750 million over one year and by \$1 billion to \$5 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries' access to hospice care. Given the current level of payments, we do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries. ■

Endnotes

- 1 When a beneficiary first elects hospice, if they do not have an attending physician, the certification can be done by the hospice physician alone. For subsequent benefit periods, only the hospice physician is required to certify the patient's eligibility (even if the patient has a separate attending physician).
- 2 In 2015, a Commission contractor conducted research that examined the literature and carried out a market-level analysis. The contractor concluded that while hospice produces savings for some beneficiaries, such as those with cancer, overall, hospice has not reduced net Medicare program spending and may have even increased it because of very long stays among some hospice enrollees with noncancer diagnoses (Direct Research 2015). In more recent years, additional studies on this topic have had varied results, and debate about hospices' effect on Medicare spending continues. Several studies provide examples of the recent mixed findings in the literature on hospice's effect on Medicare spending. A recent study found that for-profit hospice enrollment led to large savings for some beneficiaries with dementia (Gruber et al. 2025). An industry-sponsored study reported that hospice saved 3 percent in the last year of life, with savings for long stays across all diagnoses (NORC at the University of Chicago 2023). However, several other studies that looked at spending in the last 6 or 12 months of life had more mixed results, finding that hospice was associated with higher Medicare spending or no difference in Medicare spending for beneficiaries with dementia (Aldridge et al. 2023, Zuckerman et al. 2016); lower Medicare spending for beneficiaries with cancer (Hung et al. 2020, Zuckerman et al. 2016); higher spending for beneficiaries with noncancer diagnoses and stays exceeding 30 days (Hung et al. 2020); and higher spending for beneficiaries residing in nursing facilities (Gozalo et al. 2015).
- 3 The Congress also established a second cap, which limits the share of inpatient care days that a hospice can provide to 20 percent of its total Medicare patient-care days. This cap is rarely exceeded; any inpatient days provided in excess of the cap are paid at the RHC payment rate.
- 4 For example, for a hypothetical hospice with a wage index of 1.0 whose patients received only RHC, if half of the hospice's patients each had a length of stay of 30 days, the other half could have an average length of stay of up to 335 days before that provider would exceed the cap. The length-of-stay patterns in this hypothetical example are much longer than typical for the hospice population (for patients with both short and long stays) because median lifetime length of stay among decedents in 2024 was 19 days, and length of stay was 291 at the 90th percentile.
- 5 Throughout this chapter, we use the term "FFS Medicare" as equivalent to the CMS term "original Medicare."
- 6 When an MA enrollee elects hospice, the beneficiary remains in the MA plan for Part D drugs and supplemental benefits. If an MA beneficiary is discharged alive from hospice, any Part A or Part B services that the beneficiary receives following the live discharge through the end of that calendar month are paid by FFS. At the beginning of the next month, responsibility for all Part A, Part B, and Part D services for the beneficiary reverts to the MA plan.
- 7 According to the most recent MA-VBID evaluation report, MA plans and hospice providers reported some implementation challenges. Specifically, the report stated that "although most continuing POs [MA plans referred to as "parent organizations"] and in-network hospices indicated that Hospice Benefit component implementation was manageable in 2023 because beneficiary volume was relatively low, they predicted that any substantial increase in the number of Hospice Benefit component-eligible beneficiaries would greatly increase implementation burden and require additional investments" (Eibner et al. 2025). According to the report, administrative processes (such as timely submission of notices of election and claims submission and adjudication) were the top implementation challenges cited by MA plans and hospices. Additional implementation challenges cited by some hospices included delayed payments, data-reporting and communication requirements varying across MA plans, lack of a definition of palliative care and transitional concurrent care, and concerns about reimbursement rates.
- 8 Type of hospice reflects the type of cost report filed (a hospice files a freestanding hospice cost report or the hospice is included in the cost report of a hospital, home health agency, or SNF). The type of cost report does not necessarily reflect where patients receive care. For example, all hospice types may serve some nursing facility patients.
- 9 We are missing data on hospice type for more providers than typical in 2024—about 2.8 percent of providers that year. In recent years, new hospice entrants have mostly been freestanding providers, so missing data on the type of hospice for 2024 likely understate growth in freestanding providers. However, it is also possible that providers lacking data on hospice type for 2024 are home health-, hospital-, or SNF-based providers, which would lessen the estimated decline or possibly result in an increase in these categories between 2023 and 2024.

- 10 This comparison of hospice use across years is based on paid Medicare claims. These data slightly understate hospice use in 2022 through 2024 because they exclude beneficiaries who received hospice care that was paid for by MA plans participating in the hospice VBID demonstration. About 19,065 beneficiaries in 2022 and 23,828 beneficiaries in 2023 received hospice care that was paid for by MA plans participating in the hospice VBID demonstration, according to a CMS contractor evaluation report (Eibner et al. 2025). A report for 2024 is not yet available.
- 11 The difference in length of stay for hospice decedents with neurological conditions treated by for-profit and nonprofit hospices is particularly pronounced for patients with the longest stays. In 2024, the 75th percentile length of stay for hospice decedents with neurological conditions who were treated by for-profit hospices was 243 days compared with 139 days at nonprofit hospices; the 90th percentile length of stay was 566 days at for-profit hospices and 380 days at nonprofit hospices.
- 12 The share of hospices exceeding the cap is based on the Commission's estimates. While our estimates are intended to approximate CMS claims-processing contractors' calculations, differences in available data, methodology, and the timing of the calculations can lead to different estimates. Our estimates assume all hospices use the proportional methodology and rely on claims data through 15 months after the end of each cap year. The claims-processing contractors may reopen the hospice cap calculation for up to three years; the reopening process and timing may vary across contractors.
- 13 Coe and Rosenkranz, using data from 2001 to 2018, found that hospices nearing the cap in the last quarter of the cap year increased enrollments by 5.8 percent and live discharges by 4.3 percent (equivalent to about 1.54 additional enrollments and 0.37 additional live discharges per program year), with smaller effects post-2012 when CMS shifted from the streamlined cap methodology to the proportional methodology (Coe and Rosenkranz 2025). They also reported that hospices on track to exceed the cap did not appear to change their service provision (visit frequency or hospice care levels) and their marginally enrolled patients appeared healthier on average. Gruber et al., using data from 2000 to 2019 and assuming the streamlined cap methodology was in effect for the entire period, estimated that patients in hospices facing cap pressure were 2 percentage points more likely to die within 12 months, 1 percentage point more likely to be discharged alive, and were less likely to receive inpatient hospice care over that period (Gruber et al. 2025).
- 14 Recently enacted legislation has increased the penalty for hospices that do not report quality data. Beginning in fiscal year 2024, nonreporters face a 4 percent payment penalty. In the fiscal year 2024 hospice final rule, CMS estimated that the increase in the penalty from 2 percent to 4 percent in 2024 would reduce hospice spending by about \$41 million (Centers for Medicare & Medicaid Services 2023c).
- 15 The hospice CAHPS response rate was 29 percent in the most recent period (CAHPS Hospice Survey 2024).
- 16 Both Soltoff et al. (2024) and Anhang Price et al. (2023) examined CAHPS performance among different types of for-profit ownership. Although the studies used different ownership category definitions, the findings had some similarity. Anhang Price et al. found that for-profit hospices owned by chains, and Soltoff found that for-profit hospices owned by chains or private equity firms generally had lower CAHPS scores than other types of for-profit hospices (Anhang Price et al. 2023, Soltoff et al. 2024).
- 17 For both of the claims-based quality measures, the public-reporting program uses an eight-quarter reference period with the aim of increasing the sample size at the provider level to enable CMS to report data on as many providers as possible.
- 18 The Medicare conditions of participation require hospices to have the capacity to furnish all four levels of hospice care, including high-intensity levels of care.
- 19 Our analysis focuses on the broadest measure of live discharge, including live discharges initiated by the hospice (because the beneficiary is no longer terminally ill or because the beneficiary is discharged for cause) and live discharges initiated by the beneficiary (because the beneficiary revokes hospice enrollment, transfers hospice providers, or moves out of the area). Some stakeholders argue that live discharges initiated by the beneficiary are outside the hospice's control and should not be included in a live-discharge measure. Because beneficiaries choose to revoke hospice for a variety of reasons, which in some cases are related to the hospice provider's business practices or quality of care, we include revocations in our analysis. A CMS contractor found that rates of live discharge—due to beneficiary revocations and to beneficiaries no longer being terminally ill—increase as hospice providers approach or surpass the aggregate cap (Plotzke et al. 2015). The contractor's report suggested that this pattern could reflect hospice-encouraged revocations or inappropriate live discharges and thus merit further investigation.
- 20 The Medicare Care Choices Model (MCCM) permitted certain terminally ill FFS beneficiaries who were eligible for, but not enrolled in, hospice to enroll in the MCCM and receive palliative and supportive care from a hospice provider while continuing to receive “curative” care from other providers. MCCM eligibility was limited to beneficiaries with a life

expectancy of 6 months or less who met several criteria (diagnoses of cancer, congestive heart failure, chronic obstructive pulmonary disease, or HIV/AIDS; at least one hospital encounter and at least three office visits in the last 12 months; no election of hospice in the last 30 days; and lived in a traditional home continuously for the last 30 days). An evaluation of the MCCM found, based on the experience of 5,153 MCCM enrollees who enrolled between January 2016 and June 2021 and died before December 2021, that the MCCM was associated with a 13 percent net reduction in Medicare expenditures for these beneficiaries relative to a matched comparison group because of greater hospice use and lower acute care costs at the end of life (Kranker et al. 2022). The evaluation also reported that MCCM enrollees were more likely to receive better-quality end-of-life care (as measured by less aggressive care in the last 30 days of life). The report cautioned against broadly extrapolating from these findings because the model involved a very small number of beneficiaries and hospice providers.

- 21 Financial reports for Amedisys are available only through the second quarter of 2025 because it was acquired by UnitedHealth Group in August 2025. All other companies' financial reports discussed in this section reflect 2025 through the third quarter.
- 22 Soltoff and colleagues (2025) analyzed hospice cost patterns by ownership type based on their research classifying hospices into the following ownership categories: private equity, publicly traded, other for profit, and nonprofit. The study found that nonprofit hospices had higher spending on direct patient care service per day than each of the three types of for-profit hospices, with spending on nurses accounting for much of the difference. In terms of spending on administrative services, the study found private equity-owned hospices had lower spending on nonsalary administrative expenses than nonprofit hospices and other types of for-profit hospices, which the authors hypothesized might reflect private equity-owned hospices having efficiencies from economies of scale.
- 23 In our March 2017 report, the Commission examined indirect costs for provider-based and freestanding hospices. Indirect costs include, among others, management and administrative costs, accounting and billing, and capital costs. In 2014, indirect costs made up 32 percent of total costs for freestanding hospices, compared with 40 percent for home health-based hospices and 42 percent for hospital-based hospices (Medicare Payment Advisory Commission 2017). We noted that the structure of the cost report for provider-based hospices likely results in some overallocation of overhead costs that are not actually related to the hospices' operations or management. We also noted that it is possible that provider-based hospices have higher indirect costs for certain overhead activities. For example, provider-based

hospices might have higher indirect costs than freestanding providers if administrative-staff wages are higher for parent providers (e.g., hospitals or home health agencies) or if provider-based hospices expend more administrative resources coordinating with their parent provider. This pattern of higher indirect costs among provider-based hospices was observed historically over a number of years (from 2008 to 2014), and, although the data are more than 10 years old, it seems likely that it continues to be a factor (Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2010).

- 24 The aggregate FFS Medicare margin is calculated as follows: $((\text{sum of total Medicare payments to all providers}) - (\text{sum of total Medicare costs of all providers})) / (\text{sum of total Medicare payments to all providers})$. Estimates of total Medicare costs come from providers' cost reports. Estimates of Medicare payments and cap overpayments are based on Medicare claims data. Although we refer to this margin as the "FFS Medicare margin," it incorporates hospices' payments and costs for MA beneficiaries whose hospice care is paid for by FFS Medicare. FFS Medicare pays for hospice care for most MA enrollees, with the exception of those who are in MA plans that are participating in the VBID hospice component.
- 25 Hospices that exceed the Medicare aggregate cap are required to repay the excess to Medicare. We do not consider the overpayments as part of hospice revenues in our margin calculation. We also exclude from our calculation the nonreimbursable bereavement and volunteer costs, which are reported in nonreimbursable cost centers on the Medicare cost report. Statute requires that hospices offer bereavement services to family members of deceased Medicare patients (Sec. 1861(dd)(2)(A)(i) of the Social Security Act); however, the statute prohibits Medicare payment for these services (Sec. 1814(i)(1)(A)). Including nonreimbursable bereavement and volunteer costs in our margin calculation would reduce the aggregate Medicare margin for 2023 by at most 1.1 percentage points and 0.3 percentage points, respectively.

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C H A P T E R

11

**Ambulatory surgical center
services: Status report**

Ambulatory surgical center services: Status report

Chapter summary

Ambulatory surgical centers (ASCs) provide outpatient surgical procedures to patients who do not require an overnight stay. In 2024, about 6,400 ASCs treated 3.4 million fee-for-service (FFS) Medicare beneficiaries. (Beneficiaries enrolled in Medicare Advantage (MA) may also be treated in ASCs, but due to data limitations, the focus of this chapter is on FFS volume and spending.) FFS Medicare program and beneficiary spending 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, 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 about 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

In this chapter

- Supply of ASCs and volume of services continue to grow
- Factors affecting the shift in services from hospital-based settings to ASCs
- Performance on measures in the ASC Quality Reporting Program was mixed in 2024
- Aggregate FFS Medicare payments rose substantially in 2024, continuing a trend
- Ambulatory surgical centers should submit cost data

(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 service provision 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. ■

An ambulatory surgical center (ASC) is a facility that primarily provides outpatient surgical procedures to patients who do not require an overnight stay. Outpatient surgical procedures are also provided in hospital outpatient departments (HOPDs) and, in some cases, physicians' offices. Fee-for-service (FFS) Medicare covers more than 3,700 surgical procedures in ASCs, though historically volume has been concentrated in a small number of procedures. (Beneficiaries enrolled in Medicare Advantage (MA) may also be treated in ASCs, but due to data limitations, the focus of this chapter is on FFS volume and spending.)

For procedures performed in an ASC, FFS Medicare makes two payments: one to the facility through the ASC payment system and the other to the physician for their professional services through the payment system for physicians and other health professionals, known as the physician fee schedule (PFS). For the facility portion, Medicare pays ASCs for a bundle of services and items—such as nursing, recovery care, anesthetics, and supplies—through a system that is linked primarily to the outpatient prospective payment system (OPPS), which Medicare uses to set payment rates for most services provided in HOPDs. Payment rates in the ASC payment system are the product of a set of relative weights and a conversion factor (or base payment amount). The relative weights used in the ASC payment system, which indicate each procedure's resource intensity relative to other procedures, are based on those in the OPPS. The ASC conversion factor (\$56.32 in 2026) is less than the factor used in the OPPS (\$90.97 in 2026). However, since 2019 CMS has updated the ASC conversion factor using the same method used to update the OPPS conversion factor: the hospital market basket index minus the multifactor productivity.¹

The ASC payment system is also partly linked to the PFS. For services that were first covered under the ASC payment system in 2008 or later and for which volume is greater in freestanding physician offices than in ASCs, the ASC payment rate is set to the lesser of the standard ASC payment rate or the nonfacility practice expense from the Medicare PFS. The rationale for this policy is to encourage provision of these services in the lowest-cost setting.

In this status report, we examine FFS beneficiaries' access to ASC care, growth in FFS Medicare's payments to ASCs, and, to the extent possible, the quality of care provided in ASCs. Signs point to a robust industry, with long-term growth in the number of ASCs, the volume of services provided to FFS Medicare beneficiaries, and total FFS Medicare payments. Although CMS has never required ASCs to submit cost data and information, the Commission has recommended that CMS require ASCs to do so.

Supply of ASCs and volume of services continue to grow

The number of ASC facilities increased in 2024, as did the volume of ASC services provided to FFS Medicare beneficiaries. Access to ASCs may be preferable to patients and physicians compared with HOPDs, the provider type that is most like ASCs. For patients, ASCs can offer more convenient locations, shorter waiting times, lower cost sharing, and easier scheduling relative to HOPDs. ASCs provide physicians with specialized staff and more control over their work environment. However, these same qualities could lead to overuse of some surgical procedures.

The number of ASCs is increasing

From 2023 through 2024, the number of Medicare-certified ASCs rose 2.2 percent to 6,436 ASCs, aligned with the average annual growth of 2.2 percent from 2019 through 2023 (Table 11-1, p. 328). During 2024, 248 new ASCs opened while 108 ASCs closed or merged with other facilities, for a net increase of 140 facilities.

Numerous factors have likely influenced the steady growth in the number of ASCs:

- Changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings. The share of hip, knee, and shoulder arthroplasties (replacements) performed in ambulatory settings has continued to grow.²
- Physicians may have greater autonomy in ASCs than in HOPDs, enabling them to design customized surgical environments and hire specialized staff. These features of ASCs may allow

**TABLE
11-1**

Number of ASCs grew, 2019–2024

	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
Total number of ASCs	5,760	5,857	6,015	6,145	6,296	6,436	2.2%	2.2%
New	243	189	266	225	256	248	N/A	N/A
Closed	128	92	108	95	105	108	N/A	N/A

Note: ASC (ambulatory surgical center), N/A (not applicable). We display the average annual percentage change for the “new” and “closed” categories as “N/A” because they are outside the purpose of this table, which is to show the growth in the number of ASCs. “New” refers to a new location for ASC services, while “closed” refers to an ASC that terminated operations, either because it closed operations or merged with another facility. The number of ASC closures and openings in a given year can change from prior publications as ASCs reopen and newer data become available.

Source: MedPAC analysis of Provider of Services file from CMS, 2025.

physicians to perform more procedures in ASCs than in HOPDs in the same amount of time, earning more revenue from professional fees (Munnich and Parente 2014).

- ASCs can offer patients greater convenience than HOPDs, such as patients having less “nonoperative” time (the total time a patient spends in an operating room, minus the procedure time) in ASCs (Imran et al. 2019).
- For most procedures covered under the ASC payment system, FFS beneficiaries’ coinsurance is lower in ASCs than in HOPDs.³
- State certificate-of-need (CON) laws have been reduced, such as South Carolina eliminating CON requirements for ASCs in 2023, Georgia implementing CON exemptions for some single-specialty ASCs owned by individual physicians or practices in 2024, and North Carolina eliminating CON requirements for ASCs locating in counties with populations over 125,000 in 2025.

Most ASCs are for profit, and geographic distribution is uneven

Consistent with previous years, most ASCs in 2024 were for profit (95.3 percent) (Table 11-2). According to surveys, most ASCs have partial or complete physician ownership (Ambulatory Surgery Center Association

2023, Leapfrog 2019). Physician owners of ASCs receive additional income through distributions of facility profits according to their ownership interest. Other owners of ASCs include hospitals and corporate entities, such as payers and private equity (PE) firms. One change that is occurring in the structure of ASC ownership is the extent of corporate involvement. In the ASC industry, five corporate entities are considered major holders of ASCs: United Surgical Partners International (USPI), AmSurg, HCA Healthcare, Surgery Partners Holdings, and Surgical Care Affiliates (which is owned by the largest private payer, UnitedHealthcare). From 2019 to 2024, the number of ASCs in which these 5 entities have some degree of ownership increased by 19.1 percent (rising from 1,152 to 1,372), and the share of ASCs in which these entities have an ownership stake increased from 20.0 percent to 21.5 percent (Hawkins et al. 2025). While factors associated with corporate-owned ASCs are not well-understood, early evidence suggests that PE firms may target high-volume ASCs and that payer-owned ASCs tend to operate in competitive outpatient procedure markets where the payer has substantial beneficiary market share (Lin et al. 2023, Zhao et al. 2024).

ASCs were also disproportionately located in urban areas in 2024 (93.7 percent) (Table 11-2). Stakeholders contend that rural areas typically lack the surgical specialists needed for ASCs and that the lower

**TABLE
11-2**

Most ASCs are for profit and located in urban areas, 2019–2024

Type of ASC	2019	2020	2021	2022	2023	2024	
						All	New
For profit	95.3%	95.3%	95.2%	95.2%	95.2%	95.3%	95.0%
Nonprofit	3.8	3.8	3.9	3.9	3.8	3.8	5.0
Government	0.9	0.9	0.9	0.9	0.9	0.9	0.0
Urban	96.1	93.4	93.4	93.6	93.7	93.7	94.4
Rural	3.9	6.6	6.6	6.4	6.3	6.3	5.6

Note: ASC (ambulatory surgical center). We defined “urban” as being in metropolitan statistical areas (MSAs) and “rural” as being outside MSAs.

Source: MedPAC analysis of CMS Provider of Services file, 2025.

population density in rural areas makes them less viable locations for ASCs. Even though some areas have low ASC penetration, beneficiaries who do not live near an ASC can usually obtain ambulatory surgical services in HOPDs and, in some cases, physicians’ offices. Beneficiaries who live in rural areas may travel to urban areas to receive care at ASCs.

We found that rural FFS beneficiaries—defined as those who live outside metropolitan statistical areas (MSAs)—are less likely to receive care in ASCs than are urban beneficiaries, defined as those living in an MSA (data not shown).

The concentration of ASCs varies widely across states. At the close of calendar year (CY) 2024, Maryland had the most ASCs per Medicare beneficiary (36 ASCs per 100,000 Part B beneficiaries (both FFS and MA)), followed by Georgia, Arizona, and Alaska (respectively, 24, 18, and 17 ASCs per 100,000 Part B beneficiaries) (Figure 11-1, p. 330). The District of Columbia, West Virginia, and Vermont had the fewest ASCs per Part B beneficiary (three or fewer ASCs per 100,000 Part B beneficiaries).

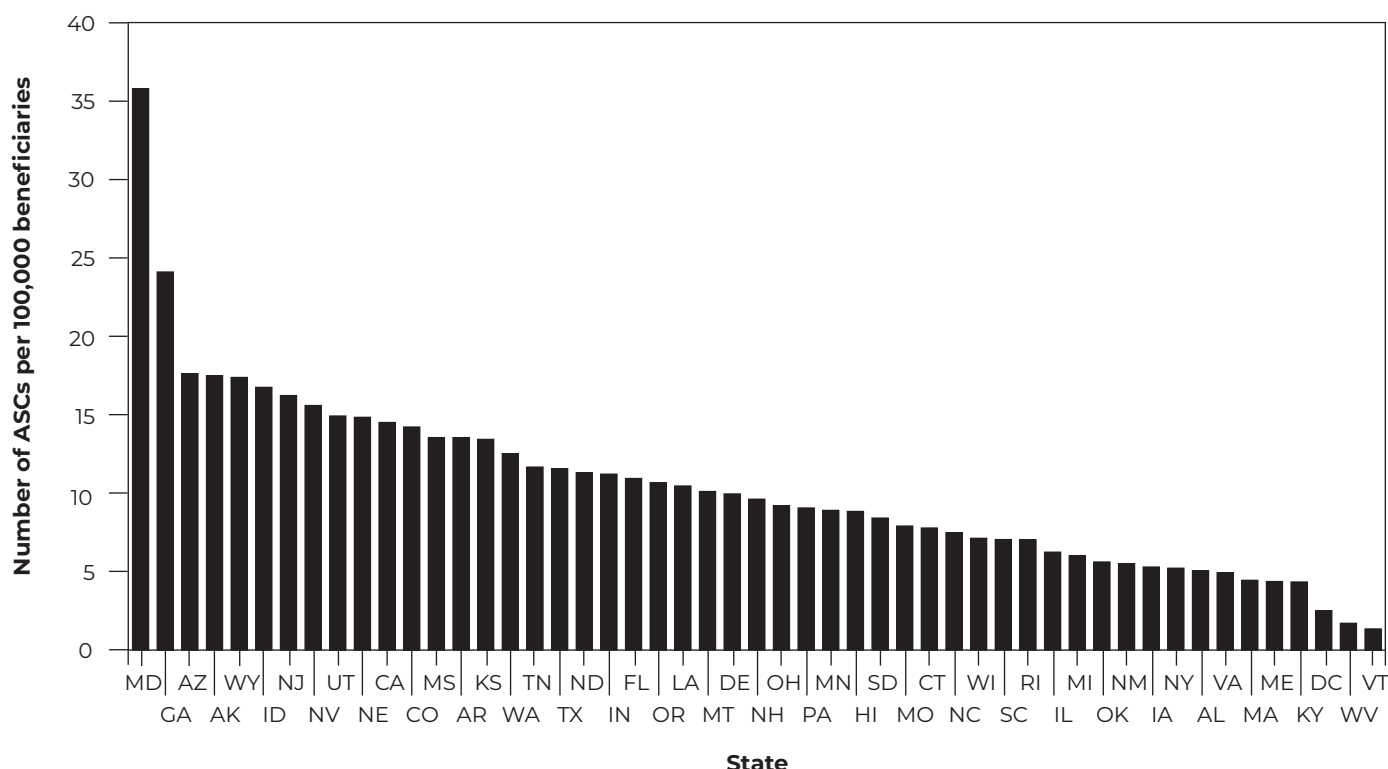
Several factors contribute to variation in ASCs per Part B beneficiary among states. One factor that appears to have a strong effect is whether a state has a

CON law for ASCs. However, even among the 22 states (plus the District of Columbia) that have CON laws, the stringency varies substantially. For example, Nevada, which has a relatively weak CON law for ASCs, has one of the highest concentrations of ASCs per Medicare beneficiary; by contrast, Vermont has very strict CON laws and has by far the lowest number of ASCs per Medicare beneficiary.

Moreover, some states have characteristics that appear to overwhelm the effects of having or not having a CON law. For example, Maryland has a strong CON law but has by far the most ASCs per Medicare beneficiary, likely due to the presence of an all-payer global budget revenue model in the state that provides an incentive for hospitals to shift care from HOPDs to ASCs.⁴ To help hospitals meet their budgets, it appears that they avoid providing many ambulatory surgical procedures in the hospitals, resulting in these procedures being provided in ASCs. New Mexico, by contrast, does not have a CON law for ASCs but has only about half as many ASCs per 100,000 Part B beneficiaries (6) as the average among all states (10), perhaps due to the large number of sparsely populated rural areas in the state.

**FIGURE
11-1**

Number of ASCs per beneficiary varied widely by state, 2024



Note: ASC (ambulatory surgical center). The count of beneficiaries includes beneficiaries enrolled in fee-for-service Medicare or Medicare Advantage.

Source: MedPAC analysis of CMS Provider of Services file for 2025 and the Common Medicare Environment file.

Specialization of ASCs remained mostly unchanged; largest growth in pain management and orthopedics

In 2024, 68 percent of ASCs that billed FFS Medicare specialized in a single clinical area. Gastroenterology and ophthalmology were the most common specialties, with each comprising about 21 percent of all ASCs that provided services to FFS Medicare beneficiaries. The remaining 32 percent of ASCs were multispecialty facilities, providing services in more than one clinical specialty (Table 11-3).⁵ In 2024, the most common multispecialty ASCs were those focusing on pain management, orthopedics, and other surgeries. Multispecialty ASCs that included a focus on gastroenterology and ophthalmology were also common. From 2023 to 2024, the number of single-specialty ASCs specializing in cardiology (6.3 percent),

respiratory (8.3 percent) and orthopedic (18.9 percent) services grew most, though their share of all ASCs did not change. The number of multispecialty ASCs specializing in both pain management and orthopedics grew most (20.9 percent), and their share of all ASCs increased by 1 percentage point.

Volume of services per FFS beneficiary rose in 2024

In 2024, 3.4 million FFS Medicare beneficiaries received ASC services. For several years, aggregate volume of ASC services provided to FFS Part B beneficiaries declined as the number of beneficiaries in FFS Medicare decreased and the number in MA rose. That decline in the number of FFS beneficiaries was somewhat mitigated by a slow but steady increase in the number of services per FFS Part B beneficiary,

**TABLE
11-3****Specialization of ASCs billing FFS Medicare, 2023–2024**

Type of ASC	2023		2024		Percent change in number of ASCs, 2023–2024
	Number of ASCs	Share of all ASCs	Number of ASCs	Share of all ASCs	
Single specialty	3,917	68%	3,955	68%	1.0%
Gastroenterology	1,193	21	1,208	21	1.3
Ophthalmology	1,152	20	1,162	20	0.9
Pain management	800	14	808	14	1.0
Cardiology	221	4	235	4	6.3
Dermatology	197	3	178	3	–9.6
Urology	152	3	156	3	2.6
Orthopedic	53	1	63	1	18.9
Podiatry	62	1	59	1	–4.8
Respiratory	36	1	39	1	8.3
OB/GYN	15	<1	14	<1	–6.7
Other	36	1	33	1	–8.3
Multispecialty	1,827	32	1,848	32	1.2
Pain management and orthopedics	172	3	208	4	20.9
Gastroenterology and ophthalmology	220	4	191	3	–13.2
Pain management and other surgery	182	3	174	3	–4.4
Pain management, orthopedics, and other surgery	470	8	497	9	5.7
Pain management, gastroenterology, and ophthalmology	329	6	298	5	–9.4
Other	454	8	480	8	5.7
Total	5,744	100	5,803	100	N/A

Note: ASC (ambulatory surgical center), FFS (fee-for-service), OB/GYN (obstetrics and gynecology). We define a “single-specialty ASC” as one with more than 67 percent of their FFS Medicare claims in one clinical specialty. We define a “multispecialty ASC” as one with less than 67 percent of their FFS Medicare claims in one clinical specialty. The total number of ASCs in this table is less than the total number of ASCs listed in Table 11-1 (p. 328) because the ASCs included in this table are limited to those in the 50 states and the District of Columbia that had a paid FFS Medicare claim while the ASCs in Table 11-1 include all ASCs in the 50 states, the District of Columbia, and Puerto Rico. Values may differ from prior years due to small methodological changes.

Source: MedPAC analysis of Medicare physician/supplier standard analytic files, 2023–2024.

which rose at an average annual rate of 1.3 percent from 2019 to 2023. However, in 2024, the number of services per FFS Part B beneficiary increased by 3.5 percent, resulting in an aggregate increase in ASC services provided to FFS Part B beneficiaries of 0.8 percent (Table 11-4, p. 332).

The growth in volume in 2024 was partly driven by large percentage increases in the volume of total knee arthroplasty (27.6 percent) and total hip arthroplasty

(28.7 percent) procedures, as well as total shoulder arthroplasty procedures (which Medicare began reimbursing in ASCs starting in 2024). Smaller, albeit still notable, growth in volume was observed for some colonoscopy procedures and several pain management procedures.

Services that historically contributed the most to overall ASC volume continued to be a large share of the total in 2024. For example, in both 2019 and 2024,

**TABLE
11-4****Volume of ASC services per FFS beneficiary rose in 2024**

	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
FFS Part B beneficiaries (in millions)	33.1	32.3	30.9	29.7	28.6	27.9	–3.6%	–2.5%
Volume of FFS Medicare services (in millions)	7.0	5.6	6.3	6.2	6.4	6.4	–2.2	0.8
Volume per 1,000 FFS beneficiaries	211.3	174.7	204.5	210.2	222.1	229.9	1.3	3.5

Note: ASC (ambulatory surgical center), FFS (fee-for-service). Numbers may differ from prior years due to small methodological changes. Percent changes were calculated using unrounded data.

Source: MedPAC analysis of physician/supplier standard analytic claims files, 2019–2024.

extracapsular cataract removal with intraocular lens insertion had the highest volume, accounting for 18.2 percent of the total in 2019 and 18.0 percent in 2024 (Table 11-5). Moreover, 18 of the 20 most frequently provided ASC services in 2019 were among the 20 most frequently provided in 2024. These services made up about 70 percent of ASC FFS Medicare volume in 2019 and 68 percent in 2024. Of the surgical procedures provided to FFS Medicare beneficiaries in ASCs in 2024, 50 percent of the volume was concentrated in seven procedures.

Of the surgical procedures provided to FFS Medicare beneficiaries in ASCs in 2024, 50 percent of the FFS Medicare revenue was concentrated in 12 procedures. Relative to the highest-volume surgical procedures though, there was more change among the highest-revenue surgical procedures, reflecting a shift to higher-complexity services in ASCs. Four of the highest-revenue services in 2024—total knee arthroplasty, total hip arthroplasty, total shoulder arthroplasty, and a cataract removal procedure that includes insertion of an aqueous drainage device—were not covered under the ASC payment system in 2019. For another high-revenue procedure in 2024—percutaneous laminotomy or laminectomy—revenue increased by a factor of 13 over the 2019 level.

Factors affecting the shift in services from hospital-based settings to ASCs

It could be beneficial for surgical procedures to migrate from the HOPD setting to ASCs. As noted above, ASCs offer several advantages for surgeons, because they can customize their surgical environments and hire specialized staff, which allows them to perform more procedures in ASCs than in HOPDs in the same amount of time, earning more revenue from professional fees. For beneficiaries, ASCs offer shorter nonoperative times than HOPDs (Imran et al. 2019). In addition, because FFS Medicare payment rates are lower in ASCs than in HOPDs for all services that are covered in both settings (for most services, the ASC payment rates are 46 percent lower than the HOPD payment rates), the cost to FFS beneficiaries (via cost sharing) and the Medicare program (as well as taxpayers) is lower.⁶

However, because ASCs can select their patients, as the number of ASCs grows, there is potential for ASCs to account for an increasingly larger share of the more profitable ambulatory procedures, leaving the less profitable ambulatory procedures

**TABLE
11-5**

For FFS beneficiaries, the 20 most frequently provided ASC services in 2019 were similar to those provided in 2024

Procedure	2019		2024	
	Percent of volume	Rank	Percent of volume	Rank
Extracapsular cataract removal with IOL insert	18.2%	1	18.0%	1
Upper GI endoscopy, with biopsy: single or multiple	7.8	2	7.3	3
Colonoscopy and biopsy	6.9	3	6.4	4
Colonoscopy with lesion removal, snare technique	6.4	4	8.0	2
Injection transforaminal epidural: lumbar or sacral	4.7	5	4.2	5
After cataract laser surgery	4.0	6	3.7	6
Injection paravertebral facet joint: lumbar or sacral, single level	3.4	7	3.2	7
Injection interlaminar epidural: lumbar or sacral	2.6	8	1.9	10
Colorectal cancer screening, high-risk individual	2.1	9	2.3	8
Destroy lumbar/sacral facet joint, single	1.8	10	2.0	9
Diagnostic colonoscopy	1.7	11	1.1	16
Colorectal cancer screening, not high-risk individual	1.5	12	1.6	11
Injection procedure for sacroiliac joint, anesthesia	1.5	13	1.5	12
Extracapsular cataract removal complex without ECP	1.3	14	1.3	13
Cystoscopy	1.2	15	1.3	14
Injection paravertebral facet joint: cervical or thoracic, single level	1.2	16	1.1	15
Injection interlaminar epidural: cervical or thoracic	1.0	17	0.8	18
Blepharoplasty, upper eyelid	0.9	18	1.0	17
Upper GI endoscopy diagnostic brush wash	0.9	19	0.6	23
Upper GI endoscopy, guide wire insertion	0.7	20	0.6	25
Total	69.8	N/A	67.9	N/A

Note: FFS (fee-for-service), ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal), ECP (endoscopic cyclophotocoagulation), N/A (not applicable). In both percentage columns, the numbers do not sum to the total because of rounding.

Source: MedPAC analysis of physician/supplier standard analytic files from 2019 and 2024.

to other settings, primarily HOPDs (Plotzke and Courtemanche 2011). Further, it is possible that this shift could result in higher-complexity patients clustering in HOPDs. Currently, the profile of FFS beneficiaries who receive their ambulatory surgeries in ASCs is different from those who receive their ambulatory surgeries in HOPDs. ASCs are less likely than HOPDs to serve FFS Medicare beneficiaries who are dually eligible, those who are age 85 or older,

and those who are eligible for Medicare because of disability (Table 11-6, p. 334).

Research indicates that when an ASC enters a market or a physician who performs surgical procedures in HOPDs and/or ASCs becomes an ASC owner, surgical procedures shift from HOPDs to ASCs and overall outpatient surgical volume in the market may slightly increase. Courtemanche and Plotzke found

**TABLE
11-6**

FFS Medicare patients treated in ASCs differed from patients treated in HOPDs, 2024

Characteristic	Characteristics of FFS Medicare patients who received at least one ASC and/or HOPD service	
	ASC	HOPD
Dually eligible status		
Not dually eligible	92.0%	86.2%
Dually eligible	8.0	13.8
Age		
<65	5.3	8.6
65-84	89.3	82.5
85+	5.5	8.9
Sex		
Male	43.9	46.6
Female	56.1	53.4

Note: FFS (fee-for-service), ASC (ambulatory surgical center), HOPD (hospital outpatient department). All differences between ASC and HOPD patients are statistically significant ($p < 0.05$). This analysis excludes FFS beneficiaries who received services that are not covered under the ASC payment system. The numbers in the age categories for the ASC column do not sum to 100 due to rounding.

Source: MedPAC analysis of carrier and outpatient standard analytic claims files for 2024 and the Common Medicare Environment file.

that the addition of an ASC to a hospital's market reduces a hospital's outpatient surgical volume by 2 percent to 4 percent if the facilities are within four miles of each other, but they found that this impact on HOPD surgical volume is unlikely to have a serious impact on the financial viability of a typical hospital (Courtemanche and Plotzke 2010). Hollenbeck and colleagues found that the entry of an ASC into a market that previously did not have any ASCs reduced outpatient surgical procedures provided in HOPDs by 7 percent. Within these markets, the volume of procedures provided in ASCs was significantly greater than the decline in procedures provided in hospitals, and thus the volume of outpatient surgical procedures increased overall (Hollenbeck et al. 2015). Munnich and colleagues found that most physicians who provide surgical procedures in outpatient settings furnish those services in both ASCs and HOPDs (Munnich et al. 2021). They also found that two years after physicians obtained an ownership

stake in an ASC, the share of the surgical procedures that those physicians provided in ASCs had increased by 22 percent, while the share they provided in HOPDs had decreased by about the same percentage. At the same time, the total number of outpatient surgical procedures they provided to both FFS Medicare and non-FFS-Medicare patients increased by 9 percent. However, the total number of outpatient surgical procedures provided to FFS Medicare patients increased by a small amount, and this change was not statistically significant.

Impact of CMS's inpatient-only list on ASC-covered procedures

The ASC covered procedure list (CPL) is the list of procedures covered under the ASC payment system. A potential factor affecting the breadth of services included on the ASC CPL is the inpatient-only (IPO) list maintained by CMS, which, as of 2026, consists of more than 1,400 Healthcare Common Procedure

Coding System (HCPCS) codes that are typically provided in an inpatient setting and cannot be paid under the ASC payment system or the OPPS. Each year, CMS reviews the procedure codes on the IPO list and determines whether any services should be added or removed.

Throughout its rulemaking for the ASC payment system and the OPPS, CMS has received comments from some stakeholders recommending that CMS eliminate the IPO list, while others have recommended that CMS should maintain the list (Centers for Medicare & Medicaid Services 2025). In the rulemaking for CY 2026, CMS finalized the phase-out of the IPO list over a three-year period, beginning January 1, 2026, and ending January 1, 2029. As part of the first step of the IPO phase-out, for 2026, CMS removed 285 HCPCS codes (mostly for musculoskeletal procedures) from the IPO list and added 271 of these HCPCS codes, including total hip arthroplasty revisions and spinal procedures, to the ASC CPL.⁷

The extent to which the elimination of the IPO list will expand the volume of services that ASCs provide is not clear. ASCs generally have provided low quantities of these procedures. Important exceptions include knee arthroplasty and hip arthroplasty, which have increased in ASC volume since CMS removed them from the IPO list and made them covered services under the ASC payment system in 2018 and 2020, respectively.

Further expansion of ASC-covered procedures

There are many surgical procedures (not on the IPO list) that are covered under the OPPS but not the ASC payment system, due to certain CMS regulatory criteria that restrict which services can be included on the ASC CPL. However, in the CY 2026 final rule, CMS finalized revisions to their regulatory criteria to evaluate potential additions to the ASC CPL (Centers for Medicare & Medicaid Services 2025). Under the revised criteria beginning in CY 2026, 276 surgical or surgery-like procedures (that were not on the CY 2025 IPO list) were added to the ASC CPL, including laparoscopy, laminectomy, and several cardiovascular procedures.

As noted above, a longstanding feature of the services provided in ASCs to FFS Medicare beneficiaries is that although the ASC payment system covers over

3,700 procedures, the provision of ASC services has been concentrated in a relatively small number of procedures (Table 11-5, p. 333). It is not yet clear to what extent the addition of more than 500 procedures to the ASC CPL in 2026 will expand the volume of services that ASCs provide.

Performance on measures in the ASC Quality Reporting Program was mixed in 2024

CMS established the Ambulatory Surgical Center Quality Reporting (ASCQR) Program in 2012 (Centers for Medicare & Medicaid Services 2011). Under this system, ASCs that do not successfully submit quality measurement data have their payment rate reduced by 2 percentage points for that year. Actual performance on these quality measures does not affect an ASC's payments; CMS requires ASCs only to submit the data to receive a full update. The Commission has recommended that CMS implement a value-based purchasing program for ASCs that would reward high-performing providers and penalize low-performing providers (Medicare Payment Advisory Commission 2012).

The ASCQR Program currently has four claims-based measures tied to unplanned hospitalizations in four ASC specialties: gastrointestinal, orthopedics, urology, and general surgery (Table 11-7, p. 336). However, CMS should implement additional quality measures to make the ASCQR Program more effective.

From 2019 to 2023, ASCs statistically significantly improved their performance on ASC-12: Facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy (Table 11-7, p. 336). From 2023 to 2024, measure outcomes were generally stable. However, two of the four measures (ASC-17 and ASC-18) had statistically significant outcome rates that were slightly worse, though it is not clear if these changes are representative of clinically meaningful differences.

CMS should implement additional quality measures to make the ASCQR Program more effective. More expansive data about the quality of care provided in ASCs would also inform and facilitate beneficiaries'

**TABLE
11-7****ASCs' performance on quality measures was mixed
in 2024 after improvement from 2019–2023**

Description of quality measure	2019	2020	2021	2022	2023	2024
ASC-12: Facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy (per 1,000 colonoscopies)	12.0%	12.0%	11.4%	9.8%	9.8%	9.9%
ASC-17: Unplanned hospital visits within 7 days after orthopedic ASC procedure (per 1,000 procedures)	N/A	N/A	2.2	2.2	2.2	2.3*
ASC-18: Unplanned hospital visits within 7 days of urology ASC procedure (per 1,000 procedures)	N/A	N/A	5.5	5.1	5.1	5.2*
ASC-19: Facility-level 7-day hospital visit rate after general surgery procedures performed at ASCs (per 1,000 procedures)	N/A	N/A	N/A	1.0	1.0	1.0

Note: ASC (ambulatory surgical center). N/A (not applicable). "General surgery procedures" includes abdominal, alimentary tract, breast, skin, wound, and varicose vein-stripping procedures. All results represent median outcome rates.

* 2024 value is statistically different from 2023 value ($p < 0.05$).

Source: MedPAC analysis of data on quality measures for ambulatory surgical centers from CMS, 2019–2024.

decision-making about where they choose to receive care. Although the ASCQR Program includes four measures that are claims based and measure clinical outcomes (ASC-12, ASC-17, ASC-18, and ASC-19, Table 11-7), these measures exclude many services provided at ASCs, such as eye procedures and pain management. To improve the ASCQR Program, and consistent with the Commission's principles, we assert that CMS should include more claims-based measures that assess clinical outcomes for the various specialties practiced at ASCs. In addition, CMS should synchronize ASCQR measures with measures included in the Hospital Outpatient Quality Reporting (OQR) Program to facilitate comparisons between ASCs and HOPDs. Currently, the ASCQR and the OQR possess four common quality measures that pertain to cataract procedures, colonoscopy procedures, and patient assessments. CMS should consider expanding the overlap of the ASCQR and OQR, relying on either measures of general surgical procedures or measures of specific surgical procedures common to both settings. For example, CMS could consider including

OQR measure OP-36 (the number of hospital visits after any outpatient surgery) in the ASCQR.

**Aggregate FFS Medicare payments
rose substantially in 2024, continuing a
trend**

In 2024, ASCs received \$7.5 billion in FFS Medicare payments and beneficiaries' cost sharing (Table 11-8). Spending by the FFS Medicare program was \$6 billion, and beneficiary cost-sharing liability was \$1.5 billion (data not shown).

Payments per FFS beneficiary rose at an average annual rate of 9.4 percent from 2019 through 2023 and by 15.9 percent in 2024 (Table 11-8). The increase in 2024 reflects a 3.2 percent increase in the ASC conversion factor, a 0.8 percent increase in per capita volume, an 8.4 percent increase in the average relative weight of ASC services provided, and a 0.4 percent effect from an increase in spending from 2023 to 2024 on separately

**TABLE
11-8**

FFS Medicare payments to ASCs rose rapidly, 2019–2024

							Average annual percent change	Percent change
	2019	2020	2021	2022	2023	2024	2019– 2023	2023– 2024
FFS Medicare payments (billions)	\$5.3	\$4.8	\$5.7	\$6.0	\$6.6	\$7.5	5.6%	13.0%
FFS Medicare payments per FFS beneficiary	161	150	185	201	231	268	9.4	15.9
FFS Medicare payments per FFS beneficiary using ASC services	1,458	1,619	1,710	1,790	1,954	2,211	7.6	13.1

Note: FFS (fee-for-service), ASC (ambulatory surgical center). Medicare payments include FFS program spending and beneficiary cost sharing for ASC facility services. Payments include spending for new-technology intraocular lenses. We calculated the percentage change columns using unrounded numbers. Numbers may differ from prior years due to small methodological changes and updates to data.

Source: MedPAC analysis of data from the Office of the Actuary at CMS and data from physician/supplier standard analytic files.

paid drugs provided to FFS Medicare beneficiaries treated in ASCs. Also, payments per FFS beneficiary who used ASC services rose at an average annual rate of 7.6 percent from 2019 through 2023 and by 13.1 percent in 2024.

Although the ASC payment system covers over 3,700 surgical procedures, the revenue that ASCs receive for providing services to FFS Medicare beneficiaries is concentrated in a relatively small number of procedures. In 2024, 12 procedures accounted for 50 percent of the FFS Medicare revenue from surgical procedures (data not shown).

ASCs do not submit cost reports, so we cannot analyze the financial standing for all ASCs. However, the Pennsylvania Health Care Cost Containment Council collects data on total operating costs and total operating revenue from all ASCs in Pennsylvania, which allows for the calculation of operating margins for those ASCs. For 2024, the operating margin for the Pennsylvania ASCs was 29.5 percent, which is substantially higher than the range of their historical operating margins of 22.3 percent to 25.6 percent from 2015 through 2023 (Pennsylvania Health Care Cost Containment Council 2025).⁸

Ambulatory surgical centers should submit cost data

The Commission has frequently expressed concern that Medicare does not require ASCs to submit cost data, unlike other types of facilities. Every year from 2010 to 2022, the Commission recommended that the Congress require ASCs to submit cost data (Medicare Payment Advisory Commission 2010); the Commission reiterated this recommendation in 2024 and 2025 (Medicare Payment Advisory Commission 2025b, Medicare Payment Advisory Commission 2024). Cost data would enable policymakers to establish payment rates that accurately reflect ASC costs. Currently, ASC payment rates are not based on ASC cost data but instead are largely derived from the OPPS relative weights, which are based on HOPD charges adjusted to cost. To the extent that there is a difference in the cost structures of HOPDs and ASCs, ASC payment rates do not accurately reflect the cost of ASCs. Though some evidence suggests that FFS Medicare's payments for ASC services are higher than ASC costs on average, it is plausible that ASC payment rates are higher than ASC costs for some services and lower than ASC costs for

others. This disparity would create incentives for ASCs to focus on providing high-margin services, which would narrow their scope of services relative to what they might offer if the payment rate for each service accurately reflected ASC costs.

Cost data are also needed to determine whether an alternative input price index would be an appropriate proxy for ASC costs. The Commission has previously expressed concern that the price index that CMS used to update the ASC conversion factor from 2010 through 2018 (the Consumer Price Index for All Urban Consumers) likely does not reflect ASCs' cost structure (Medicare Payment Advisory Commission 2010). Similarly, the price index that CMS has used to update the ASC conversion factor since 2019—the hospital market basket—likely does not reflect ASCs' cost structure.

CMS has shown some interest in collecting cost data to help determine ASC payment rates and has requested comments from stakeholders on whether the Secretary should collect cost data from ASCs. Most recently, the ASC industry has shown openness to submitting cost data but has indicated that such data should not be used to develop an ASC-specific market basket. Instead, the industry has suggested that CMS could establish an HOPD market basket and use it to update payments in both the ASC payment system and the OPPI (Ambulatory Surgery Center Association 2024).

However, the Commission has asserted that the cost structures of ASCs and HOPDs are likely very different. ASCs tend to be single specialty, for profit,

and are not required to comply with the Emergency Medical Treatment and Labor Act (EMTALA), while HOPDs are multispecialty, typically nonprofit, and most of them must comply with EMTALA. In addition, relative to hospitals, ASCs are more urban, serve a different mix of patients demographically and by payer type, have a much higher share of expenses related to medical supplies and drugs, and have a smaller share of employee compensation costs (Medicare Payment Advisory Commission 2025a, Medicare Payment Advisory Commission 2018). Therefore, using an HOPD-specific market basket for ASCs would likely result in inaccurate payments.

The Commission recognizes that ASCs are small facilities, but we have contended that it is feasible for ASCs to provide cost information. Small businesses like ASCs typically keep records of their costs for filing taxes and other purposes. In addition, all other facility providers submit cost data to CMS, including other small facilities such as rural health clinics, home health agencies, and hospices. Indeed, ASCs in Pennsylvania submit cost and revenue data annually to a state agency that uses the data to estimate margins for those ASCs (Pennsylvania Health Care Cost Containment Council 2025). The State of Pennsylvania has required ASCs to submit these data since at least 2005, and that has not appeared to be a barrier to the entry of additional ASCs in the state. From 2005 to 2018, the number of ASCs in Pennsylvania rose from 153 to 242 (an average increase of 3.6 percent per year). In 2024, there were 240 ASCs. ■

Endnotes

- 1 The ASC payment system has several nuances that we have not discussed here. For a discussion of these nuances, see the Commission's *Payment Basics* for ambulatory surgical centers at https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_ASC_FINAL_SEC.pdf.
- 2 Total knee arthroplasty (Current Procedural Terminology (CPT) Code 27447) was first covered under the ASC payment system in 2020. About 10,800 of these procedures were provided in ASCs to FFS Medicare beneficiaries in 2020. The number of these procedures rose to 49,258 in 2024. Total shoulder arthroplasty (CPT Code 23472) was first covered under the ASC payment system in 2024, and the number of these procedures was 11,047 in that same year.
- 3 By statute, coinsurance for a service paid under the OPPTS cannot exceed the Medicare Part A inpatient hospital deductible (\$1,736 in 2026). The ASC payment system does not have the same limitation on coinsurance; for a small percentage of billing codes covered under the ASC payment system, beneficiary coinsurance exceeds the inpatient deductible. In these instances, coinsurance for an ASC-delivered procedure exceeds coinsurance for an HOPD-delivered procedure. Nearly all these services are “device-intensive” procedures, which are procedures in which the cost of a device is at least 30 percent of the ASC payment rate for the procedure. Of these procedures, the most frequently provided in 2024 were total knee arthroplasty and total hip arthroplasty.
- 4 The relatively high number of ASCs per Part B beneficiary in Maryland is due, at least in part, to a response to a Medicare waiver under which Maryland hospitals operate under global budgets called the Total Cost of Care (TCOC) Model. Under the TCOC Model, hospital budgets are capped, and they receive no additional revenue if they exceed their budgets. If a Maryland hospital shifts a surgical procedure from the hospital to an ASC, the hospital would receive an increase in its revenue. However, the Maryland system reduces the hospital's global budget by 50 percent of the Medicare payment for those services, allowing the hospital to retain the other 50 percent as continued incentive to move care to the usually lower-cost ASC setting. A study has found that this system of sharing the revenue from a shift of services from HOPDs to ASCs has had little or no effect on the extent to which hospitals make these shifts relative to the system that preceded the TCOC under which hospitals did not share the revenue from shifting services from HOPDs to ASCs (Mathematica 2024).
- 5 We define “single-specialty ASCs” as having more than 67 percent of their FFS Medicare claims in one clinical specialty. We define “multispecialty ASCs” as having less than 67 percent of their FFS Medicare claims in one clinical specialty.
- 6 For some services, the OPPTS cost sharing is lower than the ASC cost sharing because under the OPPTS the cost sharing for a service cannot exceed the Medicare Part A inpatient hospital deductible (\$1,736 in 2026), while the ASC system does not have a limit on beneficiary cost sharing.
- 7 The 14 procedures that were removed from the IPO list but not added to the ASC CPL are anesthesia procedure codes that are excluded from ASC payment for CY 2026 (see Addendum EE of CY 2026 OPPTS/ASC final rule).
- 8 The margins for ASCs in Pennsylvania are different from the margins calculated by the Commission for other facilities because the margins for the ASCs do not include taxes or distributions to physician owners.

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CHAPTER 12

The Medicare Advantage program: Status report

The Medicare Advantage program: Status report

Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program, which gives Medicare beneficiaries the option of receiving benefits from private plans rather than from traditional fee-for-service (FFS) Medicare. 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 is required by law to report in March of each year on the status of the MA program, including a review of payment policies, risk-adjustment methods, the impact of risk selection, mechanisms for promoting quality, access to care, and other issues. We examine MA enrollment trends, plan availability for the coming year, plan generosity (including enhanced financial protections and supplemental benefits), and

In this chapter

- Robust MA enrollment, plan availability, and rebates
- Higher payments to MA plans stem from favorable selection and coding intensity
- Industry concentration and integration
- Quality in MA
- Medicare payment and MA plan costs for enrollees with ESRD
- Technical Appendix 12-A: Base comparison
- Technical Appendix 12-B: Favorable selection
- Technical Appendix 12-C: Coding intensity

Medicare spending. We also provide information about Medicare payments and MA plan costs for enrollees with end-stage renal disease (ESRD).

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.

When risk-based payment for private plans was first added to Medicare in 1985, payments to private plans were set at 95 percent of FFS payments because it was expected that plans would share savings from their efficiencies (relative to FFS) with taxpayers. But 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. For example, MA benchmarks are set above FFS spending in many markets in part to encourage more uniform plan participation across the country. Payments under the quality-bonus program further increase MA payments above FFS without producing meaningful information on plan quality for Medicare beneficiaries or the Medicare program.

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.

We estimate that Medicare will spend 14 percent—a projected \$76 billion—more for MA enrollees in 2026 than it would spend if those beneficiaries were enrolled in FFS Medicare, an amount equal to 12 percent of total MA payments. 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 discussed above, which beneficiaries in our annual focus groups report are the primary reason that enrollees choose MA. But 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).

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 favorable selection and coding intensity. 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. 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 finds 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. 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. Our prior reports had not included the ESRD population because we had not yet developed the analytic framework for constructing an estimate for that group. 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 are 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 at least 5 percentage points higher 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 rewards contracts with a high star rating by increasing their benchmark. In 2026, about \$16 billion in payments to MA plans will result from the program. 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. For example, scores for all measures on the MA Consumer Assessment of Healthcare Providers and Systems surveys, except

for the annual flu vaccine, were above 82 percent from 2018 to 2024. 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 nor 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—In the March 2021 report to the Congress, the Commission compared MA plans’ medical costs with their revenues for individuals with ESRD, described MA enrollment trends by coinsurance amounts, and estimated the prices that plans paid for dialysis services in 2018. In this report, we update those analyses using the most recent available data.

Medicare payments to MA plans grew faster, on average, than plans’ reported medical costs for enrollees with ESRD, and were substantially higher relative to costs in 2023 than in 2018. In 2018, MA plans roughly broke even on medical costs for enrollees with ESRD, on average, implying that plans may have lost money on ESRD patients once administrative costs were accounted for. By 2023, Medicare payments to plans were much higher relative to plans’ medical costs for enrollees with ESRD, by 12 percent. Most MA enrollees with ESRD in 2023 (93 percent) were enrolled in contracts with higher ESRD revenues than medical costs.

Most plans apply the maximum allowable amount of cost sharing—20 percent coinsurance—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. MA enrollees with ESRD are likely to receive some financial protection from the maximum out-of-pocket limit (\$9,250 in 2026) that MA plans are required to offer.

MA plans pay, on average, more than FFS rates for dialysis services. In 2022, the average MA plan price for dialysis was 22 percent higher than the FFS Medicare rate, down from 28 percent higher in 2020. The high level of consolidation in the dialysis industry—and the associated provider market power—could help explain, at least in part, the difference between average MA and FFS prices for dialysis. Since 2021, increasing MA enrollment by beneficiaries with ESRD, combined with the removal of network-adequacy rules for outpatient dialysis facilities, may have increased negotiating leverage for many MA plans, accounting for the drop in MA prices for dialysis in 2021 and 2022. ■

Each year, the Commission provides a status report on the Medicare Advantage (MA) program, as required by law. The MA program allows Medicare beneficiaries enrolled in both Part A and Part B to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. MA plans typically have flexibility to use alternative payment models, negotiate with individual providers, use care-management techniques that fill potential gaps in care delivery, and provide incentives for beneficiaries to seek care from more efficient providers. By contrast, traditional FFS Medicare has lower administrative costs but has fewer incentives to coordinate care and is limited in its ability to make care delivery more efficient.¹

The Commission strongly supports including private plans in the Medicare program. 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, such as reduced premiums and cost-sharing liability. MA plans are required by statute to offer an out-of-pocket (OOP) spending limit that is not included in FFS Medicare. MA plans can also offer integrated Part D benefits, provide supplemental benefits not covered by Part A or Part B of Medicare, and reduce cost-sharing liability and premiums. These benefits are particularly appealing for those who are unable to afford a Medicare supplemental insurance (Medigap) policy that would help cover cost sharing in FFS Medicare.² In exchange for these benefits, MA plan enrollees accept provider networks and utilization-management tools such as prior authorization to ensure that a health care service is medically necessary before it will be covered by the plan. Because private plans and FFS Medicare have structural aspects that appeal to different segments of the Medicare population, the Commission supports payment policies that do not unduly favor MA or FFS.

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. But the Commission is concerned that the MA program, as currently structured, does not serve beneficiaries or taxpayers as it should. Indeed, current MA payment policies distort the goal of plans

competing to reduce health care costs and improve quality; instead, these policies increase program spending and Part B beneficiaries' premiums. The rapid growth of MA enrollment and spending elevates the urgent need for reform. Over the past decade, the Commission has developed four recommendations (some that incorporate and update prior recommendations) that would substantially improve the MA program for both beneficiaries and taxpayers (see text box, "Commission recommendations to improve MA payment policies," pp. 352–354).

In this chapter, we review types of MA plans and Medicare's mechanisms for paying them to provide Medicare benefits to enrollees. We then provide updated information on MA enrollment and plan availability. We also discuss MA rebates, used by plans to provide supplemental benefits to enrollees, which are projected to reach record levels in 2026. Next, we examine Medicare's payments to MA plans, including the impact of higher MA coding intensity and favorable selection into MA on spending. Overall, we estimate that Medicare's payments to plans substantially exceed what would have been spent on MA beneficiaries had they instead been enrolled in FFS Medicare. We then assess the structure of the MA market, including trends in the concentration of enrollment and the integration of MA organizations with other entities in the health care sector. We also review MA's flawed system for quality reporting and measurement. Finally, we update our 2021 analysis of Medicare payments and MA plan costs for individuals with end-stage renal disease (ESRD), who are increasingly enrolling in MA plans.

Background

Medicare Advantage (MA) plans include health maintenance organization (HMO), preferred provider organization (PPO), private fee-for-service (PFFS), and medical savings account (MSA) plans.³ For payment purposes, there are two categories of MA plans: local plans and regional plans. Local plans may be any of the available plan types and may serve one or more counties. Medicare pays them based on their enrollees' counties of residence. Regional plans, however, must be PPOs and must serve an entire region as established by CMS; there are 26 regions and each region comprises

Commission recommendations to improve Medicare Advantage payment policies

For some enrollees, the supplemental benefits that Medicare Advantage (MA) plans offer fill gaps in the Medicare benefit by adding coverage for services that are not included in traditional Medicare.⁴ These benefits are particularly appealing for those who are unable to afford a Medigap policy that would cover cost sharing in fee-for-service (FFS) Medicare. But the Commission is concerned that many of Medicare's payment policies and policies to incentivize high-quality care do not serve beneficiaries or taxpayers. Indeed, MA payment policies distort the goal of plans competing to reduce health care costs and improve quality; instead, these policies increase program spending and Part B beneficiaries' premiums.

- CMS's annual coding adjustment has for many years been inadequate to address the level of MA diagnostic coding that we have estimated. For 2026, we find that the V28 risk model has made important improvements in addressing the overall level of coding and in improving the fairness of risk adjustment across MA organizations. However, we estimate that after the coding adjustment, higher MA coding intensity continues to result in higher payments to MA plans and inequity across MA organizations.
- The quality-bonus program boosts payments to plans for 64 percent of MA enrollees but does not effectively promote high-quality care.
- Benchmarks are set at a high level, and we estimate that MA plan bids in 2026 are, on average, roughly equal to the costs of covering the Medicare benefit under FFS, when we account for the effects of higher coding intensity and favorable selection in MA.
- Plan-submitted data about beneficiaries' health care encounters are incomplete. If these data were complete and accurate, they could be used to identify MA plan efficiencies, improve quality

measurement, and provide more robust oversight of the MA program.

Overall, we estimate in 2026 that Medicare is paying MA plans 14 percent, or \$76 billion, more than it would spend if MA enrollees were covered under FFS Medicare, which increases the financial burden on taxpayers and beneficiaries who fund the MA program. Paying MA plans more than FFS spending for beneficiary care also creates inequities among beneficiaries since beneficiaries in FFS Medicare help finance the higher payments that MA plans use to provide supplemental benefits for their enrollees (benefits that FFS beneficiaries generally must pay for out of pocket or through supplemental insurance). We estimate that aggregate Part B premiums will be about \$11 billion (8 percent) higher in 2026 because of payments above FFS spending (equivalent to about \$175 per beneficiary per year, or \$14.61 per beneficiary per month).⁵ Further, incentives for efficient delivery of care are undermined by paying MA plans more than the program pays for FFS beneficiaries.

The Commission continues to support including private plans in the Medicare program so that beneficiaries can choose among Medicare coverage options. But the rapid growth of MA enrollment and spending elevates the urgent need for reform. As MA enrollment continues to grow, higher payments to plans relative to FFS will worsen Medicare's fiscal sustainability. To encourage efficiency and promote value for taxpayers and beneficiaries, an overhaul of MA payment policies should include reducing the level of Medicare payments to MA plans. Past experience with reductions in MA payments under the Affordable Care Act of 2010 (ACA) has demonstrated that plans can adjust their bidding behavior and lessen the effects on plan participation and beneficiary enrollment. If payments to MA plans were lowered, plans might reduce the supplemental benefits they offer, but research has found that plans have responded to past payment

(continued next page)

Commission recommendations to improve Medicare Advantage payment policies (cont.)

reductions by modifying other aspects of their bids in order to continue offering benefits to attract enrollees (Cabral et al. 2018, Chernew et al. 2023, Congressional Budget Office 2022, Song et al. 2013).

Over the past decade, the Commission has developed four recommendations (some that

incorporate and update prior recommendations) that would improve the MA program for both beneficiaries and taxpayers. Table 12-1 summarizes the Commission's standing recommendations to (1) account for continued coding differences between MA and FFS and address those differences

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TABLE 12-1 Commission's recommendations to improve MA payment policies

Recommendation

Fully account for MA coding intensity—March 2016

The Congress should direct the Secretary to develop a risk-adjustment model that uses two years of FFS and MA diagnostic data and does not include diagnoses from health risk assessments from either FFS or MA, and then apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.

Improve encounter-data accuracy and completeness—June 2019

The Congress should direct the Secretary to establish thresholds for the completeness and accuracy of MA encounter data and rigorously evaluate MA organizations' submitted data and provide robust feedback; concurrently apply a payment withhold and provide refunds to MA organizations that meet thresholds; and institute a mechanism for direct submission of provider claims to Medicare administrative contractors as a voluntary option for all MA organizations that prefer this method starting in 2024, for MA organizations that fail to meet thresholds, or for all MA organizations if program-wide thresholds are not achieved.

Replace the quality-bonus program—June 2020*

The Congress should replace the current MA quality-bonus program with a new MA value-incentive program that scores a small set of population-based measures, evaluates quality at the local-market level, uses a peer-grouping mechanism to account for differences in enrollees' social risk factors, establishes a system for distributing rewards with no "cliff" effects, and distributes plan-financed rewards and penalties at a local market level.

Establish more equitable benchmarks—June 2021**

The Congress should replace the current MA benchmark policy with a new MA benchmark policy that applies a relatively equal blend of per capita local-area FFS spending with price-standardized per capita national FFS spending; a rebate of at least 75 percent; a discount rate of at least 2 percent; and the Commission's prior MA benchmark recommendations—using geographic markets as payment areas, using the FFS population with both Part A and Part B in benchmarks, and eliminating the current pre-Affordable Care Act cap on benchmarks.

Note: MA (Medicare Advantage), FFS (fee-for-service).
* The June 2020 quality recommendation incorporates the Commission's prior recommendations to eliminate the doubling of the quality increases in specified counties (recommended in March 2016) and to establish a geographic basis for MA quality reporting that reflects health care market areas (June 2005, March 2010, and March 2018).
** The June 2021 benchmark recommendation incorporates the Commission's prior recommendations to eliminate the cap on benchmark amounts implemented by the Affordable Care Act of 2010 (ACA) (recommended in March 2016), base benchmarks on FFS spending data only for beneficiaries with both Part A and Part B (recommended in March 2017), and establish a geographic basis for MA payments that reflects health care market areas (recommended in June 2005, March 2010, and March 2018).

Source: Medicare Payment Advisory Commission (2021a), Medicare Payment Advisory Commission (2020a), Medicare Payment Advisory Commission (2019), Medicare Payment Advisory Commission (2016c).

Commission recommendations to improve Medicare Advantage payment policies (cont.)

in a complete and equitable way (Medicare Payment Advisory Commission 2016c); (2) ensure the completeness and accuracy of encounter data to improve the MA payment system, serve as a source of quality data, and facilitate comparisons with FFS Medicare (Medicare Payment Advisory Commission 2019); (3) replace the quality-bonus program with a market area-based, plan-financed reward program (Medicare Payment Advisory Commission 2020a); and (4) establish more equitable MA benchmarks for the Medicare program (Medicare Payment Advisory Commission 2021a). Through reforms to the MA payment system, the Commission aims to improve the program for the beneficiaries it serves and to harness plan efficiencies to strengthen Medicare's long-term financial sustainability.

The Commission has separately expressed concern about the FFS benefit design and has recommended changes to give beneficiaries better protection against high out-of-pocket (OOP) spending and to

create incentives for them to make better decisions about their use of discretionary care. Protecting beneficiaries against high OOP spending would modernize the FFS benefit and mitigate the need for beneficiaries to purchase supplemental insurance (Medicare Payment Advisory Commission 2012a). That recommendation also would create clearer incentives for beneficiaries to make better decisions about their use of care through adjustments and refinements in cost sharing based on evidence of service value while holding the aggregate beneficiary cost-sharing liability about the same as under current law. Finally, our recommendation would add a charge on supplemental insurance (such as Medigap) to recoup at least some of the additional costs resulting from the higher service use that supplemental insurance imposes on the Medicare program while still providing beneficiaries the choice to buy supplemental coverage if they wish to do so. ■

one or more entire states. For each MA enrollee, Medicare pays plans a capitated rate that is adjusted to account for differences in expected medical costs.

Types of MA plans

Our analysis of the MA program uses the most recent data available, and we report our results by plan type as defined by CMS. CMS uses these plan types to distinguish between ways that Medicare pays MA plans, but there are important differences even within these types that we discuss below. The analysis (including the analysis of enrollment and payments to plans) does not include non-MA private-plan options (e.g., 1876 cost plans, Program of All-Inclusive Care for the Elderly plans) that may be available to some beneficiaries. The primary MA plan types (covering more than 99 percent of enrollees) are:

- **HMOs and local PPOs**—These plans have provider networks and, if they choose, can use tools such as selective contracting and utilization management to coordinate and manage care and control service use. They can choose individual counties to serve and can vary their premiums and benefits across counties. There are meaningful differences between HMOs and PPOs. For example, HMOs generally do not pay for care furnished by out-of-network (OON) providers and often require that enrollees select a named primary care provider (PCP), who manages referrals to specialists. PPOs provide more flexibility for enrollees by not requiring a named PCP and by allowing enrollees to see both in- and out-of-network specialists without a referral. However, these plans generally have both higher premiums than HMOs and higher

cost sharing for OON providers compared with in-network providers. HMO point-of-service is a subset of the HMO plan type that allows members to seek OON care for certain types of services or in certain cases (such as travel). HMO point-of-service plans offer less flexibility to seek care out of network than PPOs but more than standard HMOs.

- **Regional PPOs**—These plans must offer a uniform benefit package and premium across CMS-designated regions made up of one or more states. Regional PPOs have more flexible provider-network requirements than local PPOs. For instance, regional PPOs may meet Medicare access requirements by arranging for enrollees to obtain plan-covered services through noncontracted providers at in-network cost-sharing levels for enrollees.

Two additional plan classifications cut across plan types: special-needs plans (SNPs) and employer group plans. SNPs offer benefit packages tailored to specific populations (that is, beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). Each SNP must be an HMO or PPO plan. Employer group plans are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. SNPs are included in our plan data, with the exception of plan-availability figures because these plans are not available to all beneficiaries. Employer group plans do not submit bids and are not available to all Medicare beneficiaries, so they are not included in our analysis of bids or plan availability.

How Medicare pays MA plans

In contrast to FFS Medicare's fixed rates per service paid to providers, Medicare pays MA plans a fixed rate for each enrolled beneficiary, which is the product of a base rate and a risk score. Risk scores adjust a plan's base rate to account for differences in expected beneficiary medical costs by increasing a plan's payment rate for beneficiaries who are likely to have higher medical expenses and decreasing a plan's payment rate for beneficiaries who are likely to have lower medical expenses. The general purpose of risk adjustment is to accurately predict costs on average for large groups of beneficiaries and to reduce

incentives for plans either to avoid beneficiaries with certain unprofitable attributes or to attract those with profitable attributes.

A plan's base rate is determined by the MA plan's bid and the benchmark for the county in which the beneficiary resides. The bid is intended to represent the dollar amount that the plan estimates will cover its costs of providing the Part A and Part B benefit package for a beneficiary of average spending. The benchmark is the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits.⁶ (Medicare also pays many plans for providing the Part D drug benefit, but those payments are determined through the Part D bidding process and are not discussed here.) Plans with higher quality ratings are rewarded with a higher benchmark (although the increase to the benchmark can be limited by the Affordable Care Act of 2010 (ACA) benchmark caps).

For 2026, almost 100 percent of plans bid below their benchmarks. For these plans, the base rate is the plan's bid plus a "rebate" equal to a share of the difference between the plan's bid and the benchmark (as low as 50 percent but typically either 65 percent or 70 percent, depending on a plan's quality ratings).⁷ The beneficiary pays no additional premium to the plan for Part A and Part B benefits (but continues to be responsible for paying the Medicare Part B premium).

The rebate that plans receive must be used to provide supplemental benefits to enrollees in the form of lower cost sharing, lower premiums, or coverage of non-Medicare services (benefits not covered by Part A or Part B). Plans also devote some of the rebate to their administrative costs and profit. Plans can choose to include additional supplemental benefits that are not financed by the rebate in their benefit packages and charge premiums to cover those additional benefits.⁸ (A more detailed description of the MA program's payment system can be found in our *Payment Basics* series at <https://www.medpac.gov/document-type/payment-basic/>.)

How Medicare calculates MA benchmarks

Under the statute, each county's benchmark, excluding quality bonuses, equals a certain share (ranging from 95 percent to 115 percent, subject to caps) of the projected average per capita FFS Medicare spending for the

county's beneficiaries.⁹ Each county's benchmark is determined by organizing the counties into quartiles based on their FFS spending.¹⁰ Low-FFS-spending counties have benchmarks higher than their county's FFS spending level to help attract plans and enable enrollees to receive supplemental benefits, and high-FFS-spending counties have benchmarks lower than FFS spending with the goal of generating Medicare savings because MA plans have greater opportunity to produce spending efficiencies in these areas. Counties are assigned to quartiles based on average FFS spending; the highest-spending quartile of counties has benchmarks set at 95 percent of local FFS spending. The next-highest-spending quartile of counties has benchmarks set at 100 percent of FFS spending, followed by the third-highest quartile set at 107.5 percent of FFS spending. The lowest-spending quartile has benchmarks set at 115 percent of local FFS spending. U.S. territories are treated like counties in this lowest-spending quartile. Counties that move among quartiles from year to year receive a blended quartile factor. For example, a county that moved from the 100 percent quartile in 2025 to the 107.5 percent quartile in 2026 would have a blended rate of 103.75 percent in 2026.

By statute, plans that are awarded quality bonuses have benchmarks that are 5 percentage points higher than the standard county benchmarks (subject to benchmark growth caps); in certain counties, plans can receive a double bonus, and the benchmarks for plans awarded quality bonuses are 10 percentage points higher than the standard benchmarks.¹¹ Unlike nearly all of Medicare's FFS quality-incentive programs, these quality bonuses are not budget neutral but are instead financed by added program dollars and beneficiary premiums. The Commission has repeatedly recommended that the Congress revise the MA quality-incentive program to be budget neutral (that is, financed with a share of plan payments) and focused on measures tied to clinical outcomes and patient experience (Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2004).

How Medicare calculates risk scores

Risk scores are beneficiary-level index values that indicate the expected Medicare costs for an enrollee relative to the national average FFS beneficiary. How

well Medicare's payments to MA plans match their enrollees' costliness depends in large part on how well the risk scores predict the expected costs for the plans' enrollees.

CMS calculates risk scores with the CMS hierarchical condition category (CMS-HCC) risk-adjustment model, which uses demographic information (e.g., age, sex, Medicaid eligibility, institutional status, and disability status) and certain diagnoses grouped into HCCs to calculate a risk score for each enrollee. HCCs are medical conditions or groups of related conditions with similar treatment costs. Some conditions have more than one HCC, which differ by severity of the condition and are arrayed in a hierarchy. For example, the CMS-HCC model has four HCCs for chronic kidney disease, listed here in order of highest severity: Stage 5, Stage 4, Stage 3B, and Stage 3 (except Stage 3B). The "hierarchical" aspect of HCCs means that if a beneficiary's diagnoses map to more than one HCC in a condition hierarchy, CMS applies only the HCC that has the largest effect on the beneficiary's risk score—the highest-severity HCC applicable to that beneficiary.

CMS tracks beneficiary demographic information, but MA plans submit diagnostic information to CMS through encounter records, which contain basic information about each Medicare-covered encounter an enrollee has with a health care provider and each Medicare-covered item provided to the enrollee.¹² Diagnostic data collected from encounters in one year are used to predict Medicare costs for the following year. For example, diagnostic data collected during 2025 was used to calculate risk scores used to adjust payments to plans in 2026.

CMS designed this risk-adjustment model to maximize its ability to predict annual medical expenditures for FFS Medicare beneficiaries while also ensuring that the model's diagnostic categories were clinically meaningful and "sufficiently clinically specific to minimize opportunities for gaming or discretionary coding" (Pope et al. 2004). CMS has two requirements aimed at ensuring the validity and reliability of the diagnostic data used in an enrollee's risk score: Diagnoses must (1) appear on a claim from a hospital inpatient stay, a hospital outpatient visit, or a face-to-face visit with a physician or other health care professional; and (2) be supported by evidence in the

patient's medical record.¹³ Diagnoses resulting from telehealth services meet the face-to-face requirement when the services are provided using interactive audio and video telecommunication that enables real-time communication with the beneficiary. To verify that diagnoses are supported by evidence in the patient's medical record, CMS conducts risk-adjustment data-validation (RADV) audits. RADV audits have been limited so far, but the available results show significant issues with medical-record support for risk-adjustment diagnoses. For example, the Department of Health and Human Services Office of Inspector General (OIG) has conducted RADV-like audits of high-risk diagnoses for at least 30 MA contracts and found that 70 percent of all diagnosis codes audited were not supported by medical records and that some diagnoses were not supported over 90 percent of the time (Office of Inspector General 2023). For example, OIG audited diagnoses of acute stroke that were documented on one physician encounter record but were not documented on an inpatient or outpatient encounter record. Such acute stroke diagnoses were found to be in error 96 percent of the time, and OIG concluded generally that a "history of stroke" diagnosis (which does not map to an HCC) should have been used for such cases (Office of Inspector General 2023). (See text box, "Update on risk-adjustment data-validation audits," pp. 402–403.)

The CMS–HCC model is calibrated using FFS claims data so that each beneficiary's risk score reflects the expected spending that would occur for a beneficiary relative to the national average spending in FFS Medicare. Relying on FFS data for risk scores, and for other aspects of Medicare's payments to MA plans, generates two payment-accuracy issues. First, risk scores do not predict spending for MA enrollees as accurately as they do for FFS beneficiaries, on average. Risk scores systematically overpredict spending for MA enrollees, leading to higher average payments to MA plans relative to what FFS spending would have been for similar beneficiaries. This favorable selection of enrollees into MA results from relying on FFS data for risk scores and benchmarks. (See "Before coding differences, favorable selection causes risk-based payments to overpredict spending for MA enrollees," p. 383). Second, diagnoses are not coded with the same frequency in MA and FFS. Higher MA coding intensity leads to higher average payments to MA plans and

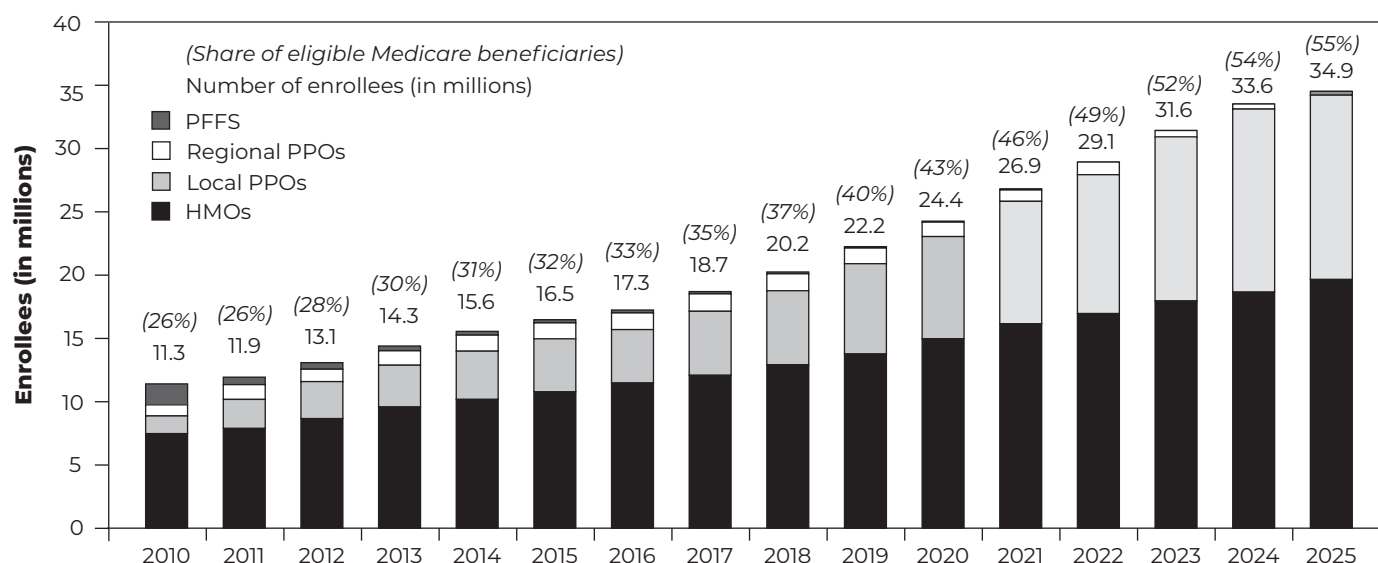
advantages plans that code more intensively than other plans. (See "Coding differences increase payments to MA plans in 2026 by an estimated \$22 billion and continue to generate inequity across plans," p. 386.)

Robust MA enrollment, plan availability, and rebates

Continued growth in MA plan enrollment, considerable plan availability, and substantial rebates indicate a robust MA program. In each year since 2023, more than half of eligible Medicare beneficiaries have been enrolled in MA plans. For 2026, the average beneficiary has access to 39 plans sponsored by eight organizations. Rebates, which are used to fund supplemental benefits, are projected to reach record-high levels in 2026.

In 2025, enrollment in MA plans grew by 4 percent; 55 percent of eligible Medicare beneficiaries were enrolled in MA plans

Between July 2024 and July 2025, enrollment in MA plans grew by 4 percent—or 1.3 million enrollees—to 34.9 million enrollees, while the total MA-eligible population (beneficiaries with both Part A and Part B coverage) grew by only 2 percent. Between 2024 and 2025, MA enrollment rose from 54 percent to 55 percent of eligible Medicare beneficiaries (Figure 12-1, p. 358). The share of eligible Medicare beneficiaries enrolled in MA has more than doubled since 2010. MA has become increasingly attractive to beneficiaries because plans provide cost-sharing reductions, subsidized Part D coverage, non-Medicare benefits, and a cap on out-of-pocket (OOP) expenses at little or no additional premium. (The magnitude of these additional benefits stems in part from Medicare's higher payments to MA plans.) Most beneficiaries with care needs that are met within plan networks and coverage policies will likely have lower total financial liability (premiums and cost sharing) compared with beneficiaries who stay in FFS and purchase the most comprehensive supplemental coverage (Ippolito et al. 2024). Some MA enrollees with high care needs do experience greater cost liabilities compared with beneficiaries in FFS (e.g., greater cost sharing for in-network and out-of-network services compared with Medigap premiums) (Keohane et al. 2015).

**FIGURE
12-1****Share of eligible Medicare beneficiaries enrolled in Medicare Advantage has more than doubled since 2010**

Note: PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). Medicare Medical Savings Account plans are included but are not shown separately due to the small number of enrollees in such plans. Beneficiaries must have both Part A and Part B coverage to enroll in a Medicare Advantage plan; therefore, beneficiaries who have Part A only or Part B only are not included in this figure.

Source: MedPAC analysis of CMS enrollment files, July 2010 to July 2025.

Among plan types, HMOs continued to enroll the most beneficiaries (20 million) in 2025. Enrollment in HMOs grew by 5 percent between 2024 and 2025, outpacing growth of local PPOs (3 percent) (Table 12-2). Between 2024 and 2025, enrollment in HMOs grew by nearly 1 million, accounting for roughly two-thirds of the overall increase in MA enrollment; enrollment in local PPOs grew by just under half a million and accounted for roughly one third of overall MA growth. For the first time in several years, HMO enrollment growth has outpaced that of local PPOs; the shift could reflect a change in the types of plans offered by MA insurers in 2025.

Increased SNP enrollment accounted for more than half of all MA enrollment growth between 2024 and 2025. In 2025, SNP enrollment grew by 10 percent—a continuation of the rapid growth (above 10 percent

per year) observed over the last six years. Some of the growth in SNP enrollment is likely due to the winding down of Medicare–Medicaid plans (MMPs), which are demonstration plans (operated outside of the MA program) that CMS and certain states have been testing as part of an effort to develop new models of care for dually eligible beneficiaries. In 2022, CMS announced that it would be ending the MMP demonstrations at the end of 2025.¹⁴ Beginning in 2026, most remaining MMPs will convert to operating as MA dual-eligible SNPs (D–SNPs). At their peak, MMPs had between 400,000 and 450,000 enrollees; in July of 2025, roughly 240,000 enrollees remained in MMPs.

Of the three main types of SNPs (D–SNP, chronic or disabling condition (C–SNP), and institutional (I–SNP)), D–SNPs are the largest, enrolling roughly 80 percent of all SNP enrollees. Enrollment in C–SNPs,

**TABLE
12-2**

Enrollment growth in HMOs outpaced growth in other plan types in 2025

	MA enrollment (in millions)		Percent change in enrollment (2024–2025)
	July 2024	July 2025	
Total MA-eligible beneficiaries	61.7	63.2	2%
Total MA enrollment	33.6	34.9	4
Plan type			
HMO	18.7	19.7	5
Local PPO	14.5	15.0	3
Regional PPO	0.4	0.2	–39
PFFS	<0.05	<0.05	24
Restricted-availability plans included in totals above			
SNPs*	6.9	7.6	10
Employer group*	5.8	5.8	0

Note: HMO (health maintenance organization), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special-needs plan). The number of MA-eligible beneficiaries excludes beneficiaries who are not eligible to enroll in an MA plan because they do not have both Part A and Part B coverage (approximately 6 million beneficiaries in 2025). Totals and calculated values may be affected by rounding.

* SNPs and employer group plans have restricted availability. Their enrollment is included in the statistics by plan type. We present them separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of CMS enrollment files.

however, has grown dramatically in recent years. C–SNP enrollment grew by 22 percent, 54 percent, and 69 percent in 2023, 2024, and 2025, respectively. This growth has been driven, in part, by a rise in the number of C–SNPs offered by MA insurers—nearly three times as many C–SNPs in 2025 as they offered in 2019 (Stein et al. 2025a). Several aspects of Medicare policy may make C–SNPs attractive to MA insurers and to Medicare beneficiaries (Polakowski et al. 2025). For example, eligible MA enrollees are permitted to enroll in a C–SNP at any point in the year (rather than just during the annual open enrollment period), and Medicare uses higher risk scores for new Medicare enrollees enrolling in C–SNPs than it would use if the same beneficiaries were to enroll in a conventional MA plan or other type of SNP. Additionally, since C–SNP enrollees must have a chronic condition to enroll, plans may have an easier time identifying risk-adjustment-eligible diagnoses for C–SNP members

than for enrollees in other types of MA plans. The chronic-condition enrollment requirement might also enable C–SNPs to offer easier access to non-primarily health-related supplemental benefits (such as food and produce, pest-control services, or housing support). This feature could be particularly important in 2026, given the end of the MA value-based insurance design (VBID) demonstration at the end of 2025. The MA–VBID demonstration enabled plans to make non-primarily health-related benefits widely available to SNP enrollees because it allowed plans to target the benefits on the basis of socioeconomic status. Without the demonstration, plans will be able to offer these benefits only as special supplemental benefits for the chronically ill (SSBCI), meaning that they must be targeted to enrollees who meet CMS’s definition of being chronically ill. Since C–SNP enrollees must have a chronic condition to enroll, giving members access to these benefits in C–SNPs

could be easier than in other plans (see the section on supplemental benefits for more information about non-primarily health-related benefits, p. 368).

Researchers, as well as CMS, have noted an uptick in the number of full-benefit dual-eligible beneficiaries enrolled in C-SNPs (Centers for Medicare & Medicaid Services 2025f, Stein et al. 2025a). For most C-SNPs, the share of enrollees who are fully dually eligible is generally low—averaging roughly 15 percent between 2011 and 2024. However, for a small but growing number of C-SNPs, the share is significantly higher (at or above 60 percent of plan enrollees) (Centers for Medicare & Medicaid Services 2025f, Stein et al. 2025a). Between 2021 and 2025, the number of C-SNPs for which dually eligible individuals comprised more than 60 percent of enrollment rose from 16 (of 207) to 66 (of 385) (Centers for Medicare & Medicaid Services 2025f). Because C-SNPs are not required to meet the same standards as D-SNPs with respect to how they coordinate Medicare and Medicaid benefits, both CMS and researchers have expressed concern that the rising number of C-SNPs with high shares of dually eligible enrollees may hamper efforts to integrate benefits for these enrollees (Centers for Medicare & Medicaid Services 2025f, Stein et al. 2025a, Stein et al. 2025b). Of all full-benefit dual-eligible individuals newly enrolled in C-SNPs in 2024, roughly 10 percent were previously enrolled (in 2023) in a highly integrated D-SNP (HIDE-SNP), fully integrated D-SNP (FIDE-SNP), or other integrated plan (such as a Program for All-Inclusive Care for the Elderly or MMP) (Stein et al. 2025b).

Looking across plan types, HMOs accounted for nearly all (90 percent) SNP enrollment growth. Enrollment in SNP HMOs grew by 12 percent, accounting for two-thirds of total HMO growth. Although local PPO SNPs have proliferated since 2018, rising from 4 percent of SNP enrollment to 19 percent in 2025, most SNP enrollees (81 percent) are enrolled in HMOs. Altogether, in 2025, Medicare beneficiaries who were eligible to enroll in SNPs were predominantly enrolled in HMOs, while enrollment of beneficiaries who did not qualify for a SNP was more evenly distributed between HMOs and PPOs.

Enrollment patterns differ in urban and rural areas. In urban areas, 57 percent of eligible beneficiaries were enrolled in MA in 2025; in rural areas, 49 percent of

eligible beneficiaries were enrolled in MA.¹⁵ The growth of MA enrollment in urban and rural areas was similar (4 percent) between 2024 and 2025. The predominant plan type often differs between urban and rural areas: In 2025, 41 percent of rural MA enrollees were in HMO plans, compared with 59 percent of urban enrollees. By contrast, 57 percent of rural enrollees were in local PPOs compared with 40 percent of urban enrollees.

Geographic variation in the growth of MA has resulted in some areas having a very high share of eligible Medicare beneficiaries enrolled in MA and other areas having a relatively low share. In some states (including Iowa, Kansas, Maryland, Massachusetts, and Nebraska), less than 40 percent of eligible Medicare beneficiaries are enrolled in MA; however, a relatively small share of the MA-eligible population (less than 10 percent) lives in such states. In contrast, in 30 states (including California, Florida, New York, Pennsylvania, and Texas) and Puerto Rico, home to more than three-quarters of eligible Medicare beneficiaries, more than half of the eligible population was enrolled in an MA plan in 2025. In 10 of these 30 states (including Alabama, Florida, Georgia, Louisiana, and Michigan), encompassing roughly 20 percent of eligible beneficiaries, the share enrolled in MA exceeded 60 percent. MA enrollment is particularly high in some metropolitan areas (e.g., El Paso, TX; Grand Rapids, MI; Miami, FL; Pittsburgh, PA; Rochester, NY) and in Puerto Rico, where more than 75 percent of eligible Medicare beneficiaries are enrolled in MA plans. MA benchmarks are computed at the county level and are based on the area's FFS spending; in an increasing number of counties, more than half of eligible Medicare beneficiaries are enrolled in MA plans.

Availability of MA plans remains high in 2026

Every year, we assess plan availability and projected enrollment for the coming year based on the bid data that plans submit to CMS. We find that access to MA plans remains high in 2026, with most Medicare beneficiaries having access to many plans and multiple insurers. Measures of availability slightly declined relative to 2025, though these measures remained high and stable. While almost all beneficiaries have had access to some type of MA plan since 2006, local HMOs and PPOs are widely available (Table 12-3). In

**TABLE
12-3****Access to Medicare Advantage plans remains high**

Type of plan	2022	2023	2024	2025	2026
Share of Medicare beneficiaries with access to at least one MA plan					
Any MA plan	99%	>99.5%	>99.5%	>99.5%	99%
Local CCP	99	99	>99.5	>99.5	99
Regional PPO	74	74	74	68	60
PFFS	35	29	30	29	26
Special-needs plans					
Dual eligible	94	94	95	95	98
Chronic condition	59	66	72	85	90
Institutional	74	77	78	80	79
Zero-premium plan with drug coverage	98	99	99	99	98
Average number of choices					
County weighted	22	26	28	28	26
Beneficiary weighted	36	41	43	42	39
Average number of insurers					
County weighted	5	5	6	6	5
Beneficiary weighted	8	8	8	8	8

Note: MA (Medicare Advantage), CCP (coordinated-care plan), PPO (preferred provider organization), PFFS (private fee-for-service). "Local CCP" includes HMO and local PPO plans. This table's figures exclude employer-only plans and Medicare Medical Savings Account plans. Special-needs plans are included in the three rows of special-needs plans but excluded from all other rows. The share of Medicare beneficiaries includes only beneficiaries with both Part A and Part B coverage (i.e., MA-eligible beneficiaries). A "zero-premium plan with drug coverage" includes Part D coverage with no Part D premium (but may include the Part B premium). "County weighted" means that each county is weighted the same and the measure is the average number of choices per county. "Beneficiary weighted" means that each county is weighted by the number of eligible beneficiaries in the county.

Source: MedPAC analysis of CMS bid and enrollment data.

2026, 99 percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, down slightly from nearly 100 percent in 2025.¹⁶

The availability of SNPs continues to be high across the types of special-needs populations served (Table 12-3). In 2026, 98 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (up from 95 percent in 2025), 90 percent live where SNPs serve beneficiaries with chronic conditions (up from 85 percent in 2025),

and 79 percent live where SNPs serve institutionalized beneficiaries (down from 80 percent in 2025). Overall, 99 percent of beneficiaries reside in counties served by at least one type of SNP (data not shown). Our measure of SNP availability reflects only the share of MA-eligible beneficiaries residing in a county served by a SNP. However, individuals must meet additional coverage criteria to be eligible to enroll in a SNP; for example, to enroll in an institutional SNP, a beneficiary would typically reside in a skilled nursing facility that has a relationship with the plan.

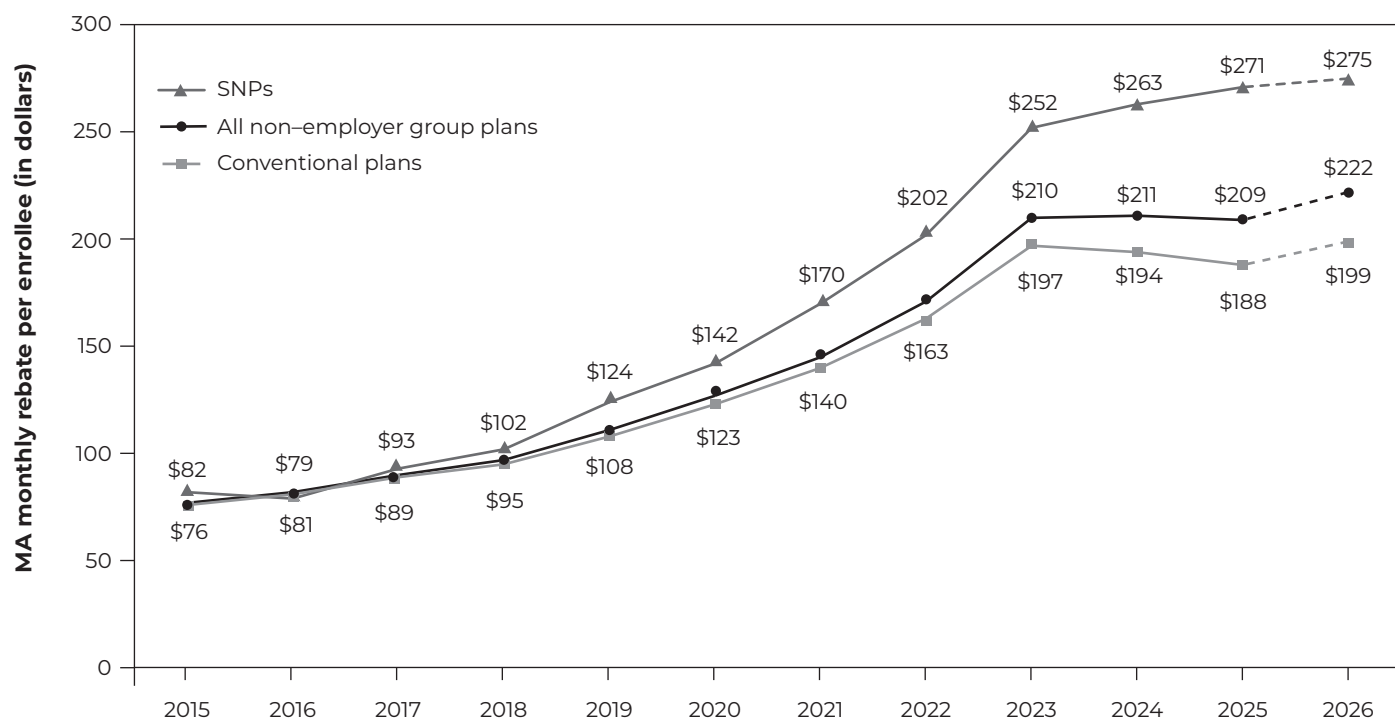
In 2026, 98 percent of eligible Medicare beneficiaries (down from 99 percent in 2025) have access to at least one “zero-premium” plan with drug coverage—that is, a conventional (open to all MA-eligible beneficiaries) MA plan that includes Part D drug coverage and charges no Part C or Part D premium (enrollees may pay the Medicare Part B premium) (Table 12-3, p. 361).¹⁷ About 76 percent of conventional MA enrollment is projected to be in these zero-premium plans (data not shown). Also in 2026, 99 percent of beneficiaries (unchanged from 2025) have access to at least one plan that offers some reduction in the Part B premium (data not shown); about 29 percent of 2026 conventional MA enrollment is projected to be in these premium-reduction plans (a decline from 32 percent in 2025); and the median monthly premium reduction is \$61 for enrollees in one of these plans (data not shown). As plans have increasingly offered Part B–premium reductions, MA enrollees may become increasingly attracted to the direct assistance these benefits provide.

In most counties, beneficiaries have access to many MA plans. While nearly all Medicare beneficiaries have had an MA plan available to them since 2006, the number of plans offered per insurer has increased substantially since 2019, coinciding with CMS’s regulatory repeal of its “meaningful differences” requirement.¹⁸ In 2018, the average number of plans available per county was 10 (equivalent to an average of 20 plans per beneficiary). In 2026, the average number of plans available in a county is 26 (down from 28 plans in 2025) (Table 12-3, p. 361). About 4 percent of counties in 2026 do not have an available conventional MA plan (up from 3 percent in 2025; data not shown).¹⁹ Plan availability can also be evaluated by the number of plan choices available to the average beneficiary. According to that calculation, the average beneficiary in 2026 has 39 available plans, down from 42 plans in 2025. An additional measure of plan access is the number of insurers offering products to the average beneficiary. In 2026, the average beneficiary can choose from plans sponsored by eight organizations (unchanged from 2025); 96 percent of beneficiaries have access to MA plans sponsored by at least three organizations, 92 percent of beneficiaries can choose from plans sponsored by at least four organizations, and 86 percent of beneficiaries can choose from plans sponsored by at least five organizations (data not shown).²⁰

Beneficiaries in our focus groups consistently report being confused about their coverage options and overwhelmed regarding the number of choices they face (NORC at the University of Chicago 2025). Across sectors, studies of marketing and consumer behavior have consistently indicated that “choice overload” can both be distressing and lead to suboptimal decisions, and the potential negative consequences of “too much choice” are amplified in sectors with a high degree of complexity, such as health care (Dar and Gul 2025, Frank and Lamiraud 2009, Misuraca et al. 2024, Reutskaja et al. 2020, Schlesinger et al. 2014, Taylor et al. 2016). One published literature review found that as the number of health plan choices increases, individuals are less likely to correctly identify the lowest-cost plan, less likely to review all of their coverage options, and more likely to select a plan that is clearly inferior to another available plan (Taylor et al. 2016). Included studies also found that individuals had difficulties even when the increase in the number of choices was relatively small, for example, from around 5 choices to around 10, and that many people have difficulty understanding concepts such as coinsurance and deductibles, tend to put too much emphasis on premiums over cost sharing when picking plans, and are susceptible to how plan choices are presented. Another study compared growth in MA enrollment with growth in the number of MA plans and found that enrollment grew faster in areas where the increase in the number of plans was relatively small (fewer than 15 plans), suggesting that beneficiaries were more likely to enroll when they had a more manageable number of choices (McWilliams et al. 2011). The Commission has expressed concern that, given the large number of plan choices, beneficiaries may find it difficult to discern differences in plan benefit packages in order to make an optimal choice (Medicare Payment Advisory Commission 2023b).

MA rebates, which plans use to provide supplemental benefits to enrollees, are projected to reach record levels in 2026

MA plans that bid below their benchmark are paid a “rebate” equal to a share of the difference between the plan’s bid and the benchmark (as low as 50 percent but typically either 65 percent or 70 percent, depending on a plan’s quality ratings). Plans are required to use rebates to provide supplemental benefits. These benefits have the potential to address health challenges

**FIGURE
12-2****Monthly MA rebates are projected to reach a record high in 2026**

Note: MA (Medicare Advantage), SNP (special-needs plan). "Conventional plans" excludes employer group plans and special-needs plans. "Special-needs plans" excludes employer group plans and non-special-needs plans. The plan rebate is the per beneficiary per month amount that the plan offers as premium-free supplemental benefits. Rebate dollar amounts are based on the enrollment-weighted national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. We use plans' actual enrollment to calculate average rebates for 2015 through 2025. The average for 2026 is weighted using enrollment projections from plans' bids. Enrollment weights are based on months of enrollment for MA enrollees without end-stage renal disease (ESRD) since plans do not receive rebates for members with ESRD. Dollar amounts are nominal figures, not adjusted for inflation. After adjusting for inflation, rebates in 2025 for conventional plans were about 1.7 times their 2016 level, and those for SNPs were about 2.5 times their 2016 level.

Source: MedPAC analysis of MA plan bid data.

that many seniors face as they age (such as vision and hearing issues) and for which there is limited coverage under FFS Medicare. Surveys of MA enrollees, as well as MedPAC's beneficiary focus groups, generally show that enrollees appreciate having access to the supplemental benefits that plans use rebates to offer (Commonwealth Fund 2025, NORC at the University of Chicago 2025). For 2026, almost 100 percent of plans bid below their benchmarks and therefore receive rebates.²¹ Average MA rebates are expected to reach an all-time high in 2026. Across all non-employer group plans, the average rebate is expected to be \$222 per

member per month (PMPM), up from \$209 in 2025 (dollar values not adjusted for inflation).²² The average rebate for conventional plans (i.e., non-employer group, non-special-needs plans) in 2026 will be about \$199 PMPM, up from \$188 in 2025; for special-needs plans, the average rebate will be about \$275, up from \$271 in 2025.²³

MA rebates have grown dramatically over the last decade (Figure 12-2). The average rebate paid to conventional MA plans in 2026 will be nearly two and a half times the amount paid to MA plans in 2016 (not

accounting for inflation). (Accounting for inflation, rebates in 2025 for conventional plans were about 1.7 times their 2016 level, and those for SNPs were about 2.5 times their 2016 level.) The increase is due primarily to rapid growth in rebates between 2018 and 2023; average rebates for conventional plans rose from \$95 PMPM in 2018 to \$197 in 2023; they then declined slightly to \$188 PMPM in 2025 before rising again to \$199 in 2026 (Figure 12-2, p. 363). For SNPs, the average rebate is significantly higher—\$275 PMPM in 2026—and has increased in every year since 2016.

MA plans are required to use the rebate to provide supplemental benefits for their enrollees. Supplemental benefits can be organized into four broad categories: reduced cost sharing for Part A and Part B services, reduced Part B premiums, enhanced Part D benefits (including reduced Part D premiums), and coverage of non-Medicare services (services not covered under FFS Medicare, such as dental, vision, and hearing services).²⁴ Plans have flexibility regarding which supplemental benefits they offer and the generosity of the coverage. Plans also use some of the rebate to cover their administrative costs and profit.²⁵ In the bids they submit to CMS, MA plans must report how much of their rebate they plan to allocate to each of the four broad categories of supplemental benefits. Plans' rebate allocations are a projection of how the plan anticipates rebate dollars will be used but might not reflect actual use. In 2026, the Medicare program will pay conventional plans approximately \$2,391 per beneficiary per year for supplemental benefits; plans report that they expect to use \$199 of those funds (about 8 percent) for plan administrative expenses and profit. Medicare will pay SNPs about \$3,306 per beneficiary per year for supplemental benefits, and plans expect to use about \$417 (about 13 percent) for plan administrative expenses and profit.

In 2026, as in most previous years, conventional MA plans project allocating the largest share of their rebate dollars (\$81 PMPM) to reducing cost sharing for Part A and Part B services (Table 12-4). That allocation represents a similar share of the total rebate as in 2025 (40 percent in 2026 vs. 41 percent in 2025) (Table 12-4).²⁶ The lower cost sharing that plans use rebates to offer can provide MA enrollees with additional financial protection. For conventional plans, the projected rebates allocated to cost-sharing reductions include

coverage for the beneficiary maximum out-of-pocket (MOOP) cap on plan-approved Part A and Part B expenses. In 2026, plans project that, on average, their liability for the MOOP will be \$19 PMPM—equivalent to 8 percent of rebates (unchanged from 2025; data not shown) and 1 percent of projected plan payments (unchanged from 2025; data not shown).^{27,28} Because cost-sharing reductions lower a beneficiary's OOP expenses, rebate dollars that are used to lower beneficiary cost sharing also lower a plan's MOOP liability. All cost-sharing reductions, including the MOOP, are subject to plan coverage policies. In certain circumstances, MA enrollees can be granted special enrollment periods that permit them to change plans midyear.²⁹ For beneficiaries who switch MA insurers midyear, their OOP spending contribution toward their MOOP limit is reset when they switch plans such that OOP expenses accumulated under their initial plan are not counted toward reaching the MOOP limit under the second plan. For beneficiaries who switch midyear between plan types offered by the same insurer, the insurer has discretion regarding whether beneficiary's OOP spending contribution toward the MOOP limit is reset. MOOP limits are not reset for beneficiaries who switch plans midyear but remain enrolled with the same insurer and in the same plan type.

Table 12-4 shows how plans expect to use rebate dollars, including any funds the plan expects to use for administrative costs and profit. In addition to the 40 percent they anticipate using to reduce cost sharing, conventional plans expect to use 25 percent for non-Medicare benefits like dental, vision, and hearing; 26 percent for Part D enhancements like lower premiums or cost sharing; and 9 percent to reduce the Part B premium for their enrollees. Accounting separately for plans' administrative costs and profits (data not shown), that amount equates to using about 35 percent to reduce cost sharing, 22 percent for non-Medicare services, 26 percent for Part D benefits, about 9 percent for Part B premiums, and about 8 percent for administrative expenses and profit.

Because most SNP enrollees are dually eligible for Medicare and Medicaid, many of their OOP costs are often covered by other programs: Medicaid generally covers Part A and Part B cost sharing and pays the Part B premium in most cases, and Medicare's Part D low-income subsidy typically covers the premium

**TABLE
12-4****In 2026, conventional MA plans project using rebates primarily to reduce cost sharing and premiums; SNPs project using rebates to offer non-Medicare benefits**

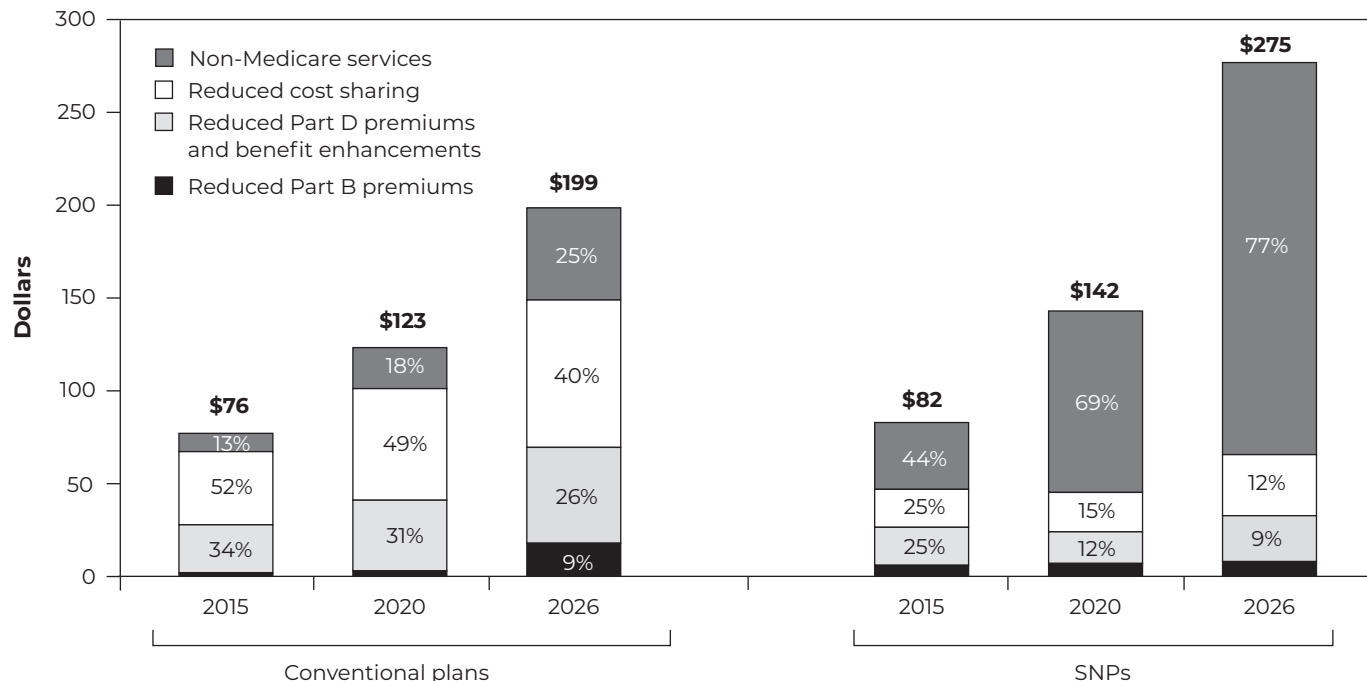
	Rebate (per member per month)		2026 percent change	Share of total rebate	
	2025	2026		2025	2026
All nonemployer plans					
Total	\$209	\$222	6%	100%	100%
Supplemental benefit type					
Cost sharing	64	66	4	31	30
Non-Medicare supplemental	95	98	3	45	44
Part D benefits	37	43	18	17	19
Part B premium	14	15	8	6	7
Conventional plans					
Total	\$188	\$199	6%	100%	100%
Supplemental benefit type					
Cost sharing	76	81	5	41	40
Non-Medicare supplemental	54	50	−7	29	25
Part D benefits	42	51	22	22	26
Part B premium	15	18	14	8	9
Special-needs plans					
Total	\$271	\$275	2%	100%	100%
Supplemental benefit type					
Cost sharing	29	32	12	11	12
Non-Medicare supplemental	213	212	0	79	77
Part D benefits	21	24	12	8	9
Part B premium	8	8	−6	3	3

Note: MA (Medicare Advantage), SNP (special-needs plan). Employer group plans are not included. Amounts for cost sharing and non-Medicare supplemental benefits include plan costs for administration and profit. Cost-sharing amounts for conventional plans include plan projections of their liability for the cap on beneficiaries' out-of-pocket expenses. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. We use plans' actual enrollment to calculate average rebates for 2015 through 2025. The average for 2026 is weighted using enrollment projections from plans' bids. Enrollment weights are based on months of enrollment for MA enrollees without end-stage renal disease (ESRD) since plans do not receive rebates for members with ESRD. We do not have reliable information about beneficiaries' use of these benefits. Components may not sum to totals due to rounding.

Source: MedPAC analysis of data from CMS on plan bids.

and all or most cost sharing for prescription drug coverage. As a result, SNPs have less reason than conventional plans to use their rebates to cover these costs. Instead, SNPs project allocating most of their rebate dollars (\$212 PMPM, or 77 percent in 2026) to cover non-Medicare supplemental benefits such

as dental, vision, or hearing services (Table 12-4). Although this amount is a slightly smaller share of the total rebate than in 2025 (79 percent), SNPs' projected spending on non-Medicare supplemental benefits has increased dramatically since 2015 (when non-Medicare supplemental benefits accounted for 43 percent of

**FIGURE
12-3****MA plans allocate a substantial share of rebates to non-Medicare services**

Note: MA (Medicare Advantage), SNP (special-needs plan). "Conventional plans" excludes employer group plans and special-needs plans. "Special-needs plans" excludes employer group plans and non-special-needs plans. The plan rebate is the per beneficiary per month amount that the plan offers as premium-free supplemental benefits. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. We use plans' actual enrollment to calculate average rebates for 2015 and 2020. The average for 2026 is weighted using enrollment projections from plans' bids. Enrollment weights are based on months of enrollment for MA enrollees without end-stage renal disease (ESRD) since plans do not receive rebates for members with ESRD. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of MA bid data.

SNPs' projected rebate allocation) (Figure 12-3). For 2026, SNPs allocated 12 percent of their rebates to reducing cost sharing, 9 percent to Part D benefits, and 3 percent to Part B premiums. Accounting separately for plans' administrative costs and profits (data not shown), that equates to about 10 percent for cost-sharing reductions, 66 percent for non-Medicare services, about 9 percent for Part D benefits, about 3 percent for Part B premiums, and about 13 percent for administrative expenses and profit.

In total, the Medicare program will pay MA plans (including conventional plans and SNPs) \$2,660 per beneficiary in 2026 for supplemental benefits (including \$263 per beneficiary per year for plan

administrative expenses and profit). Accounting separately for administrative costs and profit, plans project using about 26 percent of these rebate funds to reduce cost sharing for MA enrollees, 38 percent for non-Medicare covered services, about 19 percent to enhance plans' Part D benefit through lower premiums or reduced cost sharing, about 7 percent to reduce MA enrollees' Part B premiums, and about 10 percent for administrative expenses and profit.

The increase in the average rebate per member, combined with rapid MA enrollment growth, has resulted in a substantial increase in the amount Medicare spends on rebates. We estimate that in 2025, Medicare paid MA plans approximately \$84 billion in

rebates (accounting for 17 percent of non-ESRD plan payments).³⁰ Conceptually, the rebates paid to MA plans were originally intended to be a form of shared savings in which plans would be rewarded for providing Medicare benefits at a lower cost than would have been the case under FFS.³¹ However, the Commission has shown that a large portion of Medicare’s spending on MA rebates is financed by additional program spending rather than by savings derived from plan efficiencies (see “Higher payments to MA plans stem from favorable selection and coding intensity”). Because MA rebates are paid from the Medicare trust funds, they are partially financed by Part B premiums collected from all beneficiaries (including those in FFS Medicare). The Commission estimates that Part B premiums will finance about \$13 billion of MA rebates in 2025, with nearly \$6 billion coming from FFS beneficiaries who do not have access to the supplemental benefits financed by the rebates.³²

MA supplemental benefits

As shown in Figure 12-3, MA plans—particularly SNPs—allocate a large fraction of rebate dollars to providing non-Medicare services as supplemental benefits. Coverage for vision, hearing, and dental services are some of the most common of these benefits: In 2025, nearly all MA enrollees (in both non-SNPs and SNPs) were in plans that offered some coverage of dental, vision, or hearing services (Ochieng et al. 2025). MA plans may also offer nonmedical supplemental benefits such as nonemergency transportation services, assistance paying for over-the-counter items, meals, and gym memberships.³³ The share of plans offering these types of benefits—and the share of enrollees in such plans—has risen as MA rebates have increased. These benefits have the potential to address health challenges that many seniors face as they age and for which there is limited coverage under FFS Medicare.

Relatively little is known about the extent to which MA enrollees use the many supplemental benefits available to them. The Commission has previously examined the data that Medicare collected before 2024 about MA enrollees’ use of services and, for most supplemental benefits, found that the data were insufficient for examining utilization (Medicare Payment Advisory Commission 2025a). Most available evidence about MA enrollees’ use of supplemental benefits comes from broad surveys or from analyses conducted by MA plans.

A 2024 survey by the Commonwealth Fund found that 69 percent of MA enrollees used at least one supplemental benefit, but the survey did not shed light on which enrollees used which benefits (Commonwealth Fund 2024). The Commission’s review of surveys and other studies found that the available evidence provides little insight into MA enrollees’ use of supplemental benefits and leaves basic questions unanswered (Medicare Payment Advisory Commission 2025a).

Starting in 2024, CMS began implementing a series of actions to improve and increase the amount of data that plans report regarding supplemental benefits. Among these is a requirement that plans report their spending for a number of commonly offered supplemental benefits as part of the data used to monitor and enforce medical-loss-ratio (MLR) requirements. The data provide new insights about how much plans spend on supplemental benefits and the distribution of spending across benefits (see text box on MA MLR data, pp. 368–372, for more detail). In addition to the new MLR requirements, CMS also began, in 2024, collecting additional information about MA enrollees’ use of supplemental benefits, including encounter records for dental services and other supplemental benefits and plan-level use and spending data as part of the Part C reporting requirements (Centers for Medicare & Medicaid Services 2024b, Centers for Medicare & Medicaid Services 2024c). Those data were not available at the time of our analysis, but we anticipate the data for 2024 will be available for analysis in 2026.

Higher payments to MA plans stem from favorable selection and coding intensity

The Commission estimates that MA payments (which combine base payments to cover Medicare benefits and the rebates that finance supplemental benefits) substantially exceed what would have been spent on MA beneficiaries had they instead been enrolled in FFS Medicare. Before applying any adjustments for favorable selection or coding intensity, we estimate that Medicare payments to MA plans have generally been similar to historical spending for FFS beneficiaries with both Part A and Part B coverage. But in aggregate, the effects of favorable selection (before any coding

MA medical-loss-ratio data show MA organizations spent roughly \$24 billion on non-Medicare services offered as supplemental benefits in 2023

Medicare Advantage (MA) plans that bid below their spending benchmark receive a “rebate” from Medicare that they must use to provide supplemental benefits for their enrollees. These benefits can include reduced cost sharing for Part A and Part B services, reduced Part B and Part D premiums, enhanced Part D benefits, and coverage of non-Medicare services (services not covered under fee-for-service (FFS) Medicare, such as dental, vision, and hearing). Historically, there has been little information about how plans use the rebates they receive from Medicare and how much they spend on various types of supplemental benefits. The new data show that, across the non-Medicare services offered as supplemental benefits, MA plans spent the most on dental benefits. Non-primarily health-related benefits accounted for the second-most spending; these benefits are more commonly offered by special-needs plans (SNPs) than by conventional plans, and the data suggest that a large share of the spending was associated with benefits offered under the MA value-based insurance design (MA-VBID) demonstration, which concluded at the end of 2025. Despite the new insights enabled by these data, there are limitations to the questions they can be used to answer. Data on MA enrollees’ use of supplemental benefits is not yet available and will be important for assessing whether Medicare’s spending for supplemental benefits produces good value for Medicare beneficiaries and the taxpayers who fund the program.

MA medical-loss-ratio data provide new, but limited, information about plans’ spending on supplemental benefits

Starting in 2024, CMS began requiring MA plans to report their expenditures on supplemental benefits as part of the data used to monitor and enforce medical-loss-ratio (MLR) requirements.³⁴ Under the new requirements, MA organizations (MAOs) are required to report, for each contract, their expenditures for 16 non-Medicare services that

are commonly offered as supplemental benefits, as well as their expenditures for special supplemental benefits for the chronically ill (SSBCI) and “all other primarily health-related supplemental benefits” (a total of 18 reporting categories). The MLR data are collected at the end of the calendar year following the year in which benefits are provided (e.g., data pertaining to plans’ spending in 2023 were collected at the end of 2024). In contrast to bid data, which include plans’ projections of expected spending, MLR data reflect MAOs’ actual spending during a year. The new data represent the first time that information about plans’ actual spending for supplemental benefits has been available.

However, the data have several limitations. One limitation is that the data are reported at the contract level. MA contracts can consist of multiple plans and can span wide geographic areas. Contract-level reporting means that we cannot assess how spending on supplemental benefits varies at the plan or enrollee level. Because MA contracts can comele conventional plans, SNPs, and employer plans, it is difficult to answer certain questions such as how spending by SNPs compares with spending by conventional plans. Because employer plans do not submit bids, we do not have a basis for accurately estimating the share of the rebate that those plans expected to allocate to non-Medicare services, making it difficult to compare plans’ rebate revenue with their expectations and expenditures.

One potential use of the MLR data could be to assess how spending by MAOs compares with the rebates they received from Medicare. However, several factors make it difficult to use the data for this purpose. One barrier is that the data do not disaggregate information about how much plans spent on reducing cost sharing for their members (plan bids show that conventional plans expected that a majority of rebate dollars would be used to reduce cost sharing). In its rulemaking, CMS chose not to collect this information because it assumed it

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MA medical-loss-ratio data show MA organizations spent roughly \$24 billion on non-Medicare services offered as supplemental benefits in 2023 (cont.)

would be “exceedingly difficult for MA organizations to separately identify and track” such spending (Centers for Medicare & Medicaid Services 2022c). As a result, we cannot know the total amounts that insurers spent on all supplemental benefits; we can assess spending only for the subset of benefits that CMS requires insurers to report separately.

An additional barrier is that the spending reported in the MLR data includes benefits that are financed by rebates and benefits for which enrollees paid an additional premium.³⁵ Further, the data include only the amount the plan spent on the benefit, excluding any portion of the rebate the plan kept to cover its administrative costs or profit. In 2026, of the rebate dollars that plans project using to provide non-Medicare services as supplemental benefits, conventional plans project that 13 percent will be used for plan administrative costs and profit; SNPs project using 14 percent.

A further limitation of the data is that some of the reporting categories—including some with very high levels of spending—are somewhat broad, making it difficult to understand what types of services taxpayer dollars are being used for. (For example, non-primarily health-related benefits, which can encompass a range of items and services, are grouped into just two categories.) Last, because the data lack measures of utilization, the MLR data alone cannot tell us anything about how much MAOs are spending per user or per unit (MAOs report per member per month amounts, but these provide limited insight because benefit eligibility, access, and use can vary widely across MA plans). Altogether, although the new data provide several valuable new insights into insurers’ overall spending on supplemental benefits, data limitations significantly restrict the types of analyses for which the data can be used; the limitations underscore the ongoing importance of the other data-collection efforts that CMS has begun implementing (e.g., in the encounter data and Part C and Part D reporting requirements).

A large share of supplemental-benefit spending is on non-primarily health-related benefits

We analyzed the 2023 MLR data for a subset of MA contracts to characterize MAOs’ spending on non-Medicare services offered as supplemental benefits. We limited our analysis to contracts for HMOs, local and regional preferred provider organizations (PPOs), and private fee-for-service (PFFS) plans. We excluded contracts that included either Medicare Medical Savings Account (MSA) plans or end-stage renal disease special-needs plans (ESRD SNPs) because the rules for how these plans are paid and how they may use rebates differ from other types of MA plans (42 CFR 422.102(a)(1), 42 CFR 422.304(c)(1)). After these exclusions, our sample included 98 percent of total 2023 MA enrollment and 98 percent of reported supplemental-benefit spending. We estimate that, in 2023, Medicare paid approximately \$74 billion in rebates to the contracts included in our analysis.

We then summed the total supplemental-benefit spending that MAOs reported for non-Medicare services (Table 12-5, p. 370). For 2023, MAOs reported spending roughly \$24 billion on the non-Medicare services they offered as supplemental benefits (i.e., supplemental benefits other than cost-sharing and premium reductions). Dental benefits accounted for the most spending, encompassing more than a quarter (28 percent) of the total reported spending. This finding aligns with MedPAC’s previous analyses of MA bids, which have shown that dental benefits account for a significant portion of conventional MA plans’ projected spending on non-Medicare services (Medicare Payment Advisory Commission 2025a).

The next-largest category of spending reported by plans was for “non-primarily health-related” benefits. In 2023, plans spent nearly \$6 billion on these types of benefits—accounting for roughly a quarter (24 percent) of all reported supplemental-

(continued next page)

MA medical-loss-ratio data show MA organizations spent roughly \$24 billion on non-Medicare services offered as supplemental benefits in 2023

**TABLE
12-5**

MA organizations spent approximately \$24 billion on non-Medicare services as supplemental benefits in 2023

Benefit category	Total spending (billions)	Percent
Dental	\$6.6	28%
Non-primarily health related	5.8	24
SSBCI	0.7	3
Other non-primarily health related	5.1	21
Over-the-counter items	4.4	18
"Other" primarily health related	2.0	8
Vision	1.8	7
Transportation	0.9	4
Fitness	0.7	3
Hearing	0.7	3
Meals	0.6	3
Routine foot care	0.1	<1
Worldwide coverage	0.1	<1
Personal Emergency Response Systems	0.1	<1
Acupuncture	0.1	<1
Remote-access technologies	0.1	<1
Chiropractic care	0.1	<1
Health education	<0.01	<1
Smoking and tobacco cessation counseling	<0.01	<1
Total	23.9	100

Note: MA (Medicare Advantage), SSBCI (special supplemental benefits for the chronically ill). Includes spending reported by contracts for health maintenance organizations, local and regional preferred provider organizations, and private fee-for-service plans. Excludes spending reported by contracts that included either Medicare Medical Savings Account plans or end-stage renal disease special-needs plans. Components may not sum to totals due to rounding.

Source: MedPAC analysis of MA medical-loss-ratio data from CMS.

benefit spending. Non-primarily health-related benefits are relatively new in MA. For many years, supplemental benefits were required to be "primarily health related," meaning that their main purpose had to be "to prevent, cure, or diminish an illness or injury" (Centers for Medicare & Medicaid Services 2016). This definition included dental, vision, and hearing services but also included enhanced or expanded coverage of Medicare-

covered services (e.g., additional days of inpatient care), health-related transportation services, fitness benefits, acupuncture, enhanced disease-management services, bathroom safety devices, posthospitalization meals, over-the-counter items, and other benefits. Beginning in plan year 2019, CMS broadened its definition of "primarily health related" to permit additional services that address physical impairments, lessen the functional or psychological

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MA medical-loss-ratio data show MA organizations spent roughly \$24 billion on non-Medicare services offered as supplemental benefits in 2023 (cont.)

impact of injuries, or reduce avoidable health care utilization (Centers for Medicare & Medicaid Services 2018b). Under this new definition, plans can provide services such as adult day-care services, home-based palliative care, in-home support services, and support for caregivers of enrollees.

Beginning in 2020, as required by the Bipartisan Budget Act of 2018, MA plans were given the ability to offer non-primarily health-related items or services to chronically ill enrollees, so long as there is a “reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee” (Centers for Medicare & Medicaid Services 2019). These benefits are referred to as special supplemental benefits for the chronically ill (SSBCI) and must be targeted to MA enrollees who (1) have one or more comorbid and medically complex chronic conditions that are life threatening or that significantly limit the overall health or function of the enrollee, (2) have a high risk of hospitalization or other adverse health outcome, and (3) require intensive care coordination. Examples of SSBCI include things like meals, food and produce, pest-control services, structural home modifications, or subsidies for rent or utilities (Centers for Medicare & Medicaid Services 2019). For 2023, MA plans reported spending just under \$700 million on SSBCI—roughly 12 percent of total spending for non-primarily health-related benefits and just 3 percent of spending reported across all benefit categories.

The remainder of the roughly \$6 billion spent on non-primarily health-related supplemental benefits was reported under a catch-all “other” (non-SSBCI) non-primarily health-related supplemental benefits category. In the MLR data for 2023, plans reported more than \$5 billion in this category (88 percent of spending on non-primarily health-related benefits and 21 percent of all reported spending on supplemental benefits). This category likely consists primarily of spending for supplemental

benefits offered under the MA-VBID demonstration, which could include many of the same benefits offered as SSBCI (such as food and produce, meals, pest-control services) but offered with additional regulatory flexibilities.³⁶ MA plans participating in the MA-VBID demonstration, which ran from 2017 through the end of 2025, were permitted to offer non-primarily health-related benefits and were given additional flexibility to target the benefits to enrollees on the basis of socioeconomic status (Centers for Medicare & Medicaid Services 2020b). A substantial share of MA plans that offered non-primarily health-related benefits in 2023 (especially D-SNPs) did so through the MA-VBID demonstration (ATI Advisory 2023). In 2023, 86 percent of D-SNP enrollees were in plans participating in the MA-VBID demonstration, and the model was the predominant pathway by which D-SNPs offered non-primarily health-related supplemental benefits (ATI Advisory 2023, Friedman et al. 2024, Laktas et al. 2024). Because the MA-VBID demonstration ended at the end of 2025, the share of spending reported in this category could change in future years. Consulting groups, researchers, and some MAOs have suggested that many benefits offered under the VBID will transition to being offered as SSBCI in 2026 (Friedman et al. 2024, Health Management Associates 2025, Schmidt and Graham 2025, UnitedHealth Group 2025).

The third-highest category of reported supplemental benefit spending in 2023 was for over-the-counter (OTC) items (\$4.4 billion), which accounted for 18 percent of total reported spending. In recent years, it has been very common for OTC benefits to be offered in the form of a prepaid debit card, or “flex card,” provided to enrollees by MA plans. Often, enrollees can use the cards for expenses related to a set of plan-defined supplemental benefits; it is particularly common for plans to combine OTC benefits with other benefits through these types of arrangements (ATI Advisory 2025, Yeh and Yen 2024). (Plans define which

(continued next page)

MA medical-loss-ratio data show MA organizations spent roughly \$24 billion on non-Medicare services offered as supplemental benefits in 2023 (cont.)

benefits the cards can be used for, and the benefits can be primarily or non-primarily health related). Altogether, spending on non-primarily health-related benefits and OTC items accounted for more than 40 percent of reported supplemental benefit spending for 2023. MAOs' reported spending for most other categories of benefits was considerably lower: spending for vision, transportation, fitness, and hearing benefits—some of the most widely available benefits across MA plans—together accounted for less than \$5 billion of total reported supplemental-benefit spending (about 17 percent).

For a sample of MA contracts, insurer-reported spending on supplemental benefits is in line with projections in plans' bids

One important question about MAOs' spending for supplemental benefits is how it compares with the rebates MA insurers receive from Medicare. As with medical spending, MAOs accept financial risk for their enrollees' use of supplemental benefits. If enrollees use their supplemental benefits more intensively than the plan expected, such that the cost of that use exceeds the rebate the plan received from Medicare, the plan bears the cost of the difference. If enrollees use their supplemental benefits less than expected and the cost to the plan is less than what the plan received in rebates, the insurer benefits. (Insurers may mitigate risk by, for example, entering into risk-sharing agreements with third-party vendors or providers of supplemental

benefits). There could be cause for concern if plans' spending is consistently below the amount the plans received in rebates.

To assess this possibility, we identified a subsample of MA contracts and compared their reported spending with the rebates they received—which were estimated using information from their bids. Because employer plans do not submit bids, we limited our subsample to bids of plans in MA contracts that did not have any members enrolled in employer plans. Roughly one-third of MA enrollees from our full sample were included in our subsample.

Medicare paid the contracts in our subsample approximately \$25 billion in rebates. On average, those contracts projected spending roughly 45 percent of their rebates—roughly \$11 billion of the \$25 billion—on non-Medicare services (plans projected allocating 53 percent of their rebates to non-Medicare services when administrative costs and profit were included). Looking at the MLR data for these contracts, we found that these contracts reported spending about \$11 billion on non-Medicare services. In other words, we found that—in the aggregate—for a limited subset of contracts, plans' reported spending was roughly in line with the amount we would expect based on their bids. However, the results varied by contract and by insurer, with some insurers and contracts reporting spending that was higher or lower than the expected level (based on their bids). ■

differences) cause the risk scores of MA enrollees to overpredict what their spending would have been in FFS—increasing MA payments by an estimated 11 percent (\$57 billion) above FFS spending in 2026. In addition, even after CMS applies the coding-intensity adjustment, diagnostic coding by MA plans overstates the differences in health conditions between MA and FFS enrollees that are used for risk scores—further

increasing MA payments by an estimated 4 percent (\$22 billion) above FFS spending in 2026.

MA payments in 2026 are projected to be 14 percent higher than what FFS spending would have been for MA enrollees

In 2026, Medicare's payments to MA plans will total a projected \$615 billion.³⁷ That total includes payments

**TABLE
12-6**

MA payments estimated to be substantially above what FFS spending would have been due to the effects of coding intensity and favorable selection, 2026

	Share of FFS spending in 2026		
	Benchmarks	Bids	Payments
Overall estimate	124%*	95%*	114%
Estimated before coding and selection	107*	83*	99
Estimated coding effect	+4	+3	+4
Estimated favorable-selection effect	+12	+9	+11

Note: MA (Medicare Advantage), FFS (fee-for-service). The “overall estimate” of benchmarks, bids, and payments as a share of FFS spending incorporates all three components of the Commission’s methodology for comparing payments: a base comparison of MA payments with FFS spending that standardizes for differences in risk scores and geography but does not account for the effects of coding intensity and favorable selection; an adjustment to that base comparison for coding intensity; and an adjustment for favorable selection. The values in the “estimated before coding and selection” row reflect estimates using only the base comparison, without adjusting for the effects of coding intensity and favorable selection. The values in the third and fourth rows are the additive adjustments to the base comparison for the effects of coding and selection. Estimates of payments include beneficiaries with end-stage renal disease (ESRD). More details on our methodology can be found later in this chapter and in the technical appendixes to this chapter. Components may not sum to totals due to rounding.

* Estimates of benchmarks and bids relative to FFS spending do not include employer plans or enrollees with ESRD because MA plans do not submit bids for those enrollees.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, FFS expenditures, and risk scores.

for all enrollees, including those with ESRD. We estimate that, because of differences between MA and FFS stemming from favorable selection and coding intensity, Medicare spends 14 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates to a projected \$76 billion—or 12 percent of total payments to MA plans—in 2026.³⁸ The payments above FFS spending comprise a large share of the funding for plan rebates in 2026, which we estimate to be 17 percent of FFS spending and 15 percent of total payments to plans. These higher payments relative to FFS Medicare vary significantly across MA organizations (as shown by the variation in the effects of coding intensity across MA organizations, among other factors).

Importantly, these payments above what would have occurred in FFS Medicare are not an estimate of plan profits and administrative expenses. Instead, these additional payments are the primary reason that plans are able to provide generous supplemental benefits and better financial protection for many MA enrollees, which help attract enrollees and increase plans’ total revenues.

We reach this estimate by first projecting total payments (\$615 billion) to MA plans in 2026. We obtain this number by using the Trustees’ projections of MA enrollment and MA payments per capita (Boards of Trustees 2025).³⁹ We project that those payments, on average, will be equal to about 99 percent of FFS spending in 2026 (Table 12-6), after standardizing for differences in risk scores and the counties of residence between MA and FFS beneficiaries. Benchmarks and bids will be 107 percent and 83 percent of FFS spending, respectively. Those estimates are calculated before accounting for any inaccuracies in the risk-adjustment model used for payment.

However, to accurately compare MA and FFS spending, we must ensure that the two populations are comparable by accounting for differences in coding intensity and favorable selection. “Coding intensity” refers to the tendency for more diagnosis codes to be recorded for MA enrollees, which causes risk scores for the same beneficiaries to be higher when they are enrolled in MA than they would be in FFS. “Favorable selection” into MA occurs when beneficiaries whose risk scores overpredict their spending tend to enroll

in MA; it is the extent to which, if MA enrollees were in FFS, their risk-standardized spending would be lower than the FFS average; that is, it captures MA enrollees' preexisting tendency for lower spending before any intervention from MA plans (including coding intensity or plan management). As in prior years, we have made technical refinements to our methods for estimating coding intensity and favorable selection, and these updates are reflected in both projected and historical comparisons of MA payments and FFS spending.⁴⁰

Accounting for greater coding intensity and favorable selection in MA increases our projections of benchmarks, bids, and plan payments as a share of what FFS spending would have been for MA enrollees. Indeed, we project that benchmarks in 2026 are 124 percent of what FFS spending would have been, indicating that MA plans bid against an amount that is 24 percent more, in aggregate, than what their enrollees would have cost if they were in FFS Medicare (Table 12-6, p. 373). Actual MA payments in 2026 are an estimated 114 percent of FFS spending because nearly all plans bid below those benchmarks. Plan bids are typically far below their benchmarks but can vary (Medicare Payment Advisory Commission 2022).⁴¹

Our projection of the payment difference between MA and FFS for 2026 (14 percent) is lower than the projection we reported last year for 2025 (20 percent). That difference stems largely from a lower estimate of the effect of coding intensity on payments in 2026. That change is primarily due to the completed phase-in of the V28 risk model and the availability of new risk-score data that show slower growth in MA risk scores under the prior risk model in recent years. 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. (Medicare Payment Advisory Commission 2025b). This effect is discussed in greater detail in our estimate of coding intensity (p. 390).

MA bids and rebate levels are consistent with both plan efficiencies and higher payments from coding and selection

We project that—after accounting for coding intensity and favorable selection—plan bids (\$1,132 per enrollee per month) in 2026 are 95 percent of what FFS spending

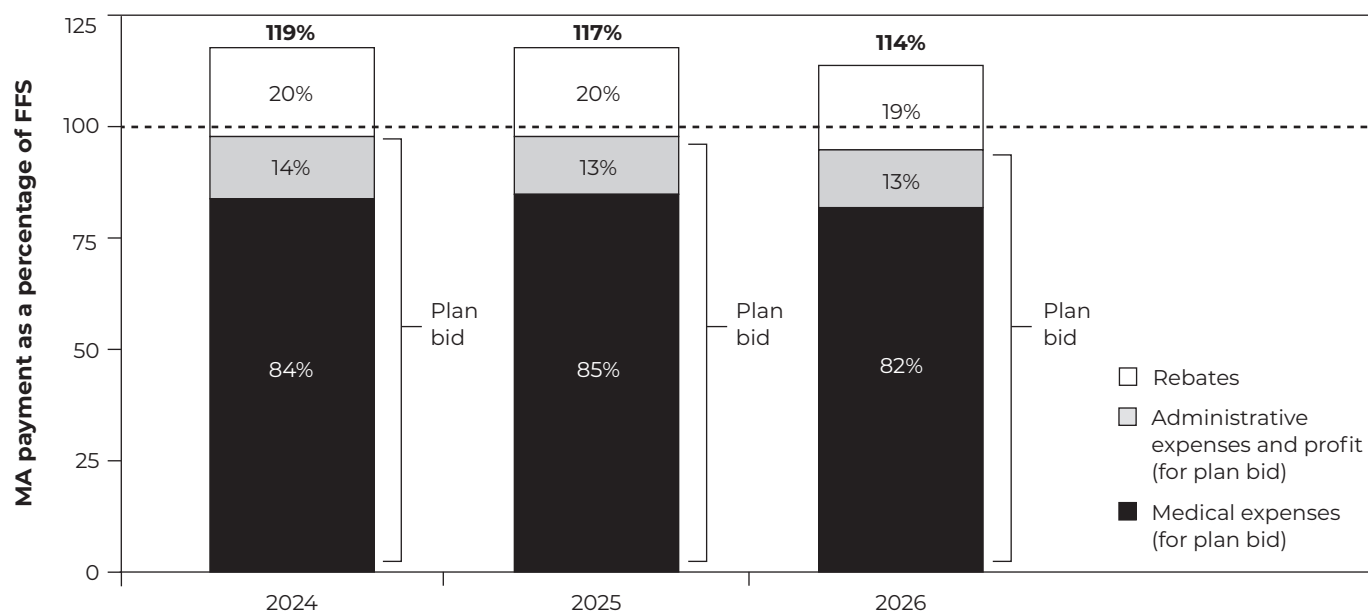
would have been for MA enrollees (Table 12-6, p. 373). In other words, plans are offering to provide the standard Medicare benefit for an estimated 5 percent less than it would cost the Medicare program to cover their enrollees in the FFS program. Bids in 2026 were the lowest relative to FFS that we have estimated in recent years. For example, we estimate that bids were about 98 percent of FFS spending in 2024 and 97 percent of FFS spending in 2025 (data not shown). This decrease in relative bids coincides with the phase-in of the V28 risk model, which decreased plan risk scores. On a risk-adjusted basis, lower risk scores caused plan benchmarks to be lower than they otherwise would have been, and it appears that plans responded to their lower risk-adjusted benchmarks with lower bids.⁴² Plan bids in 2026 are projected to be 23 percent lower than risk-adjusted benchmarks, on average, unchanged from 2025 despite the downward pressure on risk-adjusted benchmarks in 2026 (data not shown).

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 new record high) despite the complete phase-in of the V28 risk model. At the same time, the program's overall payment difference between MA and FFS fell during the years of V28 implementation. We estimate that the Medicare program paid MA plans 21 percent more than what FFS spending would have been in 2023 (the year before the transition to V28 began), which is projected to fall to 14 percent more than FFS spending in 2026 (when the model was fully implemented). Our estimates suggest that, overall, plans have largely absorbed or adapted to those lower payments in order to achieve similar levels of rebates that fund supplemental benefits to their enrollees. Those estimates reflect the average experience in 2026. Experiences may vary by market, and the Commission will continue to monitor the effects of changes in MA payments.

Further insight into plans' efficiency in providing the standard Medicare benefit relative to the FFS program can be obtained using the information that plans report in their bids. Bids represent each plan's estimate of their projected cost of providing the standard Medicare benefit to their enrollees, including the amounts they expect to spend on their enrollees' medical expenses, administrative costs, and profit. Figure 12-4 reports plans' overall projected medical expenses and

**FIGURE
12-4**

Higher MA payments relative to FFS are used to finance supplemental benefits, 2024 to 2026



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates of MA payments relative to what spending would have been in FFS incorporate all three components of the Commission's methodology for comparing MA payments with FFS spending: a base comparison of MA payments with FFS spending that standardizes for differences in risk scores and geography; an adjustment to that base comparison for favorable selection; and an adjustment for coding intensity. MA payments have two components: the bid and the rebate. Estimates of medical expenses and administrative expenses and profit relative to FFS spending break out the bid portion of plans' payments into those two components using the itemization that plans report when submitting their bids. Those separate components, along with the rebate portion of plans' payments, are then compared with the same estimate of what FFS spending would have been for MA enrollees, which is used as the denominator for the comparison of total MA payments to FFS spending. Because plans do not submit bids for beneficiaries with end-stage renal disease and do not receive rebates for these beneficiaries, the figure excludes these beneficiaries. The rebate component contains administrative expenses and profit (10 percent of the total rebate in 2024, 2025, and 2026), which is not reflected in the administrative expenses and profit component for the plan bid. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, MA bid data, and risk-adjustment files.

costs from administration and profits for 2026, and it compares those expenses with the Commission's estimate of what FFS spending would have been for MA enrollees. Our 2026 projections of MA payments and FFS spending, together with plans' projections of their costs included in their bids, are consistent with plans reducing their enrollees' medical expenses by 18 percent below what they would have been if enrollees were in FFS Medicare (Figure 12-4). Efficiencies in plans' total costs of providing the standard Medicare benefit, including medical expenses, profit, and administrative

costs, are smaller. Plans' total cost of providing medical benefits are projected to be 5 percent below what FFS spending would have been for MA enrollees in 2026 (Table 12-6, p. 373). The difference of 13 percentage points is accounted for by plans' administrative costs and profit. Plans reported that 13 percent of their bids were for administrative costs and profit in 2026, unchanged from 2025. Plans may have an incentive to understate the administrative expenses and profits reported in their bids, for example, by reclassifying some profits retained through vertical integration arrangements (i.e., payments to plan-owned providers)

(Frank and Milhaupt 2023, Frank and Milhaupt 2022). Therefore, the administrative expenses and profits reported in plan bids may be a lower bound on the portion of bids that are accounted for by those items.

One way to assess the validity of the Commission's estimate of MA payments relative to FFS spending is to verify that the overall estimate is consistent with aggregate data from several sources, including plan bids, overall rebate levels, and studies of MA plans' efficiencies in reducing the medical spending of their members relative to FFS. As just described, comparing plans' bids with our estimates of what FFS spending would have been for MA enrollees implies that medical efficiencies were between 15 percent and 18 percent on average between 2024 and 2026. In other words, our estimates are consistent with (1) plans achieving material efficiencies in their medical expenses relative to FFS and (2) higher payments from selection and coding. Without accounting for the effects of favorable selection and coding, plans' bids would have indicated that plan medical spending projections would be 28 percent below FFS spending in 2026—far more than the 18 percent medical spending reductions that our analysis finds for 2026. We reviewed recent studies to assess whether the Commission's estimates of MA plans' medical spending reductions relative to FFS were supported by the literature. The studies we reviewed generally did not indicate that MA plans reduce their enrollees' medical expenses by nearly 30 percent on average, indicating the implausibility of estimates that do not account for selection and coding.

We found that the weight of the recent evidence on MA plans' medical spending reductions is in line with the Commission's estimates. Three recent studies we identified found estimates of MA plans reducing their enrollees' medical expenses, estimates that ranged from 12 percent to 16 percent, similar to the 15 percent to 18 percent we estimated by comparing the components of plan bids to the Commission's estimate of what FFS spending would have been for MA enrollees.⁴³ Overall, the studies indicate that substantial effects of coding and selection are needed to explain the bid and rebate payments observed in the MA market.

Our review included two recent white papers (Inovalon 2025, Teigland et al. 2025a) and one recent peer-reviewed study that estimated the effect of MA

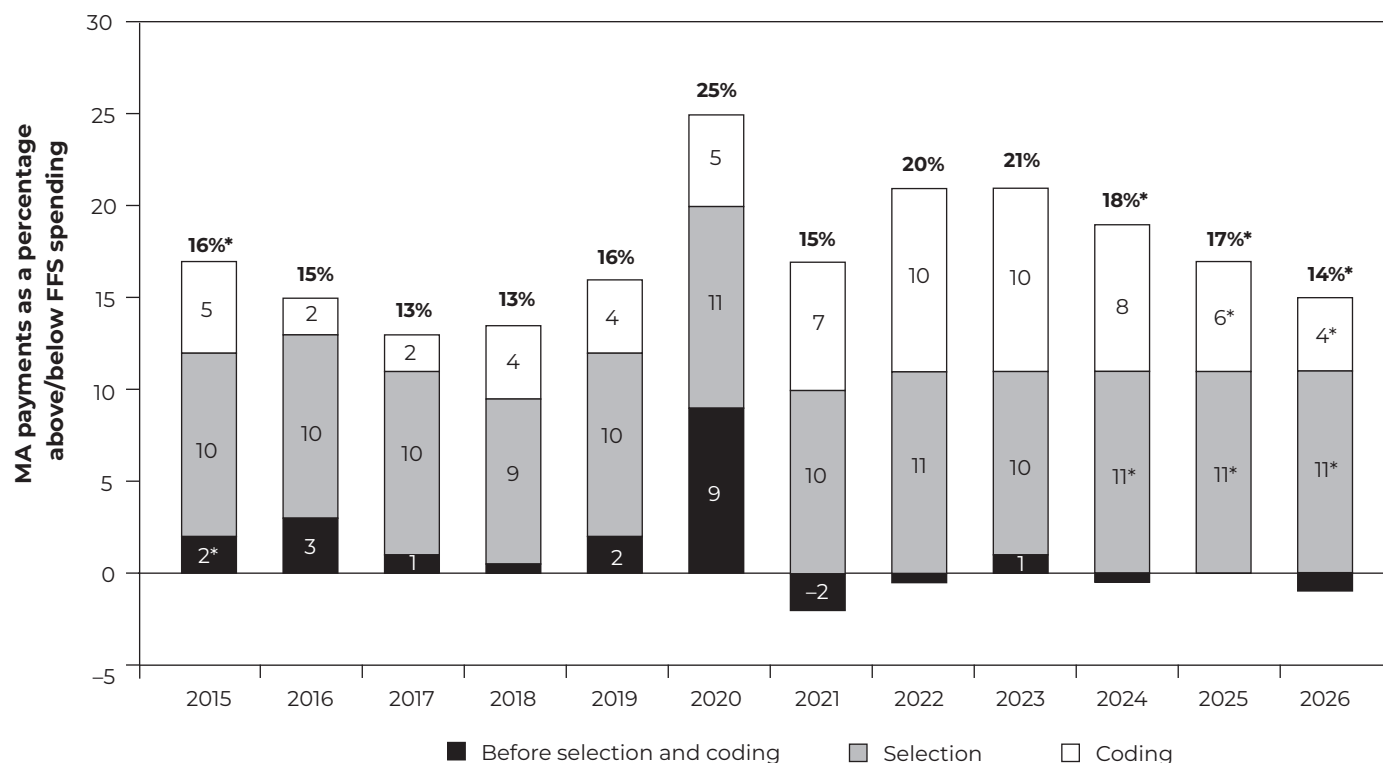
enrollment on medical spending (Jung et al. 2025). Both white papers examined the combined effect of MA enrollment on medical and prescription drug spending, and both papers used a study design that controlled for preexisting differences between a sample of MA enrollees and a FFS comparison group. One white paper focused on the non-dual-eligible population and found that MA plans reduced spending by 12 percent relative to FFS (Teigland et al. 2025a). The second white paper included non-dually eligible and the dual-eligible population in their sample and found that MA plans reduced spending by 10 percent relative to FFS, including a 16 percent reduction in spending for nonprescription medical costs (Inovalon 2025).^{44,45} Neither white paper found spending reductions for prescription drugs. The peer-reviewed study by Jung and colleagues used MA encounter data to examine differences in spending between MA and FFS beneficiaries using a sample of MA and FFS beneficiaries from every state. That study found 13 percent lower spending in MA relative to FFS when controlling for some differences in beneficiary characteristics.⁴⁶ While these studies were the best available recent evidence at the time of publication, they are subject to limitations. The two white papers used small, nonrepresentative samples for their study populations, and the study by Jung and colleagues did not include all types of medical spending and only partially accounted for differences between the MA population and FFS comparison group. The Commission will continue to monitor this literature.

Since 2015, MA payments have substantially exceeded what FFS spending would have been

Figure 12-5 shows that since 2015, payments to MA plans have been substantially above the amount FFS Medicare would have spent for the same beneficiaries, primarily due to the effects of favorable selection and coding intensity. Throughout the 11-year period from 2015 through 2026, we estimate that MA payments were more than 10 percent above FFS spending for comparable beneficiaries in each year. In 2022 and 2023, relative MA payments reached 20 percent and 21 percent above FFS spending, respectively. This change is largely explained by an increase in the effect of coding intensity. However, the phase-in of the V28 risk model reduced the effect of coding intensity starting in 2024. For 2025, the lower effect of coding intensity resulted in MA payments that are a projected 17 percent

**FIGURE
12-5**

Higher MA payments relative to what estimated spending would have been in FFS, since 2015



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates of MA payments relative to what spending would have been in FFS before selection and coding are less than 0.5 percent for 2018, 2022, 2024, 2025, and 2026. We include the effects of selection and coding for beneficiaries with end-stage renal disease in all years, but we do not include their “before selection and coding” effects between 2015 and 2022. Components may not sum to totals due to rounding.

* Specified values were derived from projected data (for 2023 to 2025) or earlier versions of the methodologies for estimating each component (for 2015). Values without an asterisk were estimated using historical data and the current and most comprehensive version of the methodology for estimating each component. See text for details.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

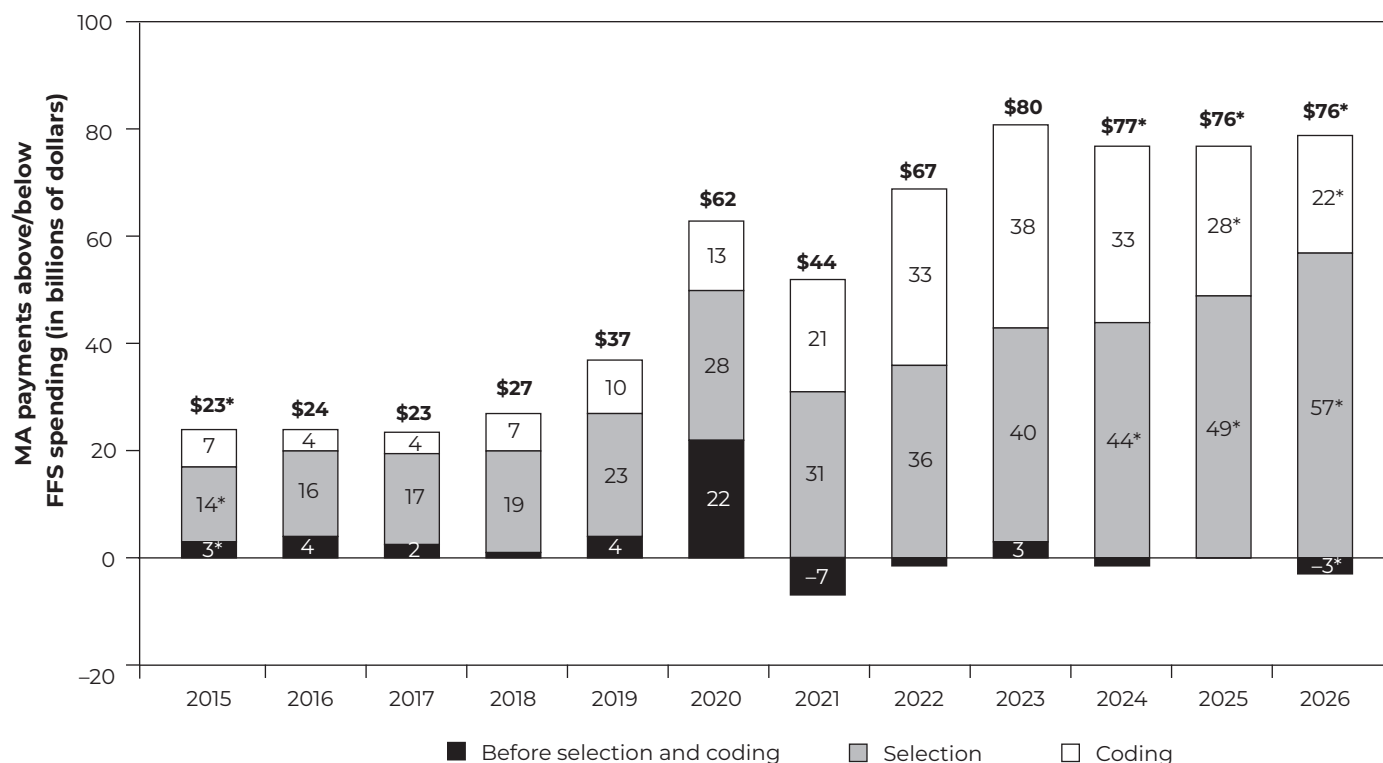
above what would have occurred in FFS Medicare, a decrease from our projection of 20 percent above FFS spending in our March 2025 report to the Congress (Medicare Payment Advisory Commission 2025b). This year’s lower estimate for 2025 is almost entirely due to a lower estimated effect of coding intensity in that year, which is explained in the text box “Updates to coding-intensity estimates reflect newly available data and other factors” (pp. 392–393). The V28 risk model will be fully phased in by 2026, further reducing the effect of coding intensity and resulting in MA payments that we

project will be 14 percent above the amount that FFS Medicare would have spent for the same beneficiaries—the lowest relative payment since 2018.

Figure 12-6 (p. 378) shows the higher payments to MA plans in dollar terms relative to what spending would have been if enrollees were in FFS. (In estimating the payment amount above FFS spending, we included MA payments for beneficiaries with ESRD, which we estimate will account for about 6 percent of MA payments in 2026.⁴⁷) We project that Medicare will pay

**FIGURE
12-6**

Estimated coding and selection have increased MA payments above what spending would have been in FFS



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates of MA payments relative to what spending would have been in FFS before selection and coding are less than \$2 billion for 2018, 2022, 2024, and 2025. We include the effects of selection and coding for beneficiaries with end-stage renal disease in all years, but we do not include their “before selection and coding” effects between 2015 and 2022. Components may not sum to totals due to rounding.

* Specified values were derived from projected data (for 2024 to 2026) or earlier versions of the methodologies for estimating each component (for 2015). Values without an asterisk were estimated using historical data and the current and most comprehensive version of the methodology for estimating each component. See text for details.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

MA plans a total of \$76 billion more in 2026 than the program would have spent if those enrollees had been in FFS Medicare.

Our current methodology for estimating MA payments relative to FFS spending has three components. These three components are estimated separately and are then combined in a single calculation of MA spending relative to FFS. First, we estimate a base comparison of MA payments relative to an estimate of FFS spending that is standardized for differences in average risk scores and geography but does not account for the

effects of coding intensity and favorable selection. Second, we estimate the effect of favorable selection and use that estimate to adjust the base comparison of MA payments with FFS spending. Third, independently of the effects of favorable selection, we estimate the effect of coding intensity and use that estimate to make an additional adjustment to the base comparison. We use historical data to estimate the effect of each of the three components on MA payments for the most recent year for which data are available (2023 for the base-comparison and favorable-selection components, 2024 for coding intensity) and earlier years. We then project

Incorporating MA enrollees with ESRD into MedPAC's comparison of payments to MA plans relative to FFS spending

Our comparison of payments to Medicare Advantage (MA) plans relative to fee-for-service (FFS) spending has three components: a base comparison, an estimate of the effect of favorable selection, and an estimate of the effect of coding intensity. In prior years, all of these analyses excluded Medicare beneficiaries with end-stage renal disease (ESRD) because Medicare uses a separate payment system based on state rates rather than bids and benchmarks and uses a separate set of risk models to pay MA plans for enrollees with ESRD. We had not yet analyzed the effects of coding intensity and favorable selection under that risk model (see section “Medicare payment and MA plan costs for enrollees with ESRD” (p. 412) for more details about those payments). In this year's report, we are now incorporating estimates for MA enrollees with ESRD into each of the three components of our comparison of Medicare spending on MA and FFS.

While only 1 percent of the MA-eligible population are beneficiaries with ESRD, their average Medicare spending is high relative to the non-ESRD population. The share of MA enrollment among beneficiaries with ESRD has grown rapidly in recent years since the implementation of the 21st Century

Cures Act, which allowed beneficiaries in dialysis status to enroll in an MA plan after starting dialysis treatment. (See section on “Medicare payment and MA plan costs for enrollees with ESRD, p. 412). CMS categorizes beneficiaries with ESRD into three groups based on their treatment status: dialysis, transplant (i.e., within the first 3 months of a kidney transplant), and functioning graft (i.e., 4 to 36 months after a kidney transplant). Unlike enrollees without ESRD, payments to MA plans for their ESRD population are not based on a plan bid. Instead, CMS pays MA plans for enrollees with ESRD based on a local risk-standardized average (e.g., rates for beneficiaries in dialysis and transplant status reflect the state-based spending average for a dialysis or transplant beneficiary with a risk score of 1.0). For enrollees in dialysis or transplant status, CMS pays plans using their projections of statewide average FFS Medicare spending for beneficiaries with ESRD who are in dialysis status. For enrollees in functioning-graft status, plans receive their non-ESRD MA county benchmark rate. CMS adjusts the base payment rate for each enrollee with ESRD using the beneficiary's risk score. CMS calibrates three separate ESRD risk models, one for each

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what we expect each component to be through 2026 in years for which data are not yet available, to provide the Congress with our best estimate for the current year. Those projections are subject to uncertainty. In future reports, we will provide updated payment comparisons for those years using historical data. More details on the methods used for estimating each of the components can be found later in this chapter and in the technical appendixes to this chapter.

Before accounting for the effects of coding intensity and favorable selection, MA payments are generally similar to what FFS spending would have been

The first component of the Commission's payment comparison involves constructing a base comparison of MA payments with FFS spending for beneficiaries with similar risk scores and counties of residence. We begin with that base comparison because it aligns with

Incorporating MA enrollees with ESRD into MedPAC's comparison of payments to MA plans relative to FFS spending (cont.)

of the dialysis, transplant, and functioning-graft populations (these models are different from the V24 and V28 risk models used for the population without ESRD). Beneficiary risk scores are calculated using the risk model that corresponds with their ESRD treatment designation during the month.

For the base comparison, we generally followed the same method of comparison we previously used for non-ESRD beneficiaries (Medicare Payment Advisory Commission 2023c), but we made some necessary modifications to account for differences in the payment system for MA enrollees with ESRD (for which plans do not bid against benchmarks). We aggregate the amount of spending for the FFS comparison group for each applicable MA enrollee with ESRD (based on having the same area of residence and risk score) and compare this amount with the aggregated MA payment amounts for those enrollees.

- For the dialysis and transplant populations, we estimated MA payments using CMS's state-based payment rates (which are risk standardized for a beneficiary with average risk, exclude indirect medical education payments, and apply CMS's user-fee deduction), the number of MA enrollee months in dialysis and transplant status within those states, and their risk scores.⁴⁸ For the FFS comparison group, we calculated the monthly average of risk-standardized spending per dialysis/transplant beneficiary at the state level.⁴⁹ State-level spending for the comparison group included nonclaims spending for provider incentive payments (e.g., shared-savings payments),⁵⁰ dialysis bad-debt payments, provider-settlement payments,⁵¹ and an administrative add-on factor that reflects CMS's estimate of administrative costs when setting rates for non-ESRD MA enrollees.⁵² We excluded medical education payments, organ-acquisition costs, and spending during hospice enrollment.⁵³ We used our calculation of the state-based

risk-standardized spending average for the FFS comparison group and multiplied this average by the risk-adjusted (using MA enrollee risk scores) MA (dialysis and transplant status) enrollment months in each state. Thus, our total estimate compares the aggregate MA payments for dialysis and transplant enrollees with their corresponding aggregate FFS spending amounts (using the same risk score and state of residence).

- For the functioning-graft population, we estimated MA payments using CMS's county-level payment rates (which use county-level benchmarks for the non-ESRD population that are risk standardized for a beneficiary with average risk), the number of MA enrollee months in functioning-graft status within those counties, and their risk scores.⁵⁴ For the FFS comparison group, we calculated the monthly average of risk-standardized spending per functioning-graft beneficiary at the county and state level.⁵⁵ Because MA payment rates for the functioning-graft population are not based on a historical baseline of the population's FFS spending, CMS does not publish historical data on nonclaims spending for this population. Thus, our FFS comparison group included our imputations of nonclaims spending for provider incentive payments (e.g., shared-savings payments),⁵⁶ provider-settlement payments,⁵⁷ and administrative costs. In addition, we applied exclusions for estimates of spending in which MA plans are not liable (medical education payments, organ-acquisition costs, and spending during hospice enrollment).⁵⁸ Because the functioning-graft population divided into counties is relatively small and could produce unreliable results, we blended our county-based estimate of risk-standardized spending with our state-based estimate (similar to CMS's framework for non-ESRD credibility adjustment).⁵⁹ We used our blended calculation of local-area risk-standardized spending averages for the FFS

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Incorporating MA enrollees with ESRD into MedPAC's comparison of payments to MA plans relative to FFS spending (cont.)

comparison group and multiplied these averages by the risk-adjusted (using MA enrollee risk scores) MA functioning-graft enrollment months in each county. Our total estimate compares the aggregate MA payments for functioning-graft enrollees with their corresponding aggregate FFS spending amounts (using the same risk score and county of residence).

Using 2023 data, we found that MA ESRD payments were 103 percent of what they would have been in FFS—before the effects of selection and coding. For the dialysis and transplant populations (representing an estimated 91 percent of ESRD spending for MA enrollees in 2023), we found that MA payments were 101 percent of what they would have been in FFS. The 1 percent estimate above FFS spending likely reflects a small degree of projection error in payment rates. We observed a sharp decline (44 percent) in total dialysis bad-debt payments in 2023, which may have been unexpected in CMS's projections and contributed to expected spending that was higher than actual spending. For the functioning-graft population (representing an estimated 9 percent of ESRD spending for MA enrollees in 2023), we found that MA payments were 123 percent of what they would have been in FFS. Developing an accurate local-area payment rate for the relatively small number of functioning-graft enrollees is challenging, and the non-ESRD county benchmark served as a poor proxy of risk-standardized spending for this population in 2023. The combined dollar-weighted estimates for all enrollees with ESRD resulted in an overall estimate of MA ESRD payments that were 103 percent of what they would have been in FFS in 2023 (before the effects of favorable selection and coding intensity). We use that 103 percent as the projected value of the base component for enrollees with ESRD for 2024 through 2026.

We conducted an analysis of favorable selection into MA for beneficiaries with ESRD using our simple method for switchers into MA from 2021 and 2023.

(See Technical Appendix 12-B, p. 425, for more details about our simple method for estimating selection.) In each year, we estimated a selection percentage of either 99 percent or 100 percent, which suggests that there is not a meaningful selection effect (either favorable or adverse) among the ESRD population into MA. Therefore, for our MA payments relative to FFS spending comparison, we estimate a selection effect of roughly 0 percent for beneficiaries with ESRD in all years.

We also conducted analyses of coding intensity for MA enrollees with ESRD, separately for the three different risk-adjustment models for ESRD beneficiaries. The transplant risk model does not rely on diagnosis codes, so differences in MA and FFS coding intensity are not possible. For enrollees in dialysis and functioning-graft status, we applied the demographic estimate of coding intensity method as outlined in Technical Appendix 12-C, pp. 440, to generate a coding-intensity estimate for beneficiaries on dialysis and for beneficiaries with a functioning graft. Then we combined the three estimates of coding intensity (including an estimate of zero for the transplant population), weighting each by its respective share of payments to MA plans for ESRD enrollees in dialysis, transplant, or functioning-graft status to generate a single ESRD coding-intensity estimate. (See Technical Appendix 12-C, p. 440, for more details about our coding-intensity estimates.) For example, we estimated 2026 coding intensity to be 9 percent for the dialysis population, 9 percent for the functioning-graft population (after coding-intensity adjustment, which applies to functioning-graft risk scores but does not apply to dialysis or transplant risk scores), and we assumed coding intensity to be 0 percent for the transplant population. To combine these estimates, we weighted these estimates by 89 percent, 9 percent, and 2 percent, respectively, for a coding-intensity estimate of 9 percent for the whole ESRD population in 2026 after coding adjustment.

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Incorporating MA enrollees with ESRD into MedPAC's comparison of payments to MA plans relative to FFS spending (cont.)

Taking our combined estimates for the MA ESRD population in 2026, we estimate that MA payments for the ESRD population were 112 percent relative to what they would have been if these enrollees were in FFS. This estimate combines our base comparison (before the effects of favorable selection and coding) of 103 percent, the 0 percentage point estimated effect of favorable selection, and the 9 percentage point effect of coding intensity. The 12 percent higher MA payments for enrollees with ESRD, relative to what spending for the same enrollees would have been if they were in FFS, translates to an estimated \$4 billion in 2026.

Last, we incorporate our estimates for the ESRD population into our overall estimates of MA payments by weighting the ESRD and non-ESRD populations by their respective share of projected spending in 2026 (a little over 6 percent for the ESRD population and a little less than 94 percent for the population without ESRD). For 2026, we project that the overall estimate before selection and coding is 99 percent (99 percent for the non-ESRD population and 103 percent for the ESRD

population). We project that the overall effect of favorable selection is 11 percent (11 percent for the non-ESRD population and 0 percent for the ESRD population). For coding intensity, we project that the overall effect is 4 percent (4 percent for the non-ESRD population and 9 percent for the ESRD population). Shown in Figure 12-5 (p. 377), we find that total payments to MA plans are 14 percent higher than they would have been had those beneficiaries instead been enrolled in FFS Medicare. We now apply the 14 percent to what total spending (including enrollees with ESRD) would have been in FFS Medicare, which we estimate—using CMS's projections of MA enrollment and payments per capita—to be \$540 billion in 2026 (i.e., \$615 billion in MA payments divided by 114 percent). Therefore, we estimate that Medicare payments to MA plans are about \$76 billion higher than they would have been under FFS Medicare. In prior years, we estimated payments to MA plans relative to FFS for the population without ESRD and applied that estimate to payments to MA plans excluding payments for enrollees with ESRD. ■

how CMS constructs its estimates of risk-standardized FFS spending that it uses to set county benchmarks. However, that base comparison does not account for how coding intensity and favorable selection cause CMS's estimates of risk-standardized FFS spending to overpredict costs for the average MA enrollee. Those effects are incorporated as separate components in the Commission's payment comparisons.

In our base comparison of MA payments to FFS spending, we account for risk score and geographic differences (at the county level) between MA and FFS beneficiaries. For MA enrollees, we use actual MA plan payments. For our FFS comparison spending, we calculate the monthly risk-standardized spending

average (i.e., adjusted for a beneficiary with average risk) in counties where MA enrollees reside and apply the risk-adjusted (using MA risk scores) MA enrollment months to the FFS spending average. The Commission uses historical data on the actual FFS spending of beneficiaries with both Part A and Part B coverage (that is, people who would be eligible to enroll in MA) to estimate the base payment comparison for the most recent year for which data are available (2023).⁶⁰ Our estimates of the base payment comparison for years in which we do not have historical data (2024 to 2026) rely instead on CMS's projections of FFS spending. Those projections differ from the actual FFS spending of MA-eligible beneficiaries for several reasons, including

that the projections include Part A-only enrollees and that CMS's projection of the FFS-spending trend is subject to uncertainty. The method that CMS uses to produce its FFS projections has been criticized because it includes beneficiaries who have Part A but not Part B coverage, although MA enrollees are required to have both Part A and Part B coverage.⁶¹ The Commission has recognized this shortcoming and previously recommended that CMS calculate MA benchmarks using FFS-spending data only for beneficiaries with both Part A and Part B coverage (Medicare Payment Advisory Commission 2021a, Medicare Payment Advisory Commission 2017).

The Commission's estimate that Medicare payments to MA plans in 2026 average 99 percent of projected FFS spending—without any adjustments for coding intensity or favorable selection—reflects several aspects of MA payment policy (Table 12-6, p. 373). First, benchmarks are set above projected FFS spending in some counties and below FFS spending in other counties. Second, benchmarks are increased based on plan quality scores—resulting in quality-bonus payments that are financed with additional program dollars. We estimate that quality bonuses will account for about 3 percent (an estimated \$16 billion) of MA payments in 2026. Combining both of those factors, we project benchmarks to be 107 percent of FFS spending in 2026 before accounting for coding and selection. Third, payments to MA plans are below benchmarks because bids are nearly always lower than benchmarks, and plans receive a percentage (based on quality score) of the difference between bids and benchmarks in additional rebate payments.

We estimated the base comparison of MA payments with FFS spending using both CMS's projections and the observed risk-standardized FFS spending of MA-eligible beneficiaries enrolled in both Part A and Part B in each year from 2016 to 2023 (Figure 12-7, p. 384). Our analysis of historical data has shown that using CMS's spending projections has not systematically impacted our base comparison of MA spending with FFS payments.⁶² Both methods produced results that were within 1 percentage point of each other for every year except 2020 and 2021, years that were affected by the coronavirus pandemic. The similarity of the estimates for the two methods indicates that relying on CMS's projections of FFS spending (including adjustments for Medicare as a secondary payer) for estimating

differences in MA and FFS spending has not introduced meaningful error in our analysis, and increases our confidence in relying on CMS's projections for our payment comparisons for 2024 to 2026.⁶³ We will continue to compare how our estimates differ between using CMS's projections and using historical data. Should a systematic difference between the two emerge, we will consider incorporating an adjustment to our base payment comparison for the years that rely on projected data.

We note that the comparison of our historical estimates with CMS's projections are not equivalent to examining the unadjusted differences in national raw FFS spending per capita with and without the Part A-only population. In 2023, on an unadjusted basis, national spending per capita was about 6 percent higher when excluding the Part A-only population. This finding suggests that other adjustments (e.g., Medicare as a secondary payer, risk score normalization of Part A-only enrollees, county-level standardization, county-level distribution of MA enrollment) have caused our historical estimates to be similar to CMS's projections.

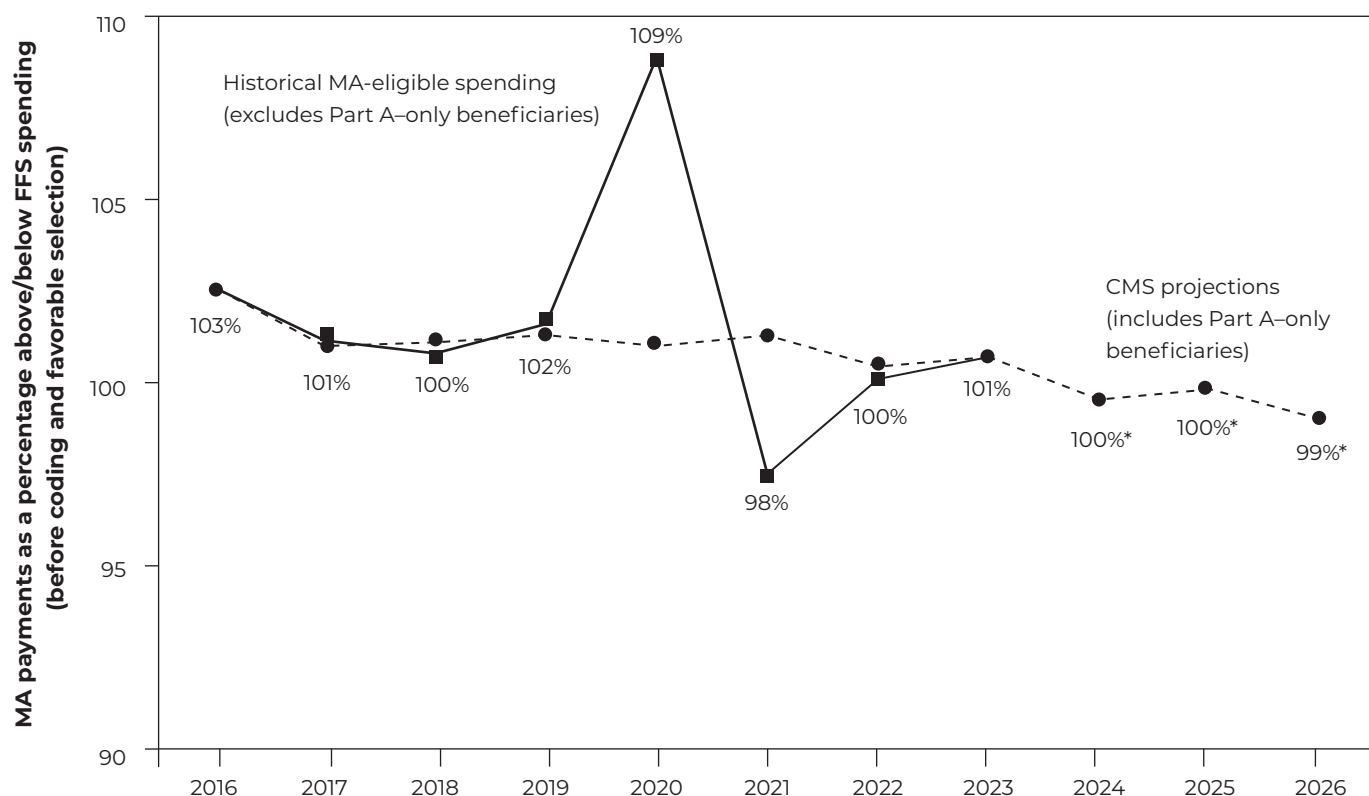
Before coding differences, favorable selection causes risk-based payments to overpredict spending for MA enrollees

The second component of the Commission's payment comparison adjusts the base comparison of MA payments relative to FFS spending for favorable selection. When setting MA benchmarks and paying plans for each enrollee, CMS implicitly assumes that if MA enrollees were in FFS Medicare, their average Medicare spending would be equal to that of current FFS enrollees in the same county after adjusting for differences in risk scores. However, applying MA risk scores to FFS-spending averages may overpredict the actual spending that MA enrollees would have had in FFS for two reasons: coding intensity and favorable selection. (The Commission's estimates of coding intensity are discussed below.)

"Favorable selection" refers to the tendency for Medicare's risk-adjustment model to—on average—overpredict the spending that the MA-enrolled population would have had if they were enrolled in the FFS program, even for beneficiaries with similar coding intensity. Favorable selection can occur due to unmeasured differences in health status but can also

**FIGURE
12-7**

Part A-only beneficiaries included in CMS's projections had no systematic effect on the Commission's base comparison of MA payments with FFS spending



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates have not been adjusted for MA coding intensity and favorable selection of beneficiaries who choose to enroll in MA plans (i.e., underlying differences in risk-adjusted spending between the MA and FFS populations that are not captured by risk scores and would increase MA payments relative to FFS spending). Estimates include both claims and nonclaims FFS spending. Estimates do not include MA payments for beneficiaries with end-stage renal disease. Estimates of actual MA payments in 2020 include remittances related to plans' medical loss ratios. Relative to estimates originally published from 2016 through 2019, prospective estimates are revised to reflect payments to employer plans and adjustments for MA enrollees with Medicare as a secondary payer. Prospective estimates use the figures for FFS per beneficiary spending that CMS's Office of the Actuary generates to determine the MA benchmarks that plans use when submitting bids. Those FFS-spending figures are calculated by summing (1) risk-adjusted Part A FFS monthly spending for all Part A enrollees and (2) risk-adjusted Part B FFS monthly spending for all Part B enrollees. Percentages shown in the figure have been rounded. * Specified values used projected data.

Source: MedPAC analysis of bid data, Medicare enrollment, Medicare claims spending, and risk-adjustment files.

result from factors such as differences in beneficiaries' propensities to seek care for reasons that are unrelated to their health (Medicare Payment Advisory Commission 2024c).

Risk models are imperfect, and beneficiaries with the same risk score typically have a wide distribution of actual spending relative to the spending predicted by their risk score (Lieberman et al. 2023). Each year, a

mix of beneficiaries enroll in MA who either have lower spending than predicted by their risk score or higher spending than predicted by their risk score. The MA program as a whole will experience favorable selection if the average MA enrollee has less spending than predicted by their risk score (before any effects from plans' utilization-management and coding efforts). Because favorable selection occurs when beneficiaries systematically spend less than is predicted by their

risk score, higher-risk beneficiaries (including dually eligible beneficiaries) are not necessarily unfavorable to MA plans. Indeed, our estimates have shown evidence of favorable selection for beneficiaries with both low risk scores and high risk scores (Medicare Payment Advisory Commission 2025b).

The effect of favorable selection may vary over time. Those differences over time reflect a combination of factors, including changes to Medicare's risk-adjustment model and changes in the composition of beneficiaries who choose MA and FFS. If the share of beneficiaries in MA continues to increase, it is not clear how favorable selection will change. It is possible that as MA grows, the favorability of the MA program will converge with the population remaining in FFS, and favorable selection will decrease. Alternatively, it is possible that as fewer beneficiaries remain in FFS, benchmarks will be set on an increasingly small group that is not representative of the overall Medicare population. For example, beneficiaries remaining in FFS may have a much higher rate of comprehensive supplemental coverage, which would tend to increase their use of care and may increase favorable selection in MA. We have found that favorable selection persists as the share of MA enrollees in a market increases (Medicare Payment Advisory Commission 2025b), which is consistent with the findings of other studies that have also found relatively small changes in favorable selection as MA penetration increases (Crow and Fiedler 2025, Lieberman et al. 2023). Thus, the increase in MA penetration has likely coincided with similar growth of average risk-standardized spending in both FFS and MA.

The Commission has developed and refined its methodology for estimating the effect of favorable selection over several years (Medicare Payment Advisory Commission 2025b, Medicare Payment Advisory Commission 2024c, Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2012a). We use our current methodology to estimate an aggregate selection percentage for the entire population of MA enrollees in each year beginning in 2015. That methodology produces a comprehensive estimate that calculates a base selection percentage in the year before enrolling in MA and then estimates how the selection percentage would have changed over time through the estimated

target year (incorporating the effects of both attrition out of MA and mean reversion).^{64,65} We assessed the selection of enrollees with ESRD using a modified approach, and we apply a selection effect of 0 percent to enrollees with ESRD based on that analysis. (See text box on incorporating MA enrollees with ESRD into our payment comparison, pp. 379–382.)

Our current methodology for estimating favorable selection followed a similar approach to the one used last year, with several refinements that had small effects on the overall estimate. We improved our method for generalizing estimates from our study population (of switchers) to other MA enrollees (i.e., those outside our study population, including beneficiaries who joined MA when they were newly eligible for Medicare). We now account for differences in dual-eligibility status when applying estimates outside our study population, along with continuing to account for differences in mortality status and year of initial enrollment. That refinement, along with the studies discussed below that find substantial selection in the newly eligible population, gives us greater confidence in our approach to modeling selection for the nonswitcher population. We also refined our methodology to more fully account for MA beneficiaries' dual-eligibility status when modeling the selection of switchers within our study population and implemented several other technical updates. More detail on our methodology for estimating favorable selection can be found in Technical Appendix 12-B, p. 425.

A substantial and growing body of research has found evidence of favorable selection in MA and provides support for the Commission's estimates and methodology (Brown et al. 2014, Crow and Fiedler 2025, Curto et al. 2021, Curto et al. 2019, Fuglesten Biniek et al. 2024, Goldberg et al. 2017, Government Accountability Office 2021, Jacobs and Kronick 2018, Jacobson et al. 2019, Lieberman et al. 2023, Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2012a, Meyers et al. 2019, Newhouse et al. 2015, Pelech et al. 2025, Rahman et al. 2015, Riley 2012, Ryan et al. 2023, Teigland et al. 2025a). The Commission's method uses data from the portion of the MA population who previously switched (i.e., "switchers") to MA from the FFS program to estimate selection for the entire population of MA enrollees, including those who enrolled upon their initial eligibility for Medicare. The Commission's

approach adjusts for many of the differences between the study and nonstudy populations by assigning selection percentages to the nonstudy population using the estimated selection of enrollees in our study population with the same year of entry, dual-eligibility status, and mortality status in the following two years.

Cumulatively, the Commission's work and that of other research provide support for our approach that generalizes estimates based on switchers in our study population to the other two segments of the MA population: beneficiaries who switched from FFS but had insufficient data to be included in our study population and beneficiaries who enrolled in MA upon becoming newly eligible for Medicare.⁶⁶

- **Beneficiaries who switch from FFS to MA**—Analyses of switchers from FFS have been used in other studies and have found substantial selection effects (Crow and Fiedler 2025, Jacobson et al. 2019, Lieberman et al. 2023, Medicare Payment Advisory Commission 2012a, Newhouse et al. 2015). In addition, the Commission found substantial selection effects among beneficiaries with only one prior year of FFS enrollment (Medicare Payment Advisory Commission 2024c).
- **Newly eligible beneficiaries directly enrolling in MA**—Two recent studies also estimated favorable selection among MA beneficiaries who enrolled upon their initial eligibility for Medicare and found estimates that were even larger than our estimates for switchers in similar years (Pelech et al. 2025, Teigland et al. 2025a).⁶⁷ These studies covered a sample of beneficiaries who had commercial insurance before enrolling in MA and beneficiaries who had Medicaid coverage before enrolling in MA.

Some FFS beneficiaries who are outside our study population may contribute to additional favorable selection. Our analyses require our FFS comparison group to have at least one full year of FFS, which means we are not able to capture the effects of switchers from MA to FFS during their first year in FFS (because risk scores include the effects of MA coding intensity). However, other studies have found that MA plans experience favorable selection when these beneficiaries switch out of MA and into FFS (Fuglesten Biniek et al. 2024, Goldberg et al. 2017, Government Accountability Office 2021, Rahman et al. 2015, Riley 2012).

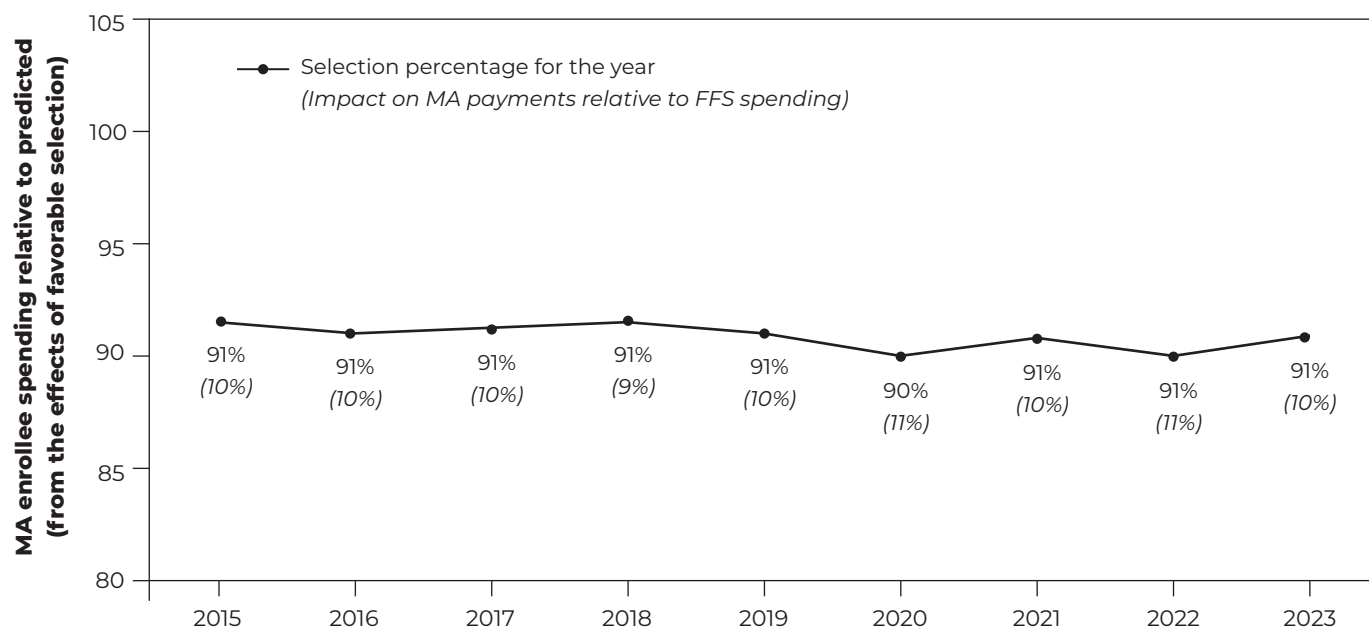
Our analysis using our comprehensive method finds persistent favorable selection over several years. We estimate that favorable selection of the overall MA population resulted in MA payments that were 10 percent above FFS spending in 2023, a slight decrease from 11 percent above FFS spending in 2022 (Figure 12-8).⁶⁸ Those estimates express favorable selection as the amount by which MA payments are above what FFS costs would have been for MA enrollees due to the payment system's overprediction of costs. Favorable selection can also be expressed as a selection percentage, which is the estimate of what FFS costs would have been for MA enrollees relative to their predicted costs. The selection percentage was below 100 percent in every year during the 2015 to 2023 period, indicating that the spending that the FFS program would incur for the MA population would be below what would be predicted by their risk score. For example, the estimated selection percentage of 91 percent in 2023 indicates that MA enrollees would have spent 9 percent less than predicted if they were enrolled in FFS. Favorable selection persisted throughout the study period even as a larger share of Medicare beneficiaries enrolled in MA, including enrollees who had higher risk scores. The estimates presented in Figure 12-8 use the Commission's comprehensive method for the non-ESRD population and apply our estimate of a 0 percent selection effect for the ESRD population, which we estimated using the Commission's simple method. We discuss these methods in greater detail in Technical Appendix 12-B, p. 425.

Coding differences increase payments to MA plans in 2026 by a projected \$22 billion and continue to generate inequity across plans

The third component of the Commission's payment comparison adjusts the base comparison of MA payments relative to FFS spending for coding intensity. Payments to MA plans are risk adjusted to account for differences in health spending risk. Higher risk scores increase payments to plans for enrollees with higher expected Medicare spending. MA enrollees' risk scores are based on demographic information and diagnoses that plans submit to CMS. Our estimates of coding intensity are independent of our estimates of the effects of favorable selection because we estimate selection before MA enrollment and subsequent changes in selection using FFS data (which are unaffected by plans' practices of coding diagnoses).

**FIGURE
12-8**

Evidence of substantial favorable selection annually from 2015 to 2023



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates include MA enrollees with and without end-stage renal disease (ESRD). Estimates for beneficiaries without ESRD were constructed using the Commission's comprehensive method for estimating favorable selection. Beneficiaries with ESRD were estimated to have no favorable-selection effect using the Commission's simple method for estimating favorable selection. Selection percentages are computed as the ratio of the estimated spending that the FFS program would have incurred for MA enrollees relative to the spending predicted by their county benchmark and Medicare's risk-adjustment model. Selection-percentage values farther below 100 percent indicate greater favorable selection. Estimates are rounded to the nearest percent. Estimates of the impact of selection on MA payments relative to FFS spending are computed using the inverse of the selection percentage (e.g., the impact of selection in 2023 was 100 percent divided by 91 percent minus 1). Thus, the impact of selection represents predicted spending for MA enrollees (for which MA payments are based) as a percentage of what spending would have been for MA enrollees in FFS.

Source: MedPAC analysis of Medicare enrollment (2006–2023), Medicare claims spending (2007–2023), and risk-adjustment files (2007–2023).

Documenting additional diagnosis codes raises plan enrollees' risk scores, which increases the monthly payments that MA plans receive from Medicare and the rebates that plans receive to provide supplemental benefits to enrollees. Plans that document relatively more diagnosis codes for enrollees with similar levels of health risk have a competitive advantage over other plans.

Documenting an additional HCC for an enrollee can significantly increase Medicare's payment to a plan for that enrollee. Because of the increased financial incentives for MA plans to code more diagnoses and the additional tools, such as health risk assessments and

chart reviews, that MA plans use to capture diagnoses—tools that are not available or are not used as frequently in FFS Medicare—coding intensity is higher in MA than in FFS, and payments to MA plans are higher than intended.

For 2026, we project that MA risk scores will be about 10 percent above risk scores for comparable FFS beneficiaries. CMS's adjustment reduces MA risk scores by 5.9 percent. Thus, overall coding intensity is only partially offset by CMS's coding-intensity adjustment. The net effect is a 4 percent increase in MA risk scores due to coding intensity, leading to \$22 billion in higher projected payments to MA plans in 2026.

To align with our overall comparison of spending on MA relative to FFS, we estimate MA coding intensity relative to FFS risk scores (i.e., MA risk scores are 10 percent higher than FFS risk scores due to coding intensity). The denominator for CMS's coding adjustment, however, is the average MA risk score. Because the average MA risk score is larger than the average FFS risk score, the two percentages are not equivalent. Based on our MA coding-intensity estimate of 10 percent above FFS, we estimate that CMS's coding adjustment would have had to reduce MA risk scores by 9.3 percent to fully account for the effects of coding intensity in 2026.⁶⁹ However, coding intensity varies significantly across MA organizations. As a result, CMS's across-the-board adjustment for coding intensity, which reduces all MA risk scores by the same amount, generates inequity across organizations by reducing net revenue for plans with lower coding intensity and allowing other plans to retain a significant amount of revenue from higher coding intensity (see Figure 12-12, p. 397). Increasing CMS's across-the-board coding adjustment to 9.3 percent would increase the penalty for plans with lower coding intensity while still not fully addressing the effects of coding intensity for the organizations with higher coding levels. A policy addressing coding intensity more fairly would reduce risk scores more for plans with the highest coding intensity.

The Commission's approach to estimating coding intensity compares risk scores for the MA and FFS populations under the assumption that demographically similar populations of beneficiaries have a similar average prevalence of health conditions. We use the combination of age, sex, Medicaid eligibility, and institutional status to define demographic similarity. Any population-level differences in risk scores that are greater than what would be predicted using those demographic factors are attributed to coding intensity. More details on the methodology can be found in Technical Appendix 12-C, p. 440, including a discussion of sensitivity analyses we conducted to assess the effect of including additional characteristics when defining demographic similarity.

In our March 2016 report to the Congress, the Commission recommended a multipronged approach that would fully account for the impact of coding differences between MA and FFS, improve the equity of the adjustment across MA contracts, and improve incentives to reduce costs and improve quality. The

Commission's approach to reducing MA coding intensity has been to address the mechanisms that generate coding differences first (e.g., remove health risk assessments and reduce year-to-year coding variations by using two years of diagnostic data) and then address remaining differences with either an across-the-board or tiered adjustment. The Commission's 2016 recommendation did not address the use of chart reviews because data were not available at that time, but eliminating chart reviews as a source of diagnoses for risk adjustment would be consistent with the Commission's approach.

Documenting more diagnosis codes increases payments to plans

Among the 20 most common HCCs in MA—which have payment amounts ranging from roughly \$1,000 to \$5,500—the average additional payment per HCC is about \$3,400 per year. Documenting each additional HCC for an enrollee can thus significantly increase Medicare's payment to a plan. We can illustrate how coding additional HCCs increases payment to a plan for Medicare-covered services using average FFS Medicare spending.⁷⁰ For example, in 2022, the annual Medicare payment to an MA organization for a non-Medicaid-eligible 80-year-old male (where the demographic component of the risk score is valued at \$6,726) with diabetes without complication (HCC 19, valued at \$1,284) would have been \$8,010. If the same 80-year-old male with diabetes were also found to have vascular disease (HCC 108, valued at \$3,620), the Medicare annual payment to the MA organization would increase to \$11,630.

Because the CMS-HCC model uses FFS Medicare claims data to estimate the size of the model coefficients, the model calculates an expected spending amount based on FFS Medicare costs and diagnostic-coding patterns. Most diagnoses are reported on physician and outpatient claims, which in FFS Medicare tend to be paid based on procedure codes, thus providing little financial incentive to document diagnoses for FFS beneficiaries. This distinction can lead to relative underreporting of diagnoses in FFS. If certain diagnoses are not reported on FFS claims, the cost of treating those conditions is attributed to other components in the model, causing the coefficients overall to be inflated above the value they would have been if the diagnoses had been more completely reported. Because Medicare's risk model is

based on diagnostic-coding patterns in FFS, when MA plans submit more diagnoses for a beneficiary than would have been documented in FFS Medicare, the program spends more for that beneficiary in MA than it would have if the beneficiary were in FFS.

Because of the increased financial incentives for MA plans to code more diagnoses and the additional tools that MA plans use to capture diagnoses, coding intensity is higher in MA than in FFS and payments to MA plans are higher than intended. Although Medicare's accountable care organization (ACO) programs and some other alternative payment models (APMs) offer incentives to increase diagnostic-coding intensity in FFS Medicare, we continue to see higher coding intensity in MA. The tools that ACOs and APMs have available result in less coding intensity than those available to MA plans; notably, chart reviews, plan-initiated health risk assessments, and subcapitation to medical groups are used only in MA. Furthermore, CMS limits annual risk-score growth for ACO enrollees when calculating shared savings or losses. Thus, we expect that FFS coding will continue to identify fewer diagnosis codes than MA coding does.

Higher MA payments due to coding differences have been under scrutiny for more than a decade. Research has consistently found that the impact of coding differences on MA risk scores produces higher payments for MA plans (Congressional Budget Office 2017, Geruso and Layton 2020, Government Accountability Office 2013, Hayford and Burns 2018, Jacobs and Kronick 2018, Kronick and Chua 2021, Kronick and Welch 2014). One study found that when controlling for differences in health status using Part D prescription drug data, from 2008 to 2015, MA risk scores grew by about 1 percent more per year than FFS risk scores (Jacobs and Kronick 2018). A second study used a difference-in-difference approach on risk-adjustment data for 2008 to 2013 to estimate that risk scores for enrollees remaining in MA grew about 1.2 percent faster per year than for beneficiaries in FFS Medicare (Hayford and Burns 2018). A third study, using county-level data, found that in the first year after MA enrollment, risk scores increased about 6 percent faster than FFS and about 2 percent faster in the second year (Geruso and Layton 2020). The Government Accountability Office used a risk-score prediction model to estimate coding intensity for 2010 through 2012, and those estimates align very

closely with the Commission's estimates over that same time period (Government Accountability Office 2013). A study focusing on diagnoses submitted on hospital claims has found higher levels of MA coding intensity for beneficiaries who subsequently had a health assessment in a skilled nursing facility (Kosar et al. 2024).

Several studies published in the past year have shown evidence of coding intensity using new approaches and data sources. The overall estimates of coding intensity produced by these studies are all slightly larger than MedPAC's estimates of coding intensity. One study controlled for mortality differences and the differences in MA and FFS coding for specific HCCs and found overall coding intensity of about 8.4 percent in 2014 (Curto et al. 2025). Another study using risk scores derived from encounter data and applying the demographic estimate of coding intensity found coding intensity of about 10.1 percent in 2016 rising to about 17.4 percent in 2021 (Kronick et al. 2025a). This study also estimated that coding intensity under the V28 model would have been about 7.3 percentage points lower than actual coding intensity under the risk model used to pay MA plans in 2021 and that removing the HCCs with the largest MA and FFS coding differences could have a significant effect on eliminating differences in overall coding intensity. (There is more discussion of the V28 risk model and its effect on coding intensity later in this section.) Another study analyzed switchers from FFS to MA and found rapidly rising risk scores across cohorts of MA entrants and an overall coding-intensity estimate of 18.6 percent for 2021 (Jacobs and Layton 2025).

Finally, one new study assessed the prevalence of certain conditions using lab data and controlling for age and sex differences and found that the prevalence of obesity, hypertension, hyperlipidemia, and chronic kidney disease was not higher among MA compared with FFS beneficiaries; however, diabetes was more prevalent in MA (Oseran et al. 2025). By reviewing medical records and using lab data to validate the true prevalence of these conditions, this study highlights the concern over the diagnosis codes that MA plans submit for risk-adjusting payments to plans. Plan-reported codes should be supported by medical records (see text box "Update on risk adjustment data validation audits," pp. 402–403); however, these conditions appear to be far more prevalent in MA relative to FFS in risk-adjustment data than they appear to be in the medical record findings

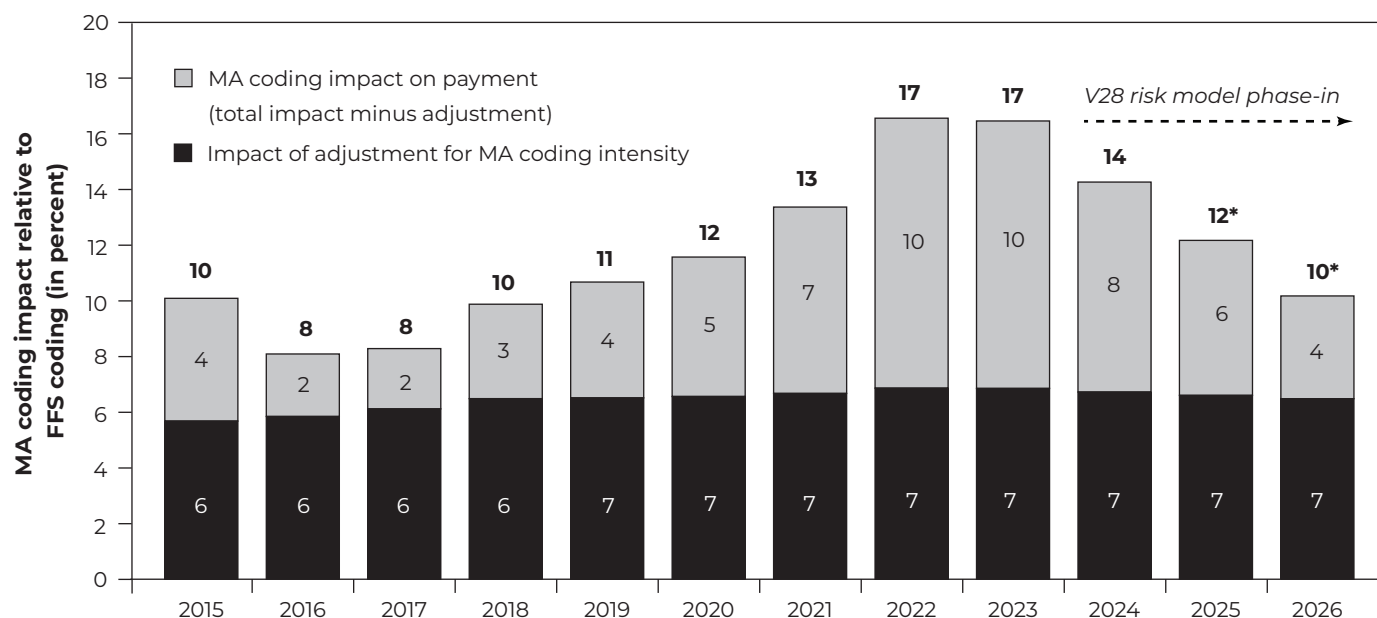
from the Oseran et al. study. One study looking at plan-reported conditions found obesity and Stage 3 chronic kidney disease to be reported, respectively, 96 percent and 56 percent more often in MA risk-adjustment data than in FFS Medicare (Kronick et al. 2025a). We previously found that angina pectoris (a symptom that is often related to hypertension) was coded far more often in MA (controlling for age, sex, and Medicaid eligibility) and was coded 2.5 times more frequently than in FFS among the MA contracts in the highest 20 percent of contracts ranked by overall coding intensity (Medicare Payment Advisory Commission 2023a). CMS removed angina pectoris from the CMS-HCC risk model due to large differences in MA and FFS coding in the risk-score data (Centers for Medicare & Medicaid Services 2022a). Although the Oseran et al. study using medical record review and lab data found a higher prevalence of diabetes in MA, we previously found higher coding intensity by level of diabetes severity reported in MA risk-adjustment data. MA plans coded diabetes without complications less frequently than FFS but coded diabetes with chronic or acute complications far more often, including MA contracts with the highest overall coding intensity reporting diabetes with acute complications two times more frequently than demographically similar beneficiaries in FFS Medicare (Medicare Payment Advisory Commission 2023a). Because of these differences in coding the severity of diabetes between MA and FFS, CMS constrained the risk-score coefficients for all three diabetes conditions (without complications, with acute complication, or with chronic complication) to be the same (Centers for Medicare & Medicaid Services 2022a).

Starting in 2010, statute requires CMS to reduce MA risk scores to address the impact of MA and FFS coding differences on payments to MA plans.⁷¹ In response, CMS reduced MA risk scores by 3.41 percent in each year from 2010 through 2013. Starting in 2014, legislation specified a minimum reduction of about 4.9 percent, which rose gradually to about 5.9 percent in 2018, where it will remain until the Secretary of Health and Human Services implements risk adjustment using MA diagnostic, cost, and use data (which is generally thought to mean a risk model that has coefficients estimated using MA encounter data rather than FFS claims data). Although larger reductions are allowed under the legislation, CMS reduced MA risk scores by only the minimum amount required by law for 2014 through 2026.

CMS has made other changes to the risk-adjustment model to better align FFS and MA risk scores. Between 2014 and 2016, CMS phased in a new risk-adjustment model that removed some diagnoses found to be coded more frequently in MA. We estimated that the new risk model reduced overall coding intensity by about 2.5 percentage points compared with the previous model. In 2017, CMS began accounting for Medicaid-benefit eligibility more accurately (full-, partial-, or no-benefit status by month), which reduced the gap in MA and FFS risk scores by about 1 percentage point, which was the amount by which MA risk scores were unduly higher than FFS due to differing shares of beneficiaries by Medicaid eligibility status. The largest reduction to MA and FFS coding differences began in 2024 when CMS initiated the phase-in of a new risk model (V28) that reduces the gap in coding intensity relative to FFS by removing or constraining the coefficients of diagnoses that were found to be coded more aggressively in MA. The V28 model will be fully phased in for payments to MA plans in 2026; the effect on coding intensity is discussed more below.

MedPAC's estimates of coding intensity

The Commission's method for estimating coding intensity compares risk scores for MA and FFS populations under the assumption that demographically similar populations of beneficiaries have a similar average prevalence of health conditions. We use the combination of age, sex, Medicaid eligibility, and institutional status to define demographic similarity. We introduced this method in 2023. The previous method used cohorts of MA and FFS enrollees matched by length of enrollment, age, and sex to estimate coding intensity. Over time, the cohort method became increasingly complex to implement. After revising the cohort method of estimating coding intensity to account for additional beneficiary characteristics, the Commission found that the new method produced substantially similar estimates of plan coding intensity over the period 2007 through 2021. A detailed description of those methods can be found in Chapter 13 of our March 2024 report to the Congress, along with the research leading to the revisions. For our 2025 report, we made additional revisions to exclude beneficiaries residing in Puerto Rico from our coding-intensity estimate because Puerto Rico's Medicaid program does not use the full-, partial-, or no-benefit structure, which is necessary for our coding-intensity estimation method. This revision

**FIGURE
12-9****Estimated impact of coding intensity on MA risk scores
was larger than the coding adjustment, 2015-2026**

Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico are excluded. The impact of the coding adjustment is calculated as the MA coding-intensity estimate relative to FFS, multiplied by the coding adjustment. For 2026, we calculate 1.10×5.9 percent = 0.065 or about 7 percent. Coding-intensity estimates reflect the risk model(s) used to pay MA plans in each year. The V28 risk model was phased in one-third in 2024, two-thirds in 2025, and completely in 2026. Components may not sum to totals due to rounding.

* For 2025 and 2026, we project coding intensity based on the annual trend from 2023 through 2024 for the V24 risk model, an increase of 0.7 percentage points per year, and account for an estimated -2.9 percentage point annual effect due to the phase-in of the V28 risk model. See Technical Appendix 12-C, p. 440, for more details.

Source: MedPAC analysis of CMS enrollment and risk-score files.

reduced our coding-intensity estimates by about 1 percentage point from what we previously reported. We also modified how we weight new enrollees so that the estimate more accurately reflects the share of payments associated with new and continuing (those with risk scores based on diagnosis codes) enrollees.

This year, we also estimate coding intensity for MA enrollees with ESRD, and we incorporate that estimate into our overall estimate of MA coding intensity. The share of payments to MA plans for enrollees with ESRD has grown rapidly since the enactment of the 21st Century Cures Act and is projected to account for more than 6 percent of MA spending in 2026. Given this trend, we expanded our estimate to include beneficiaries with ESRD; however, the change had little effect on our overall estimate of coding intensity.

Finally, based on comments from Commissioners and others, we conducted a number of sensitivity tests to assess adding variables to our demographic risk model. Those sensitivity analyses had little effect on our overall estimates of coding intensity. More details on our method for estimating MA coding intensity, how we estimate coding intensity for the ESRD population including separate estimates for the ESRD and non-ESRD populations, and sensitivity analyses can be found in Technical Appendix 12-C, p. 440.

For 2024, the most recent year of risk-score data available, we estimate that MA coding intensity fell from 17 percent in 2023 to 14 percent due to the initial phase-in of the V28 risk model (Figure 12-9). In addition to removing HCCs or constraining the coefficients on HCCs that had large differences in MA and FFS coding

Updates to coding-intensity estimates reflect newly available data and other factors

We updated the coding-intensity estimates published in last year's March 2025 report to incorporate newly available data from 2024. MedPAC updates its estimates each year to reflect the most recent data available at the time of publication. This year, the newly available data for 2024 were particularly consequential for updating our earlier projections of coding intensity because those data reflected the first year of experience with the V28 risk-adjustment model. The newly available data both allowed us to update the 2024 projection using historical data and informed updates to the methods used to project that 2024 estimate forward to 2025 and 2026.

Compared with the 16 percent estimate of coding intensity for 2025 that we published last year, we now project coding intensity to be 12 percent in 2025 and 10 percent in 2026. The difference in the estimates for 2025 is driven by three main factors, explained in Figure 12-10.

First, we observed lower overall coding intensity under V28 in 2024 relative to last year's estimate. Last year, we did not have access to V28 risk scores, so we calculated V24 and V28 risk scores using MA encounter and FFS claims data and risk-model software and then estimated coding intensity under the two models for 2021, 2022, and 2023. The average difference across the three years was 7.7 percentage points, which we assumed to represent the baseline difference in coding intensity for 2023 before the introduction of V28. We then trended that difference forward to 2024, assuming that coding intensity would grow faster

under V28 compared with V24 as MA organizations and providers adapted to the new set of diagnoses included in the V28 risk model. (We previously observed a faster rate of coding-intensity growth between 2014 and 2015 during the phase-in of the V22 risk model, which, similar to the phase-in of V28, also removed diagnoses with differing rates of coding in MA and FFS.) As a result, we projected a 6.9 percentage point difference in coding intensity between the two models in 2024. We now have V24 and V28 risk scores for 2024 and calculate that coding intensity under V28 was 8.8 percentage points lower than under V24 in that year. Therefore, the effect of incorporating actual V28 risk scores accounts for 1.8 percentage points (estimate is affected by rounding) of the difference in coding-intensity estimates for 2025.

Second, we previously projected that coding intensity would continue to grow based on the V24 trend from 2019 to 2023, or about 1.6 percentage points per year. We now find that coding intensity grew by 0.7 percentage points from 2023 to 2024 under the V24 model. Because we observed atypical coding-intensity estimates during the coronavirus pandemic, for 2022 and 2023, we now apply a trend based on only postpandemic estimates, allowing for the possibility that the coding-intensity trend has fundamentally changed. In last year's projection, we applied the 1.6 percentage point annual trend for two years, from 2023 to 2025. Therefore, the difference in trend (0.9 percentage points annually) accounts for 1.8 percentage points of the difference between coding-intensity estimates for 2025 from our March 2025 report and this report.

(continued next page)

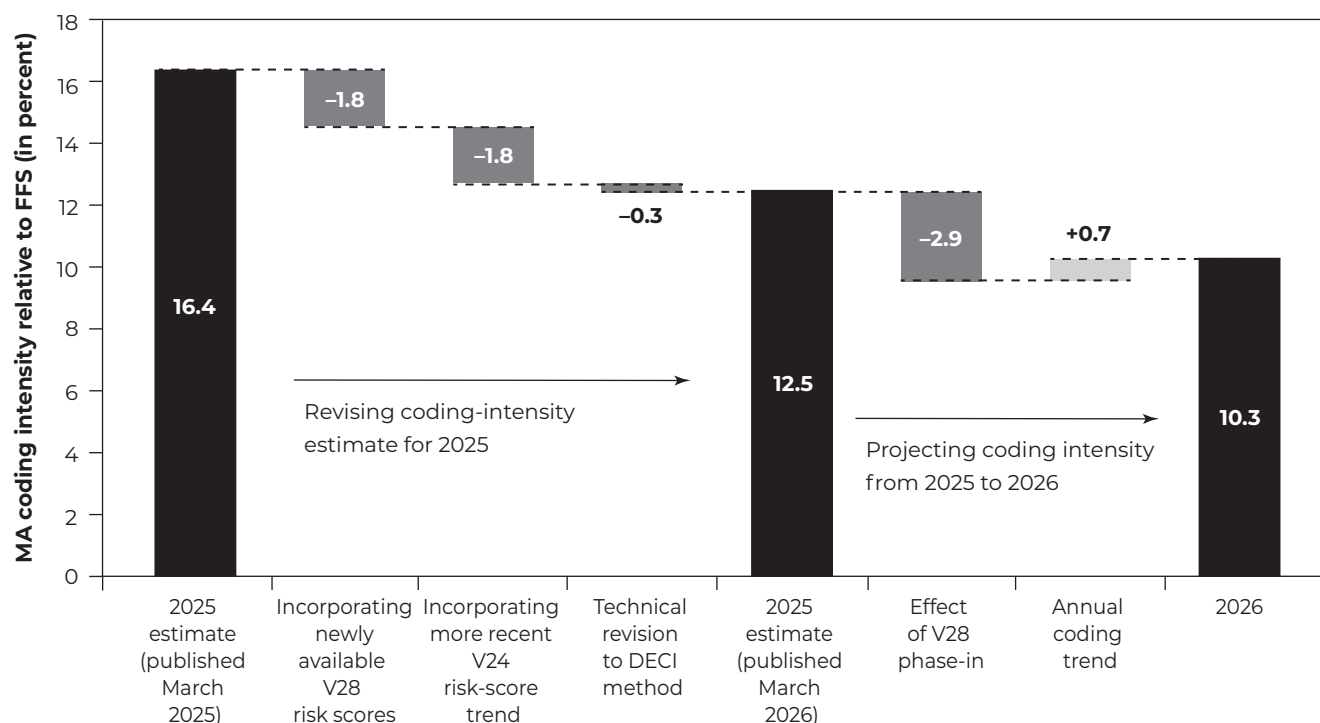
rates, the V28 model also revised the diagnosis codes used to calibrate the model, which resulted in the removal of several codes from the model.⁷² We estimate that in 2024, coding intensity would have been 8.8

percentage points lower under the V28 risk model, if that model had been fully phased in, than under the prior (V24) risk model, with coding-intensity estimates of about 9 percent and 18 percent, respectively. In 2024,

Updates to coding-intensity estimates reflect newly available data and other factors (cont.)

FIGURE 12-10

Updating the coding-intensity estimate for 2025 with new data, adjusting for other factors, and projecting coding intensity for 2026



Note: MA (Medicare Advantage), FFS (fee-for-service), DECI (demographic estimate of coding intensity). In our March 2025 report, we projected coding intensity from the most recent year of available data, 2023, to 2025. For this report, new data are available, and we have updated our method of projecting coding intensity. This figure reconciles the difference in coding-intensity estimates for 2025 due to updated data and other factors and explains the projection assumptions for 2026. These estimates are for MA enrollees without end-stage renal disease.

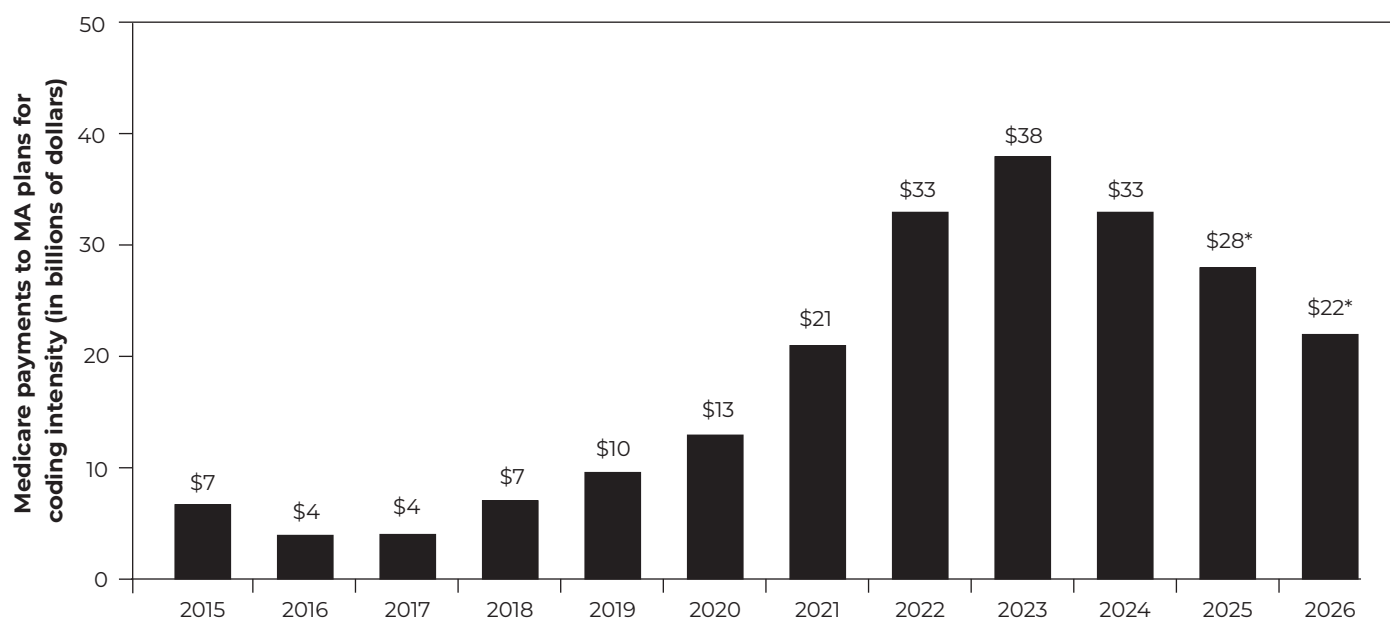
Source: MedPAC analysis of CMS enrollment and risk-score files.

Finally, we modified our method of calibrating the demographic risk model used in the demographic estimate of coding-intensity method to better align with how the CMS-HCC model is calibrated. The demographic model now uses a single denominator to calculate coefficients for differing groups of beneficiaries based on their Medicaid eligibility and institutional status. The change from using separate denominators for these groups to using a single denominator reduced our estimate of overall coding intensity for 2024 by 0.3 percentage points. We expect this effect will be similar in 2025.

For 2026, we project that coding intensity will be about 10 percent. Projecting from a 12 percent coding-intensity estimate in 2025 to 10 percent in 2026 reflects the combined effect of completing the phase-in of the V28 risk model from two-thirds for 2025 to fully phased in for 2026 (-2.9 percentage points) and an additional year of coding-intensity growth (+0.7 percentage points) based on the postpandemic trend for the V24 risk model. Next year, we will have access to a second year of V28 risk scores and can estimate a new trend based on that model. ■

**FIGURE
12-11**

**MA coding intensity is projected to increase
payments to plans by about \$22 billion in 2026**



Note: MA (Medicare Advantage). All estimates are based on the Commission's estimate of coding intensity after accounting for CMS's coding adjustment. Medicare spending for MA plans is based on the Medicare Trustees' reports.

* For 2025 and 2026, we project coding intensity based on the annual trend from 2023 through 2024 for the V24 risk model, an increase of 0.7 percentage points per year, and account for an estimated -2.9 percentage point annual effect due to the phase-in of the V28 risk model. See Technical Appendix 12-C, p. 440, for more details.

Source: MedPAC analysis of CMS enrollment and risk-score files and the Medicare Trustees' reports.

one-third of payments were adjusted with the V28 risk model, and the remaining two-thirds were adjusted with the V24 risk model.

Because the data required to estimate coding intensity are not yet available for 2025 and 2026, we project coding intensity for those years by incorporating the annual trend from 2023 to 2024 for the V24 risk model, an increase of 0.7 percentage points per year, and accounting for the effect of the continued phase-in of the V28 risk model (one-third in 2024, two-thirds in 2025, and fully phased in for 2026). (See text box "Updates to coding-intensity estimates reflect newly available data and other factors," pp. 392–393.) Based on the phase-in schedule, we project that V28 alone reduced coding intensity by an additional 2.9 percentage points in each of these years. Combining

the effect of the annual coding-intensity trend with the V28 model phase-in, we project that coding intensity will continue to decline to about 12 percent in 2025 and to about 10 percent in 2026. Given that we have V28 risk-score data only for 2024, there is uncertainty about the impact of the continued phase-in of the V28 model for MA coding intensity. In particular, the V28 projection factor does not explicitly account for plans responding to the new coding incentives under the V28 model and actual trends under the V28 model may be higher or lower than we estimate. We will continue to monitor those effects and will update our analysis as we receive additional data.

For 2026, the projection of MA coding intensity of 10 percent is partially offset by CMS's coding-intensity adjustment, which reduced MA risk scores by

5.9 percent. The net effect is a 4 percent increase in MA risk scores due to coding intensity, leading to \$22 billion in higher projected payments to MA plans.

Between 2007 and 2024, MA coding intensity resulted in \$184 billion in increased payments to MA plans (Figure 12-11). Using our projection, we estimate that MA coding intensity in 2025 and 2026 will increase program spending by another \$28 billion and \$22 billion, respectively (data not shown). In total, we estimate that between 2007 and 2026, MA coding intensity will have generated \$233 billion in higher aggregate payments to MA plans.

Documenting additional diagnosis codes increases plan rebates and can distort competition among plans

Documenting additional diagnostic codes increases the size of MA plans' rebates, which in turn allows plans to offer their enrollees more supplemental benefits than plans that document fewer additional diagnoses. For a plan submitting a bid below its benchmark (nearly all plans in 2026), the plan's rebate is based on the difference between the plan's bid for its expected enrollee population and the plan's risk-adjusted benchmark, which is the standard benchmark (for a beneficiary of average risk, with a 1.0 risk score) multiplied by the plan's expected average risk score. Raising a plan's average risk score raises the plan's risk-adjusted benchmark and widens the difference between the plan's bid and the risk-adjusted benchmark, thereby increasing the plan's rebate amount and ability to offer more supplemental benefits. Plans may also adjust their bids in response to higher benchmarks. In sum, plans can translate greater coding intensity into the ability to offer more supplemental benefits, giving them an advantage over their competitors in attracting enrollees.

MA payment policies aim to give plans an incentive to lower spending and improve quality by allowing them to offer more supplemental benefits. By reducing health care costs, plans can reduce their bids, increasing their rebate and supplemental benefit value. By improving quality scores, plans can be rewarded with a 5 percent or 10 percent increase in their benchmark or with an increase in the rebate percentage (the percentage of the bid and benchmark difference that determines the rebate amount).⁷³ These policies are intended to benefit enrollees through improved quality, more supplemental benefits, and

reduced premiums, as well as lower taxpayer funding for the Medicare program. Greater MA coding intensity, however, distorts these incentives by allowing plans to offer more supplemental benefits regardless of whether they reduce costs or improve quality.

Table 12-7 (p. 396) illustrates the relationship between coding intensity and rebate amounts using a hypothetical example of three plans covering the same set of enrollees for whom the expected cost of care is the same, at \$900 per member per month. Plan A and Plan Z have an expected risk score of 0.97, while Plan B has an expected risk score of 1.03 due to coding more diagnoses. All three plans have bids below the risk-adjusted benchmark and provide supplemental benefits funded by rebates. However, because Plan B has a higher risk score, its rebate is larger than Plan A's rebate (\$52 per month vs. \$15 per month), so it can offer enrollees more supplemental benefits. Plan B's coding efforts have therefore given it an unfair competitive advantage over Plan A.

In addition, increased coding intensity can influence the size of the rebate more than MA quality bonuses can. The higher risk score of Plan B, which has only 3.5 stars, gives it an advantage over bonus-level Plan Z, which has 5 stars: Plan B's rebate amount is higher than Plan Z's (\$52 per month vs. \$49 per month). Thus, by inflating its risk score from 0.97 to 1.03, Plan B can offer more supplemental benefits than are provided through quality bonuses.

The plans illustrated in Table 12-7 (p. 396) have a risk-score difference of 6 percentage points, reflecting different coding practices. We estimated coding intensity for MA organizations and found much greater variation in coding for 2024.⁷⁴ Figure 12-12 (p. 397) shows MA coding intensity relative to FFS coding, broken out by MA parent organization, excluding beneficiaries who reside in Puerto Rico, are enrolled in chronic-condition special-needs plans, or have ESRD, and organizations with fewer than 25,000 enrollees in the analysis.

Consistent with prior years, we find that about half of organizations (covering 16 percent of MA enrollees) have coding intensity below CMS's 2024 coding adjustment and are thereby penalized by the adjustment, while the other half of organizations (covering 84 percent of MA enrollees) have coding intensity that increases their payment even after

**TABLE
12-7****Illustrative example: A plan that codes more diagnoses
can offer its enrollees more supplemental benefits**

Plan	Bid: Monthly cost of care for expected population	Risk score of expected population	Monthly MA benchmark for the county for an average-risk population (+5% for bonus plan)	Risk-adjusted monthly benchmark (benchmark multiplied by risk score)	Difference in risk-adjusted benchmark and plan bid	Monthly value of supplemental benefits (rebate amount)*
Nonbonus plans						
Plan A (3.5 stars)	\$900	0.97	\$952	\$923	\$23	\$15
Plan B (3.5 stars)	900	1.03	952	981	81	52
Bonus plan						
Plan Z (5 stars)	900	0.97	1,000	970	70	49

Note: MA (Medicare Advantage). An average-risk population has a risk score of 1.0. This example assumes that the actual cost of care for the expected population is \$900 monthly for each of the three plans and that the plans serve the same beneficiaries. Plan B's risk score of 1.03 is inflated due to greater diagnostic-coding effort.

* Plan A and Plan B at 3.5 stars have a rebate percentage of 65 percent. Plan Z at 5 stars has a rebate percentage of 70 percent.

accounting for the 2024 coding adjustment. These differences demonstrate that CMS's across-the-board adjustment for coding intensity, which reduces all MA risk scores by the same amount, perpetuates inequity across contracts by reducing net revenue for plans with lower coding intensity and allowing other plans to retain a significant amount of revenue from higher coding intensity.

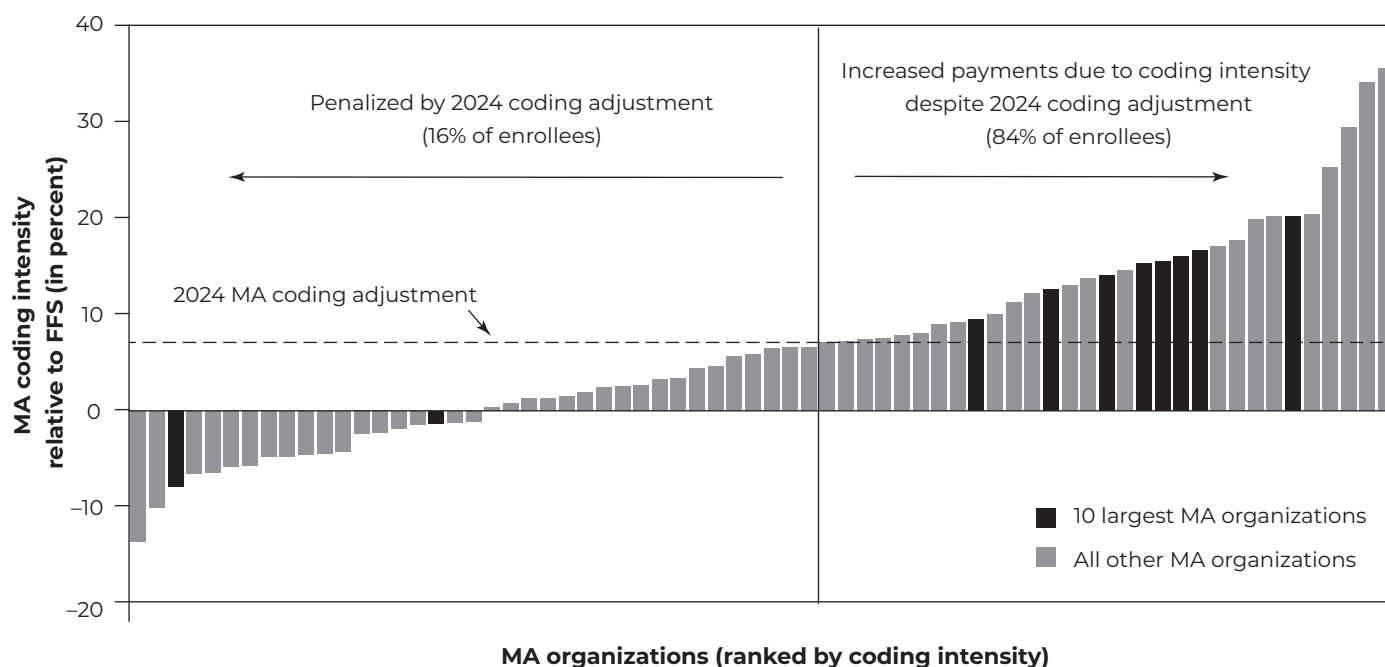
We also find significant variation in coding intensity across the 10 largest MA organizations (covering 81 percent of MA enrollees), from about 8 percent below to about 20 percent above FFS levels. Eight of the 10 largest MA organizations had greater coding intensity than the 2024 coding adjustment and therefore received a net increase in payment due to their coding practices. These differences are large enough to give MA organizations with higher coding intensity a significant competitive advantage by increasing the size of plan rebates and helping them to attract more enrollees. Our finding that coding intensity varies across MA organizations is consistent with other research (Curto et al. 2025, Geruso and Layton 2020, Kronick and Chua 2021, Kronick et al. 2025b, Kronick and Welch 2014).

As noted earlier, we found that in 2024, coding intensity under the V28 model was 8.8 percentage points lower than under the V24 model, on average. We also estimated the difference between coding intensity under the two models across MA organizations. Given the difference in coding intensity across organizations, for the V28 model to be an effective and fair approach to reducing coding intensity, it should reduce coding intensity consistent with an organization's overall coding level. Table 12-8 (p. 398) shows that in 2024, the V28 risk model reduced coding intensity more for organizations with larger V24 coding intensity. The effects are smaller for organizations with lower levels of coding intensity, particularly those with coding levels below that of FFS, suggesting that the effects of V28 on coding intensity were well-targeted to the organizations with the highest levels of coding intensity.

Organizations with coding intensity below FFS levels ("<-10 percent" and "-10 to 0 percent" rows) had no or a very small reduction in average coding intensity due to the V28 model, 0.3 percent and -1.6 percent, respectively. With the exception of the "0 to 5 percent" group at -7.9 percent difference, the

**FIGURE
12-12**

Coding intensity relative to FFS varied widely across MA organizations, 2024



Note: FFS (fee-for-service), MA (Medicare Advantage). Coding-intensity estimates reflect the one-third V28 model and two-thirds V24 model blend used for payment in 2024. All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico, enrolled in a chronic-condition special-needs plan, or with end-stage renal disease are excluded from the analysis, as well as organizations with fewer than 25,000 enrollees. MA organizations with 25,000 or more enrollees cover about 97 percent of eligible MA enrollment.

Source: MedPAC analysis of CMS enrollment and risk-score files.

magnitude of the V28 effect increases along with the level of V24 coding intensity.⁷⁵

Although there is a correlation between the V24 coding-intensity level and reduction in coding intensity due to V28, there also is variation in the V28 effect among organizations with similar V24 coding-intensity levels. Figure 12-13 (p. 399) shows coding-intensity estimates under the V24 and V28 risk models for each MA organization, ranked by V24 coding intensity in 2024. The gray shaded area represents the coding-intensity estimate under the V24 risk model, and the black bars represent the coding-intensity estimate under the V28 risk model for the same MA organization.

As shown in Table 12-8 (p. 398), the V28 risk model reduces overall coding intensity by the largest amount for organizations with the highest V24 coding intensity. However, as an example of the varying effect of V28, three organizations that had V24 coding intensity between 14.5 percent and 14.9 percent had V28 coding intensity of 8.6 percent, 0.5 percent, and 11.8 percent. Overall, we find that V28 has generally reduced overall coding intensity and improved the fairness of the MA risk-adjustment system.

MA plans have several tools to code more diagnoses

MA plans use several mechanisms, most of which do not exist in FFS Medicare, to document diagnoses for their enrollees. They can identify enrollees likely

**TABLE
12-8**

The V28 risk model reduced coding intensity more for MA organizations with higher V24 coding intensity, 2024

Level of V24 coding intensity	Share of enrollee years among MA organizations	Average difference in coding intensity (V28 estimate – V24 estimate)
<-10%	0.2%	0.3%
-10 to 0%	4.8	-1.6
0 to 5%	9.1	-7.9
5 to 10%	4.2	-5.0
10 to 15%	19.3	-5.5
15 to 20%	30.8	-8.5
20 to 25%	20.0	-11.5
>25%	1.5	-23.3

Note: MA (Medicare Advantage). All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and fee-for-service populations. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico or enrolled in a chronic-condition special-needs plan are excluded from the analysis, as well as organizations with fewer than 25,000 enrollees. MA organizations with 25,000 or more enrollees cover about 97 percent of eligible MA enrollment.

Source: MedPAC analysis of CMS enrollment and risk-score files.

to have an HCC that has not yet been documented using data the plan already has: an enrollee's historical claims, risk-score data, and prescription drug data (e.g., a prescription for insulin likely indicates a diabetes diagnosis). Of all the mechanisms to document more diagnosis codes, evidence continues to highlight MA plans' use of health risk assessments and chart reviews as major sources of plan revenue from coding intensity.

Coordination of coding incentives through pay-for-coding programs, capitated arrangements, and corporate ownership Some plans try to ensure that providers submit all possible diagnoses for their enrollees through pay-for-coding programs, in which plans send physicians a patient-assessment form that includes diagnosis codes that the plan has identified for a beneficiary. Plans ask physicians to confirm the existence of plan-identified diagnoses on the form and document those diagnoses on subsequent claims. Plans pay physicians based on completing the form or as a dollar amount per diagnosis code submitted. The corporate ownership of physician groups by MA organizations seems to intensify such programs. One organization is reported to have a dashboard comparing chronic conditions identified for MA

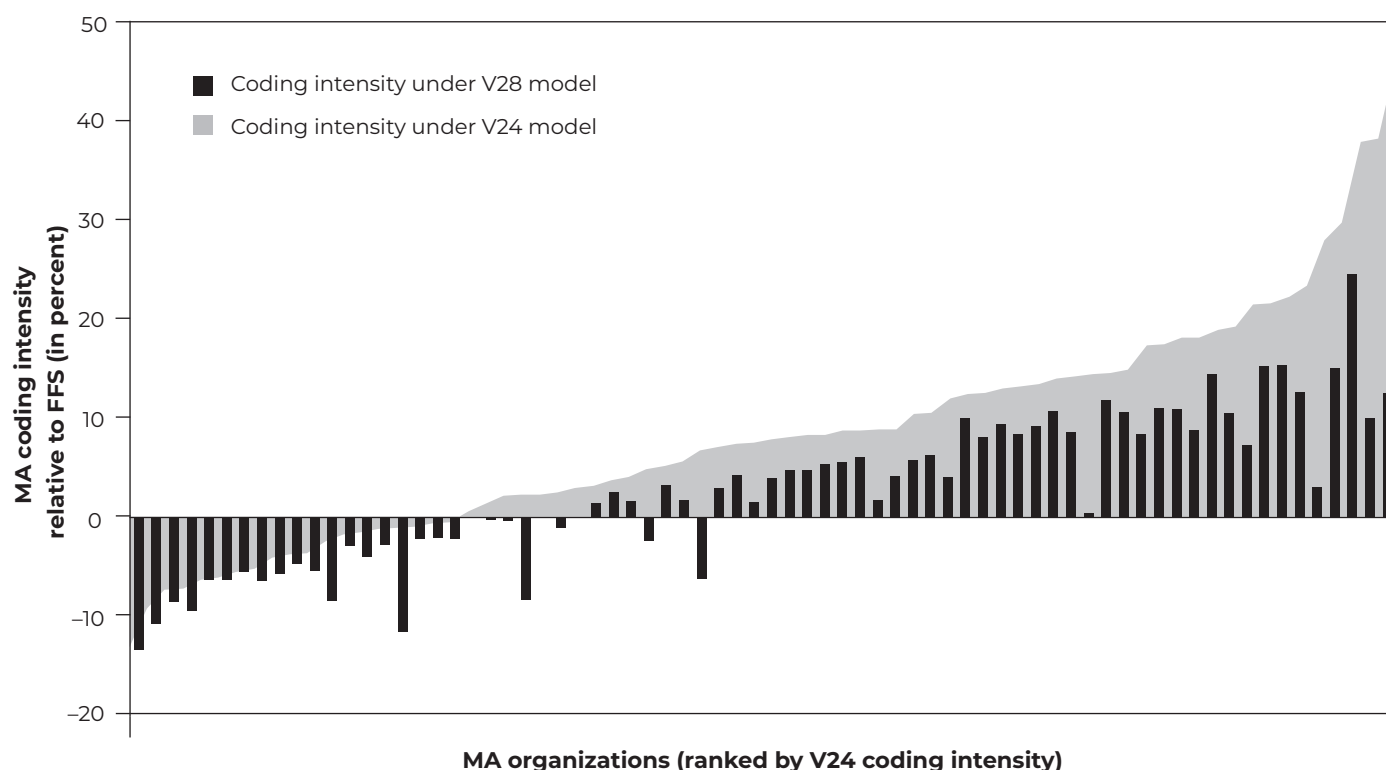
enrollees across physician groups owned by that company and to offer bonuses as an incentive.⁷⁶

Corporate ownership of physician practices by MA organizations or other companies focusing on risk-based payment arrangements with MA organizations can be an effective way to align an MA plan's coding incentives with the providers who have access to patient medical records and are responsible for coding diagnoses. Under many capitated arrangements, a portion of the increase in a plan's revenue from more diagnoses being documented is passed on through the capitated payments to providers (often determined as a percentage of the plan's revenue).

Our prior analysis has found that a disproportionate share of the organizations with the highest levels of diagnostic coding are located in California and Florida (Medicare Payment Advisory Commission 2025b). We also found a higher use of capitated payments to providers among these organizations and suggested that capitated arrangements may have contributed to higher coding-intensity estimates. A new working paper assessed the effect of corporate primary care practices (CPCPs) by tracking risk scores before and

**FIGURE
12-13**

Coding intensity under the V28 risk model was lower than under the V24 risk model, with larger differences among MA organizations with the highest V24 coding intensity, 2024



Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico, enrolled in a chronic-condition special-needs plan, or with end-stage renal disease are excluded from the analysis, as well as organizations with fewer than 25,000 enrollees. MA organizations with 25,000 or more enrollees cover about 97 percent of eligible MA enrollment. This analysis compares coding intensity for V24 and V28 risk scores and does not reflect the blending of the two risk models used for paying MA plans in 2024.

Source: MedPAC analysis of CMS enrollment and risk-score files.

after a physician joins a CPCP, practices that are primarily located in Florida, Texas, and California. The analysis found that the risk scores of MA enrollees increased by 25 percent two years after their PCP joined a CPCP and by 35 percent after five years, with no corresponding increase in utilization nor an increase in risk scores derived from pharmaceutical data (Meyers et al. 2025). We note that the alignment of clinical and financial accountability under the capitated arrangements may provide a number of beneficial incentives to constrain costs, avoid low-value care, and coordinate care.

MA plans' use of health risk assessments to increase diagnostic coding Health risk assessments are provided to all Medicare beneficiaries as part of an annual wellness visit, and, for MA enrollees, health risk assessments are often provided during a plan-initiated home visit.⁷⁷ Health risk assessments may be part of a plan's care-management approach and should continue to be used for that purpose when they are used to improve patient care. However, when health risk assessments identify diagnosis codes that are not documented on subsequent encounters with providers, which would demonstrate that the

condition was not under active management, those codes should not be used for risk adjustment when calculating payments to plans. Health risk assessments sometimes rely on patient self-reporting of medical conditions, which may result in HCCs based on inaccurate diagnoses, diagnoses that are no longer active (and therefore not eligible for risk adjustment), or diagnoses without sufficient evidence to conform to International Classification of Diseases coding guidelines (Department of Justice 2022). (More detailed information can be found in our March 2023 report chapter on Medicare Advantage.)

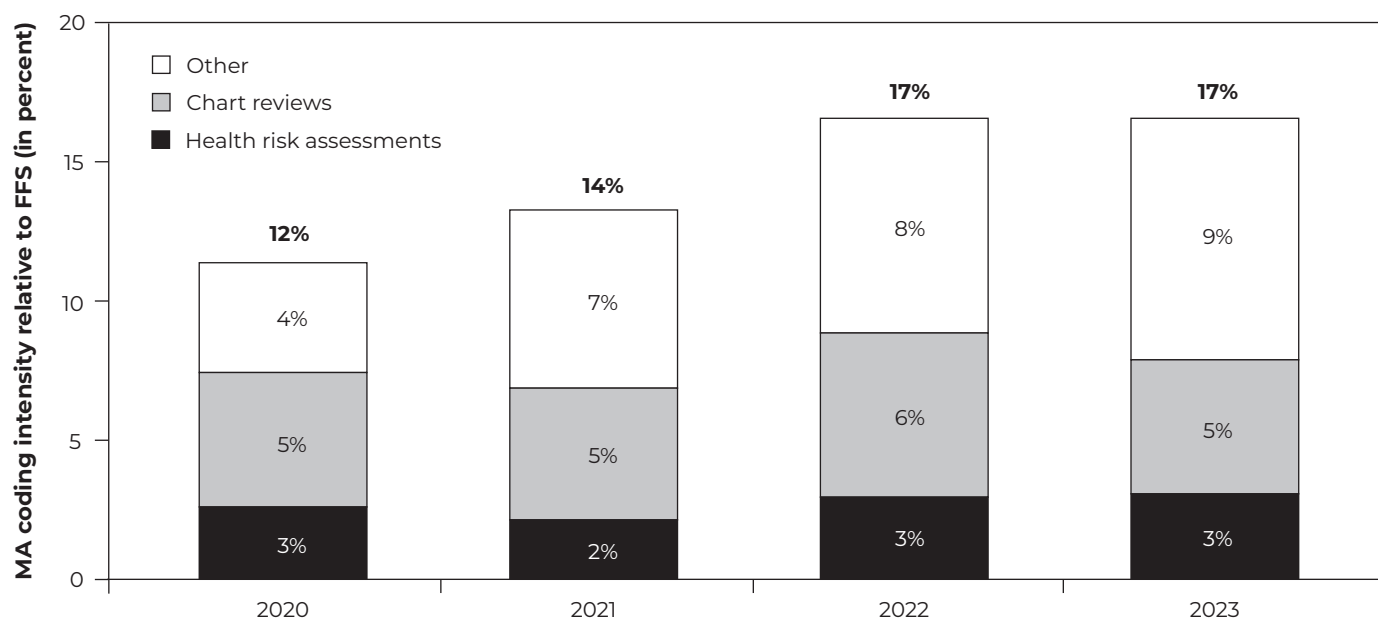
We analyzed 2022 encounter records to identify HCCs that were supported only by a health risk assessment, meaning that there was no physician or hospital service provided to treat a beneficiary for a specific health condition during the same calendar year.⁷⁸ In 2022, about 7.7 million MA enrollees had a health risk assessment that identified at least one HCC and a total of 17.1 million unique HCCs were identified through health risk assessments. Of those, 3.5 million beneficiaries had a health risk assessment that was the only source for at least one of the HCCs identified, and a total of 5.7 million HCCs (one-third of all HCCs identified on health risk assessments) were identified only on a health risk assessment. Six HCCs each generated more than \$900 million in payments from these assessments, accounting for about half of all payments generated by codes found only on health risk assessments.⁷⁹ We found that diagnostic coding that was associated with only health risk assessments accounted for \$15 billion in payments to MA plans in 2023, or a little more than 3 percent of all payments to MA plans. About 80 percent of these payments were from health risk assessments conducted as part of an annual wellness visit or initial preventive physical examination, while the rest of these payments were from in-home health risk assessments. Other researchers found similar estimates of the impact of health risk assessments, contributing about \$12 billion in payments to MA plans in 2020 (James et al. 2024). That research also found differences in the use of health risk assessments across parent organizations.

MA plans' use of chart reviews to increase diagnosis coding Some MA plans devote significant effort to conducting chart reviews to increase MA payments. Because chart reviews are not used in FFS Medicare, all diagnoses newly documented through chart reviews

contribute to differences in FFS and MA diagnostic coding and contribute to increased payments to MA plans. Chart reviews that are allowable for risk adjustment document the diagnoses made during hospital and physician encounters in which medical services were provided. MA plans use chart reviews to identify diagnoses not captured through the usual means of reporting diagnoses (e.g., claims data and encounter data): diagnoses that are not reported on the provider's claim sent to the MA plan, diagnoses made during an encounter in which the MA plan does not submit a record of the encounter to CMS, or diagnoses made during an encounter in which the total number of diagnoses from that encounter exceeds the number of diagnosis fields on the encounter record. Because Medicare requires each HCC to be supported by diagnostic evidence in a patient's medical record (chart), chart reviews are one way for plans to identify diagnoses not captured through provider claims or in plan encounter data.

Like health risk assessments, some MA plans treat chart-review programs as an independent revenue stream that yields a positive return on investment because the additional Medicare payments from newly documented diagnoses far exceed the costs of paying nurses and medical assistants to review medical charts.⁸⁰ Several lawsuits allege that MA plans use chart reviews to identify new diagnosis codes but not to verify the accuracy of already submitted codes. Some lawsuits allege that an MA organization is aware that diagnoses submitted to CMS are not supported by the medical chart and therefore violate Medicare's rules governing the reporting of diagnoses (United States of America ex rel. Benjamin Poehling v. UnitedHealth Group Inc. et al. 2016, United States of America ex rel. James M. Swoben v. Secure Horizons 2017, United States of America v. Anthem Inc. 2020). Some plans and vendors appear to selectively review charts with a higher likelihood of increasing revenue and use artificial intelligence to more accurately identify likely revenue-producing charts (Blue Health Intelligence 2020, Optum 2020). When chart reviews identify diagnoses that are not documented on subsequent encounters with providers, they increase risk scores of MA enrollees and the financial burden of the program for taxpayers and beneficiaries.

We analyzed 2022 encounter records to identify HCCs that were supported by a chart review but not through

**FIGURE
12-14****Chart reviews and health risk assessments accounted for about half of overall MA coding intensity, 2020–2023**

Note: MA (Medicare Advantage), FFS (fee-for-service). Figure shows the impact of coding intensity on payments to MA plans for the years 2020 through 2023. The underlying diagnoses were reported during health care encounters in the previous year, 2019 through 2022, respectively. “Other” sources of coding intensity can result from pay-for-coding programs, patient-assessment forms, transferring coding incentives from plans to providers via subcapitation, and other mechanisms. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS enrollment and risk-score files and the Medicare Trustees’ reports.

any other record of a physician or hospital encounter during the same calendar year. In 2022, about 12.0 million MA enrollees had a chart review that identified at least one HCC, and a total of 33.2 million unique HCCs were identified on chart reviews. Of enrollees with a chart review, 5.8 million beneficiaries had a chart review that was the only source of an HCC, and a total of 9.0 million HCCs (about 27 percent of all HCCs identified on chart reviews) were identified only through a chart review. Eight HCCs each generated more than \$1 billion in Medicare payments from chart reviews, accounting for more than half of all payments generated by codes only found on chart reviews.⁸¹ We found that in 2023, chart reviews alone accounted for about \$24 billion in payments to MA plans, or about 6 percent of all payments to MA plans.

We estimate that chart reviews and health risk assessments together accounted for about \$34 billion in payments to MA plans, or about 8 percent of all payments to MA plans in 2023.⁸² Combined with our finding that all sources of coding intensity resulted in MA risk scores that were about 17 percent higher than risk scores for comparable FFS beneficiaries in 2023, we conclude that health risk assessments and chart reviews together accounted for about half of all MA coding intensity (Figure 12-14). Our estimates are similar to the results of another published analysis in terms of the overall magnitude of the impact and of the trend in the growing impact of health risk assessments and chart reviews on payments to MA plans from 2016 to 2021 (Jacobs 2024).

Update on risk-adjustment data-validation audits

Medicare payments to Medicare Advantage (MA) plans are based, in part, on diagnostic data that plans submit to CMS. Program rules state that, to be used for payment, diagnoses submitted for risk adjustment must result from a hospital inpatient stay, hospital outpatient visit, or face-to-face visit with a physician or other health care professional; diagnoses also must be supported by evidence in the patient's medical record. MA organization leadership signs an attestation stating that the submitted diagnostic data are accurate.

CMS conducts risk-adjustment data-validation (RADV) audits after payments have been made to the plan to check whether plan-submitted diagnoses are supported by the medical record as required by Medicare. If diagnoses do not meet requirements, plans are required to return payments to Medicare. These overpayments for diagnoses that do not meet program requirements are different in concept from payments for higher MA coding intensity. Diagnoses that are documented for MA enrollees that would have not been documented FFS beneficiaries contribute to differences in coding intensity, but those diagnoses may or may not have been documented appropriately in the medical record and therefore may or may not be considered "overpayments" in the RADV audit context. Similarly, diagnoses that are not appropriately supported by the medical record contribute to RADV overpayments, but such diagnoses may have been documented for risk adjustment equally in FFS and MA and therefore do not contribute to differences in coding intensity. However, there is an unknown amount of overlap between overpayments for RADV audits and payments to plans for higher MA coding intensity.

For RADV audits of payment years through 2017, CMS has been using a protocol that audits roughly 5 percent of MA contracts per year; uses a sample of 201 enrollees in each contract across three strata of

beneficiaries with low, medium, and high risk scores; calculates an error rate for the sample population; and then calculates the overpayment amount for the sample of audited beneficiaries. The majority of MA enrollees would be eligible for audit since nearly 70 percent of MA enrollees had at least one hierarchical condition category (HCC) in 2022, and only a small fraction of these enrollees would be excluded from the audit sample for other reasons.⁸³ RADV audits of MA contracts during this period have been limited, and their results are largely unreported. Audits of 2007 risk-adjustment data identified diagnoses that did not meet risk-adjustment criteria and determined that average overpayment rates were well over 10 percent for most contracts under audit (Schulte 2016). CMS recovered \$13.7 million in overpayments from audits of 37 contracts, based on overpayments for only the 7,437 beneficiaries included in the audit sample (Centers for Medicare & Medicaid Services 2017a). No audits were conducted for payment years 2008, 2009, or 2010. Kaiser Health News obtained, through a Freedom of Information Act request, summaries of the preliminary results for 90 audits completed during 2011, 2012, and 2013 and found that 71 audits uncovered net overpayments, with 23 audits finding overpayments of \$1,000 or more per beneficiary (Schulte and Hacker 2022).

For audits of 2018 and subsequent years, the scope of RADV audits has changed in significant ways and is under review in the legal system.

- First, in the final rule published February 1, 2023, CMS outlined an audit method that would allow CMS to recover overpayments by extrapolating the error rate of the sampled enrollees to a larger population of audit-eligible enrollees in the contract (Centers for Medicare & Medicaid Services 2023c). The final rule also eliminated the use of extrapolation for RADV audits of 2017 and earlier, thereby limiting overpayment recovery to the audit sample only.

(continued next page)

Update on risk-adjustment data-validation audits

- In 2024 and 2025, CMS released audit methods (and updates to those methods) for payment years 2018 and 2019 that restrict the audit-eligible population to a much narrower set of enrollees in a given contract compared with audit-eligible populations for audits of 2017 and earlier. Audits of 2018 data will focus on only two sets of beneficiaries, or two “sampling frames”: beneficiaries in the top decile of a contract’s enrollees based on the greatest expected reduction in their risk score as a result of a RADV audit (the expected reduction in risk score due to an audit is based on a CMS improper-payment prediction model) or contract enrollees who had all of their HCCs supported only by chart reviews (Centers for Medicare & Medicaid Services 2024d). The first sampling frame includes roughly one-tenth of the beneficiaries who would have been audit eligible under the pre-2018 methods. For the second sampling frame, we estimate that between 2 percent and 3 percent of all MA enrollees (or between 3 percent and 4 percent of MA enrollees with at least one HCC) had all of their HCCs supported by only chart reviews, and those enrollees had an average of 1.5 HCCs. Audits for 2019 will focus only on the first sampling frame, beneficiaries in the top decile of a contract’s enrollees based on the greatest expected reduction in the risk score as a result of a RADV audit (Centers for Medicare & Medicaid Services 2025j).
- In May 2025, CMS issued a press release stating that the agency will conduct RADV audits of all contracts and will expand the size of the audit sample for each contract (Centers for Medicare & Medicaid Services 2025b). At the time of the press release, the agency had already identified 58 contracts under audit for 2018 (Centers for Medicare & Medicaid Services 2025h). For 2019, the agency identified 355 contracts for RADV audits, which appears to align with the May 2025 press release of auditing all contracts with a sufficient audit sample (Centers for Medicare & Medicaid Services 2025i). In the press release, the agency also announced additional resources to facilitate the expansion in audit scope, including additional medical coding staff and the use of enhanced technology.
- In the final rule establishing regulations for RADV audits, CMS took the position that the agency would not use a “FFS adjuster” when calculating overpayment amounts in the audits (Centers for Medicare & Medicaid Services 2023c, Centers for Medicare & Medicaid Services 2018a). A FFS adjuster was announced in a 2012 RADV audit methods document as an offset to account for the difference in documentation standards for FFS claims used to develop the risk model (Centers for Medicare & Medicaid Services 2012).
- After publication of the final rule, Humana sued, claiming that CMS violated the Administrative Procedure Act because of the changing justification between the proposed and final rules regarding the FFS adjuster. In September 2025, the court vacated the final rule on the grounds that CMS violated the Administrative Procedure Act generally because the proposed rule justification that FFS adjusters introduce inequities does not appear in the final rule and could not have been a contributing factor for the new justification and that there was no meaningful dialogue in the final rule regarding the costs and benefits of the policy changes after MA organizations had relied on a previous rule’s guidance from 2018 to 2023 (U.S. District Court for the Northern District of Texas 2025). CMS has not yet issued a new proposed rule to correct any Administrative Procedure Act deficits for this policy and has filed a notice of appeal of the judgment. Under the current circumstances, the scope of overpayment recovery from RADV audits under the final rule remains uncertain. ■

The Commission's 2016 recommendation on coding intensity

In our March 2016 report to the Congress, the Commission recommended a multipronged approach that would fully account for the impact of coding differences, improve the equity of the adjustment across MA contracts, and increase incentives to reduce costs and improve quality (Medicare Payment Advisory Commission 2016c). The Commission's approach to reduce MA coding intensity has been to address the mechanisms that generate coding differences first (e.g., remove health risk assessments and reduce year-to-year coding variations by using two years of diagnostic data) and then address remaining differences with either an across-the-board or tiered adjustment. The Commission's 2016 recommendation did not address the use of chart reviews because data were not available at that time, but eliminating chart reviews as a source of diagnoses for risk adjustment is consistent with the Commission's approach.⁸⁴

The recommendation, which would replace the existing mandatory minimum coding-intensity adjustment (which has reduced MA risk scores by 5.9 percent since 2018), has three parts:

- develop a risk-adjustment model that uses two years of FFS and MA diagnostic data,
- exclude diagnoses that are documented only on health risk assessments from either FFS or MA, and then
- apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.

Implementing the first two policies—using two years of diagnostic data and excluding diagnoses documented through health risk assessments alone—and excluding chart-review data from risk adjustment (consistent with the Commission's approach) would result in a more equitable, targeted adjustment to MA contracts than the current across-the-board adjustment. As noted earlier, health risk assessments and chart reviews alone account for roughly half of estimated MA coding intensity. The Commission carefully considered options for addressing coding intensity and supports this approach because it balances implementation feasibility, administrative burden, and effectiveness.

Part of the cause of coding intensity is that providers do not report all possible diagnosis codes for their FFS beneficiaries. We note that using two years of diagnostic data would help address the underreporting of FFS beneficiaries' chronic conditions by helping to capture conditions that are not reported consistently year to year.

Adjusting for any remaining coding-intensity differences could also improve equity across MA contracts. Under one illustrative approach, contracts would be grouped into tiers of high, medium, and low coding intensity, and a coding-intensity adjustment would be applied based on each tier's average level of coding intensity (Medicare Payment Advisory Commission 2016a). CMS has used a similar approach to select MA contracts for RADV audits.⁸⁵ This policy would improve the overall equity of the coding-intensity adjustment relative to the single, across-the-board adjustment used today.

Industry concentration and integration

Each year, we assess the structure of the MA market, including trends in the concentration of enrollment and the integration of MA organizations with other entities in the health care sector.⁸⁶ In 2025, the MA program included 5,492 plan options offered by 164 organizations. As noted above, on average in 2026, beneficiaries have 39 plan options to choose from, offered by eight organizations. However, enrollment is highly concentrated at the local level: The largest organization in a county typically enrolls between 40 percent and 50 percent of the market. Enrollment is also increasingly concentrated at the national level; just three organizations enrolled more than half of all MA enrollees nationally in 2025. Additionally, MA organizations are increasingly integrating vertically, with provider and insurer lines of business having common ownership (or other financially aligned arrangements). Vertical integration is greatest among provider-owned MA plans—typically offered by large health systems—though insurer ownership of providers has increased significantly in recent years.

MA market was heavily concentrated locally and nationally in 2025

Enrollment in MA is highly concentrated at the local level and increasingly concentrated at the national

level. High enrollment concentration—particularly at the local level—can be a cause for concern if it dampens the competitive pressures that might otherwise drive insurers to maintain or improve quality, make care delivery more efficient, lower premiums, or provide supplemental benefits. Researchers have shown that markets with less concentration are associated with increased MA benefit generosity and lower MA premiums (Cabral et al. 2018, Pelech 2018, Pizer and Frakt 2002, Song et al. 2013). In extreme cases, dominance by a single firm (or small set of firms) may make it difficult for competitors to enter or remain active in a market (Frakt et al. 2012, Pelech 2017).⁸⁷

Over the last decade, enrollment in MA has become increasingly concentrated at the national level in plans owned by a small set of large insurers that serve a majority of markets in the country. Between 2008 and 2025, the share of total MA enrollment in the three largest firms (UnitedHealth Group, Humana, and CVS Health) rose from 32 percent to 58 percent. Much of the growth of these firms—particularly UnitedHealth Group and Humana—has been driven by enrollment increases in counties in which the insurers have offered plans for many years (Hnath et al. 2024). However, all three have also significantly expanded the number of counties in which they offer plans. For example, UnitedHealth Group expanded from offering coordinated-care plans (i.e., HMO or PPO plans) in 41 percent of counties (a service area covering 68 percent of MA-eligible beneficiaries) in 2013, to 54 percent of counties (covering 81 percent of eligible enrollees) in 2020, to 88 percent of counties (covering 96 percent of eligible enrollees) in 2025 (Table 12-9, p. 406).⁸⁸ Humana and CVS Health have also expanded their service areas, and all three organizations now offer plans in counties that are home to more than 85 percent of MA-eligible beneficiaries. A recent study found that some of the service-area expansions for these three insurers were due to the companies acquiring existing MA contracts from another insurer (Hnath et al. 2024).⁸⁹ For example, acquisitions accounted for 30 percent of new county participation for UnitedHealth Group between 2012 and 2023 (acquisitions accounted for 16 percent and 5 percent of new county participation for CVS Health and Humana, respectively) (Hnath et al. 2024). However, the study found that nationally, for all MA insurers, only 15 percent of total market-entry events were attributable to acquisitions. These findings suggest that the service-area expansions of large national insurers have (at the

time of market entry) generally served to introduce new competitors into local markets and are not simply an artifact of changes in ownership of existing competitors.

Between 2024 and 2025, the share of enrollees covered by these top three organizations fell by 1 percentage point to 58 percent (but remained 2 percentage points higher than in 2021) (Table 12-9, p. 406).⁹⁰ Among conventional plans (i.e., plans available to all Medicare beneficiaries, excluding SNPs and employer group plans), the top three organizations nationwide had 54 percent of enrollment in 2025—a decrease from 57 percent in 2024.⁹¹

Given the relevance of local competition for MA enrollees, we place greater importance on examining competition at the county level (Table 12-9, p. 406). Measures of local-market concentration suggest that concentration remained near 2024 levels in 2025. Excluding employer plans and SNPs, in 2025, enrollment in the largest organization in each county (regardless of the insurers' national enrollment) accounted for 43 percent, on average, of all MA enrollment in the county. Enrollment in the top-three organizations in each county accounted for 82 percent, on average, of all MA enrollment (unchanged from 2021 but slightly higher than the 81 percent observed in 2024). The share of MA enrollees living in counties with highly concentrated markets (as measured using the Herfindahl–Hirschman Index (HHI), a common measure of market concentration) remained stable at 95 percent (data not shown).⁹² The geographic expansion of large national insurers has contributed to the changing concentration in local markets.

Overall, local MA markets tend to be highly concentrated, although the level of concentration has trended downward in recent years. When measured using the HHI, average county-level enrollment concentration has fallen over the last decade, despite the rising share of enrollees covered by the three largest firms nationally. This trend coincides with insurers entering new markets and steadily gaining market share in areas that have historically been very concentrated. Estimates for 2026 indicate that the average beneficiary will have access to many MA plans offered by a substantial number of organizations, as illustrated earlier in this chapter. However, large national insurers, and some regional

**TABLE
12-9****Medicare Advantage enrollment is highly concentrated
at the local and national levels, July 2021–July 2025**

Plan type	Share of MA-eligible beneficiaries living in counties in which insurer offers an MA plan*			Percentage point change in share	
	2021	2024	2025	2021–2025	2024–2025
Conventional plans					
Top 3 nationwide					
UnitedHealth Group Inc.	86%	95%	96%	+10	+1
Humana Inc.	88	93	93	+5	0
CVS Health Corporation	81	88	87	+6	–1
	Share of enrollment			Percentage point change in share	
	2021	2024	2025	2021–2025	2024–2025
All MA plans					
Top 3 nationwide					
UnitedHealth Group Inc.	27	28	29	+2	+1
Humana Inc.	18	18	17	–1	–1
CVS Health Corporation	11	13	12	+1	–1
Conventional plans					
Top 3 nationwide					
UnitedHealth Group Inc.	24	25	24	0	–1
Humana Inc.	21	22	20	–1	–2
CVS Health Corporation	9	9	11	+2	+2
County level (weighted average)**					
Top organization	44	42	43	–1	+1
Top 2 organizations	68	66	67	–1	+1
Top 3 organizations	82	81	82	0	+1

Note: MA (Medicare Advantage). Includes only MA plans (coordinated-care plans, private-fee-for-service plans, and Medicare Medical Savings Account plans). Excluded are cost-reimbursed plans and Medicare–Medicaid demonstration plans. “Conventional plans” excludes special-needs plans and employer group plans, which have restricted availability. Components may not sum to totals, differences, and market shares due to rounding.

* Counties in Connecticut are excluded due to changes over time in how the state’s counties are tabulated.

** County-level shares of MA enrollment reflect the beneficiary-weighted average of the top organizations in each county.

Source: MedPAC analysis of July 2021–2025 enrollment data and CMS landscape files.

or local insurers, frequently enroll a large fraction of MA enrollees in an area. Such concentration may dampen competition, a topic the Commission will continue to explore and monitor.

Vertical integration of MA plans and providers

MA organizations are increasingly integrating vertically, with provider and insurer lines of business having common ownership (or other financially

aligned arrangements). Some have hypothesized that MA organizations may view vertical integration as a means of more directly promoting care that is more efficient, higher quality, and more clinically integrated. Although several features of MA payment may reward firms that vertically integrate insurer and provider businesses, incentives for integration are not confined to Medicare and are influenced by trends in other sectors of the health care system, as well as by the actions of regulatory agencies—particularly the Department of Justice and Federal Trade Commission. In this section, we assess integration as it pertains to MA and discuss elements of MA payment policy that may incentivize integration.

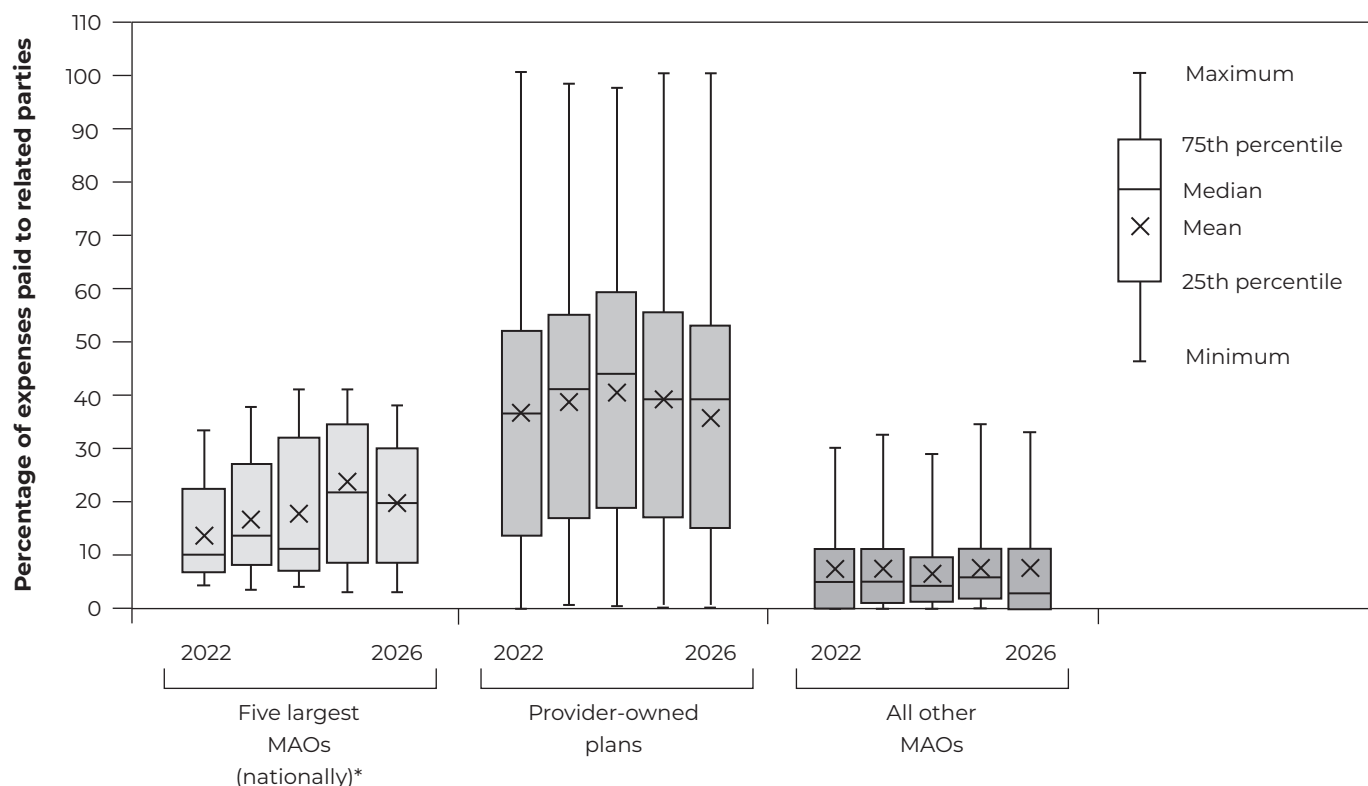
The Commission has previously found that vertical integration is highest in organizations in which a provider-based organization owns and operates a health plan, although the share of enrollees in such vertically integrated plans has decreased over time (Chartis Group 2024, Johnson et al. 2017, Medicare Payment Advisory Commission 2024c). However, insurer-led integration has accelerated in recent years, and several of the largest MA organizations (MAOs) have invested significantly in the acquisition of provider businesses, suggesting that insurers see advantages to owning a greater share of the health care delivery system (CVS Health 2023, Humana 2022, Humana 2021, Humana 2020, Signify Health 2023, UnitedHealth Group 2023, UnitedHealth Group 2022).

MA payment policy, though not the only factor influencing firms' decisions to integrate, may promote such arrangements by incentivizing efficient care delivery, rewarding plans that record diagnoses more thoroughly, and providing bonuses to plans that perform well on quality measures (Medicare Payment Advisory Commission 2024c). Although the evidence regarding the relationship between plan-provider integration and efficiency, coding intensity, and quality is limited, MAOs may view integration as a way to influence providers' activities more directly to achieve the outcomes incentivized under MA's capitated payment structure. For example, as described in the section on coding intensity (p. 398), a recent working paper that assessed the effect of corporate ownership of primary care practices on MA risk scores found that—for some insurer-provider combinations—the risk scores of MA enrollees increased substantially in the years after their PCP joined or was acquired by the vertically integrated

corporate entity (Meyers et al. 2025). Researchers have also suggested that payments to plan-owned providers may offer an opportunity for MAOs to retain a higher share of profits within the parent organization while meeting MLR requirements (Frank and Milhaupt 2023, Frank and Milhaupt 2022). Empirical evidence on this effect is limited; one recent analysis of a small nonrepresentative sample of practices found that UnitedHealthcare's payments to providers owned by Optum (which is owned by the same parent company, UnitedHealth Group) were higher than prices paid to non-Optum providers (Arnold and Fulton 2025). A different analysis, using data on prices paid in the commercial sector, also found that corporate-owned primary-care practices were paid higher rates than independent practices (Wang et al. 2025). While these findings provide some information, additional research is needed to better understand if or how vertical integration of insurers and providers affects the prices insurers pay for services.

No public data provide a systematic accounting of ownership relationships between MA plans and health care providers, which poses a significant barrier to studying the effects of vertical integration. Some researchers have endeavored to create their own datasets, focusing on particular types of providers. For example, a recent paper used information from corporate financial filings, merger and acquisition databases, and insurer directories to identify medical groups operated by large MA insurers; the study estimated that the insurer-owned share of the primary care market (measured by volume) grew from less than 1 percent in 2016 to over 4 percent in 2023 (Adler et al. 2025). The study found that Optum, owned by UnitedHealth Group, was the largest of the entities—accounting for more than 2 percent of the market nationally but more than 35 percent in some counties.

CMS requires MAOs to submit limited information about the extent of their financial relationships with providers and other entities as part of the bidding process. Specifically, plans submitting bids are required to report the amount (including medical costs and nonbenefit expenses) per member per month that they expect their members to receive from a related party.⁹³ While the submitted data are projections and not a report of actual utilization in a completed year, they provide insight as to the MAO's own assessment of its integration with providers (or other entities)

**FIGURE
12-15****Vertical integration is increasing and is highest in plans owned by provider organizations**

Note: MAO (Medicare Advantage organization). Excluded are cost-reimbursed plans, Medicare–Medicaid demonstration plans, and employer group plans.

* The five largest non-provider-owned plans are UnitedHealth Group, Humana, CVS Health, Elevance Health, and Centene. Kaiser Foundation Health Plan enrolls more beneficiaries than Centene but is categorized as a provider-owned plan in the figure. “Maximum” and “minimum” are the values for the category when outliers are excluded.

Source: MedPAC analysis of data from CMS on plan bids, MMIT Directory of Health Plans, and the Agency for Healthcare Research and Quality Compendium of U.S. Health Systems.

that deliver services covered by the plan. Such entities include providers of medical benefits (e.g., doctors and hospitals) as well as entities that provide or administer supplemental benefits. The Commission has previously found that MAOs often administer supplemental benefits through vertically integrated arrangements (Medicare Payment Advisory Commission 2025a). For example, the parent organizations of some MAOs own or operate businesses that administer OTC cards and flex cards that are often used to provide MA supplemental benefits (OTC Health Solutions 2025, Solutran 2025).

Figure 12-15 illustrates that the degree of vertical integration in MA varies widely across parent organizations and is highest in provider-owned plans. Among these plans, the share is highest in plans owned by health systems (data not shown). The data show that large national insurers, on average, remain significantly less vertically integrated than their provider-owned competitors. However, at least one large national insurer is now significantly more vertically integrated than many provider-owned plans. This finding is particularly noteworthy given that large national organizations insure a significant share of MA

enrollees nationwide, so trends in the organization of the businesses can affect millions of beneficiaries. While the information presented here is reported at the parent-organization level, health care markets operate primarily at a local level, and national statistics do not necessarily describe the markets in which most beneficiaries live.

Altogether, we find that the MA industry has become more vertically integrated over the last five years. The Commission plans to continue monitoring trends in integration in MA and evaluating its effects on enrollees and the function of the program.

Quality in MA

The Commission has long held that MA presents opportunities for innovation to achieve higher-quality care at lower cost. But the current system for MA quality reporting and measurement is flawed and does not provide a reliable basis for evaluating quality across MA plans (Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2019). It is important for the Medicare program to monitor MA plan performance and promote higher quality (1) to ensure that beneficiaries have access to high-quality health care and (2) to provide good information for beneficiaries about the quality of and access to care provided by MA plans in their local market. While the Commission has determined that current metrics do not adequately reflect the quality of care that MA enrollees receive, they are the basis for the MA quality-bonus program (QBP), which is expected to increase MA payments by about \$16 billion in 2026.

Quality-bonus program and star-rating system provide limited insight into MA quality

Quality measurement and rewards can promote better plan quality and support beneficiary choice of plans. The MA star-rating system, implemented in 2006, is composed of measures tied to clinical quality, administrative capability, and patient experience.⁹⁴ These ratings are made available through the Medicare Plan Finder website to enable beneficiaries to compare plans. As required by the ACA, since 2012 the MA star-rating system has been the basis of the QBP, which increases benchmarks for MA contracts that are rated

4 stars or higher.⁹⁵ The star rating also contributes to the level of rebate payments. Plans with higher star ratings retain a higher share of the difference between a plan bid and the benchmark when bids are below the benchmark. Beneficiaries enrolled in an MA plan with less than 5 stars can use a once-a-year special enrollment period to switch to a 5-star plan outside of the open enrollment period.

The share of MA contracts receiving quality bonuses has been declining in recent years but remains consistently high. Forty percent of rated MA contracts are in bonus status for 2026, a decrease from 41 percent in 2025 and 44 percent in 2024 (Centers for Medicare & Medicaid Services 2024a). Sixty-four percent of MA enrollees are projected to be enrolled in bonus-status contracts in 2026, compared with 64 percent in 2025 and 76 percent in 2024. The average star rating was 3.98 in 2026, a slight increase from 3.95 in 2025.

The Commission has discussed several flaws of the current approach to quality assessment in previous reports (Medicare Payment Advisory Commission 2024b, Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2020b, Medicare Payment Advisory Commission 2016b). In brief, the Commission has identified issues with:

- *The measure set used to assess quality.* An excessive number of measures are assessed, and many administrative and process measures are not reflective of the quality of care and/or experience that plan enrollees can expect to receive. Medicare currently collects close to 100 MA quality measures, over 40 of which are used to determine a star rating from 1 to 5 for each MA contract.^{96,97}
- *Reliance on MA contract-level reporting.* Measures are currently reported at the contract, rather than plan, level. Many contracts cover plans operating in wide geographic areas, some of which are not contiguous, resulting in scores that do not necessarily reflect performance in a local area. The ability of MAOs to consolidate plans into a single contract also presents an opportunity to increase the odds of achieving bonus status without meaningfully improving quality.
- *Methods for comparing performance across plans/contracts.* The way that performance is compared for purposes of the QBP can mask some true

differences in quality and amplify minor differences in other areas. For instance, contracts can aggregate plans that differ on features that are associated with quality. They may include plans across wide and noncontiguous geographic areas or bundle SNPs with conventional HMOs. On the other hand, the thresholds for scoring introduce discontinuities or “cliff effects” that may result in different rewards for contracts with relatively similar performance and may also reduce the incentive to improve for contracts that are far away from a “cliff.”

- *Funding with additional program dollars.* Unlike quality incentive programs in FFS Medicare, which are either budget neutral (balancing penalties and rewards) or penalty only, the QBP is a reward-only incentive program that is projected to increase program spending by \$16 billion in 2026. The absence of penalties for poor performance may also dilute incentives for MA organizations to focus efforts on quality improvement, contradicting the program’s aims.

The inability of the MA-QBP to meaningfully characterize the quality of care that MA enrollees receive makes it difficult for beneficiaries to make informed choices and for policymakers to assess the value that private plans bring to the Medicare program. In our June 2020 report to the Congress, the Commission recommended replacing the QBP with a value-incentive program that addresses the flaws of the QBP. First, focusing on a small set of population-based outcome and patient/enrollee-experience measures would facilitate comparisons across MA plans, enabling beneficiaries to choose based on factors that are most meaningful to their experience. A continuous scale of performance, rather than one with cliff effects, would provide MA plans with the incentive to improve quality at every level. Performance evaluation at the local-market level, rather than the contract level as is currently done, would similarly improve the information that beneficiaries can use for decision-making and the incentives for MA plans to improve quality in every geographic area.

The Commission also recommended that the value-incentive program address the variation in the demographics of MA enrollees across plans. By accounting for differences in enrollees’ social risk

factors by stratifying plan enrollment into groups of beneficiaries with similar social risk profiles, plans with higher shares of these enrollees would not be disadvantaged in their ability to receive quality-based payments, while actual differences in the quality of care would not be masked. Finally, the Commission contends that MA quality-bonus payments should not be financed with additional program dollars, especially given that, in aggregate, Medicare pays MA plans more than would have been spent on FFS for the same beneficiaries. Application of budget-neutral financing would ensure that the MA quality system is more consistent with Medicare’s FFS quality-payment programs, which are either budget neutral or produce program savings (Medicare Payment Advisory Commission 2020a).

MA patient experience

Good information on the quality and experience of care that MA enrollees receive—and how they compare with FFS Medicare—is necessary for beneficiaries and policymakers to properly evaluate program and plan options. However, several data and methodological challenges affect the ability to compare performance across MA plans and between MA plans and FFS Medicare. The Commission has discussed its concerns with these limitations in previous reports (Medicare Payment Advisory Commission 2024c, Medicare Payment Advisory Commission 2023c, Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2020b, Medicare Payment Advisory Commission 2016b). Despite these challenges, the Commission has expressed a strong interest in assessing the quality of care that all Medicare beneficiaries receive. To that end, we include a summary of MA Consumer Assessment of Health Providers and Systems (CAHPS) survey scores, a standardized and validated measure of patient experience collected by the Agency for Healthcare Research and Quality.⁹⁸ The CAHPS survey represents only one indicator of the quality of care that MA enrollees receive, but it is subject to fewer methodological limitations than other metrics that are currently used in the star-rating system. On the other hand, contract-level reporting means that responses may not reflect the experience of enrollees in a particular geographic area.

Patient-experience measures are an important indicator of quality of care because they assess,

**TABLE
12-10**

Medicare Advantage CAHPS performance scores, 2018–2024

CAHPS composite measure	2018	2020	2021	2022	2023	2024	Score change, 2023–2024
Getting needed care and seeing specialists	84	83	82	81	81	82	1
Getting appointments and care quickly	78	79	78	77	83	84	1*
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical record, helps with managing care)	86	86	86	85	86	87	1
Customer service	90	91	90	90	90	90	0
Rating of health plan	87	88	88	88	88	87	–1
Rating of health care quality	87	87	87	86	87	87	0
Annual flu vaccine	75	76	75	74	71	69	–2

Note: CAHPS (Consumer Assessment of Healthcare Providers and Systems), CAHPS responses are case-mix adjusted for the predictable effects of the response tendencies of the people who complete them (e.g., age, sex, health status). The first four measures are composite measures of multiple survey questions that have responses of “never,” “sometimes,” “usually,” and “always.” CMS converts these to a linear mean score on a 0 to 100 scale. The fifth and sixth measures are global rating measures in which survey questions have responses of 1 to 10, which CMS also converts to a linear mean score on a 0 to 100 scale. The annual flu vaccine measure has a yes/no response. Years represent the experience of care during the last six months from the survey. For example, 2024 scores are based on beneficiaries’ self-reported experience in the last six months from surveys collected in the spring of 2025. The 2019 CAHPS surveys were halted due to the coronavirus pandemic. We report values for 2018 to include a prepandemic comparison year.

* CMS revised which CAHPS survey items are scored in the “getting appointments and care quickly” composite measure in 2023. We caution against comparing 2023 and 2024 scores with prior years.

Source: MA–CAHPS national mean scores published by CMS, 2024.

from the patient’s perspective, whether something that should have happened (such as getting needed care quickly) did and how often it occurred, across a population. When patients have a better experience, they are more likely to adhere to treatments, return for follow-up appointments, and engage with the health care system by seeking appropriate care (Doyle et al. 2013, Navarro et al. 2021). MAOs are required to contract with a third-party survey vendor to collect CAHPS survey responses from a random sample of each MA contract’s enrollees.⁹⁹ To calculate national scores, MA–CAHPS measures are case-mix adjusted for beneficiary characteristics and weighted at the contract level.¹⁰⁰ Table 12-10 presents CAHPS measure scores for the five most recent years available, 2020 to 2024, along with 2018 as a prepandemic comparison.¹⁰¹

MA enrollees generally rated their coverage and experience favorably in 2024, and results have been

relatively stable over time.¹⁰² Scores for “getting appointments and care quickly” have increased in 2023 and 2024 compared with previous years, but this finding is in part attributable to changes in how CMS defined the measure in 2023 (Centers for Medicare & Medicaid Services 2025e). The share of respondents receiving an annual flu vaccine has declined each year from a high of 76 percent in 2020 to 69 percent in 2024; a similar decline is observed in FFS Medicare (see Chapter 4 for a discussion of FFS–CAHPS results). On the other hand, ratings of customer service, plan quality, and care quality in MA remain consistently high.

These relatively high and consistent scores align with our focus-group findings that beneficiaries are generally satisfied with their plans and do not report widespread challenges with access to care. However, we recognize that this aggregate picture is not inconsistent with individual beneficiaries experiencing issues with access or quality of care in particular

circumstances. CAHPS surveys target a random sample of all enrollees, not just those who have sought care during the survey period. Also, certain subsets of enrollees, such as those residing in institutional settings, are excluded from participation. Further, CAHPS survey items focus on breadth of access to care, not the specifics of cases in which problems have been experienced. While the Commission has expressed concern that the small share of beneficiaries with the greatest health needs may disproportionately experience access problems, the CAHPS survey is not designed to capture the depth of those problems. For this reason, the Commission aims to contextualize the results of these broad, population-level surveys with other potential indicators of access and quality in MA.

Medicare payment and MA plan costs for enrollees with ESRD

Although individuals with ESRD have been entitled to Medicare Part A and Part B benefits since 1972, they were mostly prohibited from joining MA plans until 2021, when the 21st Century Cures Act of 2016 allowed all beneficiaries with ESRD to sign up for MA plans.¹⁰³ Within four years of the statutory change, MA enrollment among beneficiaries with ESRD increased from 27 percent in December 2020 to 55 percent by December 2024. The increase in MA enrollment by beneficiaries on dialysis is likely linked to the same factors that have increased MA's popularity among beneficiaries without ESRD, including cost-sharing reductions, non-Medicare benefits, and a cap on OOP expenses at little or no additional premium. The cap on OOP expenses, in particular, is likely to be a valuable benefit for enrollees with ESRD who, compared with other Medicare beneficiaries without ESRD, have higher health care utilization and spending (Powers et al. 2019). Average FFS Medicare expenditures for beneficiaries with ESRD were \$84,479 in 2022, compared with \$14,044 per person per year for beneficiaries without ESRD (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2025). Cost-sharing burdens are consequently higher for beneficiaries with ESRD, particularly those without supplemental cost-sharing coverage through Medicaid, an employer-sponsored plan, or a Medigap plan.¹⁰⁴

In our March 2021 report to the Congress, we assessed MA plan costs and revenues for individuals with ESRD, MA enrollment trends by coinsurance amounts, and plan prices for dialysis. For this report, we have updated these analyses using the most recent available data. Our analysis finds that, since the 2021 statutory change, 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 for ESRD enrollees rose faster than costs. In 2023, Medicare payments to plans were about 7 percent higher than average medical costs plus an estimate of inflation-adjusted administrative expenses for enrollees with ESRD (total cost-to-revenue ratio of 0.930). (MA plans also incur additional costs for providing supplemental benefits to their enrollees with ESRD.) 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 D-SNPs are responsible for a 20 percent coinsurance for dialysis. Last, most MA plans continue to pay more than FFS rates for dialysis services, but those prices have decreased over time. In 2022, the average MA plan price for dialysis was 22 percent higher than the FFS Medicare rate, down from 28 percent higher in 2020. The relative decline in prices paid by MA plans may reflect a change in the balance of negotiating leverage between MA plans and dialysis providers over time, as a result of the increasing MA enrollment by beneficiaries with ESRD and removal of network-adequacy requirements for outpatient dialysis facilities.

Medicare's payments to MA plans for enrollees with ESRD on dialysis grew faster than plans' reported costs

For enrollees with ESRD on dialysis, a base rate is established for each state—called the “ESRD state rate”—and is equal to the average FFS spending for beneficiaries with ESRD in that state, standardized to the national average spending for FFS beneficiaries with ESRD. Medicare payments to MA plans for an enrollee with ESRD on dialysis are based on the ESRD state rate where the enrollee resides, adjusted by the enrollee's ESRD risk score.¹⁰⁵ The ESRD risk model is based on FFS beneficiaries with ESRD.

Because plans submit bids only for enrollees without ESRD (ESRD state rates are calculated entirely by CMS),

a plan's total rebate amount is based only on enrollees without ESRD. However, all MA plan enrollees are entitled to receive the same benefit package, including receipt of supplemental benefits or requirement to pay a plan premium. CMS offers plans the option to reconcile financing for enrollees with ESRD with the plan's rebate using the "ESRD subsidy" (Centers for Medicare & Medicaid Services 2025c). For plans with ESRD payments that do not cover their projected medical, administrative, and supplemental benefits costs for enrollees with ESRD, the ESRD subsidy allows plans to allocate a portion of their rebate funding to cover the gap between ESRD payments and costs (including plan costs for providing supplemental benefits to enrollees with ESRD), thereby reducing the level of rebates available to fund supplemental benefits for all enrollees. Conversely, for plans with ESRD payments that are greater than plan ESRD costs, the ESRD subsidy allows plans to add net ESRD revenues to their rebate funding and increase the level of supplemental benefits for all enrollees.

Using the same methodology as in our March 2021 report to the Congress, we analyzed bid pricing tool (BPT) data for plan years 2020 through 2025 to assess whether Medicare payments to MA plans for enrollees with ESRD covered plans' reported medical costs for those enrollees.^{106,107} BPT data include information on total revenue, net medical expenses, and the share of member months applicable, separately, to enrollees with and without ESRD. Medical expenses include costs for Medicare-covered services and Part A and Part B mandatory supplemental benefits, but they do not include expenses for optional supplemental benefits. Plans do not report administrative and profit costs separately for enrollees with ESRD in the BPT data, and therefore we are unable to include those costs in our estimate of average medical costs for enrollees with ESRD, unless noted otherwise.

In 2018, MA plans' revenues were, on average, about equal to their medical costs for enrollees with ESRD. Average medical costs for enrollees with ESRD were \$6,752 PMPM, slightly below the average plan revenue of \$6,769 PMPM—a medical cost-to-revenue ratio of 0.997. That suggests that plans, after accounting for costs of administration, likely lost money on ESRD enrollees. However, by 2023, Medicare payments were much higher relative to plans' costs for enrollees with ESRD: Average medical costs rose 8.0 percent while

plan revenues climbed 22.4 percent (\$7,291 PMPM and \$8,287 PMPM, respectively—a medical cost-to-revenue ratio of 0.880) (Figure 12-16, p. 414).

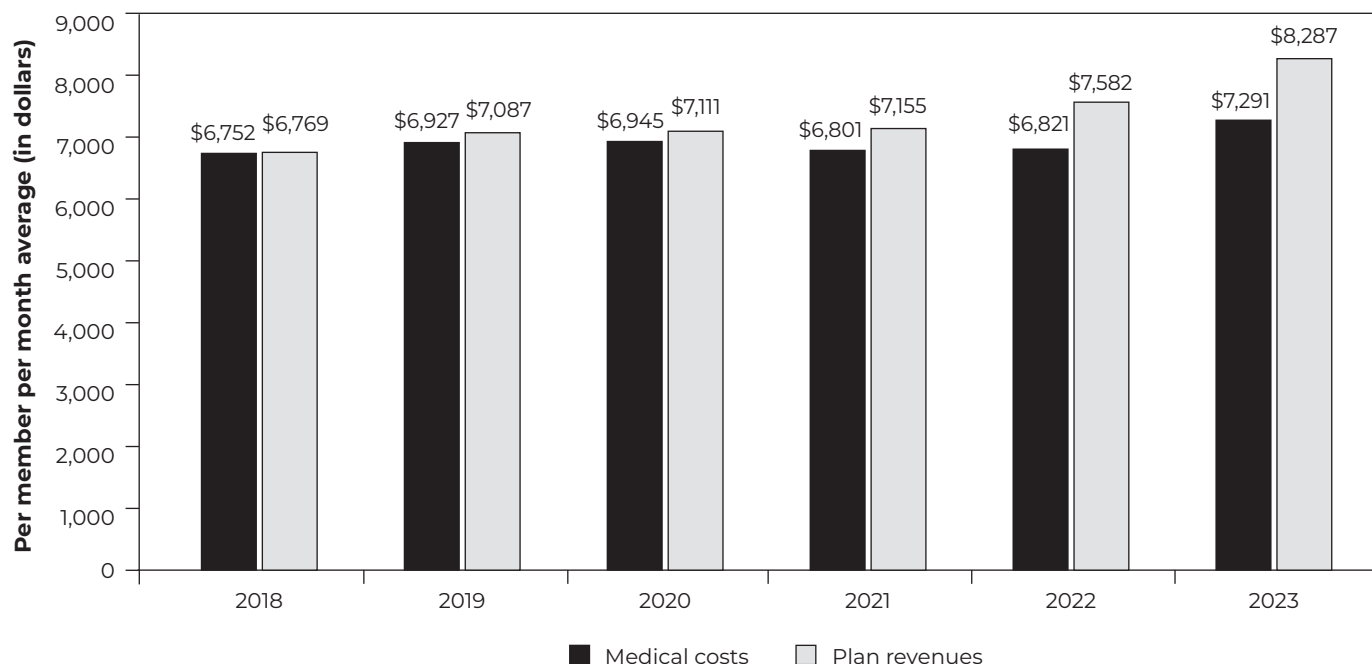
Among contracts, there was variation in ESRD enrollment-weighted medical cost-to-revenue ratios, though the amount of variation decreased between 2018 and 2023. MA contracts with lower ESRD medical costs than revenues have a cost-to-revenue ratio below 1.0. The median MA contract medical cost-to-revenue ratio in 2018, weighted by months of ESRD enrollment, was 0.971 (0.861 at the 10th percentile vs. 1.197 at the 90th percentile) versus 0.885 (0.814 at the 10th percentile vs. 0.963 at the 90th percentile) in 2023 (Figure 12-17, p. 415). Contracts with a cost-to-revenue ratio below 1.0 included about 56 percent of MA enrollees with ESRD in 2018 and 93 percent of MA enrollees with ESRD in 2023 (data not shown).

In addition to medical costs, plans incur administrative expenses for their enrollees with ESRD. Based on data from the 2019 base period, CMS estimated that plans would have nonbenefit expenses of about \$350 PMPM for plan administration of benefits for enrollees with ESRD in 2021 (Centers for Medicare & Medicaid Services 2020a). Adding inflation-adjusted administrative expenses to average medical costs for enrollees with ESRD, costs were about 7 percent lower than Medicare payments to plans (total cost-to-revenue ratio of 0.930 in 2023) (not shown in Figure 12-17, p. 415).¹⁰⁸ Depending on whether an MA contract had administrative expenses for beneficiaries above or below the average amount estimated by CMS, the actual cost-to-revenue ratio may also be higher or lower than 0.930. MA plans also incur additional costs for providing supplemental benefits to their enrollees with ESRD, but these costs are not included in our analysis.

There are several potential reasons why Medicare's payments to MA plans for enrollees with ESRD are rising faster than plan costs, though at this time we do not have evidence that affirms why. MA plans may have reduced their costs by becoming more efficient in caring for enrollees with ESRD. The literature is still sparse on how care is managed and delivered to beneficiaries with ESRD in MA. An earlier study by Powers et al. (2020) found that enrollees in an ESRD C-SNP had fewer inpatient and skilled nursing facility admissions and days than a control group of beneficiaries with ESRD in FFS from 2010 to 2013;

**FIGURE
12-16**

MA plan revenues for enrollees with ESRD grew faster, on average, than plans' reported medical costs, 2018–2023



Note: MA (Medicare Advantage), ESRD (end-stage renal disease). The black bars represent average per member per month (PMPM) medical costs, and the gray bars represent average PMPM plan revenues for enrollees with ESRD.

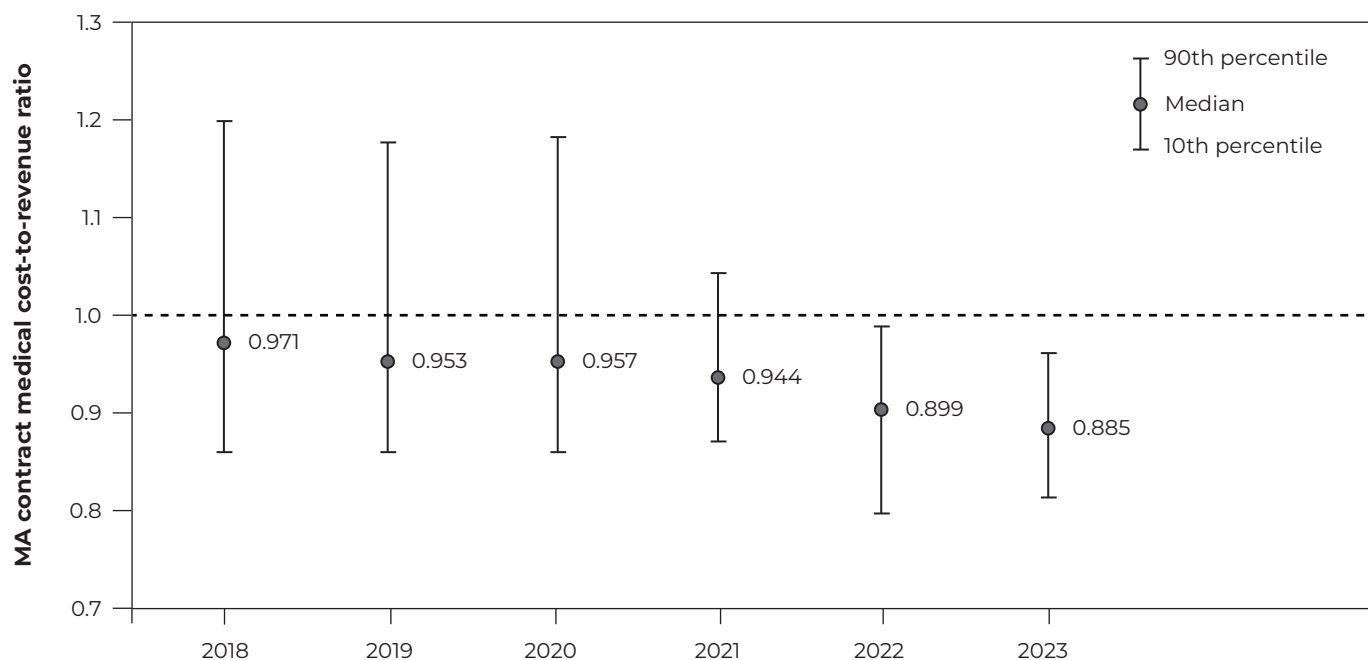
Source: MA 2020–2025 bid pricing tool data, including 2018–2023 cost and revenue information.

while not statistically significant, the authors found that relative to the FFS controls, those enrolled in the C-SNP had higher dialysis adherence and fewer inpatient admissions for ESRD complications (Powers et al. 2020). A more recent qualitative study by Tyler et al. (2025) reports that in preparation for, and response to, the ESRD enrollment growth following the 2021 statutory change, many MA plans began partnering, via risk-based contracts, with dialysis facilities and specialized care-management companies to provide tailored care coordination and case management to members with ESRD. These partners tended to focus on reducing hospitalizations and increasing the uptake of home dialysis (Tyler et al. 2025). In addition to any efficiency gains in care delivery, reductions in negotiated payment rates for dialysis services over the study period may have contributed to reductions in costs (see Figure 12-19, p. 418).

Faster growth in average plan revenues relative to costs could be driven by concentration of MA enrollment growth in states with above-average ESRD payment rates, as could more intensive coding of risk scores by MA plans for enrollees with ESRD. Additionally, if beneficiaries with ESRD who have higher spending remain in FFS Medicare, that would increase the ESRD state rate for payments to MA plans. The national average monthly FFS spending for beneficiaries on dialysis, as captured by ESRD U.S. per capita costs, has, in fact, grown from \$7,133 in 2018 to \$9,333 in 2023 (Centers for Medicare & Medicaid Services 2022b, Centers for Medicare & Medicaid Services 2017b). Beneficiaries who are eligible for Medicare solely due to ESRD (rather than age or disability) were completely barred from joining MA (except for an ESRD C-SNP) prior to 2021. Further research is needed to assess whether MA enrollment among those enrollees contributed to the differing cost and revenue trends.

**FIGURE
12-17**

MA plan revenues for enrollees with ESRD continue to cover medical costs on average, 2018–2023



Note: MA (Medicare Advantage), ESRD (end-stage renal disease). The dots represent the ESRD member month enrollment-weighted median of the MA contract medical cost-to-revenue ratio, and the bars represent the 10th percentile and 90th percentile values. The lower the ratio, the higher the contract's revenues relative to medical costs; these contracts appear below the dotted line, which represents a cost-to-revenue ratio of 1.0.

Source: MA 2020–2025 bid pricing tool data including 2018–2023 cost and revenue information.

Cost sharing for dialysis services increased, 2018 to 2022

For dialysis services, the maximum allowable cost sharing is 20 percent coinsurance. Although beneficiaries with ESRD who enroll in MA may be seeking lower OOP costs, those who enroll in plans that charge 20 percent dialysis coinsurance may pay a higher dollar value for dialysis cost sharing than is allowable in FFS Medicare if their plan pays dialysis prices above FFS Medicare rates.

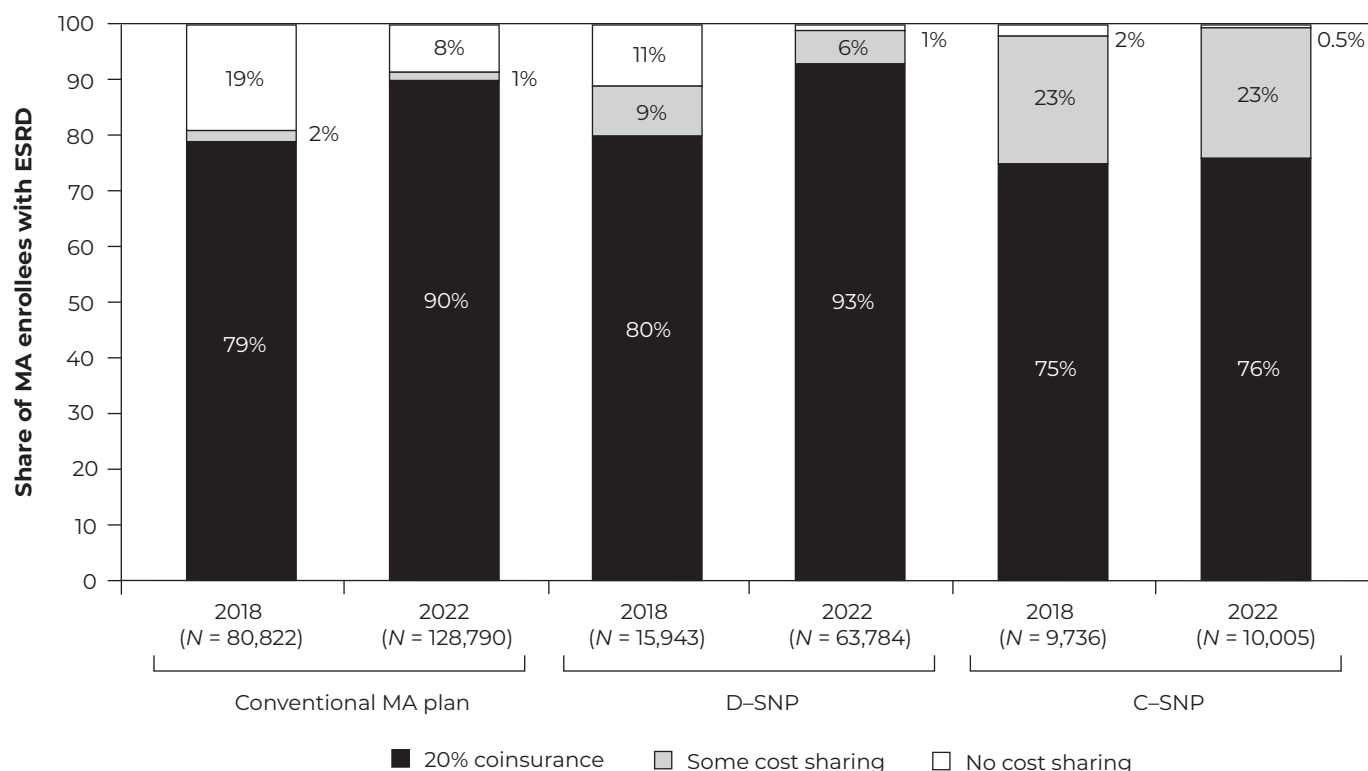
Using the same methodology as in our March 2021 report to the Congress, we analyzed MA encounter data, the plan benefits package (PBP) renal dialysis benefits file, and SNP data for 2018 to 2022 to measure the share of MA plans, and the share of ESRD enrollment in MA plans, with the maximum

coinsurance amount (20 percent) for dialysis, by MA plan type (conventional MA, D-SNP, or C-SNP).

We found that between 2018 and 2022, 80 percent to 90 percent of MA enrollees with ESRD were in plans with coinsurance for dialysis, compared with about 5 percent of enrollees in plans with a copayment for dialysis. Across all plan types—conventional MA, D-SNPs, and C-SNPs—the share of plans with a 20 percent coinsurance for dialysis increased between 2018 and 2022. Over the period, the share rose from 82 percent to 91 percent among conventional MA plans; from 72 percent to 83 percent among D-SNPs; and from 74 percent to 82 percent among C-SNPs. There was a corresponding decrease in the share of plans with no cost sharing for dialysis from 2018 to 2022: a 7 percentage point decrease among conventional MA

**FIGURE
12-18**

A greater share of MA enrollees with ESRD in 2022 were in plans with 20 percent coinsurance for dialysis services than in 2018



Note: MA (Medicare Advantage), ESRD (end-stage renal disease), SNP (special-needs plan), D-SNP (dual-eligible SNP), C-SNP (chronic-condition SNP). The bars represent MA enrollment by beneficiaries with ESRD, by plan coinsurance amounts. For example, the left-most bar indicates that 79.0 percent of 80,822 MA enrollees with ESRD in conventional MA plans were in plans with 20 percent coinsurance versus 1.9 percent in plans with some cost sharing (<20 percent coinsurance and/or a copay) versus 19.1 percent in plans with no cost sharing. Approximately 57 percent and 50 percent of enrollees in C-SNPs in 2018 and 2022, respectively, were in ESRD C-SNPs.

Source: Data compiled by MedPAC from MA encounter data, MA plan benefits data, and CMS SNP data, 2018–2022.

plans (15 percent to 8 percent), a 3 percentage point decrease among D-SNPs (10 percent to 7 percent), and a 5 percentage point decrease among C-SNPs (8 percent to 3 percent).

Consistent with these changes in plan offerings, the share of MA enrollees with ESRD in plans with the maximum allowable 20 percent coinsurance for dialysis services also grew among those enrolled in conventional MA plans and D-SNPs (Figure 12-18). Between 2018 and 2022, the share of enrollees with ESRD with a 20 percent coinsurance for dialysis increased from 79 percent to 90 percent among those

in conventional MA plans and from 80 percent to 93 percent among those in D-SNPs. However, the share among those in C-SNPs remained relatively stable (75 percent in 2018 vs. 76 percent in 2022). The share of enrollees with ESRD with no cost sharing for dialysis decreased during this time from 19 percent to 8 percent among enrollees in conventional MA plans and 11 percent to 1 percent among enrollees in D-SNPs. Among those in D-SNPs, the share of enrollees with some cost sharing (either less than 20 percent coinsurance or a copay) also decreased between 2018 (9 percent) and 2022 (6 percent).

Plans are prohibited by law from charging more than FFS for dialysis. As a result, when CMS first put limits on dialysis cost sharing in 2011, it specified that plans could not charge more than 20 percent coinsurance (the same as in FFS) or a \$30 copayment. At the time, the two amounts were actuarially equivalent. However, CMS did not update the copayment limit to reflect newer data until 2022, when it calculated that the actuarially equivalent copayment had increased to \$64. The updated figure implies that the \$30 limit had become roughly equal to 10 percent coinsurance and that any effort to use copayments meant, in effect, charging much lower cost sharing than FFS. This discrepancy between the coinsurance and copayment limits may be one reason why almost all plans use coinsurance for dialysis. The updated copayment limit (rounded to \$65) began to be phased in between 2023 and 2026; at that point, some plans might begin using copayments (Medicare Payment Advisory Commission 2023b).

Setting cost sharing for dialysis services at the maximum allowable amount allows plans to distribute rebate funding to other supplemental benefits for all enrollees in the plan, which can be beneficial for enrollees whose dialysis cost sharing is covered through Medicaid.¹⁰⁹ Although the MOOP constrains total OOP spending for MA enrollees, charging the maximum allowable cost sharing for dialysis services may discourage nondually eligible beneficiaries from enrolling in a plan or from staying enrolled in a plan throughout the year. However, while cost-sharing amounts for dialysis services are likely salient to beneficiaries with ESRD who typically receive dialysis three times per week, other factors—such as supplemental benefits, provider networks, and cost-sharing structures for other services—also influence beneficiaries’ decisions to enroll in MA (Brazier et al. 2025).

Most MA plans paid more than FFS rates for dialysis services, 2018 to 2022

For beneficiaries with ESRD in FFS Medicare, dialysis facilities are paid a single case-mix-adjusted payment under the ESRD prospective payment system (PPS) that includes composite-rate services and ESRD-related drugs, laboratory services, and medical equipment and supplies.^{110,111} For 2026, the base FFS payment rate is \$281.71 for both freestanding facilities and hospital-based facilities (Centers for Medicare & Medicaid

Services 2025g). Payments are adjusted by facility-level factors (wage index, low-volume adjustment, and rural adjustment) and patient-level factors (age, body size, onset (first four months of dialysis treatment), and comorbidities).¹¹²

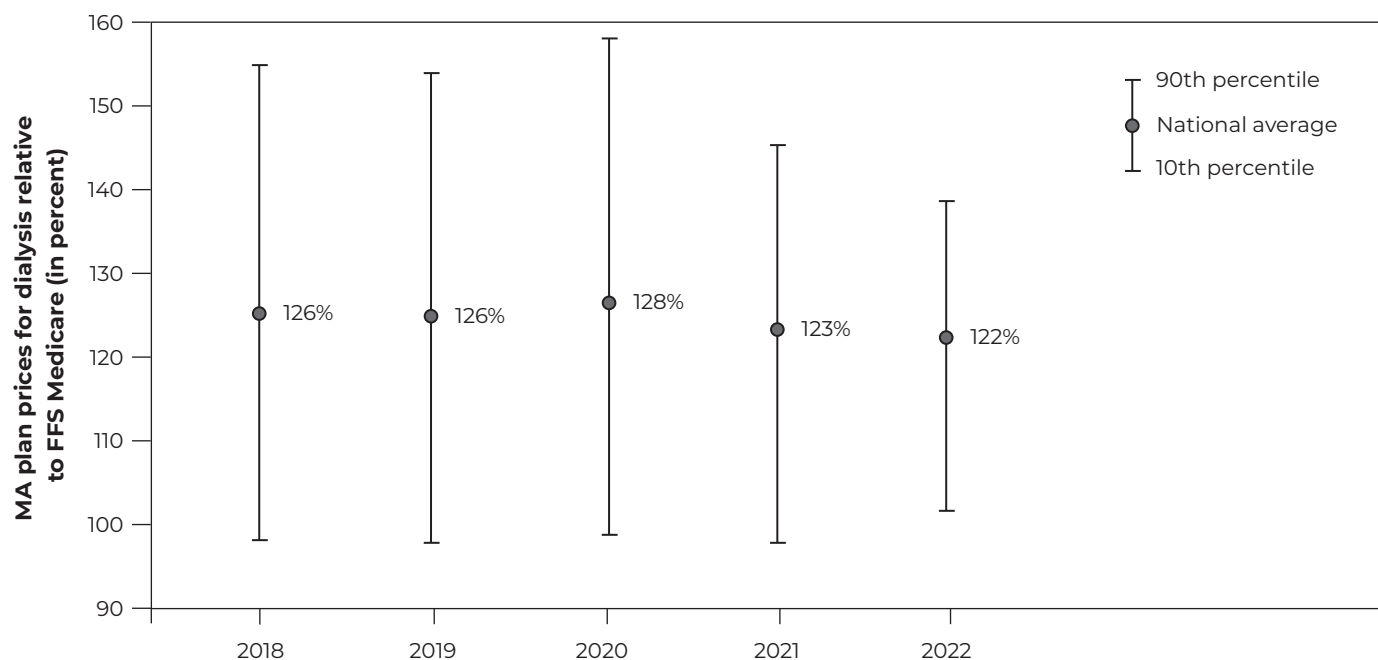
For beneficiaries with ESRD in MA, dialysis facilities are paid according to a negotiated rate that varies across MA contracts.¹¹³ If MA plans are unable to negotiate dialysis prices similar to (or lower than) FFS Medicare payment rates for dialysis, plans have to offset higher dialysis spending from higher prices for dialysis services by reducing costs for other services for all plan enrollees (e.g., care coordination to reduce inpatient hospital and emergency room visits) or they risk losses on enrollees with ESRD.

We analyzed FFS claims and MA encounter data from 2018 to 2022 for the 50 states and the District of Columbia to estimate the prices MA plans paid for dialysis. The MA encounter data did not include sufficient information to replicate the complete FFS payment calculation, but we were able to adjust MA plan payments to facilities by the two factors we consider to have the greatest importance: enrollee age and facility wage index. We do not expect differences in the other factors to significantly affect the comparison of dialysis prices. (See text box “Estimating MA prices for dialysis services relative to FFS Medicare rates,” p. 419, for details on our methodology and how it changed between the 2021 report to the Congress and this chapter.)

From 2018 through 2020, the national average MA plan prices for dialysis increased slightly from 26 percent to 28 percent higher than FFS Medicare rates, respectively. In 2021 and 2022, the national average MA plan prices for dialysis dropped to 23 percent and 22 percent higher than FFS Medicare rates, respectively. The average price paid for dialysis varied widely across contracts: Weighting by treatment volume, prices for dialysis services in 2018 ranged between 1.1 percent below FFS Medicare rates (10th percentile) to 55.6 percent above FFS Medicare rates (90th percentile). The range of treatment volume-weighted MA contract prices for dialysis service was narrower in 2022, between 2.0 percent and 39.1 percent above FFS Medicare rates (10th and 90th percentile, respectively) (Figure 12-19, p. 418).

FIGURE
12-19

Most MA contracts paid more per dialysis treatment than FFS Medicare rates, 2018–2022



Note: MA (Medicare Advantage), FFS (fee-for-service). The dots represent the national average of MA contract prices for dialysis relative to FFS Medicare. The bars represent the 10th and 90th percentiles of treatment volume-weighted MA contract prices for dialysis services relative to FFS Medicare. Estimated MA prices have been adjusted to account for differences in age and facility wage index.

Source: MedPAC analysis of FFS claims, MA encounter data, and MA plan benefits data, 2018–2022.

One reason that MA plans pay more for dialysis than FFS Medicare could be the high level of consolidation in outpatient dialysis facilities. In 2022, two large dialysis organizations (LDOs), DaVita and Fresenius, operated three-quarters of dialysis facilities (Medicare Payment Advisory Commission 2025b). Further, among 1,889 counties in which there was at least one dialysis facility in 2022, either one or both LDOs were the only

facilities available in approximately 54 percent of those counties. Increasing MA enrollment by beneficiaries with ESRD, combined with the removal of network-adequacy requirements for outpatient dialysis facilities, may have increased the negotiating leverage for many MA plans, which could have contributed to the drop in MA prices for dialysis in 2021 and 2022. ■

Estimating MA prices for dialysis services relative to FFS Medicare rates

In the March 2021 report to the Congress, we used fee-for-service (FFS) claims and Medicare Advantage (MA) encounter data to estimate average FFS versus MA prices for dialysis services by (1) summing payment amounts for dialysis revenue centers; (2) making adjustments for age and facility wage index (geographic location); and (3) dividing the adjusted payment sum by the total number of dialysis treatments. We defined price as the sum of Medicare program or MA plan payments and beneficiary cost-sharing liability. Therefore, to account for the 20 percent coinsurance for dialysis in FFS, we divided the estimated FFS average from Step 3 by 0.8 to impute the 100 percent FFS price. To account for beneficiary cost sharing in MA, we added the enrollees' cost-sharing liability reported in MA encounter data to the sum calculated in Step 1.¹¹⁴ Finally, we calculated the ratio of the 100 percent MA price versus the FFS price. We reported that the prices MA plans paid in 2018 for dialysis services, after accounting for differences in age and facility wage index, averaged about 14 percent higher than FFS Medicare rates (Medicare Payment Advisory Commission 2021b).

In this chapter, we updated our methodology for imputing the 100 percent MA price for dialysis services to address a limitation of the previous analysis. Specifically, we changed our specification to use information on beneficiary cost-sharing liability amounts for dialysis services as reported on the MA plan benefits package (PBP) renal dialysis benefits file instead of using enrollees' cost-sharing liability amounts reported in MA encounter data. We made this change to address

high levels of missingness in enrollees' cost-sharing liability amounts on encounter records submitted by MA plans: Approximately 87 percent of monthly dialysis claims reported in the encounter data had a \$0 cost-sharing liability amount, even though 79 percent of MA enrollees with ESRD were in plans with 20 percent coinsurance in 2018 (discussed in the previous section titled "Cost sharing for dialysis services increased, 2018 to 2022," p. 415). Among beneficiaries with ESRD enrolled in plans with a 20 percent coinsurance for dialysis, 83 percent of encounter records had a \$0 cost-sharing liability amount reported. Of the remaining 17 percent of encounter records for enrollees in plans with a 20 percent coinsurance for dialysis, the median enrollee cost-sharing liability amount reported was \$853 per month (interquartile range (IQR): \$599 to \$1,848); using the cost-sharing information from the PBP file, we impute the median enrollee cost-sharing liability amount for these monthly claims to be \$728 (IQR: \$616 to \$848).

Our updated methodology replaces what we suspect is missing beneficiary cost-sharing liability information from MA encounter data with imputed cost-sharing amounts from the PBP file and increases our estimate of MA plan prices for dialysis in 2018 by 10.5 percent. After accounting for differences in age and wage index, the prices MA plans paid for dialysis services averaged about 26 percent higher than FFS Medicare rates. Our new estimates are similar to Lin et al.'s (2022) finding that in 2016 to 2017, MA plans paid 27 percent more than FFS Medicare for dialysis services (Lin et al. 2022). ■

12-A

TECHNICAL APPENDIX

Base comparison

The Commission's method for estimating what FFS spending would have been for MA enrollees before favorable selection and coding effects

The Commission's method for estimating Medicare Advantage (MA) payments relative to what fee-for-service (FFS) spending would have been for MA enrollees includes three components that are estimated separately and then combined into a single estimate. The first of these components (as presented in Chapter 12, p. 379) constructs a base comparison of MA payments and FFS spending that measures how MA payments compare with the spending of FFS enrollees with the same risk scores and county of residence. The Commission's approach appropriately reflects the lower payments that MA plans receive due to the inclusion of Part A-only beneficiaries in benchmarks. The base comparison estimates the difference between actual MA payments and what FFS spending would have been for MA enrollees under the assumption that risk scores and county of residence fully account for differences between the MA and FFS populations. Differences between the MA and FFS populations that are not captured by the base comparison are found in Technical Appendix 12-B (favorable selection) and Technical Appendix 12-C (coding intensity).

Methodology for the base comparison of MA payments and FFS spending

In constructing the base comparison, we compare Medicare's actual payments to MA plans with an estimate of what the program's spending would have been if those enrollees were in the FFS program, under the assumption that risk scores and county of residence fully account for differences between the MA and FFS populations. The analytic framework for our base comparison is similar for MA enrollees with end-stage renal disease (ESRD) and enrollees without ESRD. This appendix describes the methodology for constructing the base comparison for the population without ESRD (about 99 percent of MA enrollees in 2024). The methodology for the population with ESRD (about 1 percent of MA enrollees in 2024) is described in the text box on incorporating this population into our estimates (pp. 379–382).

We compute the base comparison as a ratio in which MA payments are the numerator and FFS spending

is the denominator. For each MA enrollee, we first measure the combined payment (bid and rebate) that the Medicare program made to their plan during the year. We compare that payment to the average risk-adjusted spending of FFS beneficiaries living in the same county. We then compute the base comparison of MA payments to FFS spending as the sum of those individual payments for each MA enrollee divided by the sum of each of the FFS spending comparison amounts. Our approach differs slightly for years in which historical data are not available.

The methodology of our base comparison aligns with the population CMS uses for calibrating the hierarchical condition category (HCC) risk model and the risk-adjustment CMS applies to an MA plan's county-level benchmark. We use historical data for years in which data are available (2016 to 2023) to remove the uncertainty from projection errors. Our approach also standardizes for differences between MA and FFS enrollees based on the type of Medicare coverage, county of residence, and risk scores.

Study and comparison populations for beneficiaries

In conducting our base comparison for the non-ESRD population of MA payments and FFS spending for 2016 through 2023, we applied the same set of inclusion criteria for the MA and FFS beneficiaries included in our analysis. We restricted our analysis to beneficiaries who—for the months in which they were alive during a target year—had both Part A and Part B coverage, had Medicare as their primary payer, did not have ESRD, and had at least one nonhospice month. These restrictions are consistent with those used for CMS's non-ESRD HCC risk-model calibration. In addition, to ensure reliability, we required that beneficiaries reside in the 50 states or the District of Columbia and we removed hospice enrollment months (in which MA plans do not have liability for Part A and Part B services), which encompasses months in which an enrollee did not have at least one nonhospice day.

Methodology for comparing MA payments to FFS spending using historical data

For each MA plan, CMS publishes risk-standardized base payment rates (reconciled for actual county-level plan enrollment) and rebate amounts. To calculate total MA spending, we multiplied risk-standardized base payment rates by each beneficiary's final risk

score and actual number of months of MA enrollment, then we added rebate amounts multiplied by actual MA enrollment months. For months in which CMS applied sequestration adjustments to MA payments, we reduced the sum of all base payments and rebates by the applicable sequestration percentage (generally, a 2 percent reduction).^{115,116}

For the FFS comparison group, we calculated the monthly average of risk-standardized spending per beneficiary at the county level. We include beneficiary spending from adjudicated claims for Part A and Part B services (removing hospice payments, medical education payments, and kidney-acquisition costs^{117,118}), provider settlement amounts (e.g., reconciled payments after cost reports are submitted¹¹⁹), provider incentive payments (e.g., shared savings¹²⁰), and CMS's estimate of FFS administrative claims costs.¹²¹ We then risk standardized the average FFS spending within each county using final beneficiary risk scores.^{122,123} We used our calculation of the county-based risk-standardized spending average for the FFS comparison group and multiplied this average by the risk-adjusted (using MA enrollee risk scores) MA enrollment months in each county:

$$\sum_i \bar{y}_g \times r_{i,g}$$

We denote an MA enrollee as individual i , residing in county g , with risk score r , and $\bar{y}_g$ is the average risk-standardized spending of FFS enrollees in the same county g (standardized to a 1.0 risk score). Thus, our total estimate compares the aggregate MA payments for MA enrollees (denoted by p as an MA enrollee's individual Medicare payment) with their corresponding aggregate FFS spending amounts (using the same enrollment-weighted risk score and county of residence):

$$\frac{\sum_i p_{i,g}}{\sum_i \bar{y}_g \times r_{i,g}}$$

For 2023, the base comparison—before accounting for the effects of favorable selection and coding—is 100.6 percent without the ESRD population and 100.7 percent including the ESRD population.

Methodology for comparing MA payments to FFS spending using projected data

For years in which we do not have historical data (2024 to 2026), the Commission follows the same analytic

framework for our base comparison, but we rely on MA bid and benchmark data from CMS. These data include plan payment rates, plans' projected enrollment in each county, plans' projected average risk score, and CMS's projections of county-level risk-standardized FFS spending. CMS's projections of county-level FFS spending include a different population than our historical estimates (e.g., unlike the population we use for the historical estimate, they include beneficiaries with Part A only, Part B only, or with Medicare as a secondary payer). These population differences include beneficiaries who are either not eligible for MA enrollment or are not used in CMS's calibration of its HCC risk model. Despite those differences, the Commission has found that computing the base comparison using projected MA bid and benchmark data produces very similar estimates to computing the comparison with historical data that apply the appropriate exclusions to the MA and FFS populations. As shown in Figure 12-7 (p. 384), we compared the estimates from these two approaches for years that data are available and found that they produced estimates within 1 percentage point of one another (except for 2020 and 2021, when spending fluctuated during the pandemic). For 2023, the most recent year for which we can compare estimates under both approaches, we estimate that the base comparison was 101 percent of FFS spending using both historical data and projected data.

For the projections of MA spending, we calculate a payment rate for each plan using information from the bid data that MA plans submitted. Bid data include expected payments for Medicare-covered Part A and Part B services, plan rebates that fund extra benefits, and payments resulting from the quality-bonus program. These MA payment rates reflect the projected MA enrollee risk scores in plan-bid data. We then calculate total MA payments by multiplying each plan's estimated payment rate by the projected enrollment that plans also include in their bids. Because employer plans do not submit bids, we use CMS's county-level payment rates for these plans and multiply each of these rates by our projection of employer-plan risk scores and enrollment. These projections use county-level employer-plan enrollment and historic differences in risk scores between employer and nonemployer plans.¹²⁴

To calculate what Medicare FFS would have spent for MA enrollees, we use CMS's projections (as published in the MA rate book), which risk standardize CMS's Part A and Part B spending estimates to reflect average spending for a FFS beneficiary with average risk (i.e., with a 1.0 risk score) in each county. CMS is required to exclude spending for some services that FFS provides but MA plans do not: hospice services, kidney-acquisition costs, and graduate medical education (both direct and indirect). We then calculate total spending by multiplying CMS's county-level estimates of per capita FFS spending by the projected MA enrollment in each county and the MA risk scores that plans include in their bids.

We project our overall base comparison by dividing total projected MA spending by total projected FFS spending (assuming the same county of residence and MA risk score). For 2026, the base comparison is projected to be 99.2 percent without the ESRD population and 99.4 percent when including the ESRD population. This estimate does not include the effects of favorable selection and coding, which are two of the three components of our comparison of MA payments to FFS spending. Favorable selection and coding are vital to understand what FFS spending would have been for MA enrollees, and the methodologies for those components are subsequently explained in Appendix 12-B and Appendix 12-C.

Part A-only beneficiaries are appropriately accounted for in the Commission's approach

The Commission's methodology for comparing MA payments to FFS spending appropriately accounts for the Part A-only population (and the smaller Part B-only population) in both parts of the calculation of the base comparison: MA payments (the numerator) and FFS spending (the denominator).

When measuring MA payments, the Commission uses data that fully reflect the lower payments that MA plans receive due to the inclusion of Part A-only beneficiaries in benchmarks

When measuring MA payments, we use data on the actual payment rates that Medicare uses to pay plans for MA enrollees. Those payment rates are determined by county benchmarks, plans' bids, plans' quality ratings, and enrollee risk scores. The FFS population that CMS uses to compute county benchmarks

includes beneficiaries enrolled only in Part A, who have lower average spending than beneficiaries enrolled in both Part A and Part B. The inclusion of Part A-only beneficiaries in the population that CMS uses to compute county benchmarks reduces benchmarks relative to what they would have been if benchmarks were based solely on the Part A and Part B population.

The effect of Part A-only beneficiaries on benchmarks is fully reflected in the data that the Commission uses to measure MA payments in both years when we are able to use historical data (2016 to 2023) and years when we rely on projected data (2024 to 2026). The historical data use the actual payment rates (on a per enrollee basis) that Medicare used to pay plans for MA enrollees applied to each plan's actual enrollment and risk scores. The projected data use CMS's projected plan payment rates applied to each plan's projected enrollment and risk scores. Further detail on the historical and projected payment data is included in the previous section.

The Commission does not have a recent estimate of how much the inclusion of Part A-only beneficiaries reduces benchmarks. However, such an estimate is not necessary for our modeling of the base comparison. Our use of actual payment rates reflects the net effect of actual benchmarks, bids, and quality bonuses. Therefore, we do not require any assumptions or modeling about the Part A-only population for this part of the estimate. In 2017, the Commission recommended excluding Part A-only beneficiaries from the county benchmark population. If Part A-only beneficiaries were excluded from benchmarks, we expect that MA payments would be even higher relative to FFS spending than the Commission currently estimates. The numerator of the base comparison (MA payments) would increase while the denominator (FFS spending) would stay about the same.

When measuring FFS spending, the Commission's analysis of historical data excludes Part A-only beneficiaries

As described earlier, we exclude beneficiaries with Part A-only coverage from our analysis of FFS spending for all years in which historical data are available (2016 to 2023). In 2023, we estimate that MA plans received combined payments (including both the bid and rebate) that were about 1 percent higher than what the Medicare program spent on FFS beneficiaries with Part A and Part B coverage who were living in the

same county as MA enrollees, on a risk-adjusted basis. (After applying adjustments for favorable selection and coding intensity that correct for inaccuracies in risk adjustment, the Commission estimates that MA payments are substantially higher than what FFS spending would have been.)

For the three most recent years (2024 to 2026), we rely on CMS's projections to measure county-level FFS spending. Despite the inclusion of Part A-only beneficiaries in CMS's projections, our analysis indicates that our use of projected data has produced reliable estimates of the base comparison. As Figure 12-7 (p. 384) shows, we compared estimates from the approach using historical data to the approach using projected data for years that data are available and found that the two approaches produced estimates within 1 percentage point of one another (except for 2020 and 2021, when spending fluctuated during the pandemic). Based on that analysis, we have concluded that no adjustment is needed to the projected FFS spending used for the base comparison when historical

data are not available. We will continue to analyze more recent data as they become available and will incorporate an adjustment if a difference emerges.

Comparisons of MA payments to FFS spending using projected data have produced similar estimates to comparisons using historical data of FFS beneficiaries enrolled in Part A and Part B, despite the differences in populations included (Figure 12-7, p. 384). Our analysis of historical data suggests that the county FFS rates used for setting benchmarks have roughly tracked the historical spending of the FFS Part A and Part B population used in the Commission's analysis. (As described earlier, the Commission also applies other appropriate exclusions to the Part A and Part B population to align with the MA population.) That analysis suggests that there are one or more factors that offset the effects of including the Part A-only population in the calculation of the county rates that are used for benchmarks. The Commission will continue analyzing these trends and incorporate new data as appropriate. ■

TECHNICAL APPENDIX

12-B

Favorable selection

The Commission's methodology for estimating favorable selection in MA

The risk-adjustment model that CMS uses to adjust payments to Medicare Advantage (MA) plans predicts Medicare spending using beneficiary characteristics, including demographics and medical conditions. The model is estimated using data from beneficiaries enrolled in the fee-for-service (FFS) program. For any set of characteristics, some FFS beneficiaries with those characteristics will have actual spending that is more than predicted and others will have actual spending that is less than predicted by the risk-adjustment model. The goal of risk adjustment is to accurately predict spending for a population of beneficiaries, on average. In other words, risk adjustment is accurate for a population when the overprediction errors are balanced with the underprediction errors.

“Favorable selection” refers to the tendency for Medicare’s risk-adjustment model to—on average—overpredict the spending that the MA-enrolled population would have had if they were enrolled in the FFS program, even if medical conditions were recorded with similar coding intensity. Favorable selection can occur due to unmeasured differences in health status but can also result from factors such as differences in beneficiaries’ propensities to seek, or receive, care for reasons that are unrelated to their health.

The analysis described in this chapter continues to use the analytic framework from our March 2025 report to the Congress but makes technical adjustments to improve the accuracy of the estimated changes in favorable selection during MA enrollment. We made three sets of changes to address those aims:

- First, we improve how we model changes in selection during MA enrollment by including dual-eligibility status in our matching of the MA study population to the FFS proxy group.
- Second, we improve how we extrapolate our estimates of favorable selection to MA enrollees outside of our study population by accounting for the dual-eligibility status of those enrollees (along with mortality status and initial year of enrollment).

- Third, we improve the comparability between our study population and FFS comparison groups by applying a series of technical updates.

Chapter 12 presents estimates from two methods of estimating the effect of favorable selection in the MA population. The first is a comprehensive method that we apply to estimate a selection effect for the entire MA-enrolled population—except for those with end-stage renal disease (ESRD)—in each year from 2015 to 2023. We also use estimates from that method to project the effect of favorable selection for 2024 to 2026, years in which we do not yet have data available. The second is a simple method that estimates favorable selection for the portion of ESRD MA enrollees who were on dialysis and who were enrolled in the FFS program in the previous year, referred to as “recent switchers.” This simple method compares the FFS spending of recent switchers in the year before they enrolled in MA with the spending of beneficiaries who remained in FFS (“stayers”) and were alive for all 12 months, standardizing for differences in risk score and state of residence. We use that simple method to estimate selection for the years in which MA enrollees on dialysis were allowed to switch from FFS to MA and for which we have data (from 2021 to 2023).¹²⁵ Because the population of dialysis switchers into MA is relatively small, we are not able to reliably construct the cohorts of MA switchers and FFS proxy groups necessary for our comprehensive method. Instead, we use our simple method for estimating favorable selection because it is not dependent on large subcohorts of switchers by year of initial enrollment into MA and by mortality. In addition, because beneficiaries with dialysis only began switching into MA in 2021, there are fewer years for the effects of mean reversion to meaningfully change the initial estimated effects of selection. For the ESRD population in transplant status or functioning-graft status, we did not have a sufficient population to estimate selection using our simple method. We applied estimates of selection from the dialysis ESRD population to those other segments of the ESRD population. The methodology for estimating favorable selection for the ESRD population is described in more detail in the text box on incorporating MA enrollees with ESRD into our comparison of payments to MA plans relative to FFS spending (pp. 379–382).

In this appendix, we also include estimates from a simple method of estimating selection for recent

switchers into MA among the non-ESRD population. Similar to the simple method applied to estimate selection for the ESRD population, this approach compares the FFS spending of recent switchers in the year before they enrolled in MA with the spending of stayers who were alive for all 12 months, standardizing for differences in risk score and county of residence. Estimates from that simple method are an easily interpretable indicator of selection and can be more readily compared with some papers in the literature that follow the same approach. However, estimates from the simple method do not account for several important aspects of selection that are accounted for in the estimates derived from our comprehensive method. That is why we use estimates of favorable selection using our comprehensive method when reporting our overall comparisons of MA and FFS payments.

Simple methodology for estimating favorable selection of the MA population

Below, we present our analysis using a simple version of our favorable-selection method that compares the FFS spending of beneficiaries who switched from FFS to MA in the following year (“recent switchers”) with the spending of stayers, standardizing for differences in risk score and county of residence.¹²⁶ For example, we calculated the ratio of 2022 FFS spending for beneficiaries who switched to MA in 2023 with the 2022 FFS spending for beneficiaries who remained in FFS in 2023. We then converted the result to a percentage that we call the “selection percentage.” (When calculating benchmarks, CMS adjusts for geographic distribution (i.e., county-level enrollment) of beneficiaries and differences in risk scores. Similarly, we adjusted the spending of beneficiaries who remained in FFS to have the same geographic distribution and risk scores as the beneficiaries who switched to MA.) We calculated an initial selection percentage for each cohort that entered MA in 2008 through 2023.

Using the simple method, we found evidence of favorable selection among recent switchers into MA during their last year in FFS throughout the period from 2007 to 2022 (Figure 12-B1, p. 428). We estimate that the selection percentage ranged from 87 percent to 96 percent during the period. Favorable selection using the simple method was highest in 2022. (MA enrollee local-area spending was 13 percent less than predicted by their risk score, a selection percentage of 87.)

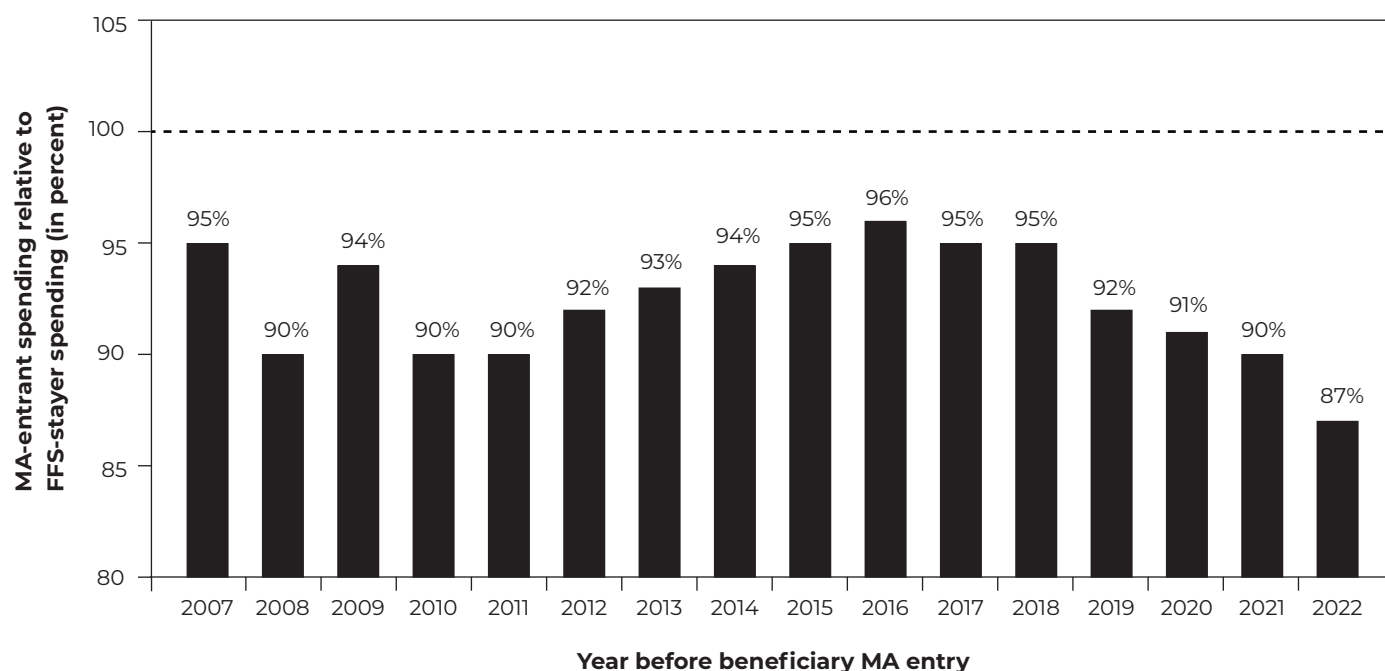
Comprehensive methodology for estimating favorable selection of the MA population

We use our comprehensive method to estimate an aggregate selection percentage for the entire population of non-ESRD MA enrollees in each year, beginning in 2015. That aggregate selection percentage represents the amount by which the predicted spending used for MA payments (estimated using the FFS population in Medicare’s risk-adjustment model) overpredicted (or underpredicted) the actual spending that the MA population would have had if those beneficiaries had been enrolled in the FFS program in that year. It is computed as a ratio of (1) the estimated spending that the FFS program would have incurred for the MA-enrolled population had they been enrolled in the FFS program (the numerator) and (2) the estimated FFS spending that the Medicare payment system predicted for that population (the denominator). We label that ratio the “selection percentage.” We cannot directly observe the selection percentage of beneficiaries during their enrollment in MA because we cannot observe what their spending would have been had they instead been enrolled in FFS in that year. However, we can directly estimate the selection percentage of MA enrollees who were previously enrolled in the FFS program in the year before they switched to MA. For that reason, we use data from MA enrollees who were previously enrolled in the FFS program as our study population and model how their selection percentage changed between the year before they enrolled in MA and their most recent year of MA enrollment.

Our study population consists of beneficiaries who had at least two years of prior enrollment in the FFS program before switching to MA (“previous switchers”) and who met our other inclusion criteria, approximately 26 percent of non-ESRD MA enrollees in 2023 (8 million MA enrollees).¹²⁷ For those enrollees, we have complete data on their spending and risk scores while they were in FFS that we can use as the basis for estimating a selection effect. The remaining non-ESRD MA population had at least two years of prior enrollment in the FFS program but did not meet all of our inclusion criteria (9 percent in 2023), switched from FFS to MA but had less than two years of prior FFS enrollment (30 percent in 2023), or enrolled in MA upon their initial eligibility for Medicare Part A and Part B and had no FFS months (35 percent in 2023).¹²⁸

**FIGURE
12-B1**

Beneficiary FFS spending in the year before MA enrollment indicates favorable selection for recent entrants from 2007 to 2022



Note: FFS (fee-for-service), MA (Medicare Advantage). Estimates were constructed using the Commission's simple method for estimating favorable selection. "MA entrants" are beneficiaries who switched from FFS to MA in the following year. "FFS stayers" are beneficiaries who remained in FFS in the following year. "Spending" reflects the year before MA entry and is risk standardized. Values farther below 100 percent indicate greater favorable selection. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B before the year of MA entry as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory).

Source: MedPAC analysis of Medicare enrollment (2006–2023), Medicare claims spending (2007–2022), and risk-adjustment files (2007–2022).

For enrollees outside our study population, we assign a selection percentage using data from our study population of previous switchers who joined MA in the same year and had the same dual-eligibility status during the target year and mortality status in the following two years. Assigning selection percentages to the nonstudy population using the estimated selection of enrollees in our study population with the same year of entry, dual-eligibility status, and mortality status adjusts for many of the differences between the study and nonstudy populations. MA enrollees with ESRD, who accounted for 1 percent of the MA population in 2023, are assigned a selection effect equal to zero on the basis of the analysis described later.¹²⁹

We estimate selection for the study population of MA enrollees who were previous switchers using two main components: the selection percentage before each beneficiary was enrolled in MA ("base-year selection") and the estimated change in selection between the base year and the most recent year of MA enrollment. We describe below how we measure base-year selection and the change in selection for that population.

Study and comparison populations

We include beneficiaries in our study population if they (1) were enrolled in MA for at least one month of the year for which we are estimating selection (referred to

as the “target year,” which is 2023 for the most recent estimate); (2) had joined MA between 2010 and 2023; and (3) had been enrolled in FFS and had both Part A and Part B coverage for at least two full calendar years before enrolling in MA. Because hospice enrollees receive their Medicare Part A and Part B coverage only from FFS and not from MA plans, we remove MA enrollment months while the beneficiary is in hospice (unless they were participants in CMS’s value-based insurance design hospice demonstration). We address the issue of decedents separately (discussed below).

Consistent with our comparisons of MA payments and coding relative to FFS spending, we include beneficiaries enrolled in conventional MA plans (available to all beneficiaries), special-needs plans, and employer plans because the Medicare program makes payments to plans for all of these populations, and they all can experience favorable selection. We require beneficiaries to have at least two full calendar years of FFS enrollment because the CMS hierarchical condition category (HCC) risk-adjustment model calculates risk scores using diagnoses from the prior year’s claims. Thus, we require data on MA beneficiaries with two years of prior FFS enrollment to calculate risk scores for their last year of FFS enrollment. We divide the study population for each target year into 14 annual cohorts based on the year that they previously enrolled in MA (2010 through 2023). The study population of MA enrollees is used to construct the numerator of the selection percentages we estimate.

For the comparison population used to construct the denominator for the selection percentages, we include FFS beneficiaries who generally would have met the inclusion criteria for CMS’s calibration of its HCC risk model and had the necessary data to construct risk scores. We also apply an additional exclusion to the FFS population used by requiring the comparison population to have had both Part A and Part B FFS coverage for at least one full calendar year before the base year and at least one month of nonhospice coverage in the base year (the study population’s last year of FFS enrollment). That exclusion is applied to enhance similarity to the MA-enrolled population and to align with the population used to construct the base spending component of the Commission’s comparison of MA to FFS spending. Restricting to beneficiaries enrolled in both Part A and Part B also aligns with the

population used to calibrate the risk-adjustment model. In addition, we exclude from our FFS comparison population beneficiaries with any Part A-only, Part B-only, or MA months during the base year.

We exclude beneficiaries from both the study and comparison populations if they had characteristics that would have excluded them from CMS’s non-ESRD HCC risk-model calibration: ESRD coverage, Part A-only coverage, Part B-only coverage, hospice election, or if they had another source of health coverage for which Medicare acted as a secondary payer.¹³⁰ CMS excludes beneficiaries with ESRD from benchmark calculations, pays MA plans state-based FFS rates for ESRD beneficiaries, and adjusts benchmarks and payments for those with Medicare as a secondary payer to remove the secondary-payer effect. In addition, we exclude beneficiaries who did not reside in the 50 states and the District of Columbia. Further, to ensure geographic comparability, we exclude beneficiaries who did not reside in the same county during any year in which their spending is calculated. That restriction allows beneficiaries in our study population to change their county of residence provided that it does not interfere with the calculation of spending in the base year and the target year.

Base-year selection percentage

Each beneficiary has a selection percentage that represents by how much their predicted spending estimated using Medicare’s risk-adjustment model (“predicted spending”) in year t underpredicts or overpredicts the actual spending they would have had if they were enrolled in the FFS program in that year. That individual-year-level selection percentage is denoted as $S_{i,g,t}$ for individual i , residing in county g , in time t . Time t indexes the time since individuals in each cohort of MA switchers switched from FFS to MA, with $t = 0$ representing the year before the switch occurred and $t = 1$ representing the first year the cohort was enrolled in MA. We use year $t = T$ to denote the “target year” in which we are measuring selection of the MA population. For example, consider a group of MA enrollees in 2023 who previously switched from the FFS program to MA in 2019 (and stayed in MA through at least one month in 2023). For those enrollees, $t = 0$ is 2018, $t = 1$ is 2019, and $t = T$ is 2023.

We refer to a beneficiary’s selection percentage in the year before switching to MA as the base-year selection

percentage and denote the base year as $t = 0$. Because MA switchers were enrolled in FFS in year $t = 0$, we can use their actual FFS spending to estimate their selection percentage in that year.

We estimate their base-year selection percentage as the ratio of each individual's actual spending relative to an estimate of their predicted spending (which is specific to their county g):

(1)

$$S_{i,g,t=0} = \frac{y_{i,g,t=0}}{\bar{y}_{g,t=0} \times r_{i,g,t=0}}$$

Where $y_{i,g,t=0}$ is the individual's actual FFS spending in year $t = 0$, $\bar{y}_{g,t=0}$ is the average risk-standardized spending of FFS enrollees in the same county g (standardized to a 1.0 risk score), and $r_{i,g,t=0}$ is the individual's risk score in year $t = 0$.¹³¹ That initial selection percentage represents by how much Medicare's risk-adjustment model underpredicted or overpredicted the actual spending that the MA switchers had during their last year in FFS.

Selection in the base year is measured with a very high degree of accuracy for the population of MA switchers with the requisite two prior years of enrollment in FFS. However, our primary objective is to measure the degree of selection for the population of MA enrollees during the target year in which they were enrolled in MA in time $t = T$.

An individual's selection percentage at time $t = T$ could differ from their selection in the base year for several reasons, which can be seen from considering the terms in the formula above. First, the spending an individual would have had in FFS (the numerator) could get closer to their predicted spending over time, holding constant the risk model and the composition of the FFS population used to calibrate risk scores and calculate average spending. That phenomenon is known as "mean reversion."¹³² Second, an individual's predicted spending in the denominator could get closer to or farther from the numerator, holding the numerator constant. That could occur if changes to the risk model between $t = 0$ and $t = T$ improve the accuracy of predicted spending or if changes in the composition

of the FFS population used to calibrate the risk model and compute predicted spending change over time. The composition of the FFS population can change due to the net effect of inflows of people who newly enroll in FFS and outflows of beneficiaries who die or switch to MA. Our approach to estimating the change in selection accounts for all of those reasons.

Change in selection

We are interested in measuring the selection percentage in year $t = T$, when beneficiaries are enrolled in MA and we cannot directly estimate their selection percentage. To estimate their selection percentage in that year, we note that selection in later years can be expressed as the sum of an individual's base-year selection percentage (which we can directly estimate) and the change in their selection percentage:

(2)

$$S_{i,g,t=T} = \underbrace{S_{i,g,t=0}}_{\text{selection in base year}} + \underbrace{(S_{i,g,t=T} - S_{i,g,t=0})}_{\text{change in selection}}$$

We can estimate the change in selection for each MA enrollee as the average change in selection percentage calculated for a proxy group of similar enrollees who were enrolled in the FFS program between $t = 0$ and $t = T$.¹³³ We define $P_{b,d,m}^{c,T}$ as the set of beneficiaries that serve as the proxy group for any given cohort, c , of MA enrollees in year T (defined by the year they first enrolled in MA) who have the same base year ($t = 0$), selection percentage b , year of death d relative to the target year ($t = T$), and Medicaid eligibility status m . The average change in selection for the proxy group is calculated as

(3)

$$\Delta S_T^p = \sum_{i \in P_{b,d,m}^{c,T}} (S_{i,g,t=T} - S_{i,g,t=0}) \times \alpha_i$$

Each individual's weight in the calculation is represented by α_i .¹³⁴ The term $S_{i,g,t=0}$ is defined in equation (1), and $S_{i,g,t=T}$ is defined similarly as the ratio of each individual's actual spending in the target year relative to an estimate of their predicted spending in that same year:

(4)

$$S_{i,g,t=T} = \frac{y_{i,g,t=T}}{\bar{y}_{g,t=T} \times r_{i,g,t=T}}$$

Proxy groups are constructed by segmenting the population of beneficiaries who were enrolled in FFS from $t = -1$ through at least one month of $t = T$ into 110 mutually exclusive groups.^{135,136} Those FFS enrollees are assigned to groups according to three key characteristics. First, they are assigned to one of three mortality groups based on their mortality in year $t = T$, $t = T + 1$, and $t > T + 1$. Second, they are assigned to a group based on their base-year selection percentage at $t = 0$. Third, for beneficiaries assigned to mortality in year $t > T + 1$, they are assigned to a group based on their dual-eligibility status for Medicaid (fully dual, partially dual, nondual).¹³⁷ Each MA enrollee is matched to the proxy group that has the same mortality status, level of base-year selection, and dual-eligibility status (where applicable). The enrollee is then attributed the average change in selection for their matched proxy group.

For example, consider the set of MA enrollees in 2023 who were last enrolled in FFS in 2017 (including all of 2016), died after 2024, were full duals, and had a selection percentage of 92 percent in 2017. The proxy group for those enrollees consists of beneficiaries who were enrolled in FFS in 2017 (including all of 2016) through 2023, died after 2024, were full duals, and had a selection percentage between 90 percent and 100 percent in 2017.¹³⁸ The average change in selection percentage for that proxy group between 2017 and 2022 is used as the estimate for the change in selection percentage for the MA enrollees who match that proxy group.

Matching on base-year selection percentage is important for capturing the potential for mean reversion because people who begin the period with a large degree of favorable (or unfavorable) selection may be more likely to experience larger changes that bring them closer to the mean. Matching on mortality is important because people closer to death tend to have higher spending on average, both in absolute terms and relative to their predicted spending. Matching

on dual-eligibility status is important because these beneficiaries comprise a larger share of MA enrollees compared with FFS enrollees. The average change in selection for the proxy group also accounts for changes to the Medicare risk-adjustment model, changes in the composition of the FFS population, and secular trends in FFS spending over the period. For example, changes to Medicare's risk-adjustment model are reflected in the calculation through changes in risk scores for the proxy group, which we include when measuring change in selection for MA enrollees.

Cohort-level estimates of MA switchers

We construct aggregate selection percentages at the mortality–dual status–cohort–group level by aggregating the estimates of individual-level selection effects, weighting by predicted spending and number of months enrolled in MA during year $t = T$.

(5)

$$S_{c,d,m,T} = \sum_{i \in c,d,m,T} (S_{i,g,t=0} + \Delta S_T^p) \times w_{i,T}$$

Because the risk scores of MA enrollees at year $t = T$ are influenced by the coding practices of their plans, in constructing the weights for this calculation we estimate what each individual's risk score would have been in year $t = T$ had they been enrolled in FFS.¹³⁹ To do this estimate, we take the beneficiary's FFS risk score from the base year before they switched to MA and trend it forward based on the change in risk score for members of their proxy group.

Assigning cohort-level estimates to the remaining MA population

About 26 percent of the MA-enrolled population in 2023 (8 million enrollees) are in our study population and have their selection percentage estimated using the method outlined above. The bulk of the remaining MA population either switched from FFS to MA but did not have sufficient data (39 percent) or enrolled in MA upon their initial eligibility for Medicare and had no prior FFS months (35 percent).¹⁴⁰ For those enrollees, we assign a selection percentage as the estimated selection percentage of switchers in our study population who joined MA in the same year, had the same mortality status in the following two

years, and had the same dual-eligibility status in the target year. That is, selection percentages are assigned to MA enrollees outside the study population at the mortality–dual status–cohort–group level. (We also assign selection percentages to all beneficiaries who enrolled in MA before 2010 using the estimated selection percentages for the 2010 cohort of our study population. This group consists of beneficiaries who had any prior Medicare FFS enrollment and those who had no prior Medicare FFS enrollment.)

The decision to generalize estimates of selection from our study population to switchers outside our study population and enrollees who joined upon initial eligibility for Medicare is supported by our own analysis and external studies. Our analysis suggests that MA enrollees who switched from FFS but had less than two years of prior FFS coverage had favorable-selection effects that were at least as large as the MA enrollees in our study population with at least two years of prior FFS coverage. In our March 2024 report to the Congress, we used risk scores constructed from concurrent diagnoses to examine the effect of favorable selection for beneficiaries who had only one full year of prior FFS enrollment (before switching to MA). We estimated favorable-selection effects that were consistently larger for these beneficiaries than for our study population of MA switchers (i.e., beneficiaries who had at least two years of FFS enrollment before joining MA) (Medicare Payment Advisory Commission 2024c).

For beneficiaries who enroll in MA upon initial Medicare eligibility, the available evidence is also consistent with favorable selection. One study used mortality as a rough proxy for MA favorable selection and found substantially lower mortality rates among enrollees who elected MA during their first year of Medicare eligibility relative to those who elected FFS during their first year of Medicare eligibility (Newhouse et al. 2019). Further, another group of researchers examined pre-Medicare spending for a sample of about 11,000 beneficiaries who enrolled in MA at age 65 between 2015 and 2019. When comparing the risk-adjusted pre-Medicare spending of these MA enrollees with the pre-Medicare spending of a sample of beneficiaries who elected FFS at age 65, these researchers found about 13 percent lower risk-adjusted spending in the MA sample relative to the sample of FFS beneficiaries (Teigland

et al. 2025a). That estimate of favorable selection exceeds our estimate of favorable selection for MA switchers throughout the 2015 to 2019 period, which we estimate to be 4 percent to 9 percent using the Commission’s simple method, which is most comparable with that study’s methods. Moreover, a recent study examined Medicaid enrollees immediately before becoming eligible for Medicare from 2017 to 2022 (Pelech et al. 2025). Using the spending and risk-score data in Appendix Table 11 of that study, MA enrollees had 23 percent lower risk-standardized medical spending than the FFS population before Medicare eligibility. Our analyses combined with the results of other research suggest that the effect of favorable selection for MA entrants who have less than two years of prior FFS coverage, or none at all, may be even larger than what we observed in our study population.

Final aggregate selection percentage of MA population

The final aggregate selection percentage of the entire MA enrolled population in year $t = T$ is a dollar-weighted average of the individual selection percentages. Each enrollee is weighted by the number of months they were enrolled in MA in year $t = T$, their FFS county-level risk-standardized spending in year $t = T$, and their projected FFS risk score (using the change in risk score of the proxy group during MA enrollment). This weighting reflects each individual’s predicted spending in year $t = T$ as a share of the MA population’s predicted spending in year $t = T$.

Our approach to estimating selection for the MA population in the target year using data from people who were enrolled in MA in that year implicitly accounts for the role of selective attrition out of the MA program. “Selective attrition” refers to the tendency for the beneficiaries who either die or disenroll from the MA program to FFS to have risk scores that underpredict their spending. Analyses by the Commission and other researchers have found evidence of selective attrition, suggesting that the size of favorable selection in the MA population could be higher than estimates using data from all people who initially enrolled in MA. By defining our study population as beneficiaries who are enrolled in MA during the target year, we exclude beneficiaries who disenrolled from MA in earlier years. Because

we require more than one year of FFS data for beneficiaries to be included in our FFS comparison population, we may slightly underestimate the effect of selection because we exclude beneficiaries who disenrolled from MA in years $t = 0$ or $t = T$ but did not have enough FFS experience to be counted in our comparison population for those respective years. However, those beneficiaries account for a very small share of enrollees and are not likely to have a substantial effect on our estimate. This approach to accounting for selective attrition implicitly through the construction of the study population remains the same in the current version of the methodology and the methods used in our March 2024 and March 2025 reports to the Congress.

Technical changes relative to the methods used for the March 2025 report to the Congress

The analysis described in this chapter continues to use the analytic framework from our March 2025 report. We also continued to make refinements to improve the accuracy of our estimates and address some of the limitations of our prior method. The methodology outlined above reflects three main types of technical updates to our methods from last year. First, we now include dual-eligibility status in our matching of the MA study population to the FFS proxy group when modeling changes in selection. Second, we now account for dual-eligibility status when applying estimates outside our study population, along with continuing to account for differences in mortality status and year of initial enrollment. Those updates address the two main areas of uncertainty in the Commission's methodology (see below for further discussion). Third, we apply a series of technical updates to improve comparability between our MA and FFS populations. Overall, these changes improved the accuracy of the Commission's estimates of favorable selection but, on net, did not substantially change the magnitude of our estimates.

We now describe each of the technical updates more thoroughly:

- Matching the MA study population to proxy groups using dual status (fully dual, partially dual, or nondual): When modeling changes in selection during MA enrollment, for beneficiaries with a mortality status $t > T + 1$, we now match MA

cohorts and their proxy cohorts by dual-eligibility status (using the target year dual-eligibility status), mortality (using the number of years to death relative to the target year $t = T$) and the initial selection percentage in year $t = 0$. This modification allows our estimate to better account for changes in selection that may be different for fully dual-eligible beneficiaries and partially dually eligible beneficiaries. Previously, we assumed that full duals and partial duals had the same change in selection percentage as MA enrollees who were nondually eligible. In general, the selection estimates in target year $t = T$ were similar after including dual eligibility as a matching characteristic. To maintain a reliable number of beneficiaries in each of our MA and proxy group subcohorts, we are unable to apply our dual status match to the smaller decedent ($t = T$) and near-decedent ($t = T + 1$) populations. Matching on dual status is likely to be less important for those populations because we anticipate fewer differences in the changes in risk-standardized spending between duals and nonduals among these mortality groups. In other words, we expect being close to death to be the most consequential factor for modeling changes in selection for both duals and nonduals.

- Assigning selection percentages to the nonstudy MA population using dual status: We use estimates of favorable selection for MA enrollees in our study population to assign selection percentages to MA enrollees outside of our study population. Under the previous version of our method, we matched MA enrollees who were outside our study group to those in our study group based on their year of entering MA and their mortality status. For example, individuals who entered MA in 2018 but did not have the required number of years in FFS to be in our sample were assigned the average selection percentage of members of our study cohort who entered MA in 2018 and who had the same mortality status (using the number of years to death relative to the target year $t = T$). Under our updated method, we now also match MA enrollees outside our study population to those in our study population by dual status (using dual status in the target year $t = T$) when assigning them a selection percentage. (To maintain a reliable estimate, we apply this match only to MA enrollees with a mortality status of $t > T + 1$.) In

addition, we trend forward the initial average risk score of each individual in each study-population cohort by the increase in risk score of their proxy cohort—dual status—mortality group. We apply this trended risk score to the broader MA cohort—dual status—mortality group, which is used to weight individuals in different cohorts. Thus, under our updated method, each MA enrollee in the nonstudy population receives a selection percentage and expected risk score based on their MA entry year, dual status, and mortality status in year $t = T$. We previously implicitly assumed that enrollees outside our study population had the same average selection percentage as individuals with the same mortality status and year of MA entry within the study population. That did not allow our estimates to reflect any differences in selection percentage by dual status within those subcohorts when assigning selection percentages outside our study population. Because MA enrollees in our study population have a somewhat larger share of dually eligible beneficiaries relative to the general MA population, reflecting those differences allows us to more fully account for differences between our study and nonstudy populations and increases the accuracy of our estimates.¹⁴¹ Thus, this update to our method more accurately accounts for dual-status differences between MA enrollees included and not included in our study populations.

- Other updates to enhance comparability of the MA and FFS populations include:
 - Ensuring consistent county of residence in the MA study population and FFS comparison population: We rely on an annual spending file for each beneficiary to estimate the average risk-standardized spending in each county for the FFS population. This county-level spending is used to construct the denominators of the selection percentages for MA enrollees in our study population and FFS enrollees in our proxy group. Under our previous method, we allowed beneficiaries to reside in multiple counties during the year in which spending was calculated. Thus, we assumed that county-level differences in spending would not be altered by beneficiaries who may have resided in a different county during the year. Under our updated method, we

exclude beneficiaries who did not reside in the same county during the years in which spending is calculated. This change applies to the FFS comparison group in each year of our study, and it applies to the MA study population and proxy group during the base year ($t = 0$) and during the target year ($t = T$). While this update did not affect our overall estimates of favorable selection, it ensures that we better account for geographic differences in spending.

- Removing the weighting of hospice months from spending calculations: Because MA plans are not liable for Medicare spending during hospice enrollment, we exclude beneficiaries who were in hospice status for the entire year from our analysis. For beneficiaries who were in hospice status for part of the year, we would ideally exclude all of their hospice and nonhospice spending that was incurred during hospice months. However, our ability to do so is imperfect because we rely on annual spending totals divided by the number of enrolled months to construct average monthly spending. To exclude spending on hospice services, we subtract hospice spending from the annual totals we use to calculate spending for our MA study population, proxy group, and FFS comparator. Under our prior method, we included all of a beneficiary's enrolled months (including months in hospice status) when converting those annual totals into average monthly spending amounts for beneficiaries who were enrolled in hospice for part of the year. Under our current method, we remove hospice months from the calculation of average monthly spending in order to better measure average spending during nonhospice months, which increases the average monthly spending of beneficiaries who were in hospice status for part of the year.¹⁴² While this update did not affect our overall estimates of favorable selection, it ensures better comparability between the MA and FFS populations when calculating risk-standardized spending differences.
- Correcting for historical errors in the count of decedent months from 2016 to 2020: In our March 2024 report to the Congress, our estimates relied on beneficiaries who were enrolled in

Medicare from the base year ($t = 0$) through the target year ($t = T$), and all beneficiary months were scaled to a full year (i.e., 12 months). In our March 2025 report to the Congress, we updated our method to include decedents. Under our current method, we correct two discrepancies that had moved our estimates in two different directions. First, we correct a discrepancy in the 2017 to 2020 estimates published in the March 2025 report that undercounted decedents. This discrepancy scaled decedent months to a full year instead of reflecting the number of months in the year that the decedents were alive. This error did not affect our 2021 and 2022 estimates of favorable selection, which were the basis for our projections of favorable selection for 2023 to 2025 that we published in the March 2025 report. Second, we corrected an error in our 2016 estimate of favorable selection that overcounted decedents. This discrepancy assigned decedents in 2017 as decedents in 2016. This adjustment increased our 2016 estimate of selection by 2 percentage points.

We compared the estimates that we published in the March 2025 report to the Congress for the MA population from 2016 to 2022 with our estimates for the 2016 to 2022 MA population under the updated methodology. The updated methodology did not meaningfully change our overall estimates of favorable selection for 2021 and 2022. However, our overall estimate of the MA selection percentage in 2016 decreased by 2 percentage points (a 2 percentage point increase in MA payments relative to FFS spending) and increased our selection percentage in 2017 through 2020 by 2 percentage points to 3 percentage points (a 2 percentage point to 3 percentage point decrease in payments relative to FFS spending) each year. Overall, our updates make our estimate of favorable selection much more consistent over the entire 2016 to 2022 period (Figure 12-B2, p. 436). We will continue working to update our methods where appropriate.

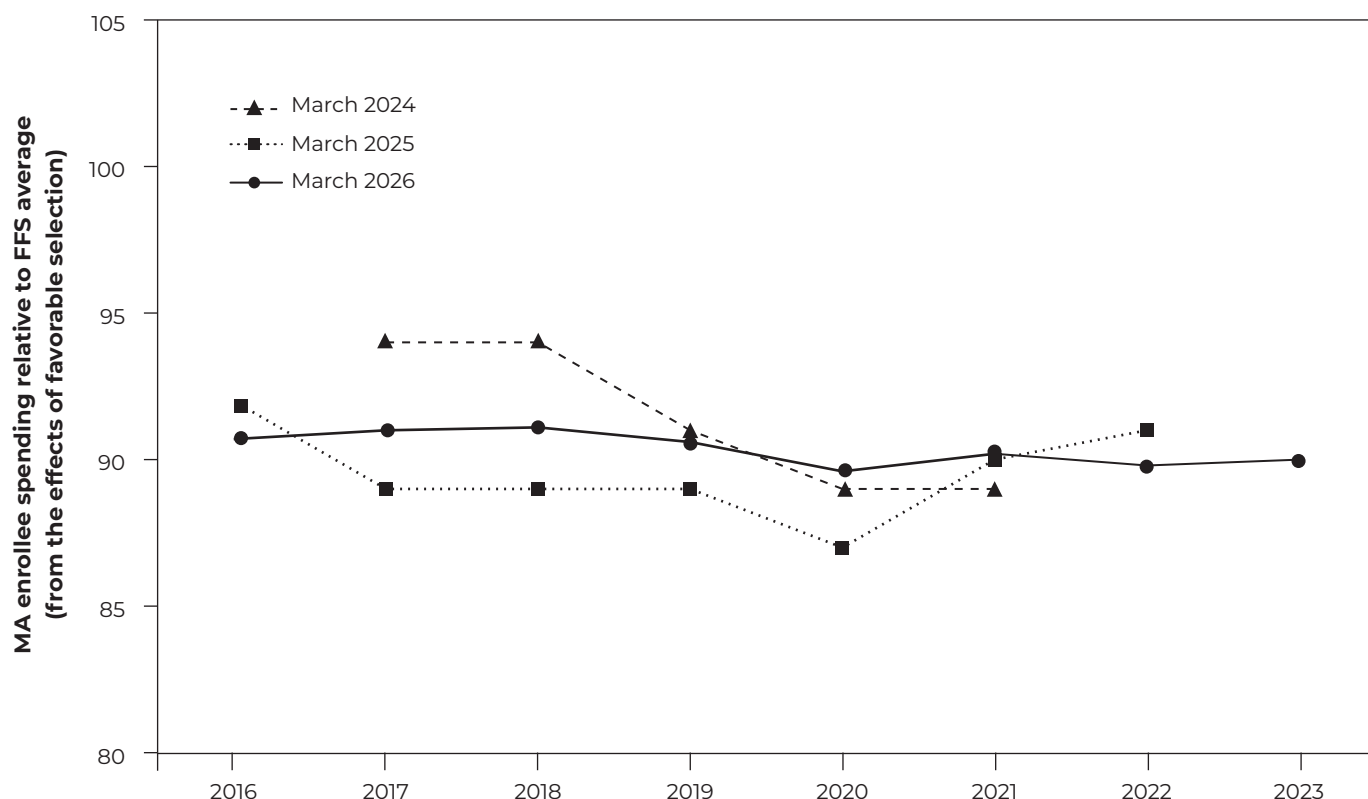
Sensitivity analysis to assess the robustness of modeling how selection changes over time

One of the most uncertain aspects of the Commission's methodology for estimating favorable selection is the modeling of how selection changes over time (reverts to the mean) while beneficiaries are enrolled in MA. We

rely on data from our MA-switcher study population and the FFS population for that modeling. Our modeling goes through two steps of matching:

- First, we match our study population of MA switchers to our FFS proxy group using base-year (i.e., year in which our study population switched into MA) mortality status, base-year selection percentage, and dual-eligibility status. The average change in selection percentage experienced by each FFS proxy group is used to estimate the change in selection during MA enrollment for the study population of MA switchers with the same characteristics.
- Second, we match our study and nonstudy populations by assigning selection percentages to the nonstudy population using the estimated selection of enrollees in our study population with the same year of entry, dual-eligibility status, and mortality status.

Neither step in our matching process originally included dual-eligibility status, and we now add this characteristic to our matching steps to better account for the ways in which the MA population (both the study and nonstudy populations) is demographically distinct from the FFS population. While dual-eligibility status is one important factor that makes the MA population distinct, we wanted to understand how using other characteristics as matching factors may affect our estimate of the MA selection percentage. We started with our original matching characteristics that were restricted to base-year selection percentage (for the FFS proxy group only), year of entry into MA, and mortality status. We compared the selection percentage of that original matching with our estimated selection percentage when adding one additional matching factor in 2022 and 2023. For example, Figure 12-B3 (p. 437) reports that the estimated selection percentages when matching only on base-year selection percentage, year of entry into MA, and mortality status was 90.3 percent for 2022 and 90.5 percent for 2023. When adding one further matching factor to the FFS proxy group—base-year risk score—those percentages slightly changed to 90.2 percent (2022) and 90.4 percent (2023). The remaining columns in that figure report the estimated selection percentage when adding one factor to the original matching characteristics (rather than report effects

**FIGURE
12-B2****Updated favorable selection estimates are consistent across years**

Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates are for beneficiaries without end-stage renal disease and were constructed using the Commission's comprehensive method for estimating favorable selection. Selection percentages are computed as the ratio of the estimated spending that the FFS program would have incurred for MA enrollees relative to the spending predicted by their county benchmark and Medicare's risk-adjustment model. Selection-percentage values farther below 100 percent indicate greater favorable selection. Estimates are rounded to the nearest percent.

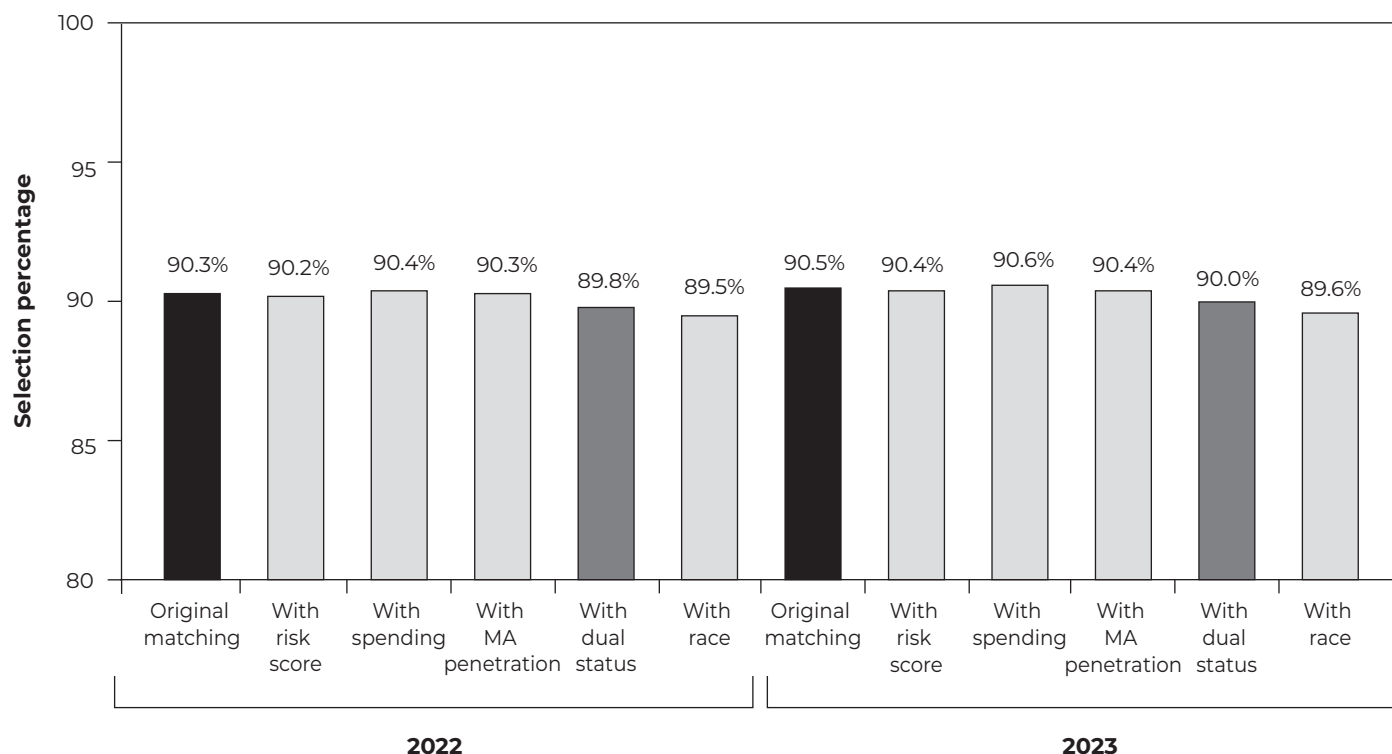
Source: MedPAC analysis of Medicare enrollment (2006–2023), Medicare claims spending (2007–2023), and risk-adjustment files (2007–2023).

from cumulative matching characteristics, which would have compromised the reliability of our subcohort estimates). One set of factors—base-year risk-score level and base-year spending level—were applied only to the matching of our study population of MA switchers with our FFS proxy group, not to matching our study population with the nonstudy population.¹⁴³ (We are not able to match risk-score level and spending level to our nonstudy MA population.) A second set of factors—base-year MA market-penetration level, dual-eligibility status, and race—were applied to both steps in our matching process.

For 2022 and 2023, our estimates of selection percentages under the different matching scenarios were all within 1 percentage point, indicating that our estimate is relatively robust to alternative specifications (Figure 12-B3). For example, our original matching—year of MA entry and mortality status—resulted in a selection percentage of 90.5 percent in 2023. When we added risk-score level, spending level, or MA market-penetration level, our overall selection percentage was nearly identical, indicating that we do not estimate different levels of favorable selection when accounting for these characteristics. Alternatively, we found that

**FIGURE
12-B3**

Accounting for the effects of dual eligibility and race slightly increases the effects of favorable selection



Note: MA (Medicare Advantage). Estimates were constructed using the Commission's comprehensive method for estimating favorable selection. Estimates do not include beneficiaries with end-stage renal disease. Each estimate contrasts the matching approach used to construct the proxy groups that are used to model changes in selection during MA enrollment. The original matching approach used in our March 2025 report is based on initial selection percentage, year of entry into MA, and mortality status. The other estimates use one of the specified additional factors as a matching factor when constructing the proxy groups. Risk scores, spending, and MA penetration are based on base-year (i.e., the year before MA enrollment) tiers. "Dual status" consists of categories for fully dual eligible, partially dual eligible, and nondually eligible during the target year (e.g., 2023). Categories of race consist of White, Black, Hispanic, and other. Selection percentages are computed as the ratio of the estimated spending that the FFS program would have incurred for MA enrollees relative to the spending predicted by their county benchmark and Medicare's risk-adjustment model. Selection percentage values farther below 100 percent indicate greater favorable selection.

Source: MedPAC analysis of Medicare enrollment (2006–2023), Medicare claims spending (2007–2023), and risk-adjustment files (2007–2023).

dual-eligibility status (a selection percentage of 90.0 percent in 2023) and race (a selection percentage of 89.6 percent in 2023) had a marginal impact on our results. These social risk factors produced marginally lower selection percentages (i.e., higher estimates of favorable selection) in both 2022 and 2023. Thus, dually eligible beneficiaries and Black and Hispanic beneficiaries have somewhat different levels of favorable selection that are not captured in the original matching method. To better capture the increasing share of dually eligible beneficiaries in MA (and any differences in dual status between our study and

nonstudy populations), our estimates of favorable selection now explicitly adjust for dual-eligibility status (i.e., fully dual, partially dual, and nondual).¹⁴⁴ Adding further matching characteristics, such as race, is challenging because maintaining adequate sample sizes in each subgroup is not always possible. An additional challenge with using race as a matching characteristic is that the data are incomplete for some beneficiaries. We will continue to explore other opportunities to refine our methods in estimating favorable selection.

Sources of uncertainty in the Commission's estimate of favorable selection

There are four main sources of uncertainty in the Commission's estimate of favorable selection. Below, we discuss those sources. We have tried to make reasonable modeling assumptions where there is uncertainty. This year, we incorporated two modeling updates to address two of the sources of uncertainty and conducted additional sensitivity analyses; however, our estimate of favorable selection could be higher or lower if actual trends differ from those assumptions.

- We have a high degree of confidence in our estimate of favorable selection for beneficiaries in our study population before they enter MA ("base-year selection"). However, there is uncertainty in our estimate of the change in selection while our study population was enrolled in MA because that change cannot be observed directly with available data and must be estimated using a different population of beneficiaries who are enrolled in FFS. We make the best use we can of available data to estimate the change in selection by matching our study population to FFS "proxy groups" using their base selection before entering MA and their mortality status and dual-eligibility status during the year of MA enrollment. Our previous analysis suggests that this portion of the estimate is conservative because using narrower proxy groups of FFS beneficiaries who later enrolled in MA produced larger selection effects (Medicare Payment Advisory Commission 2025b). The sensitivity analyses we conducted this year to assess the impact of matching on additional characteristics when constructing FFS proxy groups demonstrated that the estimated change in selection was robust to alternative specifications. However, the actual change in selection could be higher or lower than we estimate.
- There is also uncertainty regarding the selection effect for MA enrollees outside our study population. Due to a lack of data, we assign a selection percentage to those beneficiaries using data from MA beneficiaries in our study population. Our analysis, described earlier in the appendix, indicates that assigning selection percentages that we estimate by using our study population to the remaining MA population is appropriate and may be conservative. This year, we improved our methodology for assigning selection effects to MA enrollees outside our study population. We now account for differences in dual-eligibility status when applying estimates outside our study population, along with continuing to account for differences in mortality status and year of initial enrollment. That refinement, along with the studies cited earlier that found substantial selection in the newly eligible population, gives us greater confidence in our approach to modeling selection for this population. We will continue looking for ways in which we can better account for differences between our study population and the general MA population in our modeling.
- Another source of uncertainty stems from data limitations that require us to exclude beneficiaries who lack a full prior year of FFS enrollment from the FFS comparison population used for the denominators. That method excludes some beneficiaries from the FFS comparison group (denominator) whom studies have demonstrated to have unfavorable (that is, higher) risk-standardized spending if they had recently disenrolled from MA to FFS (Fuglesten Biniek et al. 2024). This suggests that our FFS comparison group should have slightly larger risk-standardized spending than what we currently estimate, and our estimated selection effects would be slightly larger if FFS beneficiaries who recently (within 12 months of the target year) disenrolled from MA were included in our study. In addition, we also exclude FFS beneficiaries who recently became eligible for Medicare. Their risk-standardized spending may be higher or lower than the population of FFS beneficiaries with complete data who are in our comparison group, so omitting those beneficiaries may cause our estimate of favorable selection to be either higher or lower.
- Finally, there is uncertainty in our estimate of roughly zero favorable selection for MA enrollees with ESRD. Because our estimate of favorable selection is limited by observing plan switching, it is particularly difficult to estimate favorable selection for this small population. However, our analysis using the simple method (detailed on pp. 379–382 of Chapter 12) suggests that it is appropriate to estimate a zero-selection effect

for MA enrollees with ESRD, given our limitations. We include this zero selection effect in our overall estimate of favorable selection. Because payments to MA plans for ESRD enrollees account for a

projected 6 percent of total payments to MA plans in 2026, the inclusion of ESRD enrollees did not have a large effect on our overall estimate. ■

12-C

TECHNICAL APPENDIX

Coding intensity

The Commission's method for estimating MA coding intensity

The Commission's method for estimating coding intensity is based on the demographic estimate of coding intensity (DECI) method, originally developed by Kronick and Chua (2021). In prior years, we applied the DECI method to estimate coding intensity for Medicare Advantage (MA) enrollees without end-stage renal disease (ESRD) but had not yet analyzed coding intensity for ESRD enrollees. This year, we have incorporated enrollees with ESRD in our analysis of coding intensity. Analyzing coding intensity for ESRD enrollees must be conducted separately from analysis of coding intensity for enrollees without ESRD because payments for ESRD enrollees are adjusted using separate risk models. The estimates presented in this chapter reflect our combined estimate of coding intensity for the overall MA population, including both enrollees with and without ESRD. We first explain the methodology used to estimate coding intensity for beneficiaries without ESRD. Subsequent sections explain additional analysis for beneficiaries with ESRD and how we combine estimates for beneficiaries with and without ESRD to arrive at a final estimate of overall MA coding intensity.

Estimating coding intensity for MA enrollees without ESRD

The Commission's method for estimating coding intensity for the non-ESRD population uses the same DECI methodology used last year. The DECI method implicitly assumes that MA enrollees have a similar average prevalence of health conditions as fee-for-service (FFS) Medicare beneficiaries with similar demographic characteristics. The method first estimates the ratio of the national average MA CMS hierarchical condition category (CMS-HCC) risk score to the national average FFS CMS-HCC risk score. This ratio reflects differences in risk scores due to coding intensity and true differences in health condition prevalence between the two populations. Second, the method estimates the ratio of the national average MA demographic-only risk score to the national average FFS demographic-only risk score. The DECI estimate is the result of dividing the MA-to-FFS CMS-HCC risk-score ratio by the MA-to-FFS demographic-only risk-score ratio. Therefore, the DECI method attributes

higher demographic-adjusted MA risk scores relative to FFS to higher MA coding intensity rather than worse health acuity or complexity among MA enrollees than FFS beneficiaries. Figure 12-C1 (p. 442) shows how the DECI method estimates coding intensity.

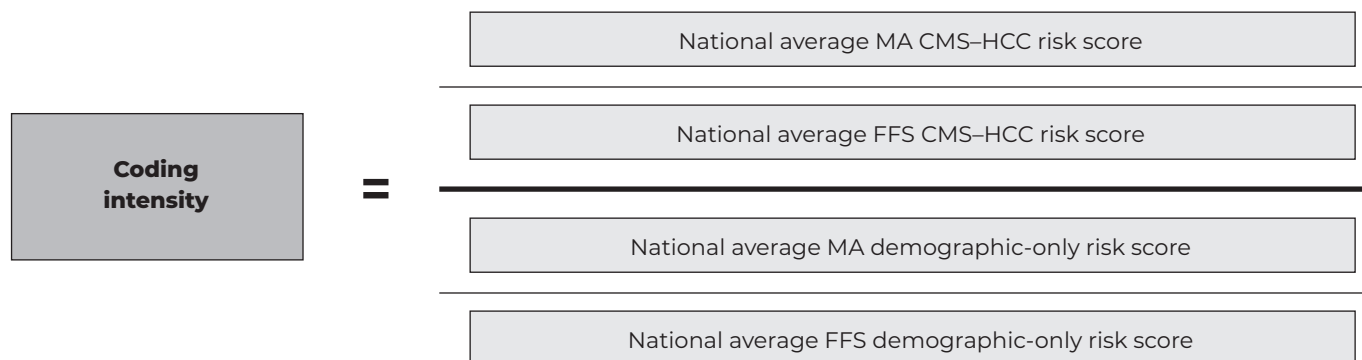
National average CMS hierarchical condition category risk scores

We use data from the Medicare common enrollment files and risk-score files to construct national average CMS-HCC risk scores for the MA and FFS populations. To define the two populations, we identify monthly MA or FFS enrollment using the plan identifier in the Medicare common enrollment file, and we require all MA and FFS beneficiaries to have both Part A and Part B using the "Medicare enrollment code" data field. We exclude beneficiaries residing in Puerto Rico based on their monthly county of residence. (Starting with our March 2025 report, we excluded beneficiaries residing in Puerto Rico from our coding-intensity estimate because Puerto Rico's Medicaid program does not use the full-, partial-, or no-benefit structure, which is necessary for our coding-intensity estimation method.) Then we use monthly indicators in risk-score data to exclude beneficiary months in which an ESRD risk score would be applied and to assign "new-enrollee" and institutional risk scores as appropriate. For all remaining months, we assign the appropriate community-model risk score using the monthly Medicare-Medicaid dual status code from the enrollment file to adjust for full, partial, or no Medicaid benefits, and we use the beneficiary's age from risk-score data to determine aged or disabled status. In each year, we use the version of the risk model or blend of versions that was used for payment to MA plans. Finally, we aggregate the monthly risk scores to calculate national average MA and FFS CMS-HCC scores for the four groups identified below.

When developing this method, we benchmarked our estimate of the national average risk score for all FFS beneficiaries in 2019 (including those with Part A only) of 1.0682 against the national average published by CMS of 1.0685 to confirm that we were assigning risk scores appropriately. (When estimating the effects of coding intensity, we exclude beneficiaries with Part A-only coverage.) Our estimate of the average risk score for all FFS beneficiaries was similarly close to CMS's published results for 2017 and 2018.

**FIGURE
12-C1**

DECI method estimates coding intensity as the ratio of two ratios



Note: DECI (demographic estimate of coding intensity), MA (Medicare Advantage), CMS-HCC (CMS hierarchical condition category), FFS (fee-for-service).

Source: Kronick and Chua 2021.

National average demographic risk scores

We calibrate an annual risk model based only on demographic characteristics for FFS beneficiaries with both Part A and Part B (excluding beneficiaries with ESRD) by including age category (from the CMS-HCC model), sex, Medicaid eligibility (full benefits, partial benefits, or no benefits), and institutional status (see text box, p. 444). We use the same enrollment and risk-score indicator variables as in the CMS-HCC risk-score analysis described above.

We calculate monthly Medicare spending by summing the annual spending amounts in the Medicare beneficiary summary file (excluding beneficiaries with any hospice use) and dividing by the months of Part A and Part B enrollment in the year. We calculate a single risk model (with dollar-value age and sex coefficients) with fully interacted indicators for beneficiary age category $\times$ sex $\times$ Medicaid or institutional status (if not in institutional status, we identify eligibility for full Medicaid benefits, partial Medicaid benefits, and no Medicaid benefits). The dollar coefficients are then converted to risk scores by dividing each coefficient by the average spending for all beneficiaries in the analytic sample. Note that this step reflects a technical

revision to the approach used in prior years. The change resulted in our 2023 coding-intensity estimate being 0.3 percentage points lower than under the prior method, and the effect was smaller on earlier years of analysis. Previously, we divided the coefficients for each group by the average spending for beneficiaries in that group. Given this change, the average risk score for the whole model is 1.0. Finally, we apply those demographic risk scores to MA and FFS beneficiaries with both Part A and Part B and aggregate them to national averages for each of the four groups identified below.

Calculate coding-intensity accounting for Medicaid eligibility and institutional status

For MA and FFS, we calculate average CMS-HCC and demographic risk scores separately for continuing (not new-enrollee) beneficiary months with institutional status, full Medicaid benefits, partial Medicaid benefits, and no Medicaid benefits. We then calculate average CMS-HCC and demographic risk scores for continuing enrollees by using the share of MA enrollees in each of the four groups as weights for both the MA and FFS averages. Then we calculate a DECI estimate for continuing enrollees using the formula in Figure 12-C1.

**TABLE
12-C1****Calculation of MedPAC's coding-intensity estimate for beneficiaries without ESRD, 2024**

Beneficiary group	CMS-HCC risk-score average		Demographic risk-score average		MA share of continuing enrollees
	MA	FFS	MA	FFS	
Continuing enrollees					
No Medicaid	1.067	0.950	0.911	0.921	76.8%
Partial Medicaid	1.363	1.078	1.001	0.997	8.1
Full Medicaid	1.645	1.342	1.246	1.204	14.2
Institutional	2.436	2.203	4.847	4.815	1.0
MA weighted average risk scores	1.186	1.028	1.004	1.005	
Beneficiary group	CMS-HCC MA/FFS risk-score ratio		Demographic MA/FFS risk-score ratio		
Continuing enrollees	1.186 / 1.028 = 1.153		1.004 / 1.005 = 0.999		
Beneficiary group	DECI estimate		MA share of enrollees	MA average HCC risk score	Group weight
Continuing enrollees	1.153 / 0.999 = 1.154 (15.4%)		91.9%	1.186	95.6%
New enrollees	1.000 (0.0%)		8.1	0.624	4.4
All enrollees	1.147 (14.7%)				

Account for coding adjustment: Multiply 1.147 × (1 – 5.9 percent) = 1.079

All enrollees after coding adjustment **1.079 (7.9%)**

Note: ESRD (end-stage renal disease), CMS-HCC (CMS hierarchical condition category), MA (Medicare Advantage), FFS (fee-for-service), DECI (demographic estimate of coding intensity). Analysis excludes beneficiaries with ESRD and beneficiaries residing in Puerto Rico. Risk scores reflect the two-thirds V24 and one-third V28 risk model blend that was used for payment in 2024. The DECI estimate is the ratio of the MA/FFS CMS-HCC risk score ratio and the MA/FFS demographic risk score ratio. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. For 2024, we use the most recently available (2023) Master Beneficiary Summary File for the FFS spending used to calculate the demographic risk-score models. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of 2024 Medicare enrollment and risk score files and 2023 Medicare enrollment and Master Beneficiary Summary Files.

Finally, we calculate a DECI estimate for all enrollees by adding together the continuing-enrollee DECI estimate multiplied by the risk-score-weighted share of continuing MA enrollees and the new-enrollee DECI estimate multiplied by the risk-score-weighted share of new enrollees in the analysis. This final step constrains risk scores for new enrollees to have no coding intensity because their risk scores are not based on diagnostic coding. We use a risk-score-weighted new and continuing enrollment share to combine new

and continuing enrollee DECI estimates because those weights reflect the share of MA payment associated with each group. Table 12-C1 shows an example DECI calculation for 2024 that accounts for Medicaid-eligibility and institutional status in MA and FFS.

Calculating the effect of CMS's coding adjustment

CMS's adjustment reduces MA risk scores by 5.9 percent. To account for this adjustment, we multiply

Sensitivity estimates of alternative demographic risk-model specifications

Applying the demographic estimate of coding intensity (DECI) method involves calibrating a risk model based only on demographic characteristics. That model is used to construct an alternative measure of Medicare Advantage (MA) and fee-for-service (FFS) population-level risk that, unlike the CMS hierarchical condition category (HCC) model, is not affected by coding intensity. The ratio of MA and FFS demographic risk scores is used to measure the relative risk of the two populations, and any population-level differences in risk scores that are greater than what would be predicted using the demographic model are attributed to coding intensity.

Because the demographic risk model is how the DECI method controls for differences in the MA and FFS populations, including additional demographic characteristics that are not affected by plan coding may improve the model's ability to measure differences in population risk. Commissioners and other researchers have provided suggestions about other demographic characteristics that could be included in the demographic model. This year, we modeled alternative demographic risk models to assess the robustness of our coding-intensity estimates.

We tested three alternative model specifications that add race, original reason for entitlement code (OREC), or both to the demographic risk model. Race was identified for each beneficiary based on the RTI race code in the common Medicare enrollment file and defined as Black, Hispanic, non-Hispanic White, or other (including Asian/Pacific Islander, American Indian/Alaskan native, other, and unknown categories). For original reason for entitlement, we combined entitlement based on ESRD and disability with entitlement based on ESRD to create three categories: aged, disabled, or ESRD. For each alternative model specification, we started with our primary demographic model, which has 96 fully interacted variables: 12 age categories × 2 sexes × 4 statuses

(eligible for full, partial, or no Medicaid benefits or in institutional status). The first alternative model added race by fully interacting the four race categories with each of the 96 variables in our original model for a total of 384 variables. The second alternative model added original reason for entitlement by including indicator variables for OREC being disabled and OREC being ESRD (OREC being aged is the reference category) for a total of 98 variables. We did not fully interact OREC with the other demographic variables because of the small number of beneficiaries with OREC being ESRD. The third alternative model added both race and original reason for entitlement by starting with the first alternative model that has race fully interacted with our original model variables and adding two indicator variables for OREC being disabled and OREC being ESRD, for a total of 386 variables.

We found that adding race notably increased the accuracy of the demographic-only risk model as measured by the R^2 statistic, but adding original reason for entitlement did not improve model accuracy. The R^2 statistic is an indicator of the proportion of variance in the dependent variable (annual Medicare spending for all models in this analysis) that can be explained by the independent variables in the model.

Coding-intensity estimates for all alternative demographic models were within 1 percentage point of coding intensity when using our original demographic risk model for both V24 and V28 risk models in 2024. The largest difference in coding intensity occurred for the alternative demographic model that adds race and had coding-intensity estimates that were 0.7 percentage points or 0.6 percentage points larger than estimates for our original demographic model for V24 and V28 risk models, respectively. Overall, we found the two alternative specifications had little effect on our estimates of coding intensity. ■

our estimate of coding intensity by 1 minus 5.9 percent. For example, for 2024 we multiply 1.147 percent (average MA risk score due to coding intensity if average FFS risk score is 1.0) by 94.1 percent and subtract 1 to get a coding-intensity estimate after adjustment of 7.9 percent (last row of Table 12-C1, p. 443).

To align with our overall comparison of spending on MA relative to FFS, we estimate MA coding intensity relative to FFS risk scores (i.e., MA risk scores are 14.7 percent higher than FFS risk scores due to coding intensity). The denominator for CMS's coding adjustment, however, is the average MA risk score. Because the average MA risk score is larger than the average FFS risk score, the two percentages are not equivalent. Based on our MA coding-intensity estimate of 14.7 percent above FFS, we estimate that CMS's coding adjustment would have had to reduce MA risk scores by 12.8 percent to fully account for the effects of coding intensity in 2024. We calculate this amount as $(1 - (1.0 / 1.147)) = 0.128$ or 12.8 percent. However, coding intensity varies significantly across MA organizations. As a result, CMS's across-the-board adjustment for coding intensity, which reduces all MA risk scores by the same amount, generates inequity across organizations by reducing net revenue for plans with lower coding intensity and allowing other plans to retain a significant amount of revenue from higher coding intensity. Increasing CMS's across-the-board coding adjustment to 12.8 percent would increase the penalty for plans with lower coding intensity while still not addressing the effects of coding intensity for the organizations with higher coding levels. A policy addressing coding intensity more fairly would reduce risk scores more for plans with the highest coding intensity.

Estimating coding intensity for MA enrollees with ESRD

Beginning this year, we conducted a separate analysis of coding intensity for enrollees with ESRD using the Commission's DECI method. Payments to MA plans for beneficiaries with ESRD are made using a different risk model than for beneficiaries without ESRD, and the ESRD risk model is different for beneficiaries in dialysis, transplant, or postgraft status. Because different segments of the ESRD population have their payments adjusted using different risk models, we assessed coding intensity separately for the three segments.

First, beneficiaries in dialysis status have a model calibrated on FFS claims for beneficiaries in dialysis status that aligns with the state-based dialysis payment rates that MA plans receive. Second, Medicare uses a risk model for beneficiaries in transplant status for the three months following transplantation. That model includes one variable that varies depending on the month after transplantation (first, second, or third). Transplant risk scores do not vary by demographic characteristics or by diagnosis codes, so there can be no differences in coding intensity between the MA and FFS populations in transplant status. Last, Medicare uses a separate risk model for beneficiaries with ESRD who are more than three months posttransplant. The postgraft risk model is adapted from the non-ESRD risk model and is modified to remove conditions that are common to all beneficiaries in postgraft status and adds several interacted indicators to capture differences related to being 4 to 9 months posttransplant versus 10 months or more posttransplant, aged versus disabled status, eligibility for full versus partial versus no Medicaid benefits, and original reason for entitlement being disability. The postgraft risk model has separate segments for beneficiaries residing in the community or in an institutional setting for longer than 90 days.

Below, we describe steps taken to estimate coding intensity for beneficiaries in dialysis status and those in postgraft status. Beneficiaries in transplant status cannot have coding intensity because diagnoses are not used in that model, so we assign them a coding-intensity estimate of zero.

Estimating coding intensity for beneficiaries in dialysis status

To estimate coding intensity for beneficiaries in dialysis status, we applied our method for calculating coding intensity by:

- limiting our analysis to beneficiary months in dialysis status for both MA and FFS populations when calculating national average HCC scores and
- including only beneficiaries in dialysis status for all 12 months of the calibration year when calibrating the demographic risk model.

The method follows the same calculation as for beneficiaries without ESRD shown in Table 12-C1 (p. 443). We estimate that coding intensity for

**TABLE
12-C2****Calculation of MedPAC's coding-intensity estimate for beneficiaries with ESRD before coding-intensity adjustment, 2015 to 2026**

Payment year	Dialysis DECI	Transplant DECI	Postgraft DECI	Dialysis share	Transplant share	Postgraft share	ESRD DECI
2015	9%	0%	5%	89%	2%	9%	9%
2016	9	0	5	89	2	9	9
2017	9	0	4	89	2	9	9
2018	10	0	6	89	2	9	9
2019	12	0	6	89	2	9	11
2020	12	0	6	89	2	9	12
2021	9	0	9	89	2	9	9
2022	10	0	13	89	2	9	10
2023	8	0	14	89	2	9	8
2024	8	0	14	89	2	9	8
2025*	9	0	15	89	2	9	9
2026*	9	0	16	89	2	9	9

Note: ESRD (end-stage renal disease), DECI (demographic estimate of coding intensity). Analysis excludes beneficiaries without ESRD and beneficiaries residing in Puerto Rico. Risk scores reflect the ESRD risk-model version used for payment to Medicare Advantage (MA) plans in each year. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Dialysis, transplant, and postgraft shares represent the estimated share of payments to MA plans for beneficiaries in each status in 2024. CMS's adjustment for coding intensity applies to the postgraft risk model but does not apply to the dialysis or transplant risk models.

* To project estimates for 2025 and 2026 for dialysis enrollees, we used the average estimate for 2022, 2023, and 2024. To project estimates for 2025 and 2026 for postgraft enrollees, we used the average annual trend from 2022 through 2024, or 0.7 percentage points. Both projection factors reflect coding-intensity patterns after the end of the coronavirus pandemic and since the implementation of the 21st Century Cures Act of 2016.

Source: MedPAC analysis of 2014 through 2024 Medicare enrollment and risk-score files and 2014 through 2023 Master Beneficiary Summary Files.

beneficiaries in dialysis status ranged from 8 percent to 12 percent over the period 2015 to 2024 (Table 12-C2). The coding adjustment does not apply to beneficiaries in dialysis status.

Estimating coding intensity for beneficiaries in postgraft status

To estimate coding intensity for beneficiaries in postgraft status, we applied our method for calculating coding intensity by:

- limiting our analysis to beneficiary months in postgraft status for both MA and FFS populations when calculating national average HCC scores,
- including only beneficiaries in postgraft status for all 12 months of the calibration year when calibrating the demographic risk model, and

- combining age categories with small numbers, which resulted in two categories that are broader than the categories otherwise used in the risk model: 0 through 45 and 85+.

The method follows the same calculation as for beneficiaries without ESRD shown in Table 12-C1 (p. 443). We estimate that coding intensity for beneficiaries in postgraft status ranged from 4 percent to 14 percent over the period 2015 to 2024 before accounting for the effect of the coding adjustment (Table 12-C2).

Estimating coding intensity for the full ESRD population

To combine estimates for the dialysis, transplant (assigned to be zero), and postgraft populations, we calculated a weight for each estimate based on total payments to MA plans for that population. For example,

we estimated total spending for the dialysis population as the number of months that MA enrollees were in dialysis status × the average risk score for the dialysis population × the monthly denominator for the dialysis risk model (\$7,271 for 2024). The monthly denominators for transplant and postgraft risk models are \$7,271 and \$874, respectively. We estimate that payments to MA plans for enrollees with dialysis reflect 89.1 percent of all payments for enrollees with ESRD. The share of payments was 9.2 percent for enrollees with transplant status and 1.7 percent for enrollees with postgraft status.

Table 12-C2 shows how we calculated the overall ESRD coding-intensity estimate for 2015 through 2026. To project dialysis coding intensity for 2025 and 2026, we used the average dialysis coding intensity for 2022, 2023, and 2024, representing coding-intensity patterns after the end of the coronavirus pandemic and after the implementation of policies under the 21st Century Cures Act of 2016. To project postgraft coding intensity for 2025 and 2026, we used the average annual trend from 2022 through 2024, or 0.7 percentage points per year. Projecting changes in coding intensity over time is challenging. The actual coding intensity in 2025 and 2026 may be higher or lower than what we project. We used estimates since the implementation of the 21st Century Cures Act to try to limit projection errors. Finally, we note that none of the risk models used for the different groups of beneficiaries with ESRD are affected by the implementation of the V28 risk model that is used for payments to MA plans for beneficiaries without ESRD.

Estimating overall MA coding intensity

To combine our estimates of coding intensity for MA enrollees with and without ESRD, we weight each estimate based on the share of payments to MA plans for enrollees with and without ESRD.

To estimate the impact of coding intensity on payments to MA plans, we first estimate residual MA coding intensity after applying the coding-intensity adjustment, which reduces most MA risk scores by 5.9 percent. The coding adjustment applies to risk scores for beneficiaries without ESRD and to beneficiaries with ESRD who are in postgraft status. The coding adjustment does not apply to dialysis or transplant risk scores, which use a different denominator during risk-model calibration. We then repeat the same process of aggregating these postadjustment coding-intensity estimates for ESRD beneficiaries and MA enrollees overall. As noted earlier, the denominator for our coding-intensity estimate is the average FFS risk score, whereas the denominator for CMS's coding adjustment is the average MA risk score. Because the average MA risk score is larger than the average FFS risk score, accounting for the effect of the coding adjustment reduces our coding-intensity estimates (for the populations to whom the adjustment is applied) by more than 5.9 percentage points. ■

Endnotes

- 1 CMS includes FFS-claim administrative costs in MA benchmarks, which account for about 0.20 percent of FFS spending (Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2021). Expenses for FFS-claim administration are included in our comparison of FFS spending with MA payments and differ from the expenses found in Medicare's Trustees' reports, which include the administration and oversight of the MA program and the enrollment of all Medicare providers (which is required for contracting with MA plans). The Medicare Trustees reported that administrative expenses (including those for MA enrollees) accounted for 1.04 percent of CMS's total Medicare benefit costs in 2020 (Boards of Trustees 2021).
- 2 MA enrollees could have lower cost-sharing liability in FFS if they do not use many services or if they obtain a Medigap policy when they switch to FFS. While there is no maximum out of pocket limit in FFS like there is in MA, Medigap policies limit the out-of-pocket expense by covering an enrollee's cost-sharing. Beneficiaries have a federal guaranteed-issue right to a Medigap policy with no medical underwriting, even if they have a preexisting condition, if they purchase it during the six-month Medigap open enrollment period that begins on the first day a beneficiary is both 65 years old and enrolled in Medicare Part B. Only four states (Connecticut, Maine, Massachusetts, and New York) require guaranteed-issue rights to Medigap for aged (65 and over) beneficiaries in FFS Medicare, regardless of medical history, meaning that insurers cannot deny a Medigap policy to applicants based on preexisting conditions (Boccuti et al. 2018). MA enrollees joining an MA plan when they are first eligible for Part B or who leave FFS and a Medigap policy to join an MA plan have what are known as federal "trial rights" during the first year of MA enrollment, when they may return to FFS during the first year of MA enrollment and purchase a Medigap plan with guaranteed-issue rights. There are also limited circumstances (e.g., a beneficiary moves outside of their MA plan's service area) when beneficiaries have additional federal or state guaranteed-issue rights.
- 3 Because private FFS (PFFS) and medical savings account (MSA) plans have a very small number of enrollees, we do not describe them further. PFFS plans that operate without a network are limited to counties where fewer than two network-based plans are offered (32 counties, or about 1 percent of counties for 2026); by the end of 2025, PFFS plans covered about 40,000 beneficiaries. MSA plans combine a high deductible and a medical savings account, and by the end of 2025 they covered about 1,400 beneficiaries.
- 4 One study found that additional benefits and limits on out-of-pocket spending were the two leading reasons that MA enrollees chose an MA plan (Leonard et al. 2022).
- 5 Part B spending represents about 60 percent of all FFS Medicare spending (which is assumed to be the same share of spending on Part B services by MA plans). Twenty-five percent of Part B spending is financed through premiums paid by all Medicare Part B enrollees. The estimate does not account for the reduction in Part B premiums that is offered by some MA plans as a supplemental benefit.
- 6 Hospice services and kidney-acquisition costs are carved out of MA benefits, so plan bids and benchmarks do not include spending for these services. Payments described here do not apply to the relatively small number of enrollees with end-stage renal disease (ESRD). How Medicare pays MA plans for enrollees with ESRD is described later, in the section titled "Medicare payments and MA plan costs for enrollees with ESRD."
- 7 If a plan bids above the benchmark, the plan's base rate is set at the benchmark and enrollees must pay a premium (in addition to the usual Part B premium) equal to the difference between the bid and the benchmark. For 2026, almost 100 percent of plans bid below their benchmark.
- 8 Examples of non-Medicare-covered supplemental benefits include dental, vision, and hearing coverage. Plans can offer such benefits on a mandatory or optional basis. Mandatory supplemental benefits are automatically included in the benefit package for all enrollees in a plan. Plans may use rebates to finance mandatory supplemental benefits and may charge enrollees a premium to cover costs not covered by the rebate. Additionally, plans may offer optional supplemental benefits. Plans are not permitted to apply rebate dollars toward optional supplemental benefits; enrollees pay an additional premium to access these benefits. Optional supplemental benefits cannot include reduced cost sharing for Medicare Part A and Part B services.
- 9 Benchmarks are calculated using FFS spending for all Medicare beneficiaries, including those with both Part A and Part B coverage and those with only Part A or Part B. For Puerto Rico, CMS uses data for FFS beneficiaries who have both Part A and Part B enrollment. (This is because Medicare beneficiaries in Puerto Rico must opt in to Part B coverage, in contrast to other beneficiaries who are generally automatically enrolled in Part B unless they opt out.) In our March 2017 report to the Congress, we recommended that CMS change the calculation to include FFS spending for only

- those beneficiaries with both Part A and Part B coverage (that is, expenditures for only those beneficiaries eligible to enroll in MA plans) (Medicare Payment Advisory Commission 2017). This change would make the assumptions about FFS spending in the calculation of MA benchmarks and payments more reflective of the MA-eligible population.
- 10 CMS determines FFS spending quartiles using their projected FFS spending from the prior year. For example, benchmark quartiles in 2026 were determined using FFS spending from the 2025 MA ratebook.
 - 11 An MA plan's benchmark may be as high as 125 percent of CMS's local-area projected FFS spending. The ACA caps any county's benchmark at the higher of (1) its pre-ACA level, projected into the future with a legislatively modified national growth factor, or (2) 100 percent of its estimated FFS spending in the current year. Our March 2016 report to the Congress provides more detail on double-bonus counties and benchmark-growth caps. In that report, we recommended eliminating the double bonuses as well as the benchmark-growth caps, which limited the benchmarks in many counties (Medicare Payment Advisory Commission 2016c).
 - 12 Before 2022, MA plans also submitted diagnostic information through the Risk Adjustment Processing System (RAPS). The use of RAPS data was phased out from 2016 through 2021, except for contracts in the Program of All-Inclusive Care for the Elderly, which continue to use a combination of RAPS and encounter data as the source of diagnostic data for risk scores.
 - 13 Other possible sources of diagnostic information—such as encounters for home health services, skilled nursing, ambulatory surgery, durable medical equipment, lab and imaging tests, and hospice services—are not used to determine payment through the risk-adjustment model for several reasons. First, CMS has found that adding diagnoses from these sources does not improve the model's ability to predict medical expenditures. Second, concerns exist about the reliability of diagnoses from providers with less clinical training (e.g., home health and durable medical equipment providers). Third, a high proportion of reported diagnoses from certain settings (e.g., lab and imaging tests) are used to rule out having a diagnosis (Pope et al. 2004).
 - 14 CMS tied its decision to end the MMP demonstration to such factors as the Congress's decision to make dual-eligible SNPs (D-SNPs) permanent, greater flexibility for MA plans in offering supplemental benefits, and regulatory changes that incorporate some MMP features into D-SNPs. The Commission's review of evaluations of the MMP demonstrations, as well as CMS's, found that they tended to result in statistically significant increases in Medicare spending and had mixed effects on service use (Center for Medicare & Medicaid Innovation 2024, Medicare Payment Advisory Commission 2024c).
 - 15 In 2025, 16 percent of MA enrollees and 18 percent of MA-eligible enrollees resided in rural areas.
 - 16 Our measurement of beneficiary access to plans uses 2026 plan bids and July 2025 county-level enrollment for the Medicare population with both Part A and Part B coverage. Plans are included in a county only if they project enrolling at least one beneficiary in that county.
 - 17 All beneficiaries enrolling in Medicare Part B, regardless of their decision to receive benefits through FFS or MA, are required to pay the Medicare Part B premium. Some MA plans use rebate dollars to pay a portion of their members' Part B premium as a supplemental benefit. Beneficiaries enrolling in Part D may pay a separate Part D premium, although MA Prescription Drug plans may use rebate dollars to reduce the amount a beneficiary pays for drug coverage under the plan. Plans bidding above the local benchmark or offering more supplemental benefits than can be financed by the plan rebate charge enrollees an additional plan premium. We refer to plans that do not charge a separate plan premium (including any Part D premium) as "zero-premium" plans. In 2026, 93 percent of MA-eligible beneficiaries had an available zero-premium local PPO plan, and 97 percent of beneficiaries had an available zero-premium HMO plan.
 - 18 From 2011 to 2018, CMS required that insurers with multiple MA plans in the same county had to demonstrate that their plans had "meaningful differences" from each other. CMS only approved bids if the plan benefit package or plan cost structures (e.g., premiums, cost-sharing, formulary structure, benefits offered) were substantially different from those of other plans offered by the same organization.
 - 19 In most cases, beneficiaries without an available MA plan must enroll in FFS. In some cases, beneficiaries who meet certain criteria may enroll in an MA plan when there is not an available conventional plan. For example, in about 1 percent of counties in 2026, beneficiaries have an available special needs plan but not an available conventional plan. In addition, some beneficiaries may have an available employer plan. Further, some beneficiaries may have an available non-MA private plan, such as a cost plan.
 - 20 In 2026, about 1 percent of eligible beneficiaries have an available MA plan offered by only one organization (unchanged from 2025).
 - 21 In the rare circumstance in which a plan's bid is above the benchmark (after both have been adjusted to reflect a person

- of average risk), the plan's base payment rate is set at the benchmark and enrollees must pay a premium (in addition to the usual Part B premium) equal to the difference. In an analysis of plans' bid data for 2022, the Government Accountability Office found that 83 percent of MA plans, enrolling 86 percent of MA enrollees, expected to finance supplemental benefits solely with rebates; for special-needs plans, the share was even higher, at 96 percent (Government Accountability Office 2023).
- 22 In previous years, MedPAC has reported rebates only for plans that included Part D coverage (i.e., MA Prescription Drug plans (MA-PDs), excluding employer plans). This year, we include plans that do not offer Part D coverage (sometimes referred to as "MA-only" plans). Rebates for the combined group of MA-PDs and MA-only plans tend to be very similar to the rebates for MA-PDs since the vast majority of MA plans are MA-PDs. For 2026, 92 percent of MA plans are MA-PDs, and 97 percent of MA enrollees are projected to be in such plans. Additionally, in our previous reports to the Congress, we have typically used enrollment projections from plan bids as the basis for the enrollment weighting when calculating average MA rebates. In this year's report, we use plans' actual enrollment to calculate average rebates for 2015 through 2025. The weights are based on non-ESRD member months since plans do not receive rebates for members with ESRD. Non-ESRD enrollment is calculated by subtracting ESRD enrollment from total enrollment. For 2025, data on ESRD enrollment were not available at the time of our analysis, so we used information from plans' 2025 bids to account for ESRD enrollment. Figures for 2026 are weighted using enrollment projections from plans' 2026 bids. For almost all of the years we analyzed, averages calculated using actual enrollment were slightly higher (generally within 1 percent or 2 percent) of those calculated using projected enrollment.
 - 23 We exclude employer group plans because they do not submit bids and so do not receive a rebate in the same manner as bidding plans. Instead, starting in 2019, CMS began paying employer group plans based on the bidding behavior of non-employer group plans in the prior year: The employer group plans receive a base payment rate that is based on the average bid-to-benchmark ratio of non-employer group plans (by quartile of FFS spending and plan type), plus a share of the difference between the base payment rate and a county-specific benchmark.
 - 24 Part D benefit enhancements include, for instance, lowering Part D cost sharing and providing coverage of additional drugs. Using rebate dollars for such enhancements is sometimes described as a reduction in Part D supplemental premiums because the rebate enables the plan to offer the enhancements without a commensurate increase in beneficiary premiums.
 - 25 MA plans do not allocate administrative expenses or margins for Part B premium buydowns, Part D premium buydowns, or Part D supplemental benefits when submitting Part C bids.
 - 26 In 2026, of the rebate dollars plans project using to reduce cost sharing, conventional plans project that 12 percent will be used for plan administrative costs and profit (SNPs project using 14 percent). Of the rebate dollars plans project using to provide non-Medicare supplemental benefits, conventional plans project that 13 percent will be used for plan administrative costs and profit (SNPs project using 14 percent).
 - 27 The plan liability for the MOOP cap is not analogous to the amount spent by FFS beneficiaries who have out-of-pocket costs that exceed the MA MOOP limit. Most beneficiaries in FFS Medicare have supplemental insurance and are unlikely to have cost-sharing expenses that exceed the OOP cap for MA enrollees. In addition, MA enrollees are prohibited from purchasing Medigap coverage because MA plans are expected to provide cost-sharing reductions as supplemental benefits in lieu of Medigap coverage. The MOOP liability reported in plan bids is less than half of the 2.8 percent MOOP value estimated by Wakely in a report commissioned by AHIP, which used FFS claims data to estimate the MOOP value. The Wakely estimate did not account for the lower MOOP liability accrued by MA plans because of out-of-network care, claims denials, plan switching during the year, and cost-sharing reductions that are financed through plan rebates. In addition, the Wakely estimate did not consider cost-sharing reductions for FFS beneficiaries with supplemental coverage that would have reduced the MOOP liability in FFS. Further, Wakely did not adjust for Medicare Part A and Part B services that were financed by FFS on behalf of MA enrollees (e.g., Medicare services during hospice election). Wakely counted these services toward the MOOP estimate even though these types of services were not financed by MA plans.
 - 28 In contrast to prior years, we now include out-of-network MOOP liability in our estimates. While MA plans have enrolled a growing number of beneficiaries with ESRD who, on average, have higher expenditures relative to beneficiaries without ESRD, MA plans' projected MOOP liability remained at 1 percent of projected payments annually from 2023 to 2026.
 - 29 Beneficiaries who are eligible for special enrollment periods include (but are not limited to) those who move outside of their plan's service area, move to a new county with additional plan options, live in or move out of a nursing home

- or rehabilitation hospital, are eligible for Medicaid coverage, or lose Medicaid coverage.
- 30 The Commission previously estimated that Medicare would spend \$86 billion on MA rebates in 2025 (Medicare Payment Advisory Commission 2025a). The updated estimate of \$84 billion reflects updated data about non-ESRD enrollment, and it accounts for the effects of sequestration, which were not reflected in our previous estimate. Because of rounding, our estimate of the effect on Part B premiums is unchanged. We estimate that Medicare will pay approximately \$71 billion and \$13 billion in rebates to non-employer group plans and employer plans, respectively, in 2025. Rebates paid to non-employer group plans were estimated using rebate amounts from MA bids and monthly enrollment data for non-employer group plans. Employer plans do not submit bids. Instead, starting in 2019, CMS began paying employer plans based on the bidding behavior of non-employer group plans in the prior year. Because employer plans are mostly PPOs, their payment in 2025 largely reflects the average bidding behavior of non-employer group PPOs in 2024. We use employer-plan enrollment data for 2025 and apply 2025 employer-plan payment rates (adjusted to reflect recent employer-plan risk-score trends) to estimate Medicare's payments to employer plans. Rebates for employer plans are estimated using the same method CMS uses to determine employer-plan payment rates, in which the difference between the county-specific benchmark and base payment rate for employer plans (based on the average bid-to-benchmark ratio for non-employer group plans in the respective county's payment quartile) is multiplied by the plan-specific rebate percentage (based on the plan's star rating) and the risk score.
 - 31 Title 42 U.S.C. 1395w-23 describes the rebate for plans "for which there are average per capita monthly savings described in Section 1395w-24(b)(3)(C) or 1395w-24(b)(4)(C)." Sections 1395w-24(b)(3)(C) and 42 U.S.C. 1395w-24(b)(4)(C) define "average per capita monthly savings" as the difference between the plan's risk-adjusted benchmark and bid.
 - 32 We estimate that total rebate spending for 2025 will be \$84 billion. Roughly 60 percent of Medicare payments to MA plans are made from the Part B Trust Fund, and beneficiary premiums finance roughly a quarter of Part B spending. Thus, roughly 15 percent (60 percent $\times$ 25 percent) of rebate spending is financed by beneficiary premiums. Roughly 15 percent of FFS enrollees are dually eligible and thus receive Part B premium assistance through Medicaid.
 - 33 Beginning in 2019, CMS relaxed one of the criteria for eligible supplemental benefits—that the benefit be primarily health related—to include items and services that are used to diagnose, compensate for physical impairments, ameliorate the functional and psychological impact of injuries or health conditions, and reduce avoidable emergency and health care utilization. A supplemental benefit is not primarily health related if it is an item or service that is solely or primarily used for cosmetic, comfort, or general-use purposes or to address social determinants of health.
 - 34 MA plans are required to maintain an MLR of 85 percent (42 CFR Sec. 422.2410(b)). The MLR is the minimum percentage of revenue that an insurer is required to spend on benefits for their members. An MLR requirement of 85 percent means that the insurer is required to spend at least 85 percent of their revenue on care for their enrollees and can use no more than 15 percent of their revenue for administrative costs and profit. MLR requirements for MA organizations are monitored at the contract level. The numerator of the MLR includes incurred expenses for members' medical claims, including both Medicare and non-Medicare services (i.e., basic and supplemental benefits).
 - 35 MA plans can include more generous supplemental benefits than can be fully financed by the rebate they receive from Medicare. In such cases, plans can charge enrollees an additional premium. Further, plans can offer "optional" supplemental benefits, which enrollees can access by paying an additional premium.
 - 36 The MLR reporting instructions label this category "Non-Primarily Health Related Benefits – Other" but do not specifically mention the MA-VBID demonstration (Centers for Medicare & Medicaid Services 2025d). MedPAC's interpretation of the reporting instructions is that non-primarily health-related benefits offered under the demonstration would be reported in this category and that those benefits should likely account for the majority of the reported spending. However, it is possible that some plans reported spending for other types of services in the category as well.
 - 37 We estimate total MA payments by using CMS's projected MA enrollment and incurred MA payments per enrollee (Boards of Trustees 2025).
 - 38 Our estimate of MA payments relative to FFS spending does not account for other potential factors that are more difficult to measure with certainty, including the potential spillover of provider behavior that can occur from large increases in MA market share into FFS or potential spillover from FFS alternative payment models into MA, and any effect of MA and FFS improper payments found retrospectively.
 - 39 Because the Trustees do not separate ESRD payments from their enrollment and per capita payment projections, we separately estimate the share of MA payments for ESRD enrollees (an estimated 6 percent in 2026). Our estimate is guided by correspondence with CMS's Office of the Actuary. Separately estimating payments for ESRD is necessary

because MA plans do not submit bids for ESRD enrollees, and these enrollees use a different payment rate with a different risk-score model.

- 40 We note that our 2026 estimate of spending on MA relative to the amount Medicare would have spent for comparable FFS beneficiaries (114 percent) reflects some changes from the method used in the Commission's 2025 comparison (reported to be 120 percent for the year 2025 in our March 2025 report) (Medicare Payment Advisory Commission 2025b). First, in the 2025 report, we did not include the ESRD population in our projections because we had not yet constructed the analytic framework for including that population. For 2026, we included the ESRD population in our estimates. We also made technical updates to refine our methodology for estimating favorable selection; those updates resulted in similar projections in our estimates of favorable selection—continuing to account for 11 percentage points of the difference in spending. Second, we revised our estimated effect of phasing in the V28 model using newly available V28 risk scores from 2024. We also updated our estimates to reflect the slower trend in coding intensity between 2023 and 2024 that we observed using the newly available data from 2024, and we revised our method of estimating coding intensity to use a single denominator for the demographic risk model. The net effect of newer data (including access to V28 risk scores) was –3.9 percentage points on our projected coding-intensity estimate for 2025. To project coding intensity from 2025 to 2026, we reduced the 2025 projection for coding intensity by 2.3 percentage points to reflect the final phase-in of the V28 risk model and an additional year of coding intensity trend (see text box “Updates to coding-intensity estimates reflect newly available data and other factors,” p. 392–393, for more details).
- 41 Only 5 of the 5,555 MA bids submitted in 2026 (0.1 percent) are above their benchmarks. Plan bids are typically far below plan benchmarks in 2026; 93 percent of bids (representing 97 percent of projected enrollees) are below 90 percent of their benchmarks; 58 percent of bids (representing 71 percent of projected enrollees) are below 80 percent of their benchmarks; 13 percent of bids (representing 13 percent of projected enrollees) are below 70 percent of their benchmarks. On average (on a dollar-weighted basis), plans bid 77 percent of their benchmarks. On average, non-SNPs and SNPs bid 76 percent and 78 percent of benchmarks, respectively. D-SNPs and C-SNPs bid 79 percent and 74 percent of benchmarks, respectively; I-SNPs bid 91 percent of their benchmarks. HMOs both with and without a point-of-service option bid 76 percent of benchmarks; local PPOs bid 78 percent of benchmarks. Plan bids relative to benchmarks have relatively narrow differences by payment quartile in 2026. Plans in the lowest- and highest-FFS-

spending quartiles (excluding Puerto Rico) bid 77 percent of benchmarks.

- 42 Multiple studies have found that plan bids tend to decrease as plan benchmarks decrease or plan bids tend to increase as plan benchmarks increase (Cabral et al. 2018, Medicare Payment Advisory Commission 2020a, Pelech and Song 2018, Song et al. 2013).
- 43 Another study assessing the effect of MA enrollment on medical spending relied on a very small sample of 541 MA enrollees from one insurer and 541 enrollees in Medicare FFS who had Medigap coverage from the same insurer (Schwartz et al. 2021). The small sample led to imprecise estimates with the 95 percent confidence interval spanning a spending effect between –\$282 and \$0 per beneficiary per month. Schwartz and colleagues acknowledged that the true effect could be substantially smaller or larger than estimated and may not be generalizable. The authors used a difference-in-differences design with propensity score matching to control for preexisting differences between the MA treatment and FFS control group and found that MA enrollment reduced medical spending by 36 percent. The result was driven primarily by reducing inpatient spending on the 74 stays used by the MA population relative to the 56 stays for the FFS population. However, the pre-Medicare inpatient utilization patterns appeared to differ between the treatment and control groups, raising questions about whether the FFS control group provided an accurate counterfactual estimate for the MA treatment group. The study population also differed from the overall MA population in several ways, potentially limiting the study's generalizability. For example, individuals in the matched MA treatment and FFS control groups had a much higher prevalence of chronic conditions and were much more likely to reside in the Northeast compared with the insurer's overall MA membership of similar ages. Moreover, this study included members of the treatment and control group from disparate geographical locations but did not standardize Medicare rates.
- 44 The two recent white papers that examined the differences in spending for about 10,000 newly eligible Medicare beneficiaries (Inovalon 2025, Teigland et al. 2025a) may overstate the amount of MA spending reductions in three key ways. First, both studies required two consecutive years of enrollment in FFS or the same MA plan, which potentially creates some favorable selection into MA during the study period by removing beneficiaries who switched into a different plan or program. Beneficiaries who switched from MA to FFS or switched MA plans may have had relatively high risk-adjusted spending, and beneficiaries who switched from FFS to MA may have had relatively low risk-adjusted spending. Second, both papers remove decedents, and the effects of MA on reducing decedent spending may be

- particularly dampened (especially given that MA is not responsible for spending during hospice election). Third, it is unclear whether the data repository used in both white papers is able to capture the completeness of MA utilization data—particularly for subcapitated arrangements with providers— better than the CMS's MA encounter data. To the extent that FFS data are more complete, the differences in spending between MA and FFS may be overstated.
- 45 The 2025 Inovalon white paper reported higher pre-Medicare disease burden and mortality risk in the MA population compared with FFS (Inovalon 2025). However, these findings conflict with prior research, including those by Inovalon researchers. One recent white paper found that, immediately before Medicare eligibility, beneficiaries going into MA had less of a disease burden than their FFS enrollee counterparts; the researchers found that MA enrollees had 10 percent lower pre-Medicare risk scores and 12 percent lower Charlson Comorbidity Index scores. In addition, the researchers found that MA enrollees were less likely to have cancer, joint issues, and heart issues before enrolling in Medicare (Teigland et al. 2025b). One peer-reviewed study found that newly eligible beneficiaries who initially enrolled in MA had adjusted mortality rates that were 30 percent lower than FFS beneficiaries in their first year of Medicare (Newhouse et al. 2019).
 - 46 Jung and colleagues' recent study found a 13 percent reduction in spending for MA enrollees under specifications that reduced individual risk scores by excluding diagnoses found only in chart reviews or health risk assessments and adjusted for differences in beneficiary characteristics using a regression estimate (Jung et al. 2025). However, this estimate may overstate the amount of MA spending reductions in three key ways. First, the study adjusted for MA coding intensity by removing chart reviews and health risk assessments from the calculation of MA risk scores. However, our analyses and analysis from Paul Jacobs show that chart reviews and health risk assessments only account for about half of the estimated difference in coding between MA and FFS (Jacobs 2024). Second, Jung and colleagues controlled for potential beneficiary selection by matching on observable beneficiary characteristics (e.g., geography, risk score, race, dual-eligibility status) and risk of mortality. Our estimate of favorable selection suggests that selection persists even after adjusting for observable beneficiary characteristics and mortality differences. Third, Jung and colleagues' results include greater MA spending reductions in earlier years (relative to the later years in their study), which may result from less complete encounter data during those years. These three effects may be somewhat offset by the authors' exclusion of skilled nursing facility and home health spending, which may have relatively high reductions in spending when beneficiaries are enrolled in MA.
 - 47 For beneficiaries with ESRD, MA plans do not submit bids and instead receive separate base payments, which are risk adjusted using a separate risk model.
 - 48 For all MA enrollees with ESRD (in dialysis, transplant status, or functioning-graft status), we excluded MA enrollees with Medicare as a secondary payer and months during hospice election. In addition, we reduced payment rates by 2 percent to reflect the sequestration of Medicare payments that would have occurred after CMS sets rates.
 - 49 For the dialysis and transplant populations, our FFS comparison group consisted of beneficiaries who during the year (1) did not have any Part A-only coverage or any Part B-only coverage, (2) had at least one nonhospice month, (3) were in either dialysis or transplant status for all months with both Part A and Part B coverage, (4) had no months in MA, (5) had no months of Medicare as a secondary payer, and (6) resided in the same state.
 - 50 For our calculation of FFS spending for the dialysis and transplant populations, we take multiple steps to apply provider incentive payments. First, we include any state-based historical provider incentive payments that CMS publishes for its United States per capita cost (USPCC) ESRD baseline. For these incentive payments (e.g., Kidney Care Choices), we calculated our study population's share of Medicare Part A and Part B spending among dialysis and transplant beneficiaries assigned to those programs; we applied this share of spending as a factor to CMS's published estimates. Second, we include an estimate of incentive payments for programs that include the dialysis and transplant populations but are not published because CMS includes the entire payment in its USPCC non-ESRD baseline (physician bonus payments in health professional shortage areas (HPSAs), shared savings for the Medicare Shared Savings Program, shared savings for the Global and Professional Direct Contracting program, and shared savings for the Vermont All-Payer ACO program). For these shared-savings payments, we apply a factor to CMS's payment amounts using our calculation of our study population's share of Medicare Part A and Part B spending for beneficiaries assigned to each of those programs. For the HPSA payments, we calculated our population's share of evaluation and management spending in those areas; we applied this share as a factor to CMS's HPSA payment amounts.
 - 51 We received CMS's aggregate estimate of dialysis and transplant bad-debt payments and provider-settlement payments. We adjusted these payments to reflect our study population using two steps. First, we calculated the share of our study's population Medicare Part A and Part B spending among the FFS dialysis and transplant population. Second, we applied these adjusted payments to each state using our

calculation of the share of our study population's Medicare Part A and Part B spending in each state.

- 52 For all FFS comparison groups (non-ESRD, dialysis, transplant, and functioning graft), we apply CMS's estimate of FFS-claim administrative costs, which is 0.20 percent of FFS spending.
- 53 For our calculation of FFS spending for the dialysis and transplant population, we take multiple steps to apply spending exclusions for which MA plans are not liable. First, we exclude the operating-expenses portion of spending on indirect medical education using the state-based historical amounts that CMS publishes for its USPCC ESRD baseline. We estimate the amount applicable to our study population by applying a factor based on the population's share of inpatient hospitalization spending (among all FFS beneficiaries in dialysis and transplant status). Second, because CMS does not publish direct graduate medical education amounts or kidney-acquisition costs in their USPCC ESRD baseline data, we remove these amounts using the pass-through amounts in inpatient hospital claims for our study population. Third, we remove all hospice spending for our study population, and we remove the months during hospice when calculating our monthly spending average.
- 54 For MA enrollees with ESRD in functioning-graft status, we applied payment rates that corresponded with the plan's star rating for the payment year.
- 55 For the functioning-graft populations, our FFS comparison group consisted of beneficiaries who during the year (1) did not have any Part A-only coverage or any Part B-only coverage, (2) had at least one nonhospice month, (3) were in functioning-graft status for all months with both Part A and Part B coverage, (4) had no months in MA, (5) had no months of Medicare as a secondary payer, and (6) resided in the same state.
- 56 For our calculation of FFS spending for the functioning-graft population, we include an estimate of incentive payments for programs that include the functioning-graft population (physician bonus payments in HPSA and an advanced alternative payment model, incentive payments for Maryland Primary Care Plus organizations, shared savings for Kidney Care Choices, shared savings for the Medicare Shared Savings Program, shared savings for the Global and Professional Direct Contracting program, and shared savings for the Vermont All-Payer ACO program). For alternative payment model payments, we apply a factor to CMS's payment amounts using our calculation of our study population's share of Medicare Part A and Part B spending for beneficiaries assigned to each of those programs. For HPSA payments, we calculated our population's share of evaluation and management spending in those areas; we applied this share as a factor to CMS's HPSA payment amounts.
- 57 Our estimate of provider-settlement payments for the functioning-graft population is based on the experience of our non-ESRD study population. We calculated the share of non-ESRD provider-settlement payments relative to total non-ESRD Medicare Part A and Part B spending. We applied this provider-settlement-payment ratio to the functioning-graft population's total Medicare Part A and Part B spending. We then distributed the resulting provider-settlement-payment estimate to each county using the distribution of our functioning-graft study population's Part A and Part B spending.
- 58 For our calculation of FFS spending for the functioning-graft population, we take multiple steps to apply spending exclusions for which MA plans are not liable. First, we estimate the operating-expenses portion of indirect medical education (IME) spending based on the experience of our non-ESRD study population. We calculated the share of non-ESRD IME payments relative to total non-ESRD Medicare inpatient hospital spending. We applied this IME payment ratio to the functioning-graft population's total inpatient hospital spending. We then distributed the resulting IME payment estimate to each county using the distribution of our functioning-graft study population's inpatient hospital spending. Second, we remove direct graduate medical education and kidney-acquisition costs using the pass-through amounts in inpatient hospital claims for our study population. Third, we remove all hospice spending for our study population, and we remove the months during hospice when calculating our monthly spending average.
- 59 For the functioning-graft population, we use a similar framework as CMS for applying credibility adjustments to counties with less than 12,000 FFS enrollment months. For these counties, we blend spending in the county with spending at the state level. County spending is weighted by county enrollment, and spending in the state is weighted by 12,000 minus county enrollment months.
- 60 We also exclude beneficiaries for whom Medicare is a secondary payer in our comparisons using historical data.
- 61 For Puerto Rico, CMS uses data for FFS beneficiaries who have both Part A and Part B enrollment. This is because Medicare beneficiaries in Puerto Rico must opt in to Part B coverage, in contrast to other beneficiaries who are generally automatically enrolled in Part B unless they opt out.
- 62 Our estimates of the base-spending comparison for the years before 2016 continue to rely on CMS's projections of FFS spending (including adjustments that eliminate the effect of the sustainable growth rate) because those were the data we

- used under an older version of our methodology when those estimates were first published in earlier reports. We have not updated those estimates because our analysis indicates that results would be similar under our updated methodology that uses historical data. A more detailed description of the change in methodology for the base payment comparison can be found in the Commission's March 2023 report to the Congress, where it is described as a change from the prospective method to the retrospective method (Medicare Payment Advisory Commission 2023c).
- 63 The Commission's March 2023 report details our methodology for comparing our estimates using CMS's projections with historical spending for MA-eligible beneficiaries (Medicare Payment Advisory Commission 2023c). That report describes several adjustments that should be made when making this comparison. A 2024 analysis by Wakely that was commissioned by AHIP estimated the raw average spending difference between all Medicare beneficiaries and the subset of Medicare beneficiaries with both Part A and Part B coverage (Wakely 2024). This method is inadequate for comparisons of MA payment differences because CMS's payment methodology accounts for (among other things) Medicare as a secondary payer, the geographic differences in risk-standardized FFS spending, the geographic distribution of MA enrollees, and nonclaims FFS spending. The Commission's comparisons adjust for these differences, including the use of county-level FFS-spending data and risk scores, MA enrollment, MA risk scores, and MA payment rates.
 - 64 We also report estimates from a simpler, more suggestive method that focuses on the selection percentage of MA entrants who recently switched from FFS compared with beneficiaries who remained in FFS. The advantages of that simpler method are that it can more easily be compared with estimates from the literature that use similar methods, and we can compute them for more years of data (going back to 2007).
 - 65 Our estimates account for the incentives that beneficiaries have to switch from FFS to MA because of the MOOP limit. However, MOOP limits do not appear to be an important factor in MA plan selection. For example, one study found that more generous OOP maximums did not result in enrollment gains in 2022 (Cates et al. 2022). Instead, the study found that lower premiums and a higher prevalence of supplemental benefits were associated with plans that experienced enrollment growth. This finding is consistent with prior research that found premiums were a driving factor in beneficiary plan selection (Jacobson et al. 2016, Jacobson et al. 2014, Medicare Payment Advisory Commission 2015, Meyers et al. 2019, Skopec et al. 2019).
 - 66 One study found an additional effect of favorable selection that results from CMS's projections. This study found that MA enrollment increased faster in counties with overpredicted spending between CMS's historical baseline years and projected years (Ryan et al. 2023).
 - 67 The studies by Teigland and colleagues (2025a) and Pelech and colleagues (2025) do not themselves estimate selection effects that are constructed to reflect the effect of favorable selection on MA payments, as MedPAC's estimate is designed to do. However, they include estimates of the pre-Medicare spending and risk scores of individuals who go on to enroll in MA and FFS, which can be used to construct selection effects. To do so, we standardized the pre-period spending by the risk scores and converted the risk-standardized spending differences to payments above FFS spending. For the nondual Medicare population aging into the program at age 65, Teigland and colleagues' 2015 to 2019 sample indicated that MA enrollees had 13 percent lower risk-standardized spending than the FFS population (in the same state with the same type of commercial insurance) before Medicare enrollment (Teigland et al. 2025a). For Medicaid enrollees immediately before becoming eligible for Medicare from 2017 to 2022, the estimates reported by Pelech and colleagues indicated that MA enrollees had 23 percent lower risk-standardized medical spending than the FFS population before Medicare enrollment (Pelech et al. 2025).
 - 68 Our projection of favorable selection for 2026 is 11 percent. Similar to the projections in our March 2025 report to the Congress, we use the average selection effect from our two most recent years of historical data (2022 and 2023 in our most recent estimates).
 - 69 We calculate the coding adjustment that is necessary to fully account for 10 percent higher MA coding intensity as $10.3 \text{ percent} / 110.3 \text{ percent} = 9.3 \text{ percent}$.
 - 70 The actual dollar amount a plan will receive for coding a new HCC depends on several additional factors, including the version of the HCC model applied to a beneficiary and factors that affect a plan's base rate. Dollar-value coefficients are standardized relative to average FFS spending before being applied to each plan's base rate. CMS maintains separate HCC models for enrollees who lack a full calendar year of diagnostic data or have ESRD. A plan's base rate varies according to the plan's bid and the local area's benchmark.
 - 71 Social Security Act Section 1853(a)(1)(C)(ii).
 - 72 The prior V24 risk model was calibrated using International Classification of Diseases–9 (ICD–9) diagnosis codes and relied on a mapping from ICD–9 to ICD–10 diagnosis codes to implement risk adjustment after October 2015 when

- Medicare required diagnosis codes reported on claims or encounters to be ICD-10 codes. The V28 risk model was calibrated with ICD-10 diagnosis codes.
- 73 In some counties, the full 5 percent or 10 percent quality-bonus increase to a plan's benchmark is limited by the ACA benchmark caps.
- 74 This organization-level analysis, like our national estimate of coding differences, uses the method of estimating coding intensity that is described in Technical Appendix 12-C (p. 440), except that the MA risk scores are calculated separately for each MA organization and the analysis excludes beneficiaries who reside in Puerto Rico, are enrolled in chronic-condition special-needs plans, or have ESRD, and organizations with fewer than 25,000 enrollees in the analysis.
- 75 The relatively large difference between the V28 and V24 coding-intensity estimates for the "0 to 5 percent" group is driven by one large organization that had much lower coding intensity under the V28 model compared with the V24 model. Without that organization, the "0 to 5 percent" group would have had an average V28 – V24 estimate difference of –2.6 percentage points.
- 76 The description in this section is based on MedPAC's interviews with physicians, reporting from Stat News, and documentation from one insurer about their bonus program for documenting suspect conditions (Bannow et al. 2024, Herman et al. 2024, United Healthcare 2025).
- 77 Recent reporting shows that agents and brokers are often paid by plans to conduct health risk assessments of new enrollees, but such assessments are not allowable for risk adjustment because agents and brokers are not clinicians and do not submit diagnoses from assessments on claims that are used for risk adjustment (Leonard et al. 2023).
- 78 The general steps we followed were to identify physician and hospital encounter records allowable for risk adjustment; identify each record as a health risk assessment (using procedure codes for annual wellness visits or initial preventive physical exams, or an evaluation and management visit provided in the home), chart review (using a chart-review indicator), or other service; map diagnoses from those records to HCCs; apply HCC hierarchies; compare the HCCs we identified from encounter records with the HCCs in CMS's risk-score file and exclude HCCs not identified in both sources; apply HCC coefficients for the appropriate risk model; and apply Part A and Part B payment rates specific to each plan. We then identified the number of HCCs and associated dollar amounts that were supported through a health risk assessment, chart review, or both.
- 79 The six HCCs that each generated more than \$900 million in payments from health risk assessments and the percentage of the time that a health risk assessment was the only source of the HCC were vascular disease, 45 percent; major depressive, bipolar, and paranoid disorders, 44 percent; disorders of immunity, 64 percent; diabetes with chronic complications, 15 percent; chronic obstructive pulmonary disorder, 26 percent; morbid obesity, 37 percent. We note that diabetes with chronic complications has a constrained coefficient in the V28 risk model, meaning that differences in the level of severity (e.g., diabetes without complications, with chronic complications, or with acute complications) for these conditions are not reflected in the V28 risk-adjustment model coefficients.
- 80 The legal complaints cited in this section support this statement. One complaint includes exhibits of plan documents that detail the financial performance of the plan's chart-review program (United States of America v. Anthem Inc. 2020).
- 81 The eight HCCs that each generated more than \$1 billion in payments from chart reviews and the percentage of the time that a chart review was the only source of the HCC were vascular disease, 32 percent; chronic obstructive pulmonary disorder, 26 percent; diabetes with chronic complications, 17 percent; major depressive, bipolar, and paranoid disorders, 32 percent; congestive heart failure, 23 percent; disorders of immunity, 40 percent; morbid obesity, 33 percent; and rheumatoid arthritis and inflammatory connective tissue disease, 31 percent. We note that diabetes with chronic complications and congestive heart failure are among the HCCs that have a constrained coefficient in the V28 risk model, meaning that differences in the level of severity (e.g., diabetes without complications, with chronic complications, or with acute complications) for these conditions are not reflected in the V28 risk-adjustment model coefficients.
- 82 About \$5.2 billion in payments to MA plans was made based on HCCs identified on a health risk assessment and a chart review but not during any record of a physician or hospital encounter during the same calendar year.
- 83 Audit-eligible enrollees were also required to have Part B enrollment for the full data-collection year, continuous enrollment in the contract for the full data-collection year and January of the payment year, and no end-stage renal disease or hospice status.
- 84 As this chapter went to press, CMS proposed eliminating unlinked chart reviews (those that do not identify an associated encounter) from risk adjustment for payment year 2027 (Centers for Medicare & Medicaid Services 2026).

- 85 For RADV audits in 2011, CMS grouped all contracts into high, medium, and low levels of coding intensity and selected 20 high-level, 5 medium-level, and 5 low-level contracts at random.
- 86 The Commission stated in its March 2024 report to the Congress that it would consider not reporting plan margin data in future years. Given our declining confidence in the salience and accuracy of plan-reported margins, we omit these data and focus on more reliable indicators of the financial health of the MA program, such as plan availability and enrollment.
- 87 Other factors may also influence insurers' decisions to enter new markets. Examples include state and federal regulatory and financial requirements (including licensure requirements), the size of the market, the local MA penetration rate, the number of competitors, benchmark payment rates for the market relative to the health care needs of the population, availability and quality of providers, and the estimated likelihood of achieving a sustainable risk profile after accounting for CMS's coding-intensity adjustment (Buzby et al. 2022, Killian and Swenson 2016).
- 88 Counties in Connecticut are excluded due to changes over time in how the state's counties are tabulated. Employer plans are excluded because employer plans do not compete directly with non-employer group plans.
- 89 The study assessed only whether the parent organization listed for a particular MA contract changed; it did not assess whether the company acquired one or all of the acquired insurer's MA contracts or acquired the other insurer altogether.
- 90 The top three organizations nationally also had the highest share of enrollees in both urban and rural areas in 2025. In urban areas, the top three organizations covered 56 percent of MA enrollees (down from 58 percent in 2024). In rural areas, the top three organizations accounted for 65 percent of the MA enrollees (down from 67 percent in 2024).
- 91 In 2025, 18 percent of MA enrollees were eligible for Medicaid and enrolled in dual-eligible SNPs (D-SNPs). The national D-SNP enrollment is more concentrated than overall MA enrollment (the three largest D-SNP insurers had 61 percent of enrollment in 2025). Enrollment in D-SNPs has been getting more concentrated nationally: The three largest organizations nationally (regardless of plan type) had 59 percent of total enrollment in D-SNPs in 2025, an increase from 49 percent in 2020 but slightly lower than in 2024 (60 percent).
- 92 The HHI is calculated by squaring the market share of each entity competing in the market and summing the results. The index approaches zero when a market is occupied by a large number of firms of relatively equal size; the index reaches its maximum of 10,000 points when a market is controlled by a single firm. The index rises both as the number of firms in the market drops and as the disparity in size among those firms increases. Under Department of Justice and Federal Trade Commission guidelines, markets with an index above 1,800 are considered highly concentrated (Department of Justice and Federal Trade Commission 2023).
- 93 A "related party" is defined as any entity that "has a different tax identification number than that of the MAO but is associated with the MAO by any form of common, privately held ownership, control, or investment, including any arrangement in which the MAO does business with a related party through one or more unrelated parties" (Centers for Medicare & Medicaid Services 2023b). Because the MA bids measure the share of MA expenses that are paid to related parties, we assume that Part D benefits paid to related parties (such as an insurer-owned pharmacy benefit manager) are not included in our measure of MA vertical integration.
- 94 Star rating is a framework that CMS uses across MA and FFS Medicare. On its Care Compare website, CMS publishes star ratings for different types of Medicare providers (like physicians, hospitals, nursing homes, and others) so that beneficiaries can see how providers perform for FFS beneficiaries in their local area. However, there is no single quality evaluation for FFS Medicare in its entirety; star ratings of providers in FFS Medicare reflect their individual performance. The performance of a set of providers in a local area is not directly comparable with an MA star rating, which reflects the joint performance of an MAO and its network of contracted providers, at the contract level.
- 95 Currently, quality results for MA are reported on a contract-wide basis, and those results are used to determine the star rating for all plans under the contract's offerings.
- 96 MA-PD contracts were assessed on 43 measures in 2026. MA-only contracts and PDPs were evaluated on 33 and 12 measures, respectively (<https://www.cms.gov/files/document/2026-star-ratings-fact-sheet.pdf>).
- 97 Measures are assigned unique weights, and the overall score is a weighted average. The other roughly 60 measures that Medicare collects are display measures that CMS publicly reports on the Medicare.gov website (not the Medicare Plan Finder website). Some display measures were previously incorporated into the star ratings but have been transitioned out. Others may be new measures that are being tested before inclusion in the star ratings or that are otherwise reported for informational purposes only.

- 98 We discuss FFS–CAHPS results in Chapter 4 (on physicians and other health professionals).
- 99 Because MA contracts do not represent uniform geographic units, sampling at the contract level generates an average that is not necessarily geographically representative of the MA population.
- 100 Scores are adjusted for education, self-reported general health status, self-reported mental health status, proxy completion or assistance with survey completion, dual eligibility or low-income-subsidy eligibility, age, and completion of the survey in an Asian language, all of which have been demonstrated to be associated with patient-experience scores (<https://www.ma-pdpcahps.org/globalassets/ma-pdp/quality-assurance/2026/quality-assurance-protocols--technical-specifications-v16.0.pdf>).
- 101 The 2019 CAHPS surveys were halted due to the coronavirus pandemic. We report values for 2018 to include a prepandemic comparison year.
- 102 Our focus-group participants reported similar overall satisfaction with their coverage, but some also provided concrete examples of challenges accessing care in some instances. See our most recent focus-group report here: https://www.medpac.gov/wp-content/uploads/2025/07/Jun25_MedPAC_FocusGroupSiteVisitReport_CONTRACTOR_SEC.pdf.
- 103 Under the original prohibition, MA plan access was limited to (1) individuals with ESRD in an employer-sponsored health plan, who could enroll in an MA plan offered by the same insurer if one was available when initially enrolling in Medicare; (2) Medicare beneficiaries already enrolled in an MA plan, who could remain in that plan after developing ESRD; or (3) Medicare beneficiaries could enroll in an ESRD chronic-condition special-needs plan (C-SNP) and certain other SNPs. ESRD C-SNPs were created in 2003. In 2000, the Commission recommended that the Congress allow all beneficiaries with ESRD to enroll in private plans (Medicare Payment Advisory Commission 2000).
- 104 Among FFS beneficiaries without cost sharing covered by Medicaid, those on dialysis are less likely to purchase a Medigap plan than FFS beneficiaries who are not on dialysis (31 percent vs. 50 percent in 2024) because of constraints in federal guaranteed-issue rights in obtaining these supplemental plans and the affordability of a Medigap plan. Outside of the federal guaranteed-issue window, Medigap plans offered to beneficiaries with ESRD are limited; 36 states require insurers to offer at least one Medigap plan to beneficiaries under age 65, but only 26 states require insurers to offer a plan to those entitled to Medicare due to ESRD (Freed et al. 2024).
- 105 For payment purposes, CMS categorizes beneficiaries with ESRD into three groups based on their treatment status: dialysis, transplant (i.e., within the first 3 months of a kidney transplant), and functioning graft (i.e., 4 to 36 months after a kidney transplant). Unlike payment for beneficiaries on dialysis, payment for functioning-graft beneficiaries is equal to the MA county benchmark rate (FFS spending × quartile adjustment × quality-bonus adjustment), adjusted by the enrollee’s risk score (Centers for Medicare & Medicaid Services 2025a).
- 106 BPT Worksheet 1, Section V, includes information about a plan’s financial experience for both enrollees with and without ESRD from a base period, which is two years before the plan year for which the BPT is submitted. For example, BPT data for 2025 include 2023 plan costs and revenues for the vast majority of enrollees with ESRD.
- 107 We aggregated plan-level BPT data to the MA contract level in our analysis.
- 108 Adjusting for inflation, the estimated nonbenefit expenses of about \$350 PMPM in 2019 for plan administration of benefits for enrollees with ESRD would equal approximately \$416 PMPM in 2023.
- 109 Approximately 33 percent of FFS beneficiaries on dialysis had full Medicaid benefits and were, therefore, not responsible for any cost sharing for dialysis in 2024.
- 110 Composite-rate services include dialysis services paid for under the former PPS: nursing, dialysis equipment and supplies, social services, and certain laboratory tests and drugs (Medicare Payment Advisory Commission 2024a).
- 111 The base payment for each dialysis treatment is intended to cover all operating and capital costs that efficient providers would incur in furnishing dialysis-treatment episodes in dialysis facilities or in patients’ homes.
- 112 These patient-level adjustment factors apply to adult beneficiaries with ESRD who are 18 years and older. For beneficiaries under age 18, CMS adjusts the base rate by age and dialysis modality.
- 113 Out-of-network providers who accept assignment must accept FFS payment rates as payment in full for Medicare-covered services.
- 114 The form CMS uses to collect encounter records includes fields that plans can use to report the amount they paid to providers as well as the enrollees’ cost-sharing liability. The data collected in those fields are not included in the public versions of the encounter data that are available to researchers.

- 115 CMS suspended sequestration of MA payments from May 2020 through March 2022 and applied a sequester of 1 percent from April through June of 2022.
- 116 When an MA plan's contracted rate for a federally qualified health center (FQHC) is less than the Medicare prospective payment system rate, Medicare pays the FQHC the difference, less any cost-sharing amounts owed by the MA enrollee. In the past, we added Medicare's supplemental payments to FQHCs for MA enrollees, but these amounts have been negligible in our aggregate comparison of FFS spending to MA payments. We will continue to monitor these supplemental payments for MA enrollees and adjust our estimate if necessary.
- 117 We removed medical education payments using CMS's county-level medical education payment file. We used the share of our study population's FFS inpatient spending to adjust the amounts in CMS's file to remove payments for beneficiaries with Part A only, Part B only, ESRD, or Medicare as a secondary payer.
- 118 We removed kidney-acquisition costs using CMS's rate book projections of county-level factors that represent the share of kidney-acquisition costs as a percentage of total Part A and Part B spending.
- 119 CMS reports provider-settlement amounts on a national basis. To estimate provider settlements at the county level, we distributed national settlement amounts using the county distribution of Part A and Part B spending for our study population. In addition, we excluded provider settlement amounts and provider incentive payments that would have been made for beneficiaries with Part A only, Part B only, ESRD, or Medicare as a secondary payer.
- 120 CMS reports provider incentive payments on a county basis. We excluded provider incentive payments that would have been made for beneficiaries with Part A only, Part B only, ESRD, or Medicare as a secondary payer. We made this adjustment by calculating our study population's share of Medicare Part A and Part B spending among beneficiaries assigned to those programs. Because physician bonus payments in health professional shortage areas (HPSAs) do not have assigned beneficiaries like a typical alternative payment model, we calculated our population's share of evaluation and management spending in those areas, and we applied this share as a factor to CMS's HSPA payment amounts. For advanced alternative payment model (A-APM) bonuses, we applied our population's share of Part B spending among beneficiaries assigned to the Medicare Shared Savings Program, which comprises most A-APM participants.
- 121 We used CMS's most recent estimate of administrative claims costs, which have been about 0.2 percent of FFS spending in recent years.
- 122 For our base comparison, average FFS spending in the county is weighted by enrollment months in the year and standardized to a 1.0 risk score, calculated as
$$\bar{y}_{g,t} = \frac{\sum_i y_{i,g,t}}{\sum_i r_{i,g,t}}$$
 for individual i , residing in county g , in year t , where y is the individual's spending and r is the individual's risk score).
- 123 We use a framework similar to CMS's for applying credibility adjustments to counties with less than 12,000 FFS enrollment months. For these counties, we blend spending in the county with spending in a larger market within the same state (metropolitan statistical areas for urban counties and health service areas (as defined by the National Center for Health Statistics) or nonmetropolitan areas for rural counties). County spending is weighted by county enrollment, and spending in the larger market is weighted by 12,000 minus county enrollment months.
- 124 For 2026, we assume that employer plans would have a 3.0 percent growth in enrollment relative to 2025, which is lower than non-employer plans experienced in 2025 (4.0 percent). In addition, we calculated the overall risk-score ratio of employer plans to nonemployer MA plans in 2023 (reflecting diagnoses documented in 2022), and we applied this ratio to the average risk score in 2026 MA bids. The resulting adjusted risk score was applied to overall employer-plan payment rates, which CMS standardizes to a risk score of 1.0.
- 125 Our analysis of selection for the dialysis population excluded beneficiaries that had nondialysis months during the year.
- 126 Our simple method of estimating favorable selection includes beneficiaries in our study and reference populations if they were enrolled in FFS and had both Part A and Part B coverage for at least two full calendar years. We required beneficiaries to have at least two full calendar years of FFS enrollment because the CMS hierarchical condition category risk-adjustment model calculates risk scores using diagnoses from the prior year's claims. We required our MA study population to have at least one month of MA enrollment in the year following the two years of FFS enrollment. We required our FFS comparison population to have at least one month of FFS enrollment and no months enrolled in MA in the year following the two years of FFS enrollment. For both our MA and FFS comparison populations, we required that beneficiaries live in the same county during the reference year because we used county-level figures in our spending calculations. We excluded beneficiaries from either population if they had ESRD or if they had another source

- of health coverage for which Medicare acted as a secondary payer during the reference year.
- 127 The share of non-ESRD MA enrollees with at least two years of prior enrollment in FFS who meet our inclusion criteria is based on nonhospice and Medicare as the primary payer enrollment months in 2023. About 35 percent of MA enrollees in 2023 had at least two prior consecutive years in FFS Medicare between 2006 and 2022.
- 128 We exclude beneficiaries with Medicare as a secondary payer. CMS's payment rates to MA plans are adjusted with the goal of removing the effects of having Medicare as a secondary payer.
- 129 CMS sets MA payment rates using a non-ESRD population. MA plans are separately paid a state-based ESRD rate for MA enrollees with ESRD.
- 130 MA enrollees who use hospice continue receiving supplemental benefits through their MA plan, but MA plans are immediately no longer paid the base payment for Part A and Part B services for that enrollee. Thus, we remove the MA and FFS months in which a beneficiary used only hospice. We count the months in which an enrollee had at least one nonhospice day. Hospice spending while an enrollee is in hospice is excluded from our analysis entirely and is not included in our FFS denominator.
- 131 The population of FFS enrollees in each county used in the denominator includes all beneficiaries with at least one month of FFS enrollment in time $t = 0$ who were enrolled in FFS for the entire prior year ($t = -1$). It includes people who switched to MA in the following year. We use a similar framework as CMS for applying credibility adjustments to counties with less than 12,000 FFS enrollment months. For these counties, we blend spending in the county with spending in a larger market within the same state (metropolitan statistical areas for urban counties and health service areas or nonmetropolitan areas for rural counties). County spending is weighted by county enrollment, and spending in the larger market is weighted by 12,000 minus county enrollment months. Our construction is designed to closely align with the population that CMS uses to construct predicted spending while also ensuring that risk scores were constructed using CMS's HCC model. We also require the population of FFS enrollees in the denominator to be enrolled in both Part A and Part B to enhance similarity with the MA population. Average spending in the county is weighted by enrollment months in the year and standardized to a 1.0 risk score, calculated as
- $$\bar{y}_{g,t} = \frac{\sum_i y_{i,g,t}}{\sum_i r_{i,g,t}}$$
- 132 Mean reversion can occur in two directions. When an individual's spending is initially below their predicted spending, mean reversion can occur if their growth in spending exceeds their growth in risk score. Conversely, when an individual's spending is initially above their predicted spending, mean reversion can occur if their growth in spending is lower than their growth in risk score.
- 133 We bound the selection percentages of the proxy group to match the upper and lower bound of the selection percentage within the MA population. We apply a linear trend of the proxy group to the MA population. In very rare instances, when we apply a linear trend, the selection percentage estimate in base year $t = 0$ will have a more than 5 percentage point difference between the proxy group and the MA subcohorts. When this occurs, we apply a multiplicative trend to the MA population where the base-year selection percentage in year $t = 0$ is multiplied by the growth (as a factor) in selection percentage of the proxy group.
- 134 The weights represent each individual's share of the total predicted spending in the proxy group. Thus, the individual weight is defined as
- $$\alpha_i = \frac{\bar{y}_{g,t=T} \times r_{i,g,t=T}}{\sum_i \bar{y}_{g,t=T} \times r_{i,g,t=T}}$$
- 135 Each cohort of MA enrollees and their proxy cohort of FFS beneficiaries were placed into 110 mutually exclusive groups and matched on those groups. Beneficiaries were first placed into one of three mortality groups based on the year of death: year $t = T$, $t = T + 1$, and $t > T + 1$. Decedents (death in $t = T$) and near-decedents (death in $t = T + 1$) were assigned to 1 of 10 categories within their respective mortality group based on initial selection percentage in year $t = 0$. Nondecadents (death in $t > T + 1$) were placed into 1 of 3 dual status categories (fully dual eligible, partially dual eligible, and nondually eligible), and each nondecadent in a dual status category was placed into 1 of 30 categories based on initial selection percentage in year $t = 0$. Categories of initial selection percentage were developed based on the distribution of spending and enrollment, with the goal of having meaningful differences between the categories while sustaining a reliable sample of enrollees within each category.
- 136 Although there is an insufficient number of observations to match MA enrollees to proxy groups by county of residence, we required beneficiaries in the proxy group to reside in counties with at least one MA enrollee in MA cohort c. Conversely, we also required that MA enrollees reside in counties with at least one proxy-group beneficiary.
- 137 Dual-eligibility status is based on a hierarchy of Medicaid eligibility in the target year. Beneficiaries with at least one month of fully dual status are assigned as "full duals." Beneficiaries without any months of fully dual status and

- at least one month of partially dual status are assigned as “partial duals.” All other beneficiaries are assigned as “nonduals.”
- 138 Beneficiaries in the proxy group are also required to be enrolled in FFS in the year before the base year (2016 in this example) in order to have a populated HCC risk score for 2017.
- 139 The weights are constructed to reflect each individual’s predicted spending in year $t = T$ as a share of the mortality-cohort group’s predicted spending in year $t = T$:
- $$w_{i,T} = \frac{\bar{y}_{g,t=T \times r_{i,t=T} \times m_{i,T}}}{\sum_{i \in C^{d,m,T}} \bar{y}_{g,t=T \times r_{i,t=T} \times m_{i,T}}}$$
- where $m_{i,T}$ indicates months of enrollment.
- 140 Due to data limitations, beneficiaries who switched from FFS to MA before 2006 are considered to have no FFS enrollment.
- 141 We compared our 2023 MA study population with the general non-ESRD population by dual status. Full duals comprised 19 percent of our study population and 17 percent of the general MA population. Partial duals comprised 9 percent of our study population and 8 percent of the general MA population. Nonduals comprised 72 percent of our study population and 75 percent of the general MA population.
- 142 Because we rely on a beneficiary-level annual spending file, we cannot remove nonhospice spending during hospice months from our calculations. We do not anticipate that this materially affects our results. After removing the weighting of hospice months from each beneficiary’s annual spending calculation, we did not observe any difference in our overall estimate of favorable selection.
- 143 Including risk-score level or spending level resulted in each cohort of MA enrollees and their proxy cohort of FFS beneficiaries being placed into 380 mutually exclusive groups and matched on those groups. Including MA market-penetration level resulted into beneficiaries being placed into 210 mutually exclusive groups.
- 144 The Commission recognizes that social risk factors are associated with differences in health status and health care use and that switching between MA and FFS may lead to changes in a beneficiary’s use of health services and in their Medicaid eligibility. Limited evidence suggests that MA plans do not provide greater access to services overall relative to FFS (Agarwal et al. 2022, Commonwealth Fund 2021, Fuglesten Biniek et al. 2021). In addition, MA plans have a financial incentive to ensure that beneficiaries who are eligible but not enrolled in Medicaid receive those benefits while in MA. These additional Medicaid benefits would potentially reduce the cost-sharing liability for both beneficiaries and MA plans. Further, enrolling beneficiaries in Medicaid who were Medicaid eligible but previously unenrolled also increases beneficiary risk scores because their predicted costs in MA would be under a Medicaid segment in CMS’s risk model (rather than a non-Medicaid segment). To the extent that such beneficiaries would have remained unenrolled in Medicaid if still in FFS Medicare, this phenomenon would increase favorable selection in MA. Given our reliance on a beneficiary’s FFS experience when estimating favorable selection, we cannot account for these additional changes in a beneficiary’s social risk while enrolled in MA.

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CHAPTER 13

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

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

Chapter summary

In 2025, Part D paid for outpatient prescription drug coverage on behalf of more than 55 million Medicare beneficiaries. Medicare's payment system for Part D differs from Part A and Part B in that it does not pay for outpatient prescription drugs directly and instead pays private plans to administer the prescription drug benefit.

Between 2023 and 2024, Medicare's Part D program spending is estimated to have 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 Inflation Reduction Act of 2022 (IRA) made the most significant changes to Part D since its

In this chapter

- Part D plans continue to adjust to the IRA and other Part D policies
- Recent trends in Part D enrollment
- Part D program spending
- How the Medicare Drug Price Negotiation Program may affect Part D prices and costs
- Quality of Part D plans and enrollee satisfaction
- Beneficiaries' access to needed medicines
- Appendix: Analyzing recent increases in Part D bids

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 annual 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 special-needs plans (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 fee-for-service (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 Medicare Advantage (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 Medicare’s 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. ■

Each year, the Commission provides a status report on Medicare's Part D prescription drug program. In 2025, 55.8 million Medicare beneficiaries were enrolled in the Part D program for outpatient prescription drug coverage. This coverage is provided by private insurers that offer stand-alone prescription drug plans (PDPs) for fee-for-service (FFS) beneficiaries and Medicare Advantage Prescription Drug plans (MA-PDs), which combine medical and prescription drug coverage, for beneficiaries enrolled in Medicare Advantage (MA). These Part D plans compete to attract enrollees based on the breadth of the drugs they cover, premiums, cost sharing, pharmacy networks, and quality of services. The Budget Reconciliation Act of 2022 (commonly referred to as the Inflation Reduction Act (IRA)) redesigned the Part D benefit and substantially changed the financing of the program costs. These changes were expected to result in higher bids. However, the nearly 180 percent increase in average bids in 2025, followed by an additional 33 percent increase in 2026, may have exceeded expectations. In 2026, beneficiaries have access to an average of 11 PDPs and 32 MA-PDs. In 2024, Part D program costs are estimated to total over \$148 billion (Boards of Trustees 2025).

Background

The Part D program is in its 20th year. The Part D market has evolved over time in response to policy changes as well as changes in the business strategies of insurers participating in Part D. As described below, the latest policy changes were enacted through the IRA; the first change took effect in 2022 while other provisions are scheduled to take effect in 2026 or later.

Medicare's payment system for Part D is different from payment systems under Part A and Part B because Medicare does not pay for outpatient prescription drugs directly. Instead, the Medicare program makes payments to Part D plans to provide coverage for each enrolled beneficiary. Medicare makes two payments on behalf of enrollees in their plans:

- **Direct subsidy**—For each enrollee, Medicare pays a monthly (capitated) prospective payment that is set as a share of the national average bid for

Part D basic benefits, adjusted for the risk of the individual enrollee.

- **Reinsurance**—For enrollees in the catastrophic phase of the benefit—who have drug spending above an annual out-of-pocket (OOP) threshold—Medicare makes payments that cover a portion of spending above the threshold.¹

Combined, Medicare's monthly direct subsidy and reinsurance payments aim to cover 74.5 percent of the expected cost of basic benefits. Beneficiary premiums are designed to cover the remaining 25.5 percent of the expected cost of basic benefits. (Some beneficiaries pay higher premiums, for example, for additional coverage beyond the basic benefit.) In addition to monthly premiums, Part D enrollees also pay any cost sharing required by their plans. For enrollees who qualify for Part D's low-income subsidy (LIS), Medicare pays plans an additional amount on their behalf that covers most or all cost sharing and premium liabilities.

The Commission had long been concerned that past changes to Part D's benefit design combined with trends in prescription drug pricing and spending had weakened plans' incentives for cost control (Medicare Payment Advisory Commission 2022, Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2020b, Medicare Payment Advisory Commission 2016). Between 2007 and 2023, plans' overall financial liability for basic-benefit spending declined markedly, from 75 percent to less than 30 percent, while Medicare's reinsurance grew from about one-fourth to over 70 percent.

The Commission had also voiced concerns about enrollee cost sharing under Part D. Because beneficiaries historically paid an unlimited amount of cost sharing in the catastrophic phase of the benefit, a small but significant share of enrollees had high OOP spending that could pose a financial burden and hinder adherence to treatment. At the same time, limits on cost sharing for enrollees eligible for the LIS blunted their incentives to use lower-cost drugs and has made it more difficult for plan sponsors to manage benefit costs.

In 2020, the Commission recommended major changes to the Part D program to restructure the defined standard benefit and strengthen financial incentives

for plans and beneficiaries to use lower-cost medicines (Medicare Payment Advisory Commission 2020b). In addition, the Commission recommended that plans be given tools to manage enrollee spending as they assume greater insurance risk.²

The IRA changed many aspects of the Part D program, including a benefit redesign that reflected key elements of the Commission's recommendations. However, the elimination of cost sharing above the annual OOP threshold and the lowering of that threshold, while improving affordability of medicines for patients at the point of sale (POS), likely introduced considerable uncertainty regarding utilization growth because plans can no longer rely on cost-sharing tools to manage spending after beneficiaries reach the threshold. (Plans may still apply utilization-management tools such as requiring prior authorization.) The IRA also included provisions that are expected to affect the broader pharmaceutical supply chain, such as requiring manufacturers to pay rebates when the price of their drug rises faster than inflation and establishing the Medicare Drug Price Negotiation Program ("negotiation program"), which requires manufacturers of selected drugs to engage in negotiations with the Secretary of Health and Human Services over prices charged under Medicare Part B and Part D. The Commission has not made recommendations related to either of those new policies.

Recent work by the Commission has highlighted diverging trends in premiums, plan costs, and risk scores in the PDP and MA-PD markets (Medicare Payment Advisory Commission 2025c). (See text box on pp. 492–493 on the concerning trends.) These differences have made MA-PDs increasingly attractive because they offer more generous prescription drug coverage—such as lower deductibles and cost sharing—while keeping premiums relatively low, largely due to MA-PDs' ability to use MA rebates to buydown Part D premiums, a feature unavailable to PDPs. The growing divergence between the two markets raises concerns about the long-term stability of the PDP market, which plays a critical role in ensuring the availability of drug coverage options for FFS beneficiaries.

Our analysis found that some of the difference in risk-standardized costs—that is, costs divided by risk scores—was explained by higher coding intensity

among MA-PDs compared with PDPs.³ Because of the substantial overlap in the diagnoses used in Part D's risk-adjustment model, the prescription drug hierarchical condition category (RxHCC) model, and the model used to risk adjust Part C payments to MA plans, the finding that Part D risk scores are also impacted by the difference in coding intensity between MA and FFS is consistent with expectations (Medicare Payment Advisory Commission 2025c). Our findings imply that systematic differences in coding practices by MA-PDs and PDPs affected the ability of the RxHCC model to accurately predict costs for either sector. At the same time, a substantial difference in average risk-standardized costs remained unexplained between the two sectors even after accounting for differences in coding intensity, suggesting that there are other factors that differentially affect spending in the two markets.

In its announcement for 2025, CMS noted that the RxHCC model historically overpredicted costs for MA-PDs and underpredicted costs for PDPs (Centers for Medicare & Medicaid Services 2024e). Because of the systematic prediction errors CMS had observed across the two markets, the agency has begun applying a separate normalization factor for MA-PDs and PDPs to "more accurately reflect Part D costs in each of these two sectors" (Centers for Medicare & Medicaid Services 2025h, Centers for Medicare & Medicaid Services 2024e). The agency noted that the separate normalization factors are expected to increase PDP risk scores and decrease MA-PD risk scores.

However, to the extent that there are other inaccuracies in the RxHCC model that systematically affect the risk scores for the two sectors, the application of separate normalization factors alone may not be sufficient to ensure balanced competition or accurate payment adjustments. Further, the shift in financing from cost-based to capitated payments under the redesign has increased the importance of risk adjustment. The Commission will continue to examine how Part D's risk adjustment can be improved to ensure payment accuracy and to promote balanced competition across and within the two markets.

In this chapter, we describe our findings from analysis of Part D plan bids and other program data to assess how the IRA and other policy changes are affecting the Part D program.

Part D plans continue to adjust to the IRA and other Part D policies

The redesign of Part D's benefit structure, one of the most significant changes to the program, became effective with the 2025 plan year. The IRA changes are expected to continue to have wide-ranging impacts on Part D plans and their enrollees (see the text box, pp. 480–481, summarizing IRA provisions).⁴ The redesign of the Part D benefit is expected to improve plan incentives to manage prescription drug spending. At the same time, several provisions improve Part D enrollees' access to and affordability of drugs covered under Part D, with savings estimated to be in the thousands of dollars for enrollees with the highest spending (Assistant Secretary for Planning and Evaluation 2024). These benefits, however, have trade-offs. Lower cost sharing for patients makes medications more affordable but is likely to put upward pressure on overall drug utilization and benefit costs, which in turn increases both beneficiary premiums and Medicare payments to plans.

In 2026, the national average bid (a measure of plan benefit liability that is used to determine Medicare's capitated payments to plans) continued to increase, likely reflecting early 2025 spending and utilization trends that exceeded plan expectations, as well as continued uncertainty about utilization and the impact of the negotiation program (Cline et al. 2025b). For 2025, many plans expected an increase in the use of specialty drugs and other high-cost brand medications “as a direct result of the new cost-sharing limits and flexibilities created by the IRA” (Cline and Liner 2024). This significant uncertainty about how much utilization would increase likely drove the variation in 2025 bids (Cline and Liner 2024, Cline et al. 2025b). In this section, we provide an overview of the Part D redesign and how 2026 bids, premiums, and the numbers of plans have responded to these recent changes.

The IRA redesigned the Part D benefit

Medicare law defines the standard Part D basic benefit that plans must offer (or coverage that is actuarially equivalent to that standard). The design and actuarial value of the standard basic benefit have changed numerous times over the years. The transition to the IRA's new benefit design for non-LIS beneficiaries was

fully implemented in 2025, while the transition for LIS beneficiaries started in 2025 and will continue through 2031 (see text box on pp. 480–481 on IRA provisions). Since the last major reforms to the benefit design in 2010, LIS beneficiaries have had a different benefit design than non-LIS beneficiaries, but that will no longer be the case once the new benefit structure is fully implemented for LIS enrollees. (However, Medicare's low-income cost-sharing (LICS) subsidy will continue to pay most of the cost-sharing liabilities on behalf of enrollees who receive the LIS.)

In 2026, Part D's defined standard benefit for enrollees without the LIS (76 percent of enrollees in 2025), includes a deductible; beneficiaries pay 100 percent of costs until the deductible is met. Next, in the initial coverage phase, beneficiaries are responsible for 25 percent of drug spending until reaching the catastrophic-coverage limit (Figure 13-1, p. 482). There is no longer a coverage gap (or “donut hole”), and beneficiaries now have a maximum OOP cap, both representing a significant departure from the historical design. Each year, the standard benefit's parameters change at the same rate as the annual change in beneficiaries' average drug expenses. For 2026, the deductible in Part D's standard benefit is \$615 and the OOP threshold is \$2,100, which is expected to be reached after a beneficiary incurs approximately \$6,555 worth of drug spending (Centers for Medicare & Medicaid Services 2025g).

Although the OOP threshold is \$2,100 in 2026, the “true OOP” (TrOOP) required to reach the OOP threshold varies by plan and can be substantially lower for many enrollees. Beginning in 2025, TrOOP-eligible costs for enhanced plans include the “value of supplemental benefits” calculated as the difference between the cost sharing under the defined standard benefit (e.g., 25 percent coinsurance) and the actual cost sharing required under the plan (e.g., \$50 copay).⁵ Because enhanced plans, by definition, offer more generous coverage than the defined standard benefit, counting the value of supplemental benefits as TrOOP means many beneficiaries will meet their annual OOP limit without incurring the full amount (Karcher et al. 2024).⁶ In 2025, one analysis found that non-LIS enrollees, on average, spent about \$1,200 to reach the annual OOP threshold (\$2,000) (Feller et al. 2025). This method for calculating TrOOP is

The Inflation Reduction Act of 2022 and other recent Part D policies

The passage of the Inflation Reduction Act of 2022 (IRA) and other recent Part D policies changed many aspects of the Part D program. Table 13-1 lists the key IRA provisions and other Part D policies that redesign the Part D benefit

(and notes the year in which the provision was implemented). Beginning with prescriptions filled on or after October 1, 2022, manufacturers must pay a rebate to Medicare equal to the price increase above the rate of inflation for drugs dispensed

(continued next page)

**TABLE
13-1**

Key IRA and other Part D provisions and implementation timeline

IRA provisions	Implementation year
Rebates paid to Medicare from drug manufacturers if they increase prices faster than inflation	2022
Limit beneficiary cost sharing on insulin to \$35/month	2023
Eliminate beneficiary cost sharing for adult vaccines	2023
Cap on annual increase in BBP to no more than 6%	2024
Expand LIS eligibility (from 135% FPL to 150% FPL)	2024
Limit beneficiary OOP spending	2024 (remove 5% coinsurance in the catastrophic phase) 2025 (\$2,000 annual OOP limit)
MDP replaces the Coverage Gap Discount Program*	2025 (phase in over 6 years for LIS beneficiaries)
Drug price negotiations on selected drugs (Part D drugs for 2026 and 2027, Part B and Part D drugs in 2028 and thereafter)	2026 (10 drugs), 2027 and 2028 (15 drugs), 2029+ (20 drugs)
Medicare Prescription Payment Plan: Spread out OOP costs over the year	2025
Selected Drug Subsidy Program (payment from CMS to plan sponsors for 10% of drug price in the initial coverage phase for drugs selected for negotiation)	2026
Require that the BBP cover at least 20% of basic benefit costs (modifying the 6% cap on annual increases in the BBP that began in 2024)	2030
Other Part D policies	Implementation year
Pharmacy DIR payment adjustments to be applied at the point of sale (POS) such that pharmacies' initial reimbursements are the lowest possible amount	2024
Part D Premium Stabilization Demonstration	
Lower PDP premiums by up to \$15 and cap annual increase at \$35 and provide a more generous risk-corridor protection	2025
Lower PDP premiums by up to \$10 PMPM and cap annual increase at \$50 PMPM	2026
Separate RxHCC normalization factors used for PDPs vs. MA-PDs	2025

Note: IRA (Inflation Reduction Act of 2022), BBP (base beneficiary premium), LIS (low-income subsidy), FPL (federal poverty level), OOP (out-of-pocket), MDP (Manufacturer Discount Program), DIR (direct and indirect remuneration), PDP (prescription drug plan), PMPM (per member per month), RxHCC (prescription drug hierarchical condition category), MA-PD (Medicare Advantage Prescription Drug [plan]).
* Under the MDP, manufacturers are exempt from providing discounts for drugs selected for negotiation; instead, Medicare pays higher reinsurance (40 percent) and an additional subsidy for spending between the deductible and the OOP threshold under the Selected Drug Subsidy Program.

Source: MedPAC analysis of Part D program guidance and regulations from CMS.

The Inflation Reduction Act of 2022 and other recent Part D policies (cont.)

to Part D beneficiaries. The IRA also placed limits on out-of-pocket (OOP) costs applied to insulin products and vaccines beginning in 2023. In 2024, the IRA eliminated cost sharing once an individual reaches the annual OOP threshold, referred to as the catastrophic phase of the benefit. For individuals with low income and limited assets, the IRA expanded the eligibility for the full low-income subsidy (LIS) by raising the income threshold from 135 percent to 150 percent of the federal poverty level.

A separate regulatory change that went into effect in 2024 required the postsale payments (called pharmacy direct and indirect remuneration or DIR) that pharmacies often pay to plans to be reflected in the prices at the point of sale (POS). Before 2024, Part D plans that used pharmacy fees typically applied retroactive adjustments (DIR fees), which, on net, resulted in payments from pharmacies to plans. The new policy requires that the initial reimbursements at the POS must be the lowest possible amount they could receive for a given drug dispensed.

In 2025, the IRA's redesign increased the generosity of the benefit by limiting cost sharing for beneficiaries. This shift improves insurance protection for all enrollees, but also raises enrollee premiums and Medicare's program costs. To

address anticipated increase in premiums, the IRA imposed a limit on the annual increase in average beneficiary premiums. The Medicare Part D Premium Stabilization Demonstration that CMS implemented in 2025 further reduced some of the largest premium increases observed among PDPs, shifting those costs to the program. The redesign also reduced the role of Medicare's reinsurance payments—the cost-based reimbursement that had paid for most of the costs incurred by enrollees with high spending—while increasing the role of Medicare's monthly capitated direct-subsidy payments in financing the benefit.

The IRA also includes provisions aimed at addressing rising drug prices, such as requiring manufacturers to pay rebates to Medicare when the price of their drug rises faster than inflation and the Medicare Drug Price Negotiation Program, which requires manufacturers of selected drugs to engage in negotiations with the Secretary of Health and Human Services over prices charged under Medicare Part B and Part D.⁷ In 2026, for the first time, the prices of 10 single-source drugs with the highest total gross Part D spending will be set at the price negotiated by the government under the negotiation program; additional drugs will be selected in subsequent years. ■

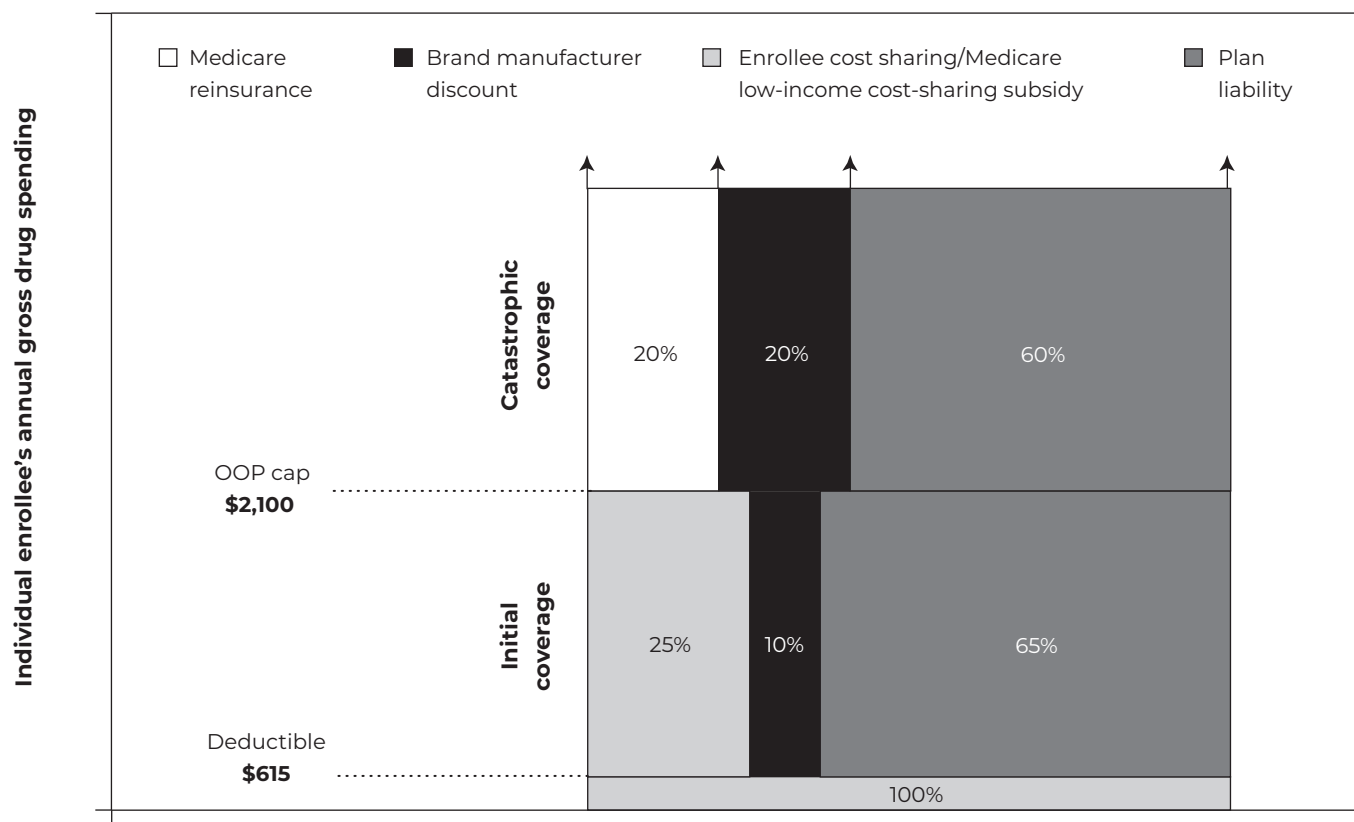
expected to improve beneficiaries' access to drugs by reducing cost-sharing liabilities for many beneficiaries without the LIS. It may also lead to more beneficiaries reaching the OOP threshold and to higher overall spending among those beneficiaries because plans can no longer use financial incentives (e.g., differential cost sharing) to manage utilization once beneficiaries reach the catastrophic phase of the benefit.

For beneficiaries with low incomes and limited assets, Medicare's LIS pays the difference between

cost-sharing amounts set by each plan and nominal copayments set by law. In 2026, individuals receiving the LIS will pay between \$0 and \$5.10 per prescription for generics and between \$0 and \$12.65 per prescription for brand-name drugs.⁸ Above the OOP threshold, LIS enrollees have never paid cost sharing; Medicare's LICS subsidy paid the 5 percent coinsurance they previously would have owed if they did not receive the LIS. As of 2024, neither LIS nor non-LIS beneficiaries pay cost sharing above the OOP threshold. Since these costs had previously been

**FIGURE
13-1**

Recently redesigned defined standard benefit, 2026



Note: The “defined standard benefit” is depicted as it would apply to brand-name drugs and biologics. For generic drugs, plans must pay 75 percent of covered benefits between the deductible and OOP cap. Medicare will pay 40 percent reinsurance above the OOP cap, with plans paying the remaining 60 percent. Total spending at the \$2,100 OOP cap is expected to be \$6,555. For beneficiaries with the low-income subsidy and for certain small manufacturers, the new manufacturer discount program will be phased in over time, reaching final levels by 2031. In addition, Medicare’s low-income cost-sharing subsidy will continue to pay most of the cost-sharing liabilities on behalf of enrollees who receive the low-income subsidy.

Source: MedPAC depiction of Part D benefit structure for 2026.

covered for LIS enrollees by the LICS subsidy, this change has reduced Medicare’s costs for this subsidy and increased plans’ liability.

In 2025, the IRA also required plans to allow enrollees to “smooth” their cost-sharing liabilities over the course of the year through the Medicare Prescription Payment Plan (M3P). Plans must advertise the program to all enrollees and specifically notify individuals who could benefit from this program of that likelihood. Beneficiaries who enroll in the M3P with their plan pay nothing when filling their prescriptions at the

pharmacy. Instead, plans pay the pharmacy the full cost-sharing amount and enrollees pay their cost-sharing liability directly to their plans over the course of the year. The amount owed each month will be based on the total cost-sharing liability owed at the time of the opt-in, the amount of TrOOP already accumulated toward the annual OOP limit, the number of months remaining in the year, and any new charges incurred in subsequent months for additional drugs. This formula could result in large fluctuations in payment amounts throughout the year that do not coincide with when individuals fill their prescriptions. This mismatch may

cause confusion for some beneficiaries. CMS thus notes that the program may be more helpful for some beneficiaries than others (Centers for Medicare & Medicaid Services 2024f). The M3P may also require Part D plans to set up new infrastructure to bill patients and to notify the pharmacy staff in a way that fits with their workflow, a process that could be administratively complex (Dusetzina et al. 2024). Plans may also be at risk of beneficiaries not paying these bills in full, potentially contributing to higher risk premiums assumed in their bids. However, evidence to date suggests that the use of M3P has been limited in its first year of implementation (Feller et al. 2026).

The national average monthly bid amount continued to increase in 2026

The IRA substantially redesigned the Part D program, shifting how the benefit is financed, restoring the role of the capitated direct subsidy as the primary mechanism for subsidizing Part D premiums instead of Medicare's cost-based reinsurance. Last year, we reported that changes in the 2025 average monthly bid amount, base beneficiary premiums (BBPs), capitated direct subsidy, and cost-based reinsurance were all directionally consistent with the changes that were expected due to the IRA's redesign. However, the magnitude of the changes exceeded expectations (BGR Group 2024, Cline et al. 2024).⁹ In 2025, the national average monthly bid amount (NAMBA) increased by 180 percent, and Medicare's total expected benefit cost (which is composed of the NAMBA plus expected reinsurance) also substantially increased, by 42 percent (Medicare Payment Advisory Commission 2025d).

This year, in 2026, the NAMBA continued to grow, increasing by 33 percent to \$239 per member per month (PMPM) (Table 13-2, p. 484). At the same time, expected cost-based reinsurance also increased by 41 percent, resulting in an increase in the total expected basic benefit cost of 35 percent. This growth comes after CMS engaged in negotiations with plans to limit significant increases in cost sharing or reductions in benefits and even deny, for the first time, bids that CMS viewed as having significantly high year-over-year premium increases or were outliers in their region, suggesting that initial bid submissions were even higher than these final amounts (Centers for Medicare & Medicaid Services 2025a).

To better understand the drivers of the growth in bids in both 2025 and 2026, we used plans' bids submitted to CMS through the bid pricing tool to examine plans' projections of enrollee spending and estimate how the IRA and other Part D policies shifted financing of the benefit. This analysis is described in the appendix to this chapter. That work provides background on how the Part D benefit is financed, how CMS pays plans, and the bidding process used to determine the direct subsidy and beneficiary premiums.

Based on our analysis of the bid data, we estimated that the increase in bids in 2025, with the start of the IRA redesign, was mostly (82 percent) due to shifting financing for the Part D benefit to the capitated direct subsidy and premium payments and away from cost-based reinsurance, beneficiary cost sharing, and the LICs subsidy. The remaining 18 percent was attributed to increases in plans' expected spending for 2025 relative to 2024. That increase in expected spending was estimated to be related to underpredicted spending in 2024 bids and expected growth in spending in 2025. In contrast, we estimate that the growth in 2026 bids was mostly (72 percent) due to plans' expected increases in spending in 2026 relative to 2025 (though we cannot yet estimate how much of that increase was correcting for the "underprediction" of spending in 2025 rather than higher expected spending in 2026). Plan actuaries we interviewed pointed out that first-quarter data in 2025 revealed higher-than-expected pharmacy costs among non-LIS enrollees, which plans reflected in their 2026 bids (see more below on interviews with actuaries, pp. 491–494). The 41 percent growth in expected reinsurance costs in 2026 (Table 13-2, p. 484) may be related to the higher reinsurance (40 percent instead of 20 percent) Medicare will pay for drugs selected for the negotiation program. Under the IRA, the drugs selected for negotiation are exempt from the MDP. As a result, Medicare's reinsurance covers the share of spending in the catastrophic phase that would have been the responsibility of manufacturers under the MDP.¹⁰

The IRA capped the annual increase in the BBP at 6 percent starting in 2024.¹¹ As shown in Table 13-2 (p. 484), the effect of the cap is greater in 2026 than in 2025 due to cumulative effects.¹² The reduction in the BBP is financed by the Medicare program paying a higher capitated direct subsidy to plans. As shown in

**TABLE
13-2****Increases in the Part D national average monthly bid amount and total expected basic benefit cost, 2025–2026**

	2025	2026	Percent change
Total expected basic benefit cost	\$219.53	\$295.61	35%
National average monthly bid amount	179.45	239.27	33
National average expected reinsurance	40.08	56.34	41
Base beneficiary premium			
Before the application of the 6% cap (25.5% of the total expected benefit cost)	55.98	75.38	35
After the application of the 6% cap	36.78	38.99	6
<i>Effect of the 6% cap</i>	–19.20	–36.39	
Medicare's direct subsidy			
Before the application of the 6% cap	123.47	163.89	33
After the application of the 6% cap	142.67	200.28	40
<i>Effect of the 6% cap</i>	19.20	36.39	
Medicare's total subsidy costs (direct subsidy plus reinsurance payments)			
Before the application of the 6% cap	163.55	220.23	35
After the application of the 6% cap	182.75	256.62	40
<i>Effect of the 6% cap</i>	19.20	36.39	
Medicare's subsidy rate			
Before the application of the 6% cap	74.5%	74.5%	
After the application of the 6% cap	83.2	86.8	

Note: The “national average monthly bid” is the enrollment-weighted average of plan bids, which include plans’ expected benefit liability net of the plan’s share of postsale rebates and discounts, plus administrative costs and profit margin. The “national average expected reinsurance” is estimated based on the expected reinsurance costs, accounting for Medicare’s share of postsale rebates and discounts, and is used to calculate the base beneficiary premium (BBP) before the application of the 6 percent cap. By law, the BBP is calculated as 25.5 percent of the total expected benefit cost per enrollee. Under the changes made by the Inflation Reduction Act of 2022, beginning in 2024, the annual increase in the BBP is limited to 6 percent through 2029. In 2030, the BBP increase will continue to be limited to 6 percent. However, the BBP cannot be less than 20 percent of the average basic benefit costs. For subsequent years, the BBP’s share of the expected benefit costs will remain at the level set for 2030. Medicare’s direct subsidy is computed as the difference between the national average monthly bid amount and the BBP. Figures do not reflect the effects of the Part D Premium Stabilization Demonstration discussed on p. 485. Figures in this table do not include the bids of special-needs plans since they are not used in calculating the national average monthly bid amount.

Source: CMS’s annual release of Part D national average monthly bid amount and other Part C and Part D bid information.

the last row of Table 13-2, after application of the cap, Medicare’s subsidy rate (including capitated direct subsidy and reinsurance) is projected to comprise 86.8 percent of total basic benefit costs in 2026. The remainder (13.2 percent) is the beneficiary’s share of the basic benefit costs. However, as discussed in the next section, other Part D policies further reduced beneficiary premiums and increased program costs.

Medicare policies that mitigate the growth in enrollees’ premiums play a large role in 2025 and 2026

Capping BBP annual growth at 6 percent was intended to help stabilize premiums as the IRA redesign was expected to substantially increase benefit costs and premiums. The BBP growth cap, first implemented in 2024, combined with a demonstration to limit PDP

premium increases, helped stabilize average PDP premiums. In 2025, the monthly total premium after applying those additional subsidies averaged about \$23 across all plans (down from \$26 in 2024). For 2026, we project the average total premium will increase slightly to \$24, which is still below the 2024 average.¹³ Premiums do, however, vary widely across and within plan types, as discussed below.

Part D Premium Stabilization Demonstration lowered PDP premiums for enrollees

In 2025, CMS noted large increases and greater variation in bids submitted by PDPs compared with bids submitted by MA-PDs, which could have resulted in premium changes causing “disruptive enrollment shifts in the PDP market during the initial implementation of the IRA benefit improvements” (Centers for Medicare & Medicaid Services 2024b). To mitigate these “destabilizing” effects, CMS implemented the Part D Premium Stabilization Demonstration for PDPs in 2025. Participating plans’ total premiums were lowered by up to \$15, and annual premium increases were limited to \$35. CMS also narrowed risk corridors to provide more generous protection against losses. In 2026, the second year of the demonstration, participating PDPs’ premiums were lowered by up to \$10, and the annual increase in their total monthly premiums was capped at \$50. Risk corridors returned to their original parameters in 2026. The demonstration was estimated to cost the government about \$6 billion in 2025 and about 40 percent less in 2026 (Mathews and Whyte 2025).

In 2026, the average PDP total (basic and supplemental) premium is expected to be \$44, up from \$39 in 2025 (solid line at the bottom of Figure 13-2, p. 486).¹⁴ Without the BBP growth cap and the Premium Stabilization Demonstration, the average total PDP premium would have been substantially higher at \$97 (dotted line with triangles at the top of Figure 13-2). The BBP growth cap was responsible for most (70 percent) of this difference in average total premium, with the demonstration accounting for the remaining difference. In 2025, without the BBP growth cap and the demonstration, the average total PDP monthly premium would have been \$84, compared with the actual average of \$39.¹⁵ The effect of the demonstration was larger in 2025, lowering the post-BBP growth cap premium from \$65 to \$39

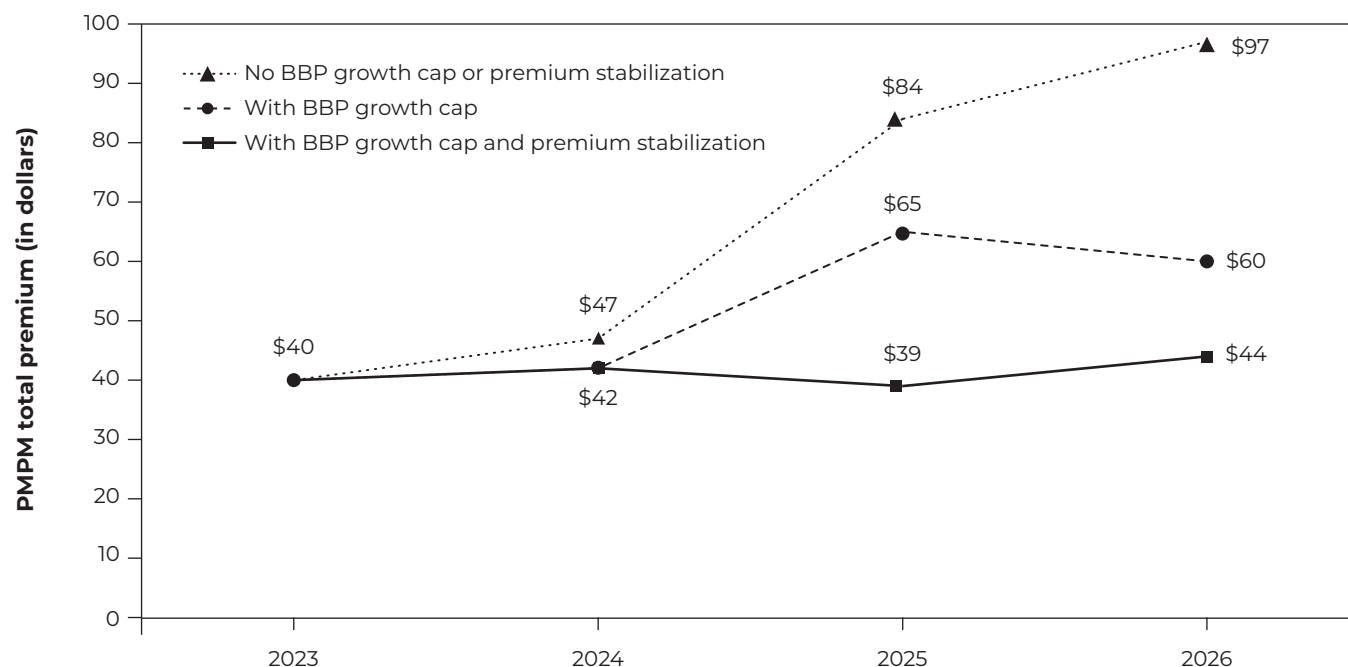
(Figure 13-2). As a result, overall, in 2026, we expect a relatively small increase in the average PDP total premium: From 2025 to 2026, average premiums for basic PDPs are expected to grow from \$35 to \$39 and for enhanced plans from \$42 to \$48 (data not shown).

MA rebate buydowns lower MA-PD plan premiums for enrollees

Across all MA-PDs, the expected average total premium in 2026 is \$11, down from \$13 in 2025. These amounts reflect both the BBP growth cap and premium reductions (or “buydowns”) that MA plans offer, financed with MA rebates. However, buydown amounts and the resulting premiums vary across types of MA-PDs.

In 2026, the average premium for conventional MA-PDs prior to the application of the BBP growth cap and MA buydowns rose from \$70 to \$98 PMPM (Figure 13-3, p. 487). This increase is likely related to the separate risk-score normalization for PDPs and MA-PDs introduced in 2025, which increased the average PDP risk score and lowered the average MA-PD risk score. Lower risk scores increase risk-standardized bids and, therefore, premiums (see pp. 519–521 in the appendix to this chapter for more information on how premiums are calculated from plans’ bids). However, in 2026, MA rebate buydowns, combined with the BBP growth cap, are projected to lower average premiums for conventional MA-PDs from \$98 to \$9, a slight increase from \$7 in 2025 (Figure 13-3). The BBP growth cap accounted for 40 percent of the reduction, while MA rebate buydowns accounted for the remaining 60 percent. As a result, in 2026, average total premiums for conventional MA-PDs continue to be below that of PDPs. Higher PDP premiums are consistent with one of the concerning trends that may affect the long-term stability of the PDP market we highlighted in our June 2025 report to the Congress (Medicare Payment Advisory Commission 2025c) (see the text box on concerning trends, pp. 492–493).

For special-needs plans (SNPs), in 2026, the BBP and MA rebate buydowns are estimated to lower premiums from \$72 to \$16, the lowest average SNP premium in recent years (Figure 13-3, p. 487). The BBP growth cap accounted for over 60 percent of the reduction, and the MA rebate buydowns accounted for the remainder. Thus, the BBP growth cap played

**FIGURE
13-2****PDP premiums are lowered through the BBP growth cap and Premium Stabilization Demonstration, 2023-2026**

Note: PDP (prescription drug plan), BBP (base beneficiary premium), PMPM (per member per month). The “BBP growth cap” is a provision in the Inflation Reduction Act of 2022 that limits annual growth in the BBP to no more than 6 percent, starting in 2024. “Premium stabilization” refers to the Part D Premium Stabilization Demonstration that began in 2025 for PDPs whereby CMS provides additional subsidies to participating PDPs to decrease total premiums and caps year-over-year premium growth (see p. 485 for more details).

Source: Part D bid pricing tool data, Part D landscape files, and Part D enrollment data from CMS.

a larger role in lowering premiums for SNPs than for conventional MA-PDs, but among all MA-PDs, the BBP growth cap was a significant contributor to lowering premiums (reducing the need to use more MA rebates to lower premiums).

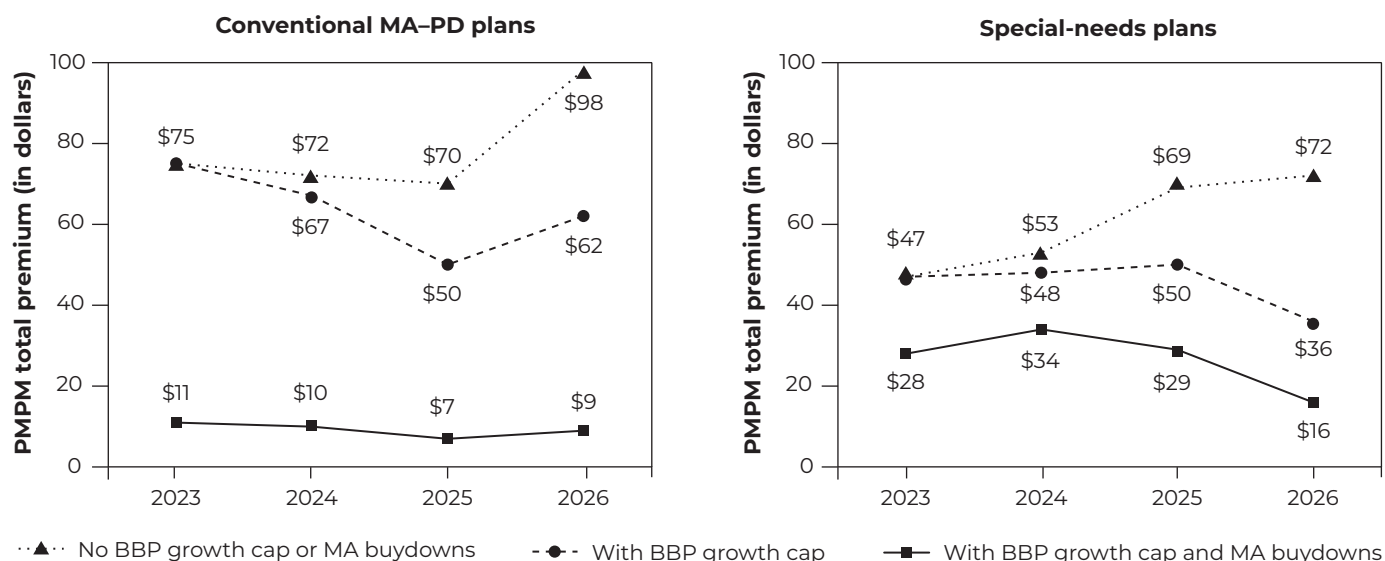
SNPs include of three types of plans—dual-eligible special-needs plans (D-SNPs), chronic-condition special-needs plans (C-SNPs), and institutional special-needs plans (I-SNPs).¹⁶ D-SNPs are the most common type of SNP, although the number of C-SNPs has been growing rapidly in recent years (see discussion below on p. 490). All D-SNP enrollees receive the LIS and pay no premium for basic benefits. Historically, most D-SNPs were basic-benefit plans, and their premiums were at or below the LIS benchmark.¹⁷ However, in 2026, 80 percent of D-SNPs are now enhanced plans.

Still, the total premium for nearly all LIS beneficiaries in D-SNPs will be \$0.

D-SNPs generally do not need to use as much of their MA rebate for buydowns because their target premiums are LIS benchmarks (unlike conventional MA-PDs that typically aim to charge \$0 premiums), and reducing premiums below that benchmark does not help them attract additional enrollees (instead, D-SNPs tend to devote more of their rebate dollars to non-Medicare services).¹⁸ The average buydown for D-SNPs is projected to be \$13 in 2026, compared with \$53 for conventional MA-PDs. C-SNPs, which are less likely to enroll beneficiaries with the LIS, have a projected average buydown of \$63 in 2026, with 60 percent of the rebates being used to buy down the supplemental portion of the premium. I-SNPs enroll only individuals

**FIGURE
13-3**

MA-PDs' premiums substantially lowered by BBP growth cap and MA rebate buydowns, 2023-2026



Note: MA-PD (Medicare Advantage Prescription Drug [plan]), BBP (base beneficiary premium), MA (Medicare Advantage), PMPM (per member per month). The "PMPM total premium" refers to the Part D portion of the MA-PD premiums. Beneficiaries enrolled in MA-PDs may pay a separate premium for their MA benefits. The "BBP growth cap" is an Inflation Reduction Act of 2022 (IRA) provision limiting annual growth in the BBP to no more than 6 percent, starting in 2024. "MA buydown" refers to MA plans' use of Part C rebates to lower Part D premiums for their enrollees.

Source: Part D and MA bid pricing tool data, Part D landscape files, and Part D enrollment data from CMS.

living in an institution and, like D-SNPs are much more likely to enroll beneficiaries with the LIS; however, these plans tend to have higher bids (and therefore higher premiums) and are expected to use \$68 in MA rebates to lower Part D premiums in 2026.

These average monthly premiums discussed above do not include two factors that can affect the premiums that enrollees pay. First, higher-income enrollees pay a higher monthly premium, known as the Income-Related Monthly Adjustment Amount. This amount reduces the monthly capitated direct subsidy that Medicare pays on their behalf. In 2025, such individuals paid between \$13.70 and \$85.80 in additional monthly premiums, depending on specified income thresholds and tax-filing status (Centers for Medicare & Medicaid Services 2025d).¹⁹ In 2025, about

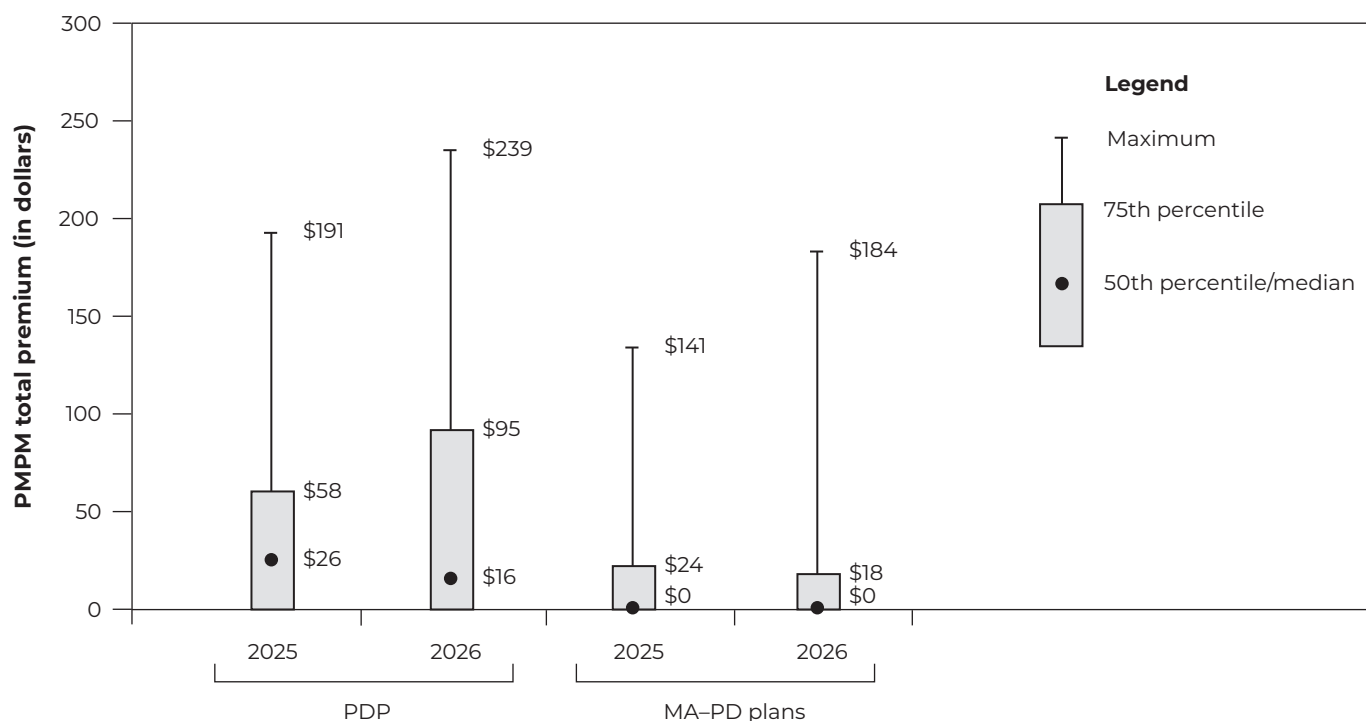
8 percent of enrollees were subject to the income-related premium, compared with less than 3 percent in 2011 (Liu and Centers for Medicare & Medicaid Services 2025). Second, individuals enrolling outside their initial enrollment period must have proof that they had drug coverage that was expected to pay, on average, at least as much as the standard benefit in order for them to avoid the late-enrollment penalty (LEP) that would be added to their premiums for the duration of their Part D enrollment.²⁰ In 2025, about 6 percent of Part D enrollees paid the LEP (Liu and Centers for Medicare & Medicaid Services 2025).²¹

Premiums vary across and within types of plans

As shown above, premiums are substantially higher for PDPs than for MA-PDs, primarily due to sizable MA-rebate buydowns that MA-PDs use to lower

FIGURE
13-4

Greater premium variation among PDPs than MA-PDs, 2025–2026



Note: PDP (prescription drug plan), MA-PD (Medicare Advantage Prescription Drug [plan]), PMPM (per member per month). The “PMPM total premium” is the sum of basic and supplemental premiums for Part D plans. The figure shows the 50th percentile, 75th percentile, and maximum plan premiums. For both PDPs and MA-PDs in 2025 and 2026, the 25th percentile premium was \$0. Premiums in 2025 were combined across plans using April 2025 enrollment. Premiums in 2026 were combined across plans using April 2025 enrollment after applying CMS’s plan crosswalk files between 2025 and 2026.

Source: Part D and MA bid pricing tool data, Part D landscape files, and Part D enrollment and plan crosswalk data from CMS.

MA-PD premiums. If underlying premium trends continue, the difference in premiums between PDPs and MA-PDs could widen as the Premium Stabilization Demonstration is scheduled to end after 2027 and the BBP growth cap is modified in 2030 by a new formula that sets a floor for the BBP at 20 percent of Part D’s total basic benefit cost (the BBP covers just 13 percent of basic benefit costs in 2026).

Even within plan types, premiums varied substantially in 2025, with large projected increases for some plans between 2025 and 2026. For PDPs, the median PDP premium was \$26 PMPM, the 75th percentile was \$58, and the maximum premium was \$191 (Figure 13-4). In 2026, the distribution of PDP premiums widened:

The median PDP premium was lower at \$16, but the 75th percentile and maximum plan premiums both increased. In both 2025 and 2026, the median MA-PD premium was \$0 (Figure 13-4). The maximum MA-PD premium is projected to increase in 2026 (from \$141 to \$184), though the 75th percentile MA-PD premium is projected to decrease (from \$24 to \$18).

The variation in premiums across plans reflects a multitude of factors that affect plans’ bids, such as assumptions about drug pricing and utilization trends, new drug launches, costs, enrollment, and risk adjustment. Several plan actuaries we interviewed noted that recent CMS changes to the risk-adjustment model, including separate normalization for PDPs and

**TABLE
13-3****PDPs continue to decline while enhanced SNPs have grown dramatically, 2023–2026**

	2023	2024	2025	2026	Average annual percent change	
					2023–2026	2025–2026
Total number of plans	5,597	5,522	5,127	5,028	–4%	–2%
Basic	1,045	1,197	1,165	717	–12	–38
Enhanced	4,868	4,325	3,962	4,311	–4	9
PDPs	804	709	464	360	–23	–22
Basic	305	266	196	183	–16	–7
Enhanced	499	443	268	177	–29	–34
Conventional MA-PDs	3,539	3,507	3,246	2,967	–6	–9
Basic	71	72	56	66	–2	18
Enhanced	3,468	3,435	3,190	2,901	–6	–9
SNPs	1,254	1,306	1,417	1,701	11	20
Basic	669	859	913	468	–11	–49
Enhanced	585	447	504	1,233	28	145

Note: PDP (prescription drug plan), SNP (special-needs plan), MA-PD (Medicare Advantage Prescription Drug [plan]). We include PDPs, local and regional preferred provider organizations' Part D plans, and HMOs' Part D plans. Plan counts exclude plans offered in U.S. territories and employer group waiver plans.

Source: Part D landscape file from CMS.

MA-PDs, raised PDP risk scores, which allowed some PDPs to offer lower premiums and remain competitive. However, these actuaries noted that further improvements were needed to ensure longer-term PDP market stability (see pp. 491–494 for a discussion of interviews with actuaries).

The number of PDPs declined, and the number of SNPs rose in 2026

In 2026, 5,028 Part D plans will be offered, a 2 percent decline from 2025 (Table 13-3). On average, the total number of Part D plans has declined by 4 percent annually since 2023, though trends in plan offerings have varied widely for PDPs, conventional MA-PDs, and SNPs.

Between 2025 and 2026, the number of PDPs decreased from 464 plans to 360 plans (22 percent decline), which is similar to the average annual decline since 2023

(Table 13-3). Nationwide, the 34 PDP regions have an average of 11 plans per region, down from an average of 14 per region in 2025 (data not shown). These plans are offered by five parent organizations per region, on average, down from an average of seven in 2024.²²

The decline in PDPs is concentrated among enhanced PDPs (a 34 percent reduction from the prior year), while basic PDPs declined by 7 percent (Table 13-3). The decline in enhanced PDPs was primarily a result of two organizations that offer Part D plans choosing to offer just one enhanced plan instead of two. For the first time since 2012, enhanced plans represent less than half of all PDP offerings. Of the 104 PDPs that did not continue into 2026, 48 plans fully terminated, and 56 consolidated with other plans.²³ Most of the fully terminated plans were enhanced (35 of the 48 fully terminated plans).

The number of PDPs has generally been declining since 2022 due to a variety of factors, including growth in MA enrollment. PDPs experienced an outsized decline of 35 percent (to 464 plans) in 2025. Speaking specifically about the most recent changes in PDP offerings, several experts we interviewed told us that the PDP market has become more “commoditized” under the redesigned benefit, which limits plans’ ability to differentiate by benefit parameters and cost-sharing amounts. This change may have contributed to the decline in enhanced PDPs (see pp. 491-494 discussing interviews with actuaries).

Conventional MA-PDs also experienced a 9 percent decline in 2026 compared with the prior year (from 3,246 to 2,967) (Table 13-3, p. 489). The average beneficiary has 32 conventional MA-PDs from which to choose (offered by an average of eight insurers), down from 34 in 2025.

At the same time, the number of SNPs increased by 20 percent, and the share of enhanced SNPs grew considerably, now accounting for 72 percent of plans, up from 36 percent in 2025 (Table 13-3, p. 489). This overall growth in the number of SNPs was driven by a 46 percent increase in C-SNPs and 13 percent increase in D-SNPs (data not shown). While SNPs continue to primarily be D-SNPs (59 percent), the number of C-SNPs now accounts for about one-third of all SNPs. (However, in terms of enrollment, in 2025, C-SNP enrollees accounted for only 17 percent, while D-SNP enrollees made up 82 percent of overall SNP enrollment.) The growth in enhanced SNP offerings is likely due to the end of the value-based insurance design (VBID) model which, from 2017 to 2025, had allowed MA-PDs to offer basic benefit plans with supplemental benefits (e.g., no cost sharing for certain drugs); with the end of the VBID model, such benefits may now be offered only in enhanced plans (Schmidt and Graham 2025).

There have been substantial changes in plan offerings since the IRA reforms have begun to take effect. While two-thirds of conventional MA-PDs required no deductible in 2023, just 15 percent of plans offer the same in 2026, although 84 percent of plans now have some drugs not subject to the deductible compared with just 33 percent in 2023. SNPs took a similar approach this year: Fewer plans are offering a \$0 deductible, despite a much greater number of

enhanced plans, but 75 percent have some drugs that are not subject to the deductible. For PDPs, the number of plans with some formulary tiers not subject to the deductible has instead declined from 53 percent in 2023 to 39 percent in 2026. As a result, MA-PDs, on average, continue to offer a more generous benefit compared with PDPs.

The number of benchmark plans is stable in 2026

Consistent with the shift in enrollment from FFS to MA in the broader Medicare program, Part D’s enrollment has also shifted from PDPs to MA-PDs. MA-PDs continue to offer more generous prescription drug coverage (for example, with fewer product exclusions and lower cost sharing) to enrollees at lower premiums (Ippolito and Vabson 2024, Joyce et al. 2024). At the same time, PDPs play an important role because they provide drug coverage for FFS beneficiaries and, critically, ensure that premium-free plan options (“benchmark” plans) are available for FFS beneficiaries with low incomes and limited assets. There are program rules that ensure the availability of at least one benchmark plan in every region.²⁴ However, when only a few plans—or just one plan—participate in a region, it can undermine the competitive model that Part D relies on and increase costs for Medicare.

In 2025, there was a large drop in the number of benchmark plans (to 90 from 126 in 2024). In 2026, the number has remained relatively stable at 88 benchmark plans, and the average remained the same at 3 per region. While some regions have more and some regions have fewer compared with 2025, the number of regions with a single benchmark plan declined from four to two. Still, the number of regions with limited choice in benchmark plans grew in 2026: 2 regions (Region 11 (Florida) and Region 22 (Texas)) have just one benchmark plan, and 16 regions have two, compared with 15 regions that had just one or two benchmark plans in 2025.²⁵ We will continue to examine characteristics of regions with few benchmark plans and other concerns related to the long-term stability of the PDP market (see text box on trends that raise concerns, pp. 492-493).

The benchmark amounts varied widely across regions, ranging from \$0 in New Mexico and Alaska to \$59 in New York. This range is wider than the

historical trend but similar to last year. For example, in 2024, benchmarks ranged from \$28 in Texas to \$49 in New York, a difference of about \$20. The larger variation in the LIS benchmarks across regions is due, in part, to the greater variability in PDP bids compared with prior years (Centers for Medicare & Medicaid Services 2024d). For 2026, CMS expects to reassign about 94,000 LIS enrollees who were in plans that were terminated or lost the benchmark status to a different plan that is premium free for LIS enrollees (Liu and Centers for Medicare & Medicaid Services 2025). (That figure is significantly lower than the 400,000 LIS enrollees who were reassigned to a benchmark plan in 2025.)

Amid ongoing uncertainty, actuaries point to risk adjustment as key to PDP market stability

To better understand how Part D plans are affected by the IRA and other recent policy changes, Commission staff interviewed individuals with extensive knowledge of the Part D market. Additional details of our interviews and findings are provided in Appendix 13A.

Recent trends in the NAMBA

Before the start of 2025, a nearly 180 percent increase in the NAMBA for 2025 was viewed by many as reflecting cautious bids due to uncertainty and higher liability under the IRA's benefit redesign. However, in the first quarter of 2025, plans began to observe higher-than-expected pharmacy costs for brand-name and specialty drugs, including glucagon-like peptide-1 receptor agonists (GLP-1s). Interviewees noted that changes to TrOOP calculations—counting supplemental benefits as enrollees' OOP—likely had a greater impact on utilization than plans expected. Consequently, plans adjusted bids upward for 2026, with much of the 33 percent NAMBA increase reflecting accelerated utilization trends during the first half of 2025.

Interviewees noted that 2026 bids varied widely, driven by continued uncertainty related to the IRA and accelerated spending trends. They also cited the implementation of maximum fair prices (MFPs) for drugs selected under the Medicare Drug Price Negotiation Program (“selected drugs”) as a major source of uncertainty, with effects expected to differ

across plans due to variation in utilization and rebate levels of the selected drugs. Predicting utilization changes from the effectuation of MFPs and the impact of rebate loss complicated bid preparation. For example, plans with higher baseline utilization of selected drugs or greater reliance on rebates faced more unpredictability in how MFPs would affect their benefit costs. Some interviewees also expressed concerns that lower OOP costs for selected drugs could increase utilization, but the magnitude of the increase was difficult to predict. In addition, because rebate revenue historically lowered bids and premiums rather than cost sharing, the loss of rebates could mean higher costs for plans even if MFPs achieve costs similar to net-of-rebate costs since some savings previously achieved through rebates would now offset cost sharing. These challenges were compounded by other policies that affect drug prices. In response, plans adopted divergent strategies, ranging from aggressive low-premium bids to conservative approaches to hedge against the impact of MFPs and other drug-pricing policies, which also contributed to variation. Some plans bid above benchmarks to prioritize margins over enrollment growth, while others exited unprofitable markets.

State of the PDP market

The PDP market has evolved significantly since the program began. Several trends have raised concerns about the long-term stability of the market (see text box on trends that raise concerns, pp. 492–493). Interviewees emphasized that uncertainty from the IRA changes—combined with the persistence of selection effects within the PDP market, benchmark plan dynamics, and recent risk-adjustment changes—continue to shape the market.

Historically, PDPs offered national insurers the scale for rebate negotiations and access to enrollees who could be moved to MA products (i.e., MA-PDs). However, the introduction of MFPs is expected to reduce the role of rebates in lowering benefit costs, eroding this financial advantage. One interviewee noted that the “squeeze” in MA margins has also diminished the value of “PDP-to-MA conversions.” These changes, coupled with higher operational costs, limited the ability to absorb margin pressure, and less regulatory flexibility relative to MA-PDs may have prompted some insurers to consolidate offerings or exit the PDP market.

Trends that raise concerns about the long-term stability of the stand-alone PDP market

Our analysis included in the Commission's June 2025 report to the Congress identified four trends that reveal differences that may affect competition between prescription drug plans (PDPs) and Medicare Advantage Prescription Drug plans (MA-PDs) and, in some cases, competition within each sector. These differences may also affect the benefits that plans offer (Medicare Payment Advisory Commission 2025c).

First, the Commission has found that Part D premiums charged by PDPs for the basic benefits have tended to exceed those of MA-PDs. Because premiums are one of the key price signals that beneficiaries compare when choosing a plan, this difference likely influences beneficiary enrollment decisions. In general, beneficiaries would be less likely to choose a plan that charges a higher premium without any obvious or perceived difference in benefits (e.g., generosity of drug coverage or breadth of pharmacy networks) relative to another plan with a lower premium. For some

beneficiaries without the low-income subsidy (LIS), the higher premiums charged by PDPs may pose a barrier to remaining in fee-for-service (FFS) Medicare even if that is their preferred option for Medicare coverage.

Second, the number of PDPs qualifying as benchmark plans in certain areas of the country has continued to decline. In some regions, FFS beneficiaries receiving the LIS have had only one premium-free benchmark plan available in 2025 and 2026. For FFS beneficiaries, PDPs are the only option for Part D's drug coverage; for FFS beneficiaries who receive the LIS, benchmark PDPs are the only premium-free option for Part D coverage. If the decline in the number of benchmark plans is the result of the PDP market lacking a sufficient number of PDPs to sustain competitive pressure, this factor could result in higher costs for the program and for beneficiaries paying premiums that do not reflect competitive market forces.

(continued next page)

The IRA dramatically reduced enrollees' cost-sharing liabilities through the benefit redesign and other coverage and cost-sharing requirements. Multiple interviewees noted that these changes have made the PDP market increasingly "commoditized," as plans now have limited ability to differentiate themselves through benefit structures or cost-sharing amounts. In turn, selection effects become more pronounced, with the lowest-premium plans attracting healthier, lower-utilization members. Several interviewees observed that this narrowing of options to manage utilization or distinguish themselves in the market encourages plans to compete primarily on premiums, reinforcing selection effects and contributing to wide variation in risk profiles and financial outcomes across PDPs.

LIS benchmark plans

Plans that bid below the regional benchmark receive FFS beneficiaries who have the LIS through CMS's auto-assignment process, which ensures drug coverage at no premium for enrollees who have not selected a plan. Interviewees explained that, because these "auto-enrollees" tend to have lower utilization and more predictable claims experience and because the process eliminates the need for marketing, auto-assignment creates strong incentives for aggressive bidding to qualify as a benchmark plan. This competitive pressure can lead to lower bids and premiums, benefiting both beneficiaries and Medicare. However, these dynamics may also contribute to market instability: If a plan's premium rises above the benchmark, it risks losing

Trends that raise concerns about the long-term stability of the stand-alone PDP market (cont.)

Third, drug costs, on average, were higher among PDPs compared with MA-PDs, despite enrolling a population that had lower average risk scores than MA-PDs between 2019 and 2023. Risk scores are intended to reflect average drug costs across a group of individuals, so the systematic difference raises questions about the accuracy of the risk-adjustment model. These two trends could be explained by PDPs managing benefit costs relatively inefficiently compared with MA-PDs, by differences in diagnostic coding in FFS compared with MA, or by other factors. In our analysis of plan formularies, we did not find any evidence to support the notion that MA-PDs achieved lower costs compared with PDPs by applying more restrictions to the drugs used by their enrollees. Our analysis of the Part D data for 2019 through 2023 found that differences in coding intensity contributed to higher risk scores for MA-PD enrollees and lower risk scores for PDP enrollees, on average. Because coding differences can cause

plans with lower relative coding intensity to receive lower Medicare payments than other plans with higher relative coding intensity (and may lead those plans to charge higher premiums to enrollees), the result can disadvantage PDPs relative to MA-PDs.

Finally, PDPs have been more likely to incur losses compared with MA-PDs. Part D's risk corridors limit each plan's overall losses or profits. Between 2018 and 2022, the most recent years of data available at the time of this analysis, aggregate risk-corridor payments showed that plans, on net, incurred losses in the risk corridors and that most of those losses were incurred by PDPs. A plan's overall losses or profits are closely related to the risk adjustments that affect the payments that plans receive from Medicare. That is, PDPs' higher costs despite lower average risk scores suggest that Part D's payment system may not have adequately adjusted for PDPs' higher costs. ■

a significant portion of its enrollees, which can have major implications for revenues. An interviewee explained that “it costs a lot of money to try and get back to benchmark status, and you don't get back all the auto-assigned members you lost.” Benchmark dynamics may also reinforce selection effects since plans with benchmark status receive auto-assignments of LIS enrollees with lower risk relative to other enrollees with the LIS, potentially giving them a competitive advantage over other plans.

Risk adjustment

Interviewees noted that recent CMS enhancements to the risk-adjustment model, including separate normalization for PDPs and MA-PDs, have improved the attractiveness of the PDP market to insurers that sponsor Part D plans. They explained that applying separate normalization factors for PDPs and MA-PDs raised PDP risk scores and payments, especially for LIS

members, allowing some plans to offer lower premiums and remain competitive. However, interviewees cautioned that while these changes improved near-term financial prospects for PDPs, using separate normalization to “drive revenue to PDPs” does not seem sustainable. Some cautioned that the “mathematical underpinnings [of separate normalization] are not sound.” Instead, interviewees argued that the long-term sustainability of the PDP market will depend on continued refinement of risk-adjustment and market-stabilization policies. They noted that, by compensating plans fairly for differences in expected costs, accurate risk adjustment would also help neutralize selection effects within the PDP market.

There was broad agreement that the current model is not keeping pace with actual utilization trends, particularly for beneficiaries without the LIS. The 2026 risk-adjustment model uses 2023 Part D data,

predating the increase in spending and use of high-priced drugs among beneficiaries without the LIS following the elimination of cost sharing above the annual OOP threshold. Some interviewees noted that the data lag has resulted in misvalued hierarchical condition categories (HCCs), in which “certain HCCs are undervalued in a way that lowers risk scores for [the] non-LIS population.” However, there was less consensus on the best approach to improve the accuracy of Part D’s risk-adjustment model. Some suggested using separate models for PDPs and MA-PDs, though others expressed concerns that separate models could create “artificial incentives” and potentially distort competition between the two markets. Others recommended incorporating rebates in the model, given that, for drugs subject to MFPs, rebates are effectively reflected at the POS, or using actual drug utilization in the model as a predictive factor rather than relying solely on diagnoses.

Understanding the full impact of the IRA changes

In our analysis of the bid data, we estimate that over 80 percent of the increase in 2025 bids was attributable to IRA changes that shifted insurance risk from beneficiaries (premiums and cost sharing) and Medicare (reinsurance and the LICs subsidy) to plans. In contrast, in 2026, higher expected drug spending under the benefit accounted for most of the growth in bids. Actuaries we interviewed attribute much of the higher cost projections to a correction for “underbidding” in 2025 as they observed accelerated utilization trends among beneficiaries without the LIS who were most affected by the reduction in cost-sharing liabilities under the IRA (Cline et al. 2025a, Cline et al. 2025b). Interviewees also highlighted continued uncertainty from the effectuation of MFPs and other drug-pricing policies as a factor in higher and varied bids for 2026.

It may take several years before the full impact of the IRA is realized. Over the coming years, we expect plans to continue to adjust as they gain claims experience and as pharmaceutical manufacturers and other supply-chain participants respond to evolving market dynamics. Ongoing policy changes, such as the effectuation of MFPs, are likely to interact in a way that complicates our understanding of the impact of any given policy in isolation. Independent and other smaller pharmacies, for example, have raised concerns about

MFPs’ impact on their ability to operate in Part D. The Commission plans to continue to monitor the effects of the IRA on the program, enrollees, and stakeholders beyond the initial years of implementation.

Recent trends in Part D enrollment

In this section, we discuss historical trends in enrollment, spending, and other aspects of the Part D program. The substantial changes affecting the Part D benefit will likely create departures from many of these trends, but this analysis will serve as important context and a baseline for measuring those changes as they are implemented.

In 2025, 55.8 million individuals—80 percent of all Medicare beneficiaries—were enrolled in Part D plans (Table 13-4). Another 1 percent of beneficiaries obtained drug coverage through former employers that provided a prescription drug benefit that was at least as generous as Part D’s defined standard benefit and received Medicare’s retiree drug subsidy (data not shown).

More enrollees in MA-PDs and enhanced plans

Beginning in 2020, the number of enrollees in PDPs has declined as more beneficiaries opt to enroll in MA and accompanying MA-PDs. Enrollees in MA-PDs are more likely to be in enhanced plans that have more generous benefits than enrollees in PDPs. Beneficiaries with the LIS are more likely to be in basic-benefit plans.

Enrollment continues to shift toward MA-PDs

Consistent with the shift in enrollment from FFS to MA in the broader Medicare program, the distribution of Part D enrollment has moved gradually toward MA-PDs. The number of enrollees in PDPs began to decline in 2020, from 25.1 million (data not shown) to about 22.5 million in 2023 (Table 13-4). In 2025, however, PDP enrollment saw a slight tick up for the second year in a row, reaching 23.4 million. Still, PDPs accounted for less than 42 percent of all Part D enrollees, down from 53 percent in 2020 (latter data not shown).

In 2025, 13.6 million beneficiaries (24 percent of Part D enrollees) received the LIS. Of these individuals, 9.1 million were eligible for both

**TABLE
13-4****Part D's enrollment has gradually shifted toward MA-PDs**

	2021	2022	2023	2024	2025	Average annual change 2021–2025
Total Medicare enrollment (in millions)	63.8	65.0	66.3	68.0	69.5	2.2%
Total enrollment in Part D plans (in millions)	48.3	49.8	51.5	54.1	55.8	3.7
<i>As a share of total Medicare enrollment</i>	<i>76%</i>	<i>77%</i>	<i>78%</i>	<i>80%</i>	<i>80%</i>	
Part D plan enrollment by plan type (in millions)						
PDP	24.0	23.3	22.5	23.0	23.4	–0.7
MA-PD	24.3	26.5	29.1	31.0	32.4	7.5
Full LIS enrollment (in millions)*						
PDP	6.0	5.5	5.2	4.7	4.3	–8.0
MA-PD	6.8	7.7	8.6	9.3	9.3	8.2
Overall	12.8	13.3	13.8	14.0	13.6	1.5

Note: MA-PD (Medicare Advantage–Prescription Drug [plan]), PDP (prescription drug plan), LIS (low-income subsidy). Part D enrollment figures do not include beneficiaries in employer-sponsored plans that receive the retiree drug subsidy but do include enrollees in employer group waiver plans. Components may not sum to totals due to rounding, and percentage changes were calculated on unrounded data.

* In addition to beneficiaries who receive full LIS assistance, a small number (0.2 million in 2023) received partial assistance; in 2024, partial assistance was replaced with full LIS benefits for all who previously qualified for only partial benefits.

Source: MedPAC analysis based on the 2025 Medicare Trustees' report and CMS Part D enrollment data.

Medicare and full Medicaid benefits (“dually eligible” beneficiaries) (data not shown) (Boards of Trustees 2025).²⁶ Between 2021 and 2024, LIS enrollment grew 2.9 percent per year, on average, compared with 4.2 percent per year among non-LIS enrollees (data not shown). Then in 2025, LIS enrollment declined for the first time in program history, which may be at least partly due to the changes regarding Medicaid eligibility that took effect between 2023 and 2024.²⁷ At the same time, the share of LIS enrollees in MA-PDs grew from 53 percent in 2021 to 68 percent in 2025, while LIS enrollment in PDPs declined by nearly a third during this period. In 2025, just 18 percent of PDP enrollees receive the LIS compared with 29 percent of MA-PD enrollees. Much of the LIS enrollment growth in MA-PDs has been in D-SNPs.

Majority of beneficiaries without the LIS chose enhanced plans in 2025

While statute sets the parameters for the defined standard benefit, in practice, most plans use alternative benefit designs that include lower deductibles or tiered copayments for some formulary tiers rather than the uniform coinsurance under the defined standard benefit. Plans, however, must demonstrate that their basic benefits have the same average value as the defined standard benefit.

An organization offering PDPs must offer a basic-benefit plan in a region before it can offer an enhanced-benefit plan (i.e., a plan that combines basic Part D benefits with supplemental drug coverage). MA-PDs do not have to offer a basic-benefit plan in order to offer an enhanced-benefit plan, which likely explains the difference in plan offerings between PDPs and

**TABLE
13-5****Majority of PDP and conventional MA-PD enrollees chose enhanced coverage, 2025**

	PDP		Conventional MA-PD		SNP	
	Number of enrollees (in millions)	Percent	Number of enrollees (in millions)	Percent	Number of enrollees (in millions)	Percent
Total	18.2	100%	20.3	100%	7.1	100%
Type of coverage						
Basic	7.6	42	0.1	1	5.1	73
Enhanced	10.6	58	20.2	99	2.0	27
Type of deductible						
Zero	2.8	16	8.0	39	0.4	6
Reduced	1.4	8	10.0	49	0.9	12
Defined standard	13.9	77	2.4	12	5.8	81

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), SNP (special-needs plan). Enrollment excludes employer group waiver plans (EGWPs), plans offered in U.S. territories, 1876 cost plans, demonstrations, and Part B-only plans. The "defined standard" deductible category includes plans that are actuarially equivalent. Beneficiaries enrolled in EGWPs, a specific type of PDP or MA-PD in which an employer contracts with a Medicare Part D carrier to provide coverage for their Medicare-eligible retirees, totaled 8.9 million. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS landscape, plan report, and enrollment data.

conventional MA-PDs, with the latter offering nearly exclusively enhanced-benefit plans. In 2025, 99 percent of enrollees in conventional MA-PDs were in enhanced plans compared with 58 percent of enrollees in PDPs (Table 13-5).

MA-PDs can use a portion of their MA payments to supplement their Part D benefits or to lower Part D premiums. As a result, enrollees in conventional MA-PDs tend to have more generous benefits than enrollees in PDPs. For example, in 2025, 88 percent of conventional MA-PD enrollees were in plans with either no or a reduced deductible, compared with roughly 24 percent of PDP enrollees (Table 13-5).

There is also a growing share of non-LIS beneficiaries in C-SNPs (SNPs exclusively for people with certain chronic conditions); these are almost entirely enhanced plans. Enrollment in these plans has grown 160 percent in the past two years, reaching 1.2 million, with over 820,000 non-LIS beneficiaries in 2025. As such,

SNPs are no longer serving LIS beneficiaries nearly exclusively, as they previously had.

Beneficiaries with the LIS were more likely to enroll in basic plans

Historically, beneficiaries eligible for the LIS have primarily enrolled in premium-free plans, which are mostly basic plans and typically either PDPs or SNPs, as opposed to conventional MA-PDs.

Of the 4.3 million LIS enrollees in PDPs in 2025, 3.6 million were enrolled in benchmark plans, which are, by definition, basic plans. Benchmark plans are those with a premium at or below the regional benchmark, which is the maximum premium amount Medicare will subsidize for LIS enrollees. Because benchmark plans require no premium from LIS beneficiaries, these plans are also the only ones into which FFS LIS beneficiaries may be auto-enrolled if they fail to choose their own plan. As a result, most PDP enrollees with the LIS are in benchmark plans. In 2025, on

average, 65 percent of the enrollees in benchmark PDPs received the LIS, a decline from 79 percent in 2024 but still substantially more compared with nonbenchmark PDPs, in which only 5 percent of enrollees received the LIS (data not shown).

For the large share of LIS beneficiaries who have chosen to enroll in an MA-PD, they have largely chosen SNPs (primarily D-SNPs). Of the roughly 9 million LIS beneficiaries in MA-PDs, only 78,000 were in basic conventional MA-PDs because almost all conventional MA-PDs are enhanced (and enrolled 2.7 million LIS beneficiaries). More than 5.1 million were in basic SNPs, though a growing share are in enhanced SNPs—1.1 million in 2025.

Still, nearly all D-SNPs and I-SNPs have historically been basic-benefit plans that use Part D's defined standard benefit structure, which requires an enrollee to pay a defined standard deductible and 25 percent coinsurance on all covered drugs. Because all dually eligible beneficiaries receive the LIS, they themselves do not pay the deductible or cost sharing set by plans; they pay nominal copays set in law, and the LICS subsidy pays most of their cost-sharing liabilities. Also, any extra cost for supplemental coverage is not covered by Medicare. Thus, LIS beneficiaries do not typically gain the same value from an enhanced plan with lower cost sharing or no deductible as non-LIS beneficiaries. Further, plans' value of the low-income premium subsidy they receive for LIS enrollees is maximized when such beneficiaries enroll in a basic plan with a premium equal to the benchmark. These factors contribute to the increased likelihood of LIS beneficiaries being in a basic plan rather than an enhanced plan. However, given the change in plan offerings for 2026, with 72 percent of SNPs now being enhanced plans, the enrollment of LIS beneficiaries in predominantly basic plans is likely to change (Table 13-3, p. 489).

Part D program spending

In 2024, the IRA provision eliminating cost sharing above the annual OOP threshold took effect. This policy was expected to increase utilization, particularly among the beneficiaries without the LIS, who no longer faced the 5 percent coinsurance in the catastrophic phase of the benefit. However, the actual increase in

utilization may have exceeded plan expectations. Net risk-corridor payments from Medicare to plans totaled \$3.6 billion in 2024—the largest net payments CMS has made to offset plan losses since the program began—indicating that average drug spending under the benefit was substantially higher than plans reflected in their bids.

In 2024, Part D expenditures continued to accelerate

In 2024, Part D expenditures are estimated to have totaled \$148.3 billion. Medicare made payments to Part D plans of \$22 billion for the monthly capitated direct subsidy, \$68.3 billion for reinsurance, and \$41.3 billion for the LIS. Medicare also paid \$0.5 billion in retiree drug subsidies (RDSs) to employers who provide creditable drug coverage to their retirees.²⁸ Enrollees paid the remaining \$16.7 billion in premiums for basic benefits (Table 13-6, p. 498). Not included in this total is an additional \$17.7 billion in cost sharing paid by enrollees, down from \$18.8 billion in 2023—a decrease that is likely largely attributable to the IRA changes that reduced enrollees' cost-sharing liabilities.

Between 2023 and 2024, program spending increased nearly 18 percent (from \$112.3 billion to \$132.1 billion), representing a sharp acceleration from growth of just over 10 percent in 2023 (Table 13-6, p. 498). The growth was driven primarily by the uptick in the use of costly medications—such as GLP-1s—as well as the IRA's redesign, which had the effect of increasing basic benefit costs.²⁹ Between 2023 and 2024, Medicare's spending for basic-benefit costs (i.e., spending other than LIS and RDS costs) rose by about 34 percent (from \$67.6 billion to \$90.3 billion). By comparison, between 2020 and 2023, Medicare's spending for basic benefits grew at an average annual rate of 4.4 percent—a markedly slower pace than in 2024.

Two IRA provisions that took effect in 2024—the elimination of the 5 percent cost sharing above the annual OOP threshold and a cap limiting the annual increase in the BBP to no more than 6 percent—substantially increased Medicare's capitated direct-subsidy payments to plans. First, the elimination of the 5 percent cost sharing in the catastrophic phase of the benefit shifted liability for drug expenses from beneficiaries and Medicare's LIS to plans, thereby increasing the direct-subsidy payments that finance plan liability.³⁰ Second, the IRA change limiting the

**TABLE
13-6****Medicare spending and enrollee premiums for Part D**

	Annual spending (in billions)					Average annual change, 2020-2024
	2020	2021	2022	2023	2024	
Total Part D program spending	\$93.0	\$94.8	\$101.7	\$112.3	\$132.1	9.2%
Capitated payments (direct subsidy)	10.9	7.1	4.9	4.5	22.0	19.2
Cost-based reinsurance payments	<u>48.5</u>	<u>52.1</u>	<u>56.8</u>	<u>63.1</u>	<u>68.3</u>	8.9
Subtotal, basic benefits	59.4	59.2	61.7	67.6	90.3	11.0
Low-income subsidy	33.0	35.0	39.4	44.2	41.3	5.8
Retiree drug subsidy*	0.6	0.6	0.6	0.5	0.5	-4.5 5.3
Enrollee premiums for basic benefits**	13.6	15.0	15.5	15.7	16.7	

Note: Figures for capitated payments account for risk-sharing payments that plans make or receive under Part D's risk corridors. Figures for amounts that are paid prospectively (cost-based reinsurance and the low-income subsidy) have been reconciled to actual spending amounts. Beneficiaries paid \$17.7 billion in cost-sharing. Components may not sum to totals due to rounding.

* Subsidy for employers providing prescription drug coverage to their retirees that is comparable with or more generous than Part D's defined standard benefit.

** Excludes low-income premium subsidies.

Source: MedPAC analysis based on Table IV.B10 of the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

annual increase in the BBP required that any growth in expected average basic-benefit costs (including expected average reinsurance) above the 6 percent threshold be covered through higher direct-subsidy payments from Medicare. This provision raised Medicare's subsidy rate to 77.5 percent in 2024, a rate that is higher than the original statutorily set amount of 74.5 percent. As a result, Medicare's payments for the capitated direct subsidy grew by nearly 400 percent compared with about 8 percent growth in payments for reinsurance, reversing the previous trend toward greater reliance on cost-based reinsurance payments.³¹

The 6 percent cap on the annual increase in the BBP, when binding, shifts the costs of basic benefits from beneficiaries to the Medicare program. In 2024—the first year the provision took effect—the cap shifted about \$2.5 billion from enrollee premiums to Medicare's direct subsidy. Because the cap was binding again in both 2025 and 2026, these effects continue to grow. In 2025 and 2026, we estimate the provision increased Medicare's direct-subsidy costs by about

\$10.5 billion and \$20 billion, respectively. Separately, as noted earlier, under its Part D Premium Stabilization Demonstration, Medicare is estimated to have spent about \$6 billion in 2025 and is projected to spend more than \$3 billion in 2026 (Mathews and Whyte 2025).

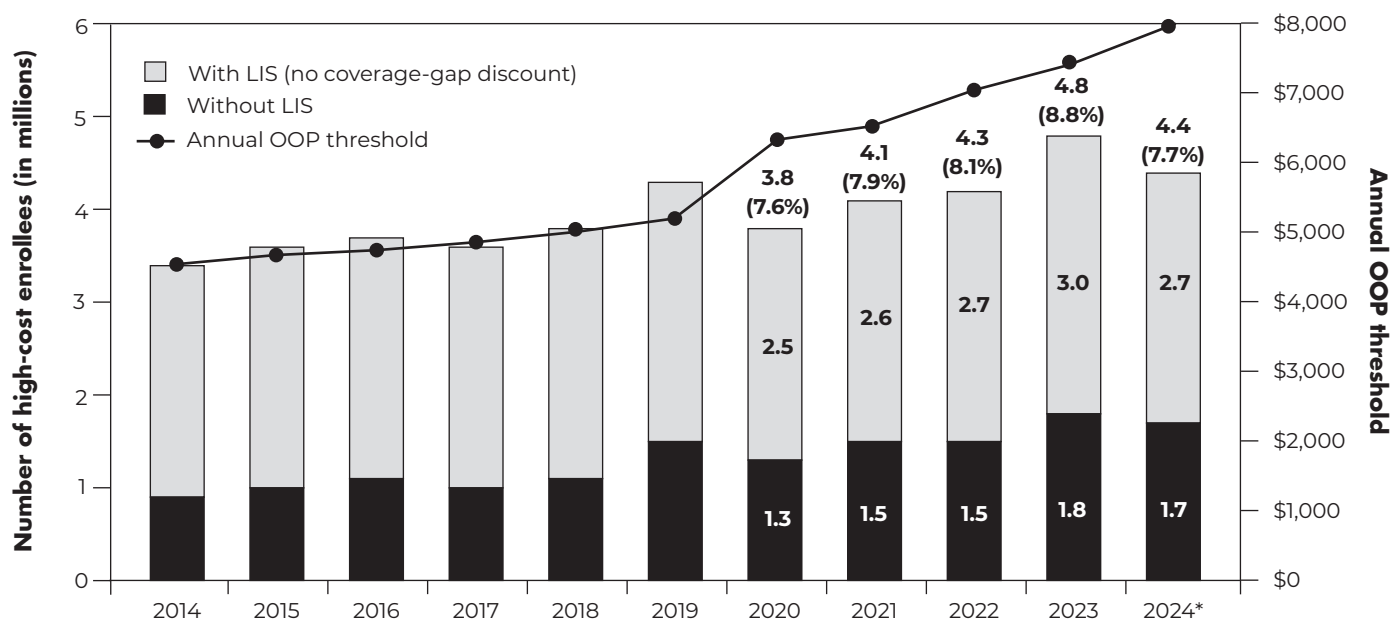
Greater uncertainty in projecting benefit costs in 2024

In addition to shifting costs from beneficiaries and Medicare's LIS to plans, the cap on annual OOP costs was expected to increase basic-benefit costs by reducing cost-sharing obligations for beneficiaries with very high drug expenses who did not receive the LIS. This change in Part D's benefit design introduced new uncertainty for plans in projecting benefit costs because enrollees faced a dramatic shift in financial incentives, creating the potential for significant and varied behavioral responses.

Coinciding with this change was a new regulatory requirement—effective January 1, 2024—to reflect

**FIGURE
13-5**

Part D enrollees reaching the benefit's catastrophic phase, 2014–2024



Note: LIS (low-income subsidy), OOP (out-of-pocket). Percentages shown in parentheses are high-cost enrollees as a share of all Part D enrollees. Components may not sum to totals due to rounding.
* Amounts are based on preliminary Part D prescription drug event data.

Source: Enrollee counts for 2014 to 2024 are based on MedPAC analysis of Part D prescription drug event data.

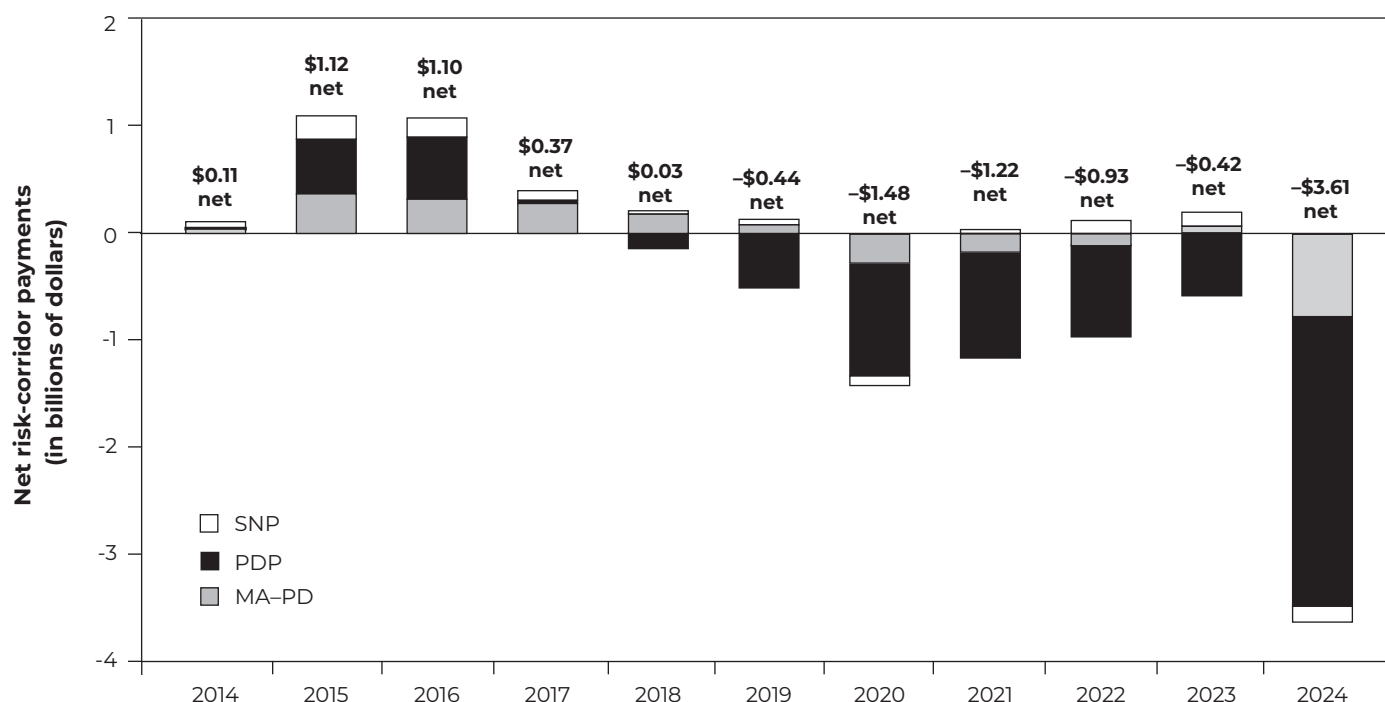
all possible pharmacy price concessions, known as pharmacy direct and indirect remuneration (DIR), at the point of sale (POS) (see text box, pp. 416–417, on the regulatory change affecting prices paid at the POS in the March 2025 report to the Congress).³² By lowering POS prices, this policy reduced OOP costs when cost sharing was based on a percentage of POS prices (coinsurance), thereby slowing progression toward the annual OOP threshold.³³ In turn, this policy change may have further increased uncertainty in projecting spending and the share of benefit costs for which plans bear risk.

Change in pharmacy DIR policy led to significant decline in POS prices in 2024

Pharmacy DIR payments have grown substantially, from less than 5 percent of total DIR in 2014 to 23 percent by 2023, one year before the regulatory

change took effect that required pharmacy DIR to be reflected in prices at the POS. As a result, total DIR fell by 14 percent between 2023 and 2024, dropping from \$92 billion to about \$79 billion.

Following the implementation of the pharmacy DIR policy, POS prices for Part D drugs declined sharply, reversing years of steady growth. Measured by the national drug code (NDC)-level price index, POS prices for all drugs and biologics declined by 11 percent in 2024 (see Table 13-7, p. 502).³⁴ (The index measures price changes for existing products and does not reflect launch prices of new products.) Because pharmacy DIR offsets a larger share of generic drug prices, POS prices for generic drugs saw the largest decline (–34 percent), while POS prices for single-source brand-name drugs and biologics fell by about 7.7 percent.³⁵

**FIGURE
13-6****Net risk-corridor payments between plans and Medicare, 2014–2024**

Note: SNP (special-needs plan), PDP (prescription drug plan), MA-PD (Medicare Advantage Prescription Drug [plan]). Positive amounts reflect the amount by which total risk-corridor payments from plans to Medicare (for a portion of the profits beyond the amounts assumed in plan bids) exceeded total risk-corridor payments from Medicare to plans. Negative amounts reflect the amount by which total risk-corridor payments from Medicare to plans (to cover a portion of their losses in risk corridors) exceeded total risk-corridor payments from plans to Medicare. Figure excludes employer group waiver plans (EGWPs), Program of All-Inclusive Care for the Elderly (PACE), and demonstration plans. EGWPs do not submit bids and are excluded from the risk-corridor reconciliation process. Between 2014 and 2024, the share of profits or losses accounted for by Medicare–Medicaid plans and PACE plans ranged from less than 1 percent to about 9 percent of the total risk-corridor payments. CMS determines whether any risk-corridor payments are due by comparing plan bids for basic benefits with actual spending. When actual spending exceeds the target amount by more than 5 percent, CMS makes payments to plans to offset a portion of the losses (and vice versa, when actual spending is lower than the target amount by more than 5 percent, CMS recoups a portion of the profit (i.e., plans make payments to CMS)).

Source: Plan reconciliation data from CMS.

Fewer high-cost enrollees but a surge in spending among those without the LIS in 2024

The annual OOP threshold is set each year according to a formula set in law. Between 2023 and 2024, this threshold increased from \$7,400 to \$8,000 (Figure 13-5 p. 499). In 2024, a substantial portion of this OOP amount was met by Medicare’s payments for the LICS subsidy and by discounts paid by manufacturers of brand-name drugs for prescriptions filled in the coverage-gap phase.³⁶ As a result, most beneficiaries who reached the catastrophic phase of the benefit paid significantly less than the full threshold amount.³⁷

In 2024, 4.4 million beneficiaries reached the catastrophic phase of the benefit (“high-cost enrollees”), a decrease of about 8 percent from 4.8 million in 2023, marking a shift from an upward trend since 2020 (Figure 13-5, p. 499). The decrease in the number of high-cost enrollees was greater among those with the LIS compared with those without the LIS (about an 11 percent and 4 percent decrease, respectively). As a result, in 2024, the share of high-cost enrollees with the LIS continued its decline to 61 percent, down from over 70 percent in 2014.

In addition to the differential trends in the number of high-cost enrollees with and without the LIS, spending among those without the LIS shifted toward more expensive drugs in 2024. High-priced medications contributed to a 24 percent increase in the specialty trend among beneficiaries without the LIS, whose cost sharing fell from 5 percent of POS prices to \$0 as a result of the IRA change that eliminated cost sharing above the OOP threshold (Cline et al. 2025b, Niyogi and Glass 2025). The average gross cost per prescription for high-cost enrollees without the LIS increased by 20 percent compared with just 4 percent for those with the LIS. Further, spending in the catastrophic phase for enrollees without the LIS rose 27 percent—more than five times the growth rate for those with the LIS. The substantial gap in catastrophic spending growth between high-cost enrollees with and without the LIS likely reflects the impact of the catastrophic cost-sharing change, which altered financial incentives only for those without the LIS.

Higher utilization among enrollees without the LIS may have exceeded plan expectations

Medicare shares financial risk with plan sponsors not only through reinsurance but also through risk corridors that limit each plan's overall losses or unexpected profits if actual drug spending (i.e., claims costs excluding profit margin and administrative expenses), excluding Medicare's reinsurance, is higher or lower than anticipated in its bid (Medicare Payment Advisory Commission 2025c). Since 2008, the structure of risk corridors has remained unchanged with the exception of 2025, when CMS narrowed risk corridors for PDPs participating in the Part D Premium Stabilization Demonstration to provide PDPs with more generous protection from losses (see our June 2025 report to the Congress for more discussion of the risk corridors used under the demonstration) (Medicare Payment Advisory Commission 2025c). Plans are fully at risk, meaning they do not receive or owe any risk-corridor payments when their actual drug spending falls within the range of 95 percent to 105 percent of a target amount (TA) based on their bid.³⁸ If actual spending is between 105 percent and 110 percent of the TA (or between 90 percent and 95 percent), Medicare splits the losses (or profits) evenly with the plan. Beyond 110 percent (or below 90 percent), Medicare covers 80 percent of losses (or recoups excess profits).

Aggregate net risk-corridor payments show that plans, on net, incurred losses in the risk corridors after 2018 (Figure 13-6). Between 2018 and 2024 (the most recent year for which data are available), most of those losses were incurred by PDPs. Net risk-corridor payments from Medicare to plans totaled \$3.6 billion in 2024, the largest net payments CMS has made since the program began, with PDPs accounting for about 75 percent of the payments.

In 2024, higher utilization among enrollees without the LIS may have exceeded plan expectations. Net risk-corridor payments that year were more than double the previous record aggregate payments Medicare made in 2020 (Figure 13-6).³⁹ Several factors likely contributed to these large risk-corridor payments. The IRA change shifting costs from beneficiaries and Medicare to plans increased the amount of plan liability that was subject to risk-corridor protection. That increase resulted in a doubling of the expected average plan liability used in risk-corridor calculations between 2023 and 2024.⁴⁰ Some portion of these losses likely stemmed from higher-than-expected use of specialty and other expensive medications by enrollees without the LIS.

How the Medicare Drug Price Negotiation Program may affect Part D prices and costs

Prices paid at the pharmacy (POS prices) are an important indicator of Part D program costs. Overall, Part D plans have used formulary tools effectively to encourage enrollees to use generic drugs: Since 2017, generic drugs have accounted for about 90 percent of all Part D prescriptions. Because generic prices, on average, decline over time, this high penetration rate has helped moderate overall POS price growth for Part D prescriptions (Table 13-7, p. 502).⁴¹ As a result, the overall price index, accounting for generic substitution, has historically grown at a more moderate rate and, in 2024, decreased by 12.4 percent compared with a decrease of 11.3 percent before accounting for generic substitution.^{42,43}

While most Part D enrollees use primarily generic drugs, and many (but not all) generic prices remain low, enrollees without the LIS who use brand-name

**TABLE
13-7****Single-source drugs increasingly affect overall Part D prices and costs, 2020–2024**

	2020	2021	2022	2023	2024
Price index as of 4th quarter (1st quarter 2014 = 1.00)					
All drugs and biologics					
Before accounting for generic substitution	1.33	1.38	1.43	1.48	1.31
After accounting for generic substitution	1.10	1.13	1.16	1.18	1.04
Generic drugs	0.51	0.47	0.43	0.41	0.27
Single-source drugs	1.66	1.78	1.88	1.98	1.82
Annual percentage change*					
All drugs and biologics					
Before accounting for generic substitution	2.6%	4.1%	3.8%	3.4%	–11.3%
After accounting for generic substitution	1.3	3.4	2.6	1.9	–12.4
Generic drugs	–8.9	–8.3	–7.4	–5.7	–34.2
Single-source drugs	5.2	6.7	5.9	5.0	–7.7
Share of Part D spending on single-source drugs	76.7	78.8	76.8	79.0	82.5

Note: Indexes are calculated using chain-weighted Fisher price indexes and are measured at the median of the distribution relative to prices as of the first quarter of 2014. Prices reflect total amounts paid to pharmacies before rebates or discounts from manufacturers and pharmacies. Indexes shown are rounded. Price indexes reflect changes in the prices of products that existed in both the measurement period and the preceding period. They do not reflect the effect of new products' launch prices. The decrease in point-of-sale (POS) prices in 2024 reflects the new direct and indirect remuneration (DIR) policy requiring pharmacy fees to be reflected at the POS. Pharmacy fees, on average, accounted for a larger share of spending for generic drugs compared with brand-name drugs and biologics. As a result, the impact of the DIR policy was greater on the generic price index than on the overall index including brand-name drugs and biologics. In 2022, the launch of generic Revlimid (lenalidomide) resulted in its reclassification to multisource drug, reducing Part D spending on single-source drugs.

* Annual percentage changes reflect growth in the price index since the fourth quarter of the previous year, calculated on unrounded data.

Source: Acumen analysis for MedPAC.

drugs often feel the effects of rising POS prices when they pay a deductible or coinsurance. Before the IRA capped the annual OOP costs (\$2,100 in 2026), these effects were particularly pronounced among the relatively small share of enrollees who use high-priced specialty drugs.

Driven primarily by the shift in the drug-development pipeline, Medicare now spends significant amounts on products without generic alternatives—brand-name drugs and biologics produced by a single manufacturer (“single-source drugs”). While the introduction of single-source drugs often represents important advances in pharmacological therapy, their high prices may create barriers to access and affordability

concerns for patients and taxpayers who finance the Part D program.

In 2024, single-source drugs accounted for about 10 percent of prescriptions but about 83 percent of gross Part D spending, up from 70 percent in 2014 (Table 13-7; latter data not shown). Between 2019 and 2024, POS prices of single-source drugs grew by between 5.0 percent and 6.7 percent per year, with the exception of 2024, when prices decreased by 7.7 percent, compared with nearly 9 percent annual growth before 2018 (latter data not shown).⁴⁴

Plans negotiate postsale rebates and discounts from manufacturers, reducing prices after POS transactions.

These “net prices” affect enrollee premiums and Medicare’s subsidies. Manufacturer rebates grew from about \$16 billion in 2014 to about \$77 billion in 2024, growing by an average of 17 percent per year.⁴⁵ Despite this growth, net prices of single-source drugs still rose by about 4 percent per year, on average, during this period and by about 5.5 percent annually between 2014 and 2023, before the new pharmacy DIR policy took effect.⁴⁶

Incentives throughout the pharmaceutical supply chain often contribute to higher POS prices because their revenues are often tied to price (Fein 2018, Feldman 2018, Garthwaite and Morton 2017, Sood et al. 2021). Meanwhile, manufacturers’ focus on developing drugs and biologics for smaller patient populations, while potentially leading to significant improvements in health for Medicare beneficiaries, means many products launch at high prices and lack direct therapeutic competitors. Over time, these factors, combined with the consolidation among supply-chain participants, have pushed POS prices higher (Sood et al. 2020).

Medicare negotiation program and selected drugs

Beginning in 2026, prices of several single-source drugs selected under the Medicare Drug Price Negotiation Program (“the negotiation program”) will be capped at the MFP negotiated by the Secretary of Health and Human Services (see text box on the Medicare Drug Price Negotiation Program, pp. 505–507). This change lowers prices at the POS, reducing cost sharing for beneficiaries whose plans use coinsurance rather than copays for selected drugs. Implications for program spending and plan costs may be more mixed. The negotiation program is also likely to affect revenues of pharmaceutical manufacturers and may affect their future investment decisions regarding pharmaceutical research and development and strategies for new-product launches. However, estimates of possible effects have varied widely (Avalere 2022, Congressional Budget Office 2022, Filson et al. 2025, Gassull et al. 2023, Girvan 2022, Philipson et al. 2023).

Spending and rebates are highly concentrated in selected drugs

Selected drugs account for a substantial share of spending at POS prices (gross spending). As a share of gross spending on single-source drugs in 2024,

drugs selected for the 2026 applicable year under the negotiation program accounted for about 26 percent, while those selected for the 2027 applicable year accounted for 18 percent (Table 13-8, p. 504). Nearly all selected drugs have high POS prices, often costing \$500 or more per month, with some in the tens of thousands of dollars (Centers for Medicare & Medicaid Services 2025f, Centers for Medicare & Medicaid Services 2024c). As a result, gross spending can reach billions of dollars even when the drug is used by a small number of beneficiaries.

On average, selected drugs are among the most highly rebated drugs in Part D. Across all single-source drugs, manufacturer rebates averaged just under 30 percent in 2024 (\$68.7 billion / \$232.7 billion). By comparison, rebates for drugs selected for 2026 averaged about 45 percent, and those for 2027 averaged about 34 percent—both well above the overall average for single-source drugs. Combined, the selected drugs for 2026 and 2027 accounted for more than 60 percent of all rebates on single-source drugs.

Expenditure growth for selected drugs was driven more by quantity than price

While high prices contribute to high expenditures, utilization growth has also contributed significantly over the past decade. We constructed indexes that measure percentage changes in Part D gross spending relative to a reference period to assess the impact of utilization growth. These expenditure indexes allow us to examine the relative contributions of price and quantity trends on the growth in total expenditures.

Expenditure growth for drugs selected under the negotiation program has been driven more by increases in quantity than by price. Between 2014 and 2024, our expenditure indexes for selected drugs grew at an average annual rate of over 25 percent, while our quantity index rose by 17 percent to 21 percent—far outpacing price growth, which averaged 6 percent to 7 percent at the POS and less than 3.5 percent net of rebates (Table 13-8, p. 504). That is, utilization growth, rather than price increases, has been the primary contributor to spending growth for selected drugs.

However, there was wide variation in how price trends versus quantities consumed contributed to overall expenditure growth. Among the 2026 selected drugs, four products (Januvia, Enbrel, Imbruvica, and

**TABLE
13-8****Medicare Drug Price Negotiation Program's selected drugs compared with single-source brand-name drugs and biologics, 2014-2024**

		Single-source drugs					
		Selected drugs*					
		All		CY 2026		CY 2027	
Total gross spending in 2024 (billions)		\$232.7		\$61.2		\$42.3	
As a share of all single-source drugs				26%		18%	
Total manufacturer rebates in 2024 (billions)		\$68.4		\$27.8		\$14.2	
As a share of all single-source drugs				41%		21%	
		Index value	Average annual growth	Index value	Average annual growth	Index value	Average annual growth
Indexes as of 4th quarter of 2024 (1st quarter of 2014 = 1.0)							
Expenditure index		3.92	13.6%	11.11	25.1%	14.10	27.9%
Quantity index		2.15	7.4	5.45	17.1	7.58	20.7
Price index (gross)		1.82	5.7	2.04	6.9	1.86	5.9
Price index (net of rebates)		1.45	3.5	1.36	2.9	1.45	3.5

Note: CY (calendar year). "Single-source drugs" include both single-source brand-name drugs and biologics. Indexes are calculated using chain-weighted Fisher indexes and are measured at the median of the distribution in the fourth quarter of 2024 relative to prices as of the first quarter of 2014. Expenditure and price indexes reflect total amounts paid to pharmacies before rebates or discounts from manufacturers and pharmacies. Index values shown are rounded. The quantity index measures the percentage change in the number of units (e.g., tablets or grams) dispensed, weighted by prices (using chain weights). Price indexes reflect changes in the prices of products that existed in both the measurement period and the preceding period. They do not reflect the effect of new products' launch prices. In 2024, aggregate gross spending for all Part D-covered drugs totaled \$288.8 billion.

* Drugs selected for price-applicability years 2026 and 2027 under the Medicare Drug Price Negotiation Program.

Source: Acumen analysis for MedPAC.

Fiasp/Novolog) saw changes in prices exert a greater impact on expenditures than changes in quantity.⁴⁷ In contrast, for 2027 selected drugs, increases in quantity for GLP-1s (Ozempic, Rybelsus, and Wegovy), which accounted for about 36 percent of spending and 42 percent of prescriptions for selected drugs for 2024, drove the overall trend. For GLP-1 drugs, expenditures grew by about 68 percent annually, while POS prices rose just 3.3 percent per year and net prices by about 1 percent per year. That is, nearly all of the expenditure growth for GLP-1s was explained by increase in utilization rather than price increases.⁴⁸

Drugs selected for applicable year 2027 also differed from those selected for 2026 in that more drugs were in the so-called "protected classes" (see text box on the Medicare Drug Price Negotiation Program, pp. 505-507). Part D's protected-class policy requires plans to cover "all or substantially all" drugs in six classes—anticonvulsants, antidepressants, antipsychotics, immunosuppressants, antiretrovirals, and antineoplastics—which expands beneficiaries' access to drug therapies but can reduce plans' negotiating leverage with manufacturers and contribute to higher prices (Kakani et al. 2024).⁴⁹ Compared with all single-

The Medicare Drug Price Negotiation Program

The Inflation Reduction Act of 2022 (IRA) established the Medicare Drug Price Negotiation Program (“the negotiation program”), under which the Secretary of Health and Human Services has new authority to negotiate directly with manufacturers for the prices of drugs covered under Medicare Part B and Part D.

The law specifically instructs the Secretary to select single-source drugs or biologics (“single-source drugs”) without therapeutically equivalent generics or biosimilar alternatives from among the top-selling drugs in Medicare based on total expenditures. The IRA authorizes the Secretary to exempt certain single-source drugs from negotiation, including cases when there is a “high likelihood” of imminent biosimilar competition.⁵⁰ Manufacturers that fail to comply with the requirements of the negotiation program may be subject to an excise tax of up to 95 percent on certain sales of the drug or be required to withdraw entirely from the Medicare and Medicaid programs.

The price negotiations for applicable years 2026 (10 Part D drugs) and 2027 (15 Part D drugs) have concluded, with the publication of negotiated prices on August 15, 2024, and November 25, 2025, respectively (Centers for Medicare & Medicaid Services 2025f, Centers for Medicare & Medicaid Services 2024c). (All drugs selected for 2026 and 2027 are Part D drugs. Beginning in 2028, the

Secretary is required to include Part B drugs in the pool of negotiation-eligible drugs.⁵¹) By law, the negotiated price, referred to as the “maximum fair price” (MFP), for selected Part D drugs cannot be greater than the lower of:

- the average Part D price, net of all price concessions and rebates, weighted by plan enrollment; or
- the applicable percentage of the drug’s average nonfederal average manufacturer price.⁵²

For the negotiation process, the Secretary may consider prices of available therapeutic alternative(s), along with information submitted by manufacturers of the selected drugs, to arrive at the MFP.⁵³

Selected drugs account for significant shares of Part D spending and rebates

Selected drugs represent a substantial share of Part D spending. Gross Part D spending for the first 10 drugs selected for negotiation totaled \$61.2 billion in 2024, representing 21 percent of total gross Part D spending (see Table 13-8). (Gross spending reflects point-of-sale (POS) prices paid at the pharmacy.) The 15 drugs selected for the second round accounted for \$42.3 billion, or 15 percent of total gross Part D spending. Combined, the two rounds represent \$103.5 billion in gross

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source drugs, expenditures for protected-class drugs have grown more rapidly, driven by both increases in utilization and prices, with very little difference between gross and net price trends. Protected-class drugs selected for negotiation tended to exhibit similar trends; however, the magnitude of expenditure growth and the relative contributions of prices and utilization varied widely across products.

MFPs will be consequential for all stakeholders

The concentration of rebates among selected drug cohorts suggests potentially material changes in plan costs as MFPs replace a large share of rebates previously used to lower plan costs and enrollee premiums. Trustees projected total DIR to decline by about 5 percentage points in 2026, reflecting the shift away from price competition that relied heavily on rebates (Boards of Trustees 2025).

The Medicare Drug Price Negotiation Program (cont.)

spending—over 36 percent of total gross Part D spending in 2024.

Rebates for selected drugs represent a disproportionate share of total manufacturer discounts. Many selected drugs, particularly those selected for 2026, are in competitive therapeutic classes with historically high rebates. In 2024, rebates for 2026 selected drugs totaled nearly \$28 billion (about 35 percent of all rebates negotiated by Part D plans), while rebates for 2027 selected drugs totaled about \$14 billion, or about 18 percent (Table 13-8). Together, these cohorts accounted for more than 55 percent of all manufacturer rebates in 2024, highlighting the magnitude of financial shifts that are expected to occur as MFPs replace rebates beginning in 2026.

Uncertainty in measuring changes in Medicare's program spending

For 2026 selected drugs, CMS estimates that, relative to list price (wholesale acquisition cost), negotiated prices achieved discounts ranging from 38 percent for Imbruvica to 79 percent for Januvia, averaging about 61 percent across the 10 products (Table 13-9). Discounts for 2027 selected drugs were similar, ranging from 38 percent for Austedo to 85 percent for Janumet, with an overall average of about 64 percent.

Although overall estimated discounts off list prices are similar for both cohorts, the estimated change in Part D's net prices differs substantially. For drugs selected for the 2026 applicable year, the agency estimated that, had the MFPs been in place in 2023, net prices would have been approximately 22 percent lower (a difference of about \$6 billion) (Centers for Medicare & Medicaid Services 2024c). In comparison, for drugs selected for the 2027 applicable year, the estimated change in net prices was about \$8.5 billion, or roughly 36 percent below net prices paid under Part D in 2024 (Centers for Medicare & Medicaid Services 2025f).

The difference is primarily driven by rebates.⁵⁴

Both cohorts include drugs in competitive therapeutic classes—such as diabetes-related drugs, anticoagulants, and treatments for asthma and COPD—in which competition among therapeutic alternatives tends to generate higher rebates. However, these drugs accounted for over 90 percent of spending in the 2026 cohort compared with about 67 percent in the 2027 cohort. Further, the 2027 cohort includes more drugs in Part D's protected classes (four cancer drugs, one for mental illnesses) and a larger number of specialty drugs—products for which market forces were most limited in lowering prices in Part D (Anderson-Cook and Frank 2025).⁵⁵ Our analysis found that rebates reduced gross Part D costs by nearly 45 percent for the 2026 cohort versus about 34 percent for the 2027 cohort. Consequently, the negotiation program appears to be more effective in lowering prices for the 2027 cohort, where rebate offsets were smaller and initial net prices were higher.

At the same time, there is considerable uncertainty about the actual magnitude of savings from the negotiation program. One reason is that the prices and utilization of selected drugs can change substantially between the selection or announcement of MFPs and their effectuation. For instance, Novo Nordisk's insulin products had gross expenditures totaling \$2.6 billion in 2023 when they were selected for negotiation, but by 2024, spending fell to less than \$1 billion primarily due to the launch of lower-priced products and, to a lesser extent, reduced utilization.⁵⁶ Savings from the negotiation program may also be affected by other drug-pricing policies.⁵⁷

Finally, savings for the Medicare program should be considered alongside potential additional costs. Similar to POS rebates, MFPs lower POS prices by largely replacing the existing rebate mechanism. That change may increase benefit costs because rebates are now effectively paid prospectively, and

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The Medicare Drug Price Negotiation Program (cont.)

part of those rebates will be used to lower cost sharing. As a result, Medicare could face higher direct-subsidy and reinsurance costs unless MFPs are set sufficiently below current net prices. In addition, because selected drugs are exempt from

the new Manufacturer Discount Program, Medicare will pay higher reinsurance for these products and an additional subsidy under the Selected Drug Subsidy Program. The net effect of savings from lower prices and higher costs is uncertain. ■

**TABLE
13-9**

Drugs selected for the Medicare Drug Price Negotiation Program for 2026 and 2027

First applicable year	Example(s) of commonly treated conditions	Selected drugs	Gross Part D spending, 2024		Estimated discount relative to list price*
			Dollars (in billions)	Percent of total Part D	
2026	Blood clots	Eliquis, Xarelto	\$26.9	9%	56%–62%
	Diabetes	Jardiance, Januvia, Farxiga, Fiasp, Novolog	21.5	7	66–79
	Autoimmune conditions	Enbrel, Stelara	6.6	2	66–67
	Heart failure	Entresto	4.0	1	53
	Blood cancers	Imbruvica	2.3	1	38
	Total, 2026 selected drugs		61.2	21	61
2027	Diabetes, obesity	Ozempic, Rybelsus, Wegovy, Tradjenta, Janumet, Janumet XR	17.3	6	71–85
	Asthma, COPD	Trelegy Ellipta, Breo Ellipta	6.7	2	73–83
	Prostate cancer, breast cancer, blood cancers	Xtandi, Pomalyst, Ibrance, Calquence	9.3	3	48–60
	Autoimmune conditions	Linzess, Xifaxan, Otezla, Otezla XR	4.2	1	63–75
	Idiopathic pulmonary fibrosis	Ofev	2.1	1	50
	Tardive dyskinesia	Austedo, Austedo XR	1.7	1	38
	Major depressive disorder, schizophrenia	Vraylar	1.1	0	44
	Total, 2027 selected drugs		42.3	15	64

Note: COPD (chronic obstructive pulmonary disease). Negotiated prices for drugs selected for the 2026 applicable year were updated to reflect inflation since the announcement of the prices in August 2024. Total gross spending for selected drugs for the 2027 applicable year (\$42.3 billion) differs from CMS's total (\$42.5 billion), which may be due to different data used to aggregate spending across national drug codes. Three drugs—Entresto, Stelara, and Xarelto—were dropped from Medicare's negotiation program for 2027 because they now face generic/biosimilar competition. Average overall discount off of list price is weighted by gross spending. Components may not sum to totals due to rounding.

* CMS used wholesale acquisition costs to estimate discount relative to list prices. For 2026 selected drugs, estimated discounts are based on a 30-day supply using prescription fills in Part D in 2022.

Source: Centers for Medicare & Medicaid Services 2025f, Centers for Medicare & Medicaid Services 2024c, and gross spending based on Acumen analysis for MedPAC of the Part D prescription drug event data.

The shift from rebates to MFPs is expected to lower POS prices for beneficiaries. At the same time, this change is also expected to affect plan operations in a way that places both downward and upward pressure on premiums and Medicare's costs. For example, reduced rebates tend to put upward pressure on spending, but lower POS and net prices would tend to lower benefit costs. The net effect of those factors is uncertain.

Further, complicating the effects of MFPs on Medicare's program spending is Medicare's higher liability for spending on selected drugs under the new MDP. Selected drugs are exempt from the MDP, which requires manufacturers to provide 10 percent discounts for spending between the deductible and the annual OOP threshold and 20 percent for spending above the annual OOP threshold. As a result, Medicare will incur higher reinsurance costs (40 percent) for these drugs. In addition, Medicare will provide an additional 10 percent subsidy for spending below the OOP threshold under the Selected Drug Subsidy Program. In 2024, payments by manufacturers for the selected drugs of the 2026 applicable year under the Coverage-Gap Discount Program (a mandatory discount program that has subsequently been replaced by the MDP) totaled about \$7 billion.

The importance of rebates in pricing dynamics also suggests that effectuation of MFPs will have significant impact on financial flows across the pharmaceutical supply chain. Pharmacy benefit managers (PBMs) and plans may lose a key source of revenue to offset benefit costs and fund administrative expenses and profits. Pharmacies could see lower margins if revenue structures tied to list prices are not adjusted. Independent pharmacies have raised concerns that the effects of lower margins could be especially severe for them because they have limited capacity to absorb financial losses and may face heightened risk of market exit (Coster 2025, National Community Pharmacists Association 2025, Three Axis Advisors 2025).

Quality of Part D plans and enrollee satisfaction

The quality of Part D plans and enrollee satisfaction are closely related to access to medicines and patient experience with the plan. Historically, the

Part D program has generally enjoyed high levels of satisfaction, based on surveys and focus groups.

CMS collects quality and performance data to monitor plan sponsors' operations and evaluate access to medicines, enrollee experience, and patient safety. A subset of these data are used in the 5-star-rating system made available through Medicare's Plan Finder at Medicare.gov to help beneficiaries evaluate their plan options (see text box on Medicare Plan Finder for more information).⁵⁸ Measures relate to beneficiary satisfaction, medication adherence, price accuracy, and medication reviews completed by pharmacists. Star ratings are also used, in part, to determine whether a plan should no longer be available to beneficiaries, if ratings are too low for three consecutive years, and as part of the MA quality-bonus payment determination. (Although both MA-PDs and stand-alone PDPs are evaluated with star ratings, only MA-PDs are eligible for quality-bonus payments through the Part C payment system.)

The average star ratings for plans offered in 2026 are slightly lower than recent years, but MA-PDs have consistently averaged roughly 4 stars, while PDPs have consistently averaged 3 stars over the past four years (Centers for Medicare & Medicaid Services 2025c). Of the plans earning 5 stars, 18 are MA-PDs while just 2 are PDPs. Approximately 40 percent of MA-PDs earned 4 stars or better for 2026, and these plans enrolled 64 percent of MA-PD enrollees in 2025. In contrast, fewer than one-fourth of PDPs being offered in 2026 have a star rating of 4 or higher, and these plans enrolled just 2 percent of all PDP enrollees in 2025.

For the three star measures related to medication adherence, scores have been relatively stable or declined slightly for the past three measurement years. Given that these measures account for one-fourth of the star measures, plans may find it valuable to try and improve these scores. Adherence is measured by the proportion of days in the year that a beneficiary who has been prescribed medication in one of the three drug classes of interest has the medication on hand. The three drug classes for which adherence is measured are noninsulin diabetes medications, renin-angiotensin system antagonists for hypertension, and statins for cholesterol. A recent investigation by the *Wall Street Journal* found that mail-order pharmacies, often owned by plans or their PBMs, often sent "early

Accuracy of drug prices displayed on Medicare Plan Finder

Medicare Plan Finder allows beneficiaries to estimate their total annual costs—including premiums and out-of-pocket expenses—and select plans that best meet their financial and medication needs. For beneficiaries to make informed decisions when choosing a plan, it is essential that the drug prices displayed on Plan Finder reflect what beneficiaries are likely to pay at the pharmacy if they enroll in that plan. However, CMS has previously raised concerns about the accuracy of the drug-price information displayed on Plan Finder during the annual enrollment period (AEP) when beneficiaries have the opportunity to choose a new (or different) Part D plan. Based on our analysis of Plan Finder drug-pricing data for benefit year 2024, prices displayed on Plan Finder during the AEP generally appeared to reflect prices displayed on Plan Finder at the start of the benefit year. However, by August, we found that prices displayed on Plan Finder tended to be higher than those displayed during the AEP. These patterns of price changes are consistent with expectations since manufacturers of brand-name drugs have historically raised prices around July (46Brooklyn 2025, Assistant Secretary for Planning and Evaluation 2023).

CMS's actions to ensure accuracy of prices displayed on Plan Finder

CMS currently uses the Plan Finder Price Accuracy measure to evaluate the accuracy of drug prices displayed on Plan Finder. This measure compares a drug's total cost at the pharmacy—which reflects both ingredient cost and dispensing fees and is calculated from Part D's prescription drug event (PDE) data—with the price displayed on Plan Finder (Centers for Medicare & Medicaid Services 2024a). Plans receive a score based on the magnitude and frequency of when the drug's cost at the pharmacy exceeds the Plan Finder price. A higher score indicates greater alignment between Plan Finder prices and actual costs at the pharmacy (i.e., greater accuracy of Plan Finder prices) for a given plan.

In the calendar year (CY) 2025 Advance Notice and Final Rate Announcement, CMS considered adopting a new measure to evaluate the accuracy of drug prices displayed on Plan Finder because the existing measure did not address CMS's concern that some Part D plans may be engaging in “pricing tactics” during the AEP (Centers for Medicare & Medicaid Services 2024a). Specifically, CMS noted that some plans may be “submitting artificially high or low prices” for display on Plan Finder to either “encourage” or “discourage” beneficiaries from selecting their plans.

In the CY 2027 proposed rule, CMS proposed retiring their current Plan Finder Price Accuracy measure starting in 2029 (Centers for Medicare & Medicaid Services 2025g). In the proposed rule, CMS noted that there is a lack of variability across contracts in this measure and that average scores across Medicare Advantage Prescription Drug plans (MA-PDs) and stand-alone prescription drug plans (PDPs) tend to be very high for this measure (98 and 97, respectively). If this measure is retired, CMS noted that it will continue to monitor the performance of plans related to displayed drug pricing on Plan Finder.

Analytical approach

We conducted an analysis of Plan Finder drug-pricing data to understand the extent to which prices displayed during the AEP provided an accurate representation of the prices that beneficiaries encountered during the benefit year. Our analysis differs from CMS's Plan Finder Price Accuracy measure, which assesses whether PDE prices align with Plan Finder pricing data for the same time period.

We compared 11-digit national drug code (NDC)-level unit costs of oral drugs for each Part D contract for benefit year 2024 during the AEP (October 2023), at the start of the benefit year (January 2024), and at midyear (August 2024) (one

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Accuracy of drug prices displayed on Medicare Plan Finder (cont.)

**TABLE
13-10**

Distribution of unit costs for oral drugs at the AEP, 2024

	10th percentile	Median	Mean	90th percentile
Unit cost at the AEP	\$0.06	\$0.20	\$5.25	\$11.71

Note: AEP (annual enrollment period). Analysis limited to oral drug products for Medicare benefit year 2024. Unit costs are weighted by Medicare Part D enrollment and utilization (number of claims per standard 30-day supply). Analysis based on Medicare Plan Finder data summarized at the contract-national drug code level.

Source: Medicare Plan Finder data (October 2023 pricing file), Part D monthly enrollment data (July 2024), Medicare Part D prescription drug event data (2024).

month after July, which historically has seen the second-highest number of list-price changes for brand-name drugs after January) (46Brooklyn 2025, Assistant Secretary for Planning and Evaluation 2023).⁵⁹ For each contract and NDC combination, we calculated an average unit cost across pharmacies in each contract's network.⁶⁰ Analyses were weighted by contract-level enrollment and volume, measured by prescriptions standardized to a 30-day supply ("weighted-contract NDCs").

Summary of findings

Unit costs at the AEP for benefit year 2024 averaged about \$5 and ranged from \$0.06 at the 10th percentile to about \$12 at the 90th percentile (Table 13-10). For an oral medicine taken once daily, these unit costs would be roughly equivalent to \$1.80 to \$360 per month. At the AEP, about three-quarters (76 percent) of the weighted-contract NDCs in our study had unit costs of less than \$1, while about 3 percent of the weighted-contract NDCs had unit costs greater than or equal to \$20 (data not shown). That is, most drugs in our study were relatively inexpensive drugs, whereas about 3 percent were brand-name or specialty drugs with a monthly price of \$600 or higher.

Between the AEP and January 2024, when the benefit year began, most products (about 95 percent) experienced either an increase or decrease in unit costs within the same contract, with very few products (4.4 percent) showing no price change (Table 13-11). Nearly half of weighted-contract NDCs experienced an increase in unit cost, with an average increase of \$0.14, or 2.7 percent of the average AEP unit cost. A comparable share of weighted-contract NDCs had a decrease in unit cost, but by a smaller amount than the average increase (\$0.03, or -0.5 percent of the average AEP unit cost). The average AEP unit costs of products that experienced an increase in unit cost were similar to those that experienced a decrease in unit cost (\$5.20 vs. \$5.52). However, a unit-cost decrease was somewhat more common among contract NDCs with slightly higher AEP unit costs.

Between the AEP and August 2024, unit-cost increases were more common (72.5 percent vs. 48.5 percent in January), with the average size of the increase rising to \$0.39 (about 6 percent of the average AEP unit cost) (Table 13-11). Products with unit-cost increases in August also had higher unit costs at the AEP (\$6.75 vs. \$5.20 in January).

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Accuracy of drug prices displayed on Medicare Plan Finder (cont.)

**TABLE
13-11**

Change in unit cost from the AEP to January and August 2024

	Number of weighted-contract NDCs ^a	Share of weighted-contract NDCs	Average unit cost at the AEP	Average dollar change in unit cost	Percentile of dollar change in unit cost	
					10th	90th
January 2024						
No change	107,355	4.4%	\$2.87	\$0	\$0	\$0
Decrease	938,317	47.2	5.52	−0.03	−0.01	0 ^b
Increase	843,275	48.5	5.20	0.14	0 ^c	0.10
Missing	25	<1	1.56	N/A	N/A	N/A
August 2024						
No change	5,124	<1%	\$0.52	\$0	\$0	\$0
Decrease	609,436	24.7	1.08	−0.14	−0.15	0 ^b
Increase	1,034,936	72.5	6.75	0.39	0 ^c	0.71
Missing	239,476	2.7	3.12	N/A	N/A	N/A

Note: AEP (annual enrollment period), NDC (national drug code), N/A (not applicable). Analysis is limited to oral drug products for Medicare benefit year 2024. Unit costs are weighted by Medicare Part D enrollment and utilization (number of claims per standard 30-day supply).

^a Analysis based on Medicare Plan Finder data summarized at the contract-NDC level.

^b Greater than -0.01 (rounds to zero).

^c Less than 0.01 (rounds to zero).

Source: Medicare Plan Finder data (October 2023, January 2024, and August 2024 pricing files), Part D monthly enrollment data (July 2024), Medicare Part D prescription drug event data (2024).

Overall, most products had only small changes in unit costs in both January and August.⁶¹ For example, in January 2024, 90 percent of products with unit-cost increases changed by \$0.10 or less. Even in August 2024, when the unit-cost changes were larger, 90 percent of products with increases had changes of less than \$0.71. These small changes suggest that, on average, prices displayed on Plan Finder during the AEP generally reflected those at the start of the benefit year. At the same time, mean unit-cost changes falling outside of the 10th and 90th percentiles indicate a skewed distribution, driven by a small number of products with large increases or decreases in unit cost.

Overall, the trend shifted from a relatively modest unit-cost change in January to a somewhat larger upward trend in costs by August. This difference makes sense since, as noted above, pharmaceutical manufacturers typically raise prices twice a year—once in January and again in July (Assistant Secretary for Planning and Evaluation 2023). Smaller unit-cost changes in January may also reflect how Part D plans—or their pharmacy benefit managers—are likely better able to incorporate expected January price changes into unit-cost prices displayed on Plan Finder during the AEP. ■

refills” of prescriptions, which former health plan executives and industry actuaries suggested could help improve performance on quality measures like adherence ratings (Weaver et al. 2025). However, repeated early refills can result in an oversupply of medicines, which can put patients and their families at risk. The *Wall Street Journal* found that auto-shipping of excess medicines cost Medicare and its beneficiaries \$3 billion between 2021 and 2023. The article specifically mentions prescriptions of noninsulin diabetes medication Jardiance and cholesterol medication atorvastatin as two of the most common automatically refilled medications.

Star-rating calculations also include performance on two measures of enrollee experience with the plan (“rating of drug plan” and “getting needed prescription drugs”). These scores are based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey responses from a random sample of each contract’s enrollees.⁶² Enrollees in both MA–PD and PDP contracts rated their coverage and experiences favorably overall in 2024 (Centers for Medicare & Medicaid Services 2025b). The 2024 MA–PD CAHPS score for “rating of drug plan” was 88 (scored on a scale of 0 to 100), which is higher than the 83 for stand-alone PDPs. The 2024 MA–PD CAHPS score for “getting needed prescription drugs” was 90, which is similar to the PDP score of 88. These results have been relatively stable over the past few years.

Consistent with CAHPS results, in focus groups convened for the Commission, Medicare beneficiaries generally continue to rate their prescription drug coverage highly, though some had complaints regarding access to medicines (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024).⁶³

Surveys have also found that many beneficiaries are unaware of some of the recent changes to the program affecting drug prices and spending. For example, a survey from KFF in 2024 found that most were aware of the \$35 monthly cap for insulin products, but just over a third knew about the new annual OOP cap or provisions related to government negotiation of drug prices; less than 10 percent were aware of the inflation rebates (Sparks et al. 2024). The annual survey from the Healthcare Leadership Council found that most beneficiaries (74 percent) are unaware of the

Medicare Prescription Payment Program, which allows beneficiaries to pay their OOP costs over the course of the year rather than all at once, but among the 5 percent who have enrolled in a payment plan, most say it has helped them afford their medication more easily (Morning Consult 2025).

Beneficiaries’ access to needed medicines

Part D plans use different tools—such as tiered cost sharing—to manage benefit spending and design products that offer attractive benefits to current and potential new enrollees. When used appropriately, these tools can lower benefit spending, which in turn lowers program spending and enrollee premiums. To aid beneficiaries in finding plans that meet their medication needs, Medicare provides a Plan Finder tool that gives personalized estimates of OOP costs based on a beneficiary’s prescription drug regimen and their pharmacies of choice. Pharmacy networks can be used to direct beneficiaries to higher-value pharmacies and offer lower cost sharing at a subset of in-network pharmacies designated as preferred. However, these networks can impede access to needed medications, for example, if beneficiaries face reduced convenience when nearby pharmacies are excluded from a plan’s preferred or standard networks.

Medicare Plan Finder can help beneficiaries choose plans that meet their medication needs

Medicare beneficiaries can use the Medicare Plan Finder to compare and select plans available in their geographic area. Plan Finder provides enrollees with a list of Part D plans along with information such as plan premiums, cost-sharing amounts, and star ratings. The cost estimates displayed on Plan Finder may be personalized to a beneficiary’s current prescription drug regimen and their pharmacies of choice if beneficiaries input that information. By default, Plan Finder sorts available plans based on these cost estimates for the specific drugs and pharmacies of interest, first displaying the plan with the lowest estimated premium and OOP cost for a beneficiary.

CMS has raised concerns about the accuracy of the drug prices shown on Plan Finder during the annual

enrollment period (AEP), when beneficiaries select a Part D plan, because inaccuracies can affect expected costs and plan selection. Cost of prescriptions is one of the most significant factors that influence beneficiaries' Part D plan decision-making (Stults et al. 2018). Given the importance of costs in plan selection, price changes during the year can have significant health and financial consequences, such as unexpected financial burden that may lead to abrupt interruptions in drug therapy. Cost-related nonadherence can lead to serious health consequences and has been associated with increased mortality rates (Chandra et al. 2024).

Based on our analysis of Plan Finder data for benefit year 2024, prices displayed on Plan Finder during the AEP generally aligned with those at the start of the benefit year (see text box, pp. 509–511, on the accuracy of drug prices displayed on the Medicare Plan Finder). However, by August, prices were typically higher than those displayed during the AEP. These changes are consistent with typical midyear price increases for brand-name drugs. Our analysis for benefit year 2024 did not raise immediate concerns about prices displayed during the AEP. However, we found that products typically experience small price increases during the course of the year, and prices displayed on Plan Finder during the AEP do not anticipate those increases. We have not done a more granular analysis to assess variation across plans or for specific drugs to learn whether certain beneficiaries face information challenges when choosing plans. It is also important to note that, depending on the benefit design, changes in prices may or may not translate directly to changes in OOP costs. For example, price changes will have no effect if the plan uses fixed copayments rather than coinsurance. We encourage CMS to continue monitoring Plan Finder prices and consider implementing a measure to ensure accuracy of prices, particularly during the AEP.

Pharmacy networks and access to pharmacies

Part D sponsors contract with pharmacies to create plan-specific networks, including preferred-pharmacy arrangements that are intended to offer lower cost sharing at a subset of in-network pharmacies, although the extent of these savings varies across plans and drug types. Medicare Part D plans must meet CMS's standards for convenient access to network

pharmacies. Under these standards, plan sponsors must demonstrate that, on average, at least 90 percent of beneficiaries in urban areas live within 2 miles of a network retail pharmacy, 90 percent of beneficiaries in suburban areas live within 5 miles, and 70 percent of beneficiaries in rural areas live within 15 miles. Recent pharmacy closures among both independent and chain pharmacies could make it difficult for plans to meet the access requirement (Guadamuz et al. 2024). However, focus groups and external surveys continue to indicate high beneficiary satisfaction with the Part D program and do not point to widespread problems with access to pharmacies or prescribed medications (Morning Consult 2024).

Several factors are reported to contribute to recent pharmacy closures. Pharmacies report increasing financial pressure as reimbursement rates for prescription dispensing have fallen amid the growing negotiating leverage of PBMs. Competition has intensified as more patients use mail-order pharmacies or fill prescriptions through large retail chains that can leverage scale to offer lower prices, making it difficult for independent and community pharmacies to match margins (Abelson and Robbins 2024). Rising operating costs and staffing shortages are also leading to reduced capacity to sustain retail operations (Berenbrok et al. 2025). These challenges have affected both independent pharmacies and large chains: Several national retailers have announced substantial reductions in their store footprints in recent years, citing low profitability and shifting market conditions (Berenbrok et al. 2025). When a nearby pharmacy closes, patients may need to travel farther to fill prescriptions, face longer wait times, or rely on mail-order options (Span 2024). Limited access and longer travel to pharmacies can reduce patients' ability to obtain medications or adhere to their prescriptions (Anderson et al. 2024, Qato et al. 2019). Patients may also face reduced access to pharmacists, who play an important role in providing vaccinations and medication management (Le et al. 2022).

Recent policy changes may also be altering the financial and contract environment for pharmacies, potentially influencing decisions about remaining open or exiting markets. The IRA's drug-price-negotiation provisions and redesign of the Part D benefit are expected to change how plan sponsors and PBMs manage costs, rebates, and formulary strategy. At the same time,

the recent change in the pharmacy DIR policy—which requires pharmacy price concessions to be reflected in POS prices beginning in 2024—has led to substantial declines in POS prices and may have shifted the timing and level of pharmacy reimbursement.⁶⁴ These shifts may affect pharmacy finances, which could have downstream implications for Part D pharmacy-network participation. If plans and PBMs anticipate

lower drug prices or changes in rebate structures, they may renegotiate pharmacy contracts or networks, including the composition of preferred cost-sharing arrangements. We plan to analyze recent trends in Part D plans' pharmacy networks to assess how evolving incentives are influencing pharmacy participation and beneficiaries' access to in-network and preferred pharmacies. ■

13-APPENDIX A

Analyzing recent increases in Part D bids

Part D uses a competitive bidding model in which private plans, typically sponsored by commercial insurers, bid to offer prescription drug coverage. Similar to commercial insurance products, these plans pool risks across their enrollees and collect premiums to cover the benefit costs with the goal of generating a profit. For Part D, policymakers chose to subsidize roughly three-quarters of the premium, with part of the subsidy taking the form of reinsurance paid on a cost basis, thereby reducing the insurance risk borne by plans. Initially, reinsurance was expected to account for about a quarter of benefit cost. However, over time, its share grew and, by 2023, accounted for more than 70 percent of benefit cost. In other words, for the majority of prescription drug spending, Part D plans were reimbursed based on actual costs.

The Inflation Reduction Act of 2022 (IRA) redesigned the benefit and shifted how Part D spending is financed (see text box, pp. 480–481, for a summary of IRA Part D provisions). Notably, the law reduced beneficiary’s cost sharing (increasing the generosity of the benefit for enrollees) and restored the role of Medicare’s capitated direct subsidy, which had diminished to compose a small share of benefit spending in the years before the implementation of the IRA redesign. Increasing the role of direct subsidies strengthens incentives for plans to actively manage drug spending for their enrollees, though the Commission has consistently held that, when plan sponsors bear more insurance risk, they should also be given tools to manage enrollee spending.⁶⁵ Lower cost sharing improves enrollees’ access to and affordability of Part D medications, especially among those with the highest Part D drug spending, but it is expected to put upward pressure on overall drug utilization and benefit costs, which in turn increases both beneficiary premiums and Medicare payments to plans.

The amount of the capitated direct subsidy each year is determined through a process in which plans submit “bids” based on their expectation of enrollees’ spending and the portion that would be covered by the fixed per capita payments. In 2025, these bids rose by 180 percent and by another 33 percent in 2026. We use CMS’s data from this bidding process to decompose the growth in the direct subsidy following the IRA’s implementation. With higher expected basic benefit costs, as reflected in the bid data, enrollee

premiums would also be expected to grow. However, IRA provisions and other Part D policies have shielded enrollees from the full impact of higher premiums while increasing program spending. Substantial variation in bids and premiums across plans exists, and further analysis of the drivers of this variation is important for promoting access to drug plans for all Medicare beneficiaries and for managing program spending.

We conducted semistructured interviews with Part D actuaries to provide context for understanding recent trends in Part D plan bids. Interviewees explained how the shift to greater plan liability in 2025 increased uncertainty and risk for plans. They highlighted higher-than-expected increases in Part D spending in 2025, especially for enrollees most affected by the IRA’s cost-sharing protections, which likely contributed to the increase in Part D bids for 2026. Our interviewees reported that, in retrospect, 2025 bids likely underestimated increases in utilization. Interviewees also discussed the effectuation of maximum fair prices (MFPs) in 2026 as a major source of uncertainty, noting that the loss of rebates and potential increases in utilization of selected drugs further complicated their bid preparation.

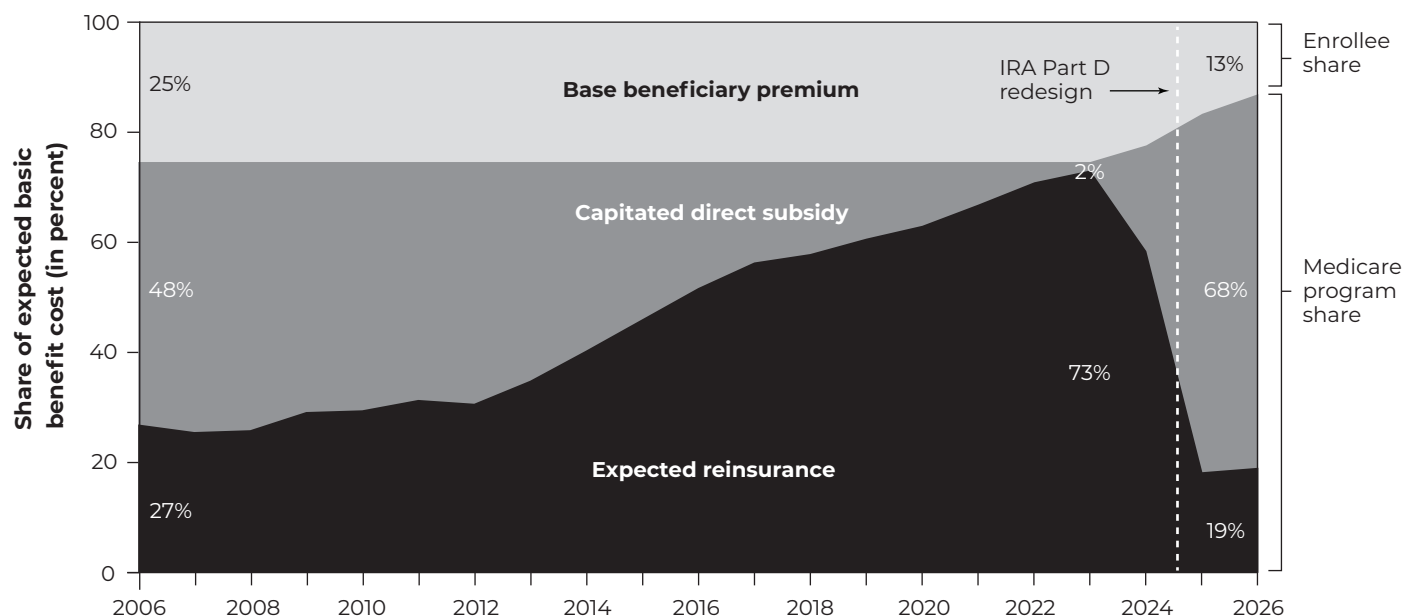
Interviewees cautioned that the lower average premiums for stand-alone prescription drug plans (PDPs) observed in 2026 relative to 2025 is not a sign of market stability but rather reflects how changes in Part D’s risk adjustment, on average, increased the risk scores for PDPs, resulting in lower risk-standardized bids and premiums than would have been the case without these changes. In the interviews, they emphasized that, while CMS’s changes to Part D’s risk adjustment (including separate normalization factors for PDPs and Medicare Advantage Prescription Drug plans (MA-PDs)) may have improved near-term financial prospects for PDPs, the risk-adjustment model needs to be further refined to ensure the long-term stability of the PDP market.

Background on Part D bids

When the Part D benefit launched in 2006, Medicare covered 48 percent of the expected basic benefit cost through direct subsidies to plans and 27 percent through federal reinsurance (Figure 13-A1).⁶⁶ The

**FIGURE
13-A1**

The IRA redesign restored the direct-subsidy share of Medicare expected basic benefit costs, 2006–2026



Note: IRA (Inflation Reduction Act of 2022).

Source: CMS's bid announcements.

national average basic benefit premium (called the base beneficiary premium, or BBP) was set at about 25 percent of Medicare's expected basic benefit cost and covered the remaining share of costs. Over time, the direct-subsidy share shrunk substantially, composing only 2 percent of Medicare's expected basic benefit cost in 2023. At the same time, the expected federal reinsurance share grew to compose 73 percent of Medicare's basic benefit costs. Thus, the role of capitated direct-subsidy payments was minimal by 2023, meaning Part D plans experienced relatively low insurance risk because all other payments (besides premiums) were cost reimbursed. The decline in the direct-subsidy share was driven by rising drug prices and benefit-design changes that increased the likelihood of enrollees reaching the catastrophic phase—where, before the IRA, Medicare reinsurance

covered 80 percent of spending—along with growth in rebates, which further reduced plans' overall spending (Avalere 2021, Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2020b).

The IRA redesign increased the role of direct subsidies and reduced the role of federal reinsurance, in line with key elements of the Commission's 2020 recommendations to restore the plan incentives to manage drug spending that were in place at the start of the program.⁶⁷ To protect beneficiaries from rising premiums, the IRA also capped year-over-year growth in the BBP, shifting more costs to the direct subsidy. As shown in Figure 13-A1, the direct-subsidy share grew to 68 percent and the expected federal reinsurance share declined to less than 20 percent in 2026. The BBP composes only 13 percent of Medicare expected basic benefit costs in 2026.

The substantial recent growth in the direct subsidy reflects not only the benefit redesign's changes to federal reinsurance and BBP policies, but other changes in program financing, such as reductions in beneficiary cost sharing and changes to manufacturer discounts and rebates. To better understand how the IRA design affected the direct subsidy, we first explain how the direct subsidy is determined through the Part D plan-bidding process.

Part D plans project their liability for enrollees' prescription drug spending

Annually, plans submit "bids" based on their expectation of enrollees' spending and the share of the basic benefit that would be covered by the direct subsidy plus beneficiary premiums. This combined amount, referred to as "plan liability," represents the portion of Part D drug spending for which plans assume insurance risk. That is, if a plan manages enrollee costs such that the portion of costs covered by the direct subsidy and premiums is lower than those payments, the plan can retain the difference. Conversely, if those costs exceed the payments, the plan must absorb the shortfall. To account for differences in enrollee health status, these payments are risk adjusted using Part D risk scores, an index of beneficiaries' expected costs, that increase Medicare's payments to plans for beneficiaries who are expected to have higher Part D spending and vice versa. Plans also include amounts for administrative costs and profit in their bids.

Part D plans prepare bids annually using their historical experience and tools provided by CMS (see text box for a description of this process). The bids are based on plans' projections of enrollees' spending and how that spending will be apportioned based on the Part D benefit design. That is, to determine their plan liability under the standard benefit, plans must project how much enrollee spending will be covered by federal reinsurance, beneficiary cost sharing, Medicare's low-income cost-sharing subsidy, and manufacturer discounts:⁶⁸

- **Medicare's reinsurance:** Federal reinsurance subsidies are payments to plans for a portion of drug spending after enrollees reach the catastrophic phase of the benefit, which occurs when the annual out-of-pocket (OOP) threshold

is met. Before the IRA redesign took effect, reinsurance covered 80 percent of drug spending after the enrollee reached the catastrophic phase (15 percent was covered by plans and 5 percent by enrollees' cost sharing). Starting in 2025, the reinsurance share of payments after enrollees meet the catastrophic threshold is 20 percent (the brand manufacturers' share is 20 percent, and plans are responsible for the remaining 60 percent).⁶⁹

- **Beneficiary cost sharing:** Beneficiaries who do not qualify for the low-income subsidy (LIS) pay 100 percent of drug costs until they meet their deductible. After meeting the deductible, they are responsible for 25 percent of drug costs until they reach the annual OOP threshold. Once the OOP threshold is met, the beneficiary has no cost sharing. Although the OOP cap in 2026 is set to \$2,100, the true OOP (TrOOP) can be substantially lower for many enrollees because the value of enhanced benefits are counted toward the OOP limit for beneficiaries enrolled in enhanced plans (Cline et al. 2025a, Medicare Payment Advisory Commission 2025d).⁷⁰ Before 2025, enhanced plans' benefits did not count toward TrOOP, though manufacturer discounts did.
- **Medicare's low-income cost-sharing subsidy:** For beneficiaries with low incomes and limited assets, Medicare's LIS pays the difference between plans' cost-sharing amounts and nominal copayments set by law.⁷¹ Before 2024, when beneficiaries exceeded the OOP threshold (and entered the catastrophic phase), they were responsible for paying 5 percent coinsurance. This amount was fully covered by Medicare for individuals receiving the LIS (referred to as the low-income cost sharing, or LICS, subsidy). After the IRA, in 2024, the 5 percent cost sharing was eliminated as was the need for Medicare's payment of the LICS subsidy during the catastrophic phase.
- **Manufacturer Discount Program (MDP):** Under the Part D MDP, manufacturers are required to pay for a portion of brand-name drug costs for beneficiaries. Before 2025, under a different program (the Coverage Gap Discount Program), they were required to pay 70 percent of brand-name drug costs filled by beneficiaries without the LIS in the coverage gap (also known as the "donut

Part D plans submit bids annually using the bid pricing tool

Plan sponsors intending to participate in Part D in the upcoming year must submit bids that represent their expected plan liability based on enrollees' historical spending or comparable plan spending (depending on whether the plan is new) using guidance and tools from CMS. Plans must also provide additional information related to their bid preparations, including projections of how total enrollee spending is distributed among Medicare's reinsurance, beneficiary cost sharing, Medicare's low-income cost-sharing subsidy, and manufacturer discounts as well as expected rebates and supplemental coverage.

The process begins around January with CMS's Advance Notice detailing proposed payment and policy changes for the upcoming year. After a public comment period, the final rate announcements with program guidance are made in April. Using this information, plans that intend to participate in the upcoming year formulate their plan benefit packages and input their financial projections in the

bid pricing tool (BPT). These projections provide the information needed to calculate expected plan liability, administrative expenses, and expected rebates and discounts. From the BPT submissions, CMS aggregates the risk-standardized bids to compute the capitated direct subsidy and national basic premium amounts. Plans must also submit their formularies and utilization-management requirements. Bids must comply with CMS rules and be certified by a qualified actuary.

CMS reviews the bids for compliance with statutory and regulatory requirements and may reject bids or ask for revisions from plans. In late July, CMS publishes information on the capitated direct subsidy, base beneficiary premium, and low-income premium-subsidy amount. Medicare Advantage Prescription Drug plans (MA-PDs) may adjust their Part C rebate allocations to meet target premium amounts based on these published figures (but cannot alter plan benefit packages, formularies, or service areas). In September, CMS makes final approvals and publicly

(continued next page)

hole"); this was an increase from the 50 percent set by the Affordable Care Act of 2010 (ACA) prior to 2019. After 2025, the coverage gap was eliminated, and manufacturers instead are now required to pay a portion of costs for both LIS and non-LIS enrollees: 10 percent of brand-name drug costs below the OOP threshold and 20 percent in the catastrophic phase.

- **Plan liability:** Plan liability is the portion of benefit spending for which plans bear risk, financed through capitated direct subsidies and enrollee premiums. It equals expected basic benefit costs (i.e., spending net of rebates and supplemental benefit costs) and excludes amounts paid by reinsurance, beneficiary cost sharing, LICS subsidies, and manufacturer discounts.⁷²

Plan liability plus administrative costs and profits compose a plan's bid for providing basic Part D coverage to enrollees in the upcoming year. Plans also estimate their average Part D risk score across their enrollees and submit a risk-standardized bid, calculated for a Medicare beneficiary with an average expected cost (risk score of 1.0). Plans' bids are expressed in per member per month (PMPM) amounts.

Plans' bids determine the national average monthly bid amount and base beneficiary premium

CMS aggregates the Part D plans' bid submissions and calculates a risk-standardized nationwide enrollment-weighted average bid amount for the upcoming year, referred to as the national average monthly bid amount (NAMBA). The NAMBA represents the average expected

Part D plans submit bids annually using the bid pricing tool (cont.)

**TABLE
13-A1**

Number and types of plans submitting bids in the BPT, 2023–2026

	Plan year			
	2023	2024	2025	2026
Total number of plans bidding	5,666	5,587	5,260	5,067
PDPs	814	719	534	367
MA-PDs	4,852	4,868	4,726	4,700
Conventional MA-PDs	3,566	3,531	3,279	2,979
SNPs	1,286	1,337	1,447	1,721

Note: BPT (bid pricing tool), PDP (prescription drug plan), MA-PD (Medicare Advantage Prescription Drug [plan]), SNP (special-needs plan). We include only plans whose data CMS uses to calculate direct-subsidy payments and the national average basic premium. These include PDPs, local and regional preferred provider organizations' Part D plans, and HMOs' Part D plans.

Source: Part D bid pricing tool data from CMS.

releases the Part D landscape file that lists the participating plans and their premiums.

On October 1, Medicare's Plan Finder is updated with plan data (premiums, benefits, formularies, star ratings) and plans can begin marketing to beneficiaries. Open enrollment begins October 15 and runs through December 7, with the plan year beginning on January 1.

BPT data used in this chapter

This appendix draws from Part D plans' finalized BPT submissions obtained from CMS. As noted in the timeline outlined above, plans' bids are projections of their enrollees' benefit liability and are based on experience that is necessarily lagged. That is, bids for 2026 were submitted in June 2025 and based on plans' available experience from 2024 (bids for 2025 were based on 2023 experience and so on). The BPT requires plans to report their historical experience (if they have it), and that information is also used in this chapter (labeled as "actual" data vs. projected data).⁷³

We include prescription drug plans, local and regional preferred provider organizations' MA-PDs, and HMOs' MA-PDs in our analysis. Plans that either do not submit bids or whose bids are not used to determine direct-subsidy payments and premiums are excluded.⁷⁴ Table 13A-1 shows the number of plan bids in each plan year (the year for which the plans submitted bids). In 2025, the plans submitting bid data represented about 80 percent of all Part D enrollees.

Throughout this chapter, when averaging information across plans, we weight by the number of projected member months (for projections) or actual member months (for historical data). When computing national averages, CMS weights by member enrollment from June before the plan year (e.g., June 2025 enrollment for the 2026 averages). While projected member months reported in the BPT may differ from actual enrollment from June, we find that national averages are very similar using the two different weights.⁷⁵ ■

amount of capitated payments (direct subsidy plus beneficiary premium) that plans receive for providing basic Part D benefits. The NAMBA plus plans' average (enrollment-weighted) expected amount of federal reinsurance (also submitted during the bidding process each year) compose Medicare's expected average total cost of the basic Part D benefit:

$$\text{Expected total basic benefit cost} = \text{NAMBA} + \text{expected federal reinsurance}$$

By statute, enrollees must share these costs. Historically, CMS has aimed to set beneficiary premiums to be 25.5 percent of Medicare's expected basic benefit cost:

$$\text{Base beneficiary premium (BBP)} = 25.5 \text{ percent} \times \text{expected total basic benefit cost}$$

Medicare's capitated direct subsidy equals the difference between NAMBA and the BBP:

$$\text{Capitated direct subsidy} = \text{NAMBA} - \text{BBP}$$

Starting in 2024, the IRA capped BBP growth at 6 percent annually, and this cap has been binding since then. As a result, the BBP share of total basic benefit costs has been below 25.5 percent since 2024. In 2026, BBP accounts for only 13 percent of expected basic-benefit costs.⁷⁶ A lower BBP translates into a higher Medicare capitated direct subsidy.

Bids from PDPs and conventional MA-PDs are used to determine the NAMBA and set the BBP (see text box, pp. 519–520, for the types of plans submitting bids). Special-needs plans' (SNPs') bids are not used in these calculations, but SNPs' payments and premiums are set using the NAMBA and the BBP. As shown in Table 13-A1 in the text box, SNPs represent a significant and growing share of Part D plans. In 2025, 7.1 million beneficiaries were enrolled in SNPs, accounting for 26 percent of MA-PD enrollees.

Medicare shares risk for plan liability through risk corridors

Medicare's capitated direct subsidy plus beneficiary basic premium together form the capitated, at-risk payments plans receive to cover their liability. The difference between the plan's bid and NAMBA determines the premium beneficiaries pay to enroll in that plan. If a plan's risk-standardized bid exceeds the NAMBA, enrollees pay the BBP plus the difference; if

the bid is below the NAMBA, they pay the BBP minus the difference. A bid equal to the NAMBA results in a premium equal to the BBP. In short, lower bids mean lower premiums, incentivizing plans to bid competitively to attract enrollees.⁷⁷

Capitated payments encourage plans to manage enrollee costs within this amount since they retain any savings as profits above and beyond costs projected in bids. However, actual costs can vary. To limit losses and prevent excessive profits, Medicare shares risk through symmetric risk corridors.⁷⁸ In recent years, plans' losses have exceeded gains, and Medicare has paid out more in risk-corridor payments than it has recouped. In 2024, CMS made net payments of \$3.6 billion to plans, the largest net payments in program history (see Figure 13-6, p. 500).

Growth in Part D bids reflects payment shifts and rising costs

Plan bids rose significantly after the IRA benefit redesign was implemented. In 2025, the NAMBA grew from \$64 PMPM to \$179 PMPM—a 180 percent increase—and continued climbing in 2026 to \$239, a 33 percent year-over-year increase (Table 13-A2, p. 522). The NAMBA reflects risk-standardized bids based on plans' projected enrollee risk scores. However, plans build their bids using unadjusted (or unstandardized) spending, which has also grown (Table 13-A2). In the discussion below, we use this unstandardized spending to analyze the components driving bid growth. We note that, in 2025, CMS applied separate normalization factors for PDPs and MA-PDs to better account for observed differences in risk-score trends between the two markets.⁷⁹ Interviewees emphasized that risk scores play a key role in variation in bids and premiums across plans (further discussed on p. 533). We intend to explore this area in future analysis.

While part of the 2025 NAMBA growth can be attributed to a shift toward the capitated direct subsidy, driven by the reduced role of federal reinsurance and the BBP growth cap, overall expected basic-benefit costs also rose (Figure 13-A2, p. 523). In 2025, total expected basic-benefit costs grew from \$154 to \$220—a 43 percent increase from the prior

**TABLE
13-A2**

Bids grew substantially in recent years, 2023–2026

Per member per month averages

	2023	2024	2025	2026
Risk-standardized bids (NAMBA)	\$35	\$64	\$179	\$239
Unstandardized bids	31	57	159	207

Note: NAMBA (national average monthly bid amount). All dollars are per member per month. Excludes special-needs plans since their bids are not included in the calculation of the NAMBA. Average unstandardized bids are weighted by projected member months as reported in the bid data. Average standardized bids are from CMS announcements, which are weighted by enrollment in June of the prior year.

Source: Part D bid pricing tool data from CMS and CMS announcements.

year. In 2026, total expected basic-benefit costs grew to \$296, a 35 percent increase from the year before. Thus, the growth in the NAMBA reflects both the rising capitated direct-subsidy share and the increase in total expected basic-benefit costs. Basic-benefit costs are expected to increase because of IRA provisions that lowered beneficiary cost sharing, shifting more costs to Medicare. This increase is further driven by higher utilization, resulting from both induced demand (from lower cost sharing) and higher drug spending not directly related to the IRA.

To examine the components of plans' growing costs, we use the bid pricing tool (BPT) data from CMS (see text box, pp. 519–520, describing the BPT data). These data include enrollee spending, which plans allocate across Part D benefit components to project plan liability. We use data from bids submitted for 2023 to 2026, which are based on the plans' actual experience from 2021 to 2024. We focus on unadjusted spending (net of rebates and supplemental cost sharing) because plans build their bids using unadjusted spending, and this approach removes the influence of risk-score trends that may differ across individual plans and plan types. We show how the financing of Part D spending, as reported by plans, has shifted since the implementation of the IRA redesign (Figure 13-A3, p. 524). Changes to each of the components can be summarized as follows:

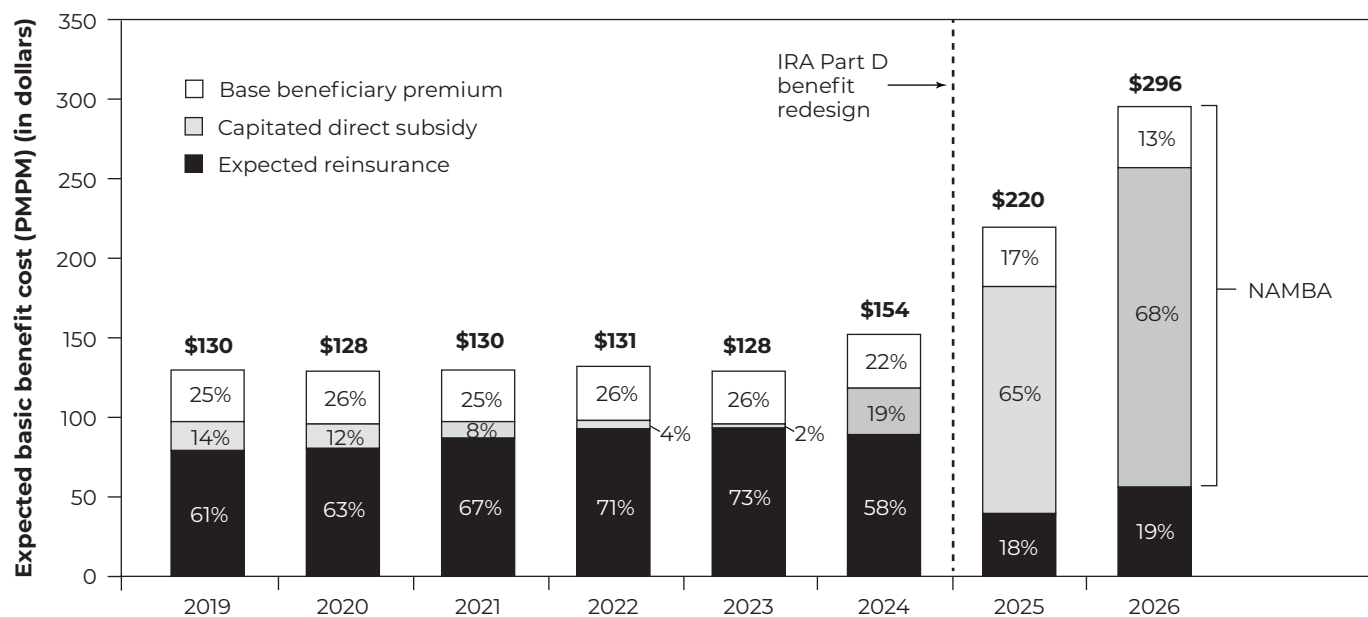
- **Medicare's reinsurance:** Between 2021 and 2024, reinsurance paid for about 40 percent of Part D spending (net of rebates and supplemental cost

sharing); plans projected this share to decline to 14 percent and 15 percent in 2025 and 2026, respectively.

- **Beneficiary cost sharing:** Plans projected that the share of Part D spending covered by beneficiary cost sharing would decrease in 2025 (8 percent) and 2026 (7 percent) compared with earlier years (e.g., 13 percent in 2021).
- **Medicare's LICS subsidy:** Between 2021 and 2026, the LICS portion of spending declined from 27 percent to a projected share of 7 percent.
- **Manufacturer Discount Program (MDP):** Plans projected that a greater share of spending would be paid through manufacturers' discounts in 2025 (18 percent) compared with 8 percent in 2021. In 2026, the share declined to 14 percent, likely related to the Medicare Drug Price Negotiation Program beginning in 2026. The drugs that are selected for negotiations are not subject to the MDP. Selected drugs are high cost and account for substantial portions of spending and thus may explain the projected decline in manufacturers' share of spending between 2025 and 2026.⁸⁰
- **Plan liability (financed through the capitated direct subsidy and beneficiary premiums):** Declines in federal reinsurance, beneficiary cost sharing, and LICS subsidies shifted more responsibility to plan liability, though growth in the MDP helped offset

**FIGURE
13-A2**

Expected total basic-benefit costs rose with the Part D benefit redesign, 2019–2026



Note: IRA (Inflation Reduction Act of 2022), PMPM (per member per month) NAMBA (national average monthly bid amount). Base beneficiary premiums are calculated after application of the IRA's 6 percent cap on year-over-year growth. Medicare's capitated direct-subsidy payments and the base beneficiary premium sum to the NAMBA. Medicare's monthly expected basic-benefit costs are composed of the NAMBA plus Medicare's reinsurance.

Source: CMS announcements.

part of this shift. Plan liability—financed through Medicare's direct subsidy and beneficiary premium payments—increased from 14 percent in 2021 to a projected 57 percent in 2026.

In addition to shifts in financing, overall spending also increased—from \$242 PMPM in 2021 to a projected \$377 PMPM in 2026—further raising the amount covered under plan liability.

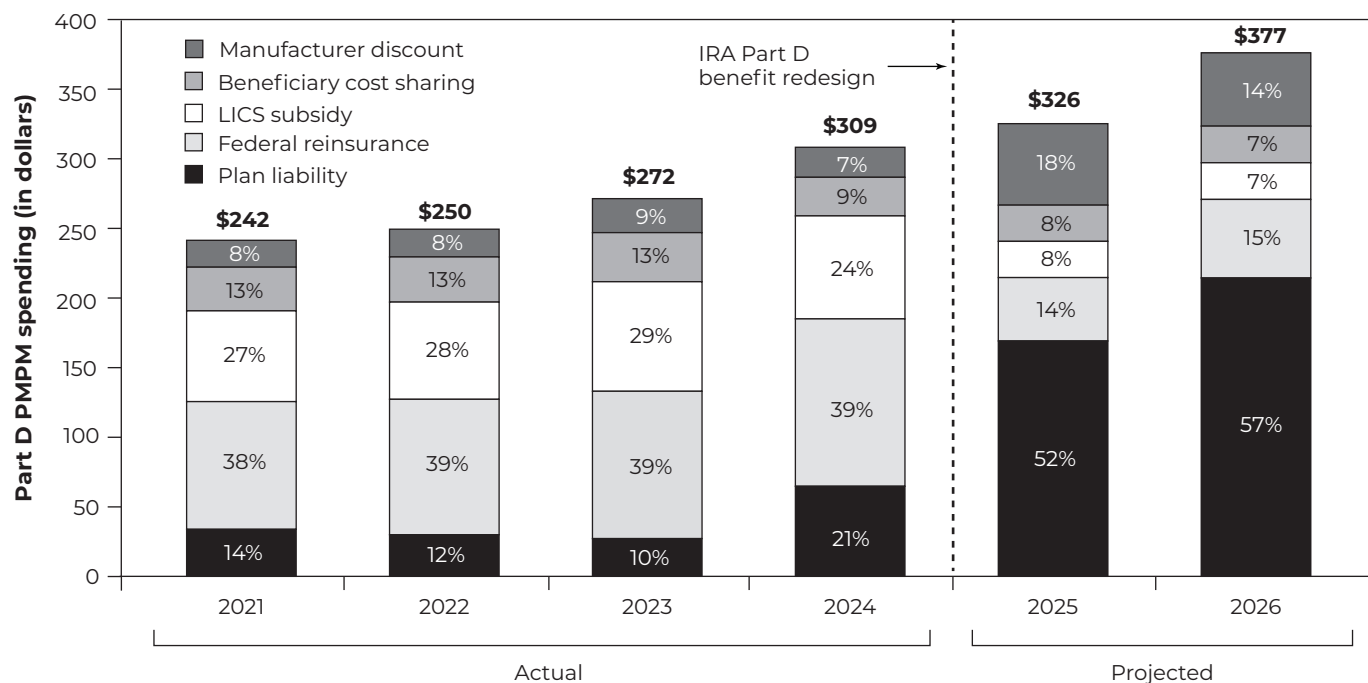
Plans' bids reflect a combination of plans' expectations of what total drug spending will be under the benefit and the portion of that total spending that plans will be liable for. To analyze bid growth, we use annual spending shares each year to approximate how much of the bid growth is driven by changes in overall drug spending versus changes in plan liability. These spending shares, shown in Figure 13-A3 (p. 524), form

the basis for estimating the components of bid growth between 2024 and 2025 and separately between 2025 and 2026.⁸¹

We estimate that, between 2024 and 2025, 82 percent of the growth in plans' unstandardized bids could be explained by the shift toward increased plan liability (Figure 13-A4, p. 525). This growth was composed of shifts from cost-based federal reinsurance payments (54 percent of the bid difference), LICs subsidies (24 percent) and beneficiary cost sharing (10 percent) (data not shown). We also estimated that 8 percent of the increase in bids was related to higher administrative costs and margin. Manufacturer discounts increased between the two years, offsetting some of the increase in plan liability. The remaining increase in bids between 2024 and 2025 is explained by plans' projections of higher spending (18 percent) (Figure 13-A4). This

**FIGURE
13-A3**

Financing for drug spending shifted under the IRA Part D benefit redesign, 2021–2026



Note: IRA (Inflation Reduction Act of 2022), LICS (low-income cost-sharing), PMPM (per member per month). PMPM spending is net of rebates and supplemental cost sharing. Projected years are based on plans' experience from two years prior (see the text box on pp. 519–520 for a description of the Part D bid data used for this analysis). Plan liability is financed by Medicare's capitated direct-subsidy payments and beneficiary premiums.

Source: Part D bid pricing tool data from CMS.

18 percent reflects two components: a 9 percent projection error in 2024 and a 9 percent expected increase in spending for 2025 compared with 2024 (data not shown). Expected spending in 2024 was underpredicted because plans had only 2022 experience available when developing those bids. Since the 2026 bids use plans' reports of actual 2024 data, we were able to quantify the projection error for 2024.⁸²

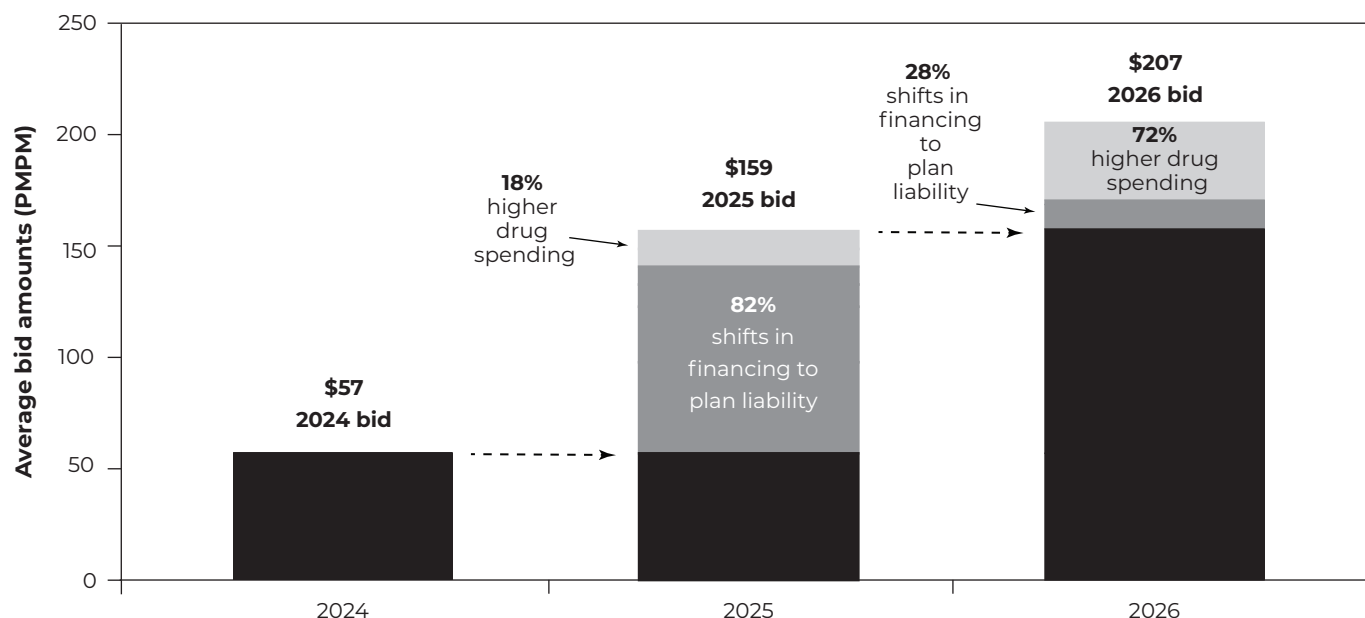
Between 2025 and 2026, the average unstandardized bid increased by \$48 PMPM, on average, to \$207 PMPM (Figure 13-A4). We estimate that, unlike the prior year, most of the increase in 2026 (72 percent) was driven by higher projected drug spending for 2026 compared with 2025. This could reflect plans underestimating spending in their 2025 bids or anticipating additional growth in 2026. (Since

2025 actual spending data were not available at the time this analysis was conducted, we are not able to separate the 2025 projection error from expected 2026 growth.) The remaining 28 percent can be attributed to shifts in benefit financing that increased expected plan liability resulting from projected decreases in manufacturer discounts and lower cost sharing, partially offset by slightly higher federal reinsurance. The decrease in manufacturer discounts is likely related to the Medicare Drug Price Negotiation Program: Drugs selected under this program are not subject to manufacturer discounts as other brand-name drugs are.⁸³

Overall, the estimates suggest that most of the increase in bids between 2024 and 2025 was driven by shifts in the distribution of financing (e.g., lower beneficiary

**FIGURE
13-A4**

Average unstandardized bids increased due to a shift in insurance risk toward plan liability and higher expected spending, 2024–2026



Note: PMPM (per member per month). Figure excludes special-needs plans since their bids are not included in the calculation of the national average monthly bid amount. Plan liability is financed by capitated direct-subsidy payments and enrollee premiums. To estimate the amount of change by payer source between 2025 and 2026, we applied the 2026 payer-source shares to 2025 spending (net of rebates and supplemental cost sharing). We then compared these simulated amounts with 2025 amounts from 2025 payer-source shares. The difference is our estimate of the amount attributable to each payer source that was shifted into (or out of) the bid. The residual difference after accounting for all the payer sources is our estimate of the growth in overall spending that increased the bid. The same method was used to estimate the change by payer source between 2024 and 2025.

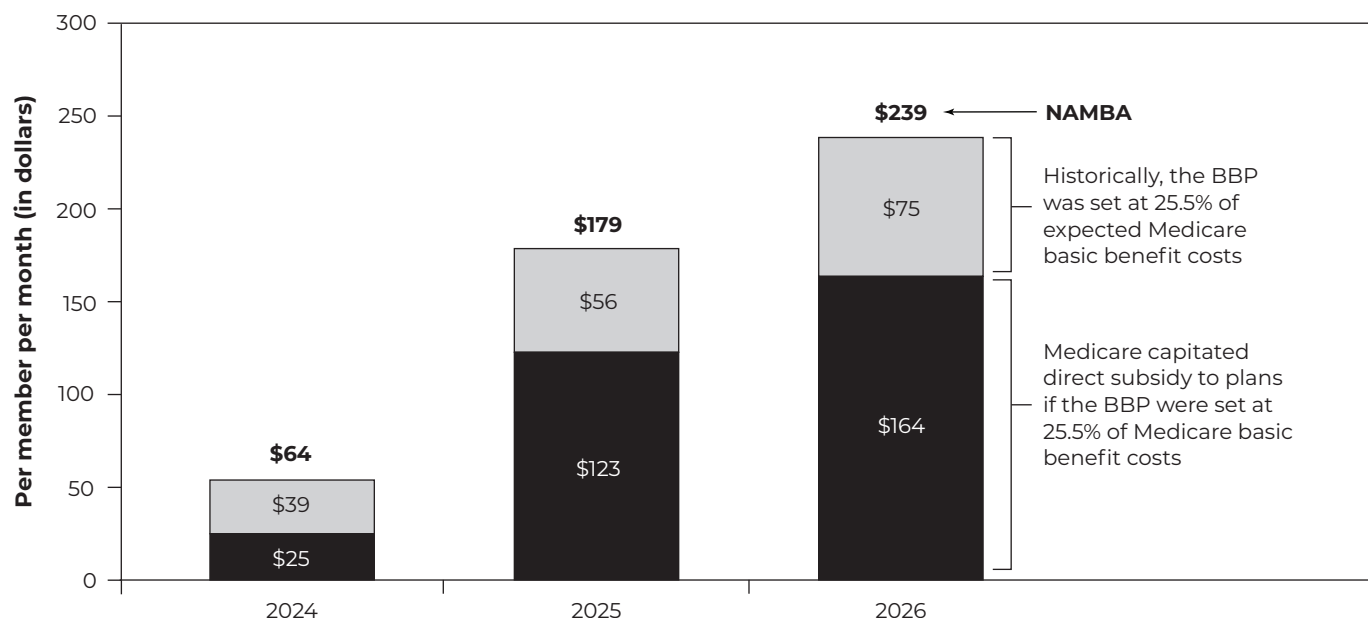
Source: Part D bid pricing tool data from CMS.

cost sharing and higher premiums) rather than higher overall Part D spending. By contrast, the increase between 2025 and 2026 appears largely attributable to plans' expectations for higher enrollee drug spending. Several factors likely contribute to these expectations. A key driver is beneficiary behavior in response to lower cost sharing, particularly with changes to how the TrOOP threshold is set. As noted earlier, the TrOOP can be substantially lower for many enrollees because the value of enhanced benefits counts toward the limit. This value is calculated as the difference between the cost sharing under the defined standard benefit (e.g., 25 percent coinsurance) and the actual cost-sharing required under the plan (e.g., \$50 copay). Because enhanced plans, by definition, offer more generous coverage than the defined standard benefit,

counting the value of supplemental benefits as TrOOP means many beneficiaries will meet their annual OOP limit without incurring the full amount.⁸⁴ Based on their available 2025 experience, plan actuaries we interviewed indicated that enrollees—especially those without the LIS—tended to increase drug spending under the redesign (see p. 529). They also suggested that higher 2026 bids may reflect adjustments for underestimated spending growth in 2025. Broader cost trends unrelated to the IRA—such as the growing prevalence of high-cost drugs like glucagon-like peptide-1 receptor agonists (GLP-1s)—also play a role. In the future, we plan to examine how changes in cost sharing are affecting enrollees' use of drugs, program costs and enrollee premiums, and the quality of pharmaceutical services under Part D.

**FIGURE
13-A5**

Part D basic premiums would grow without IRA provisions and buydown reducing them, 2024–2026



Note: IRA (Inflation Reduction Act of 2022), NAMBA (national average monthly bid amount), BBP (base beneficiary premium). Medicare's total expected basic benefit costs are the sum of NAMBA and expected federal reinsurance. Expected federal reinsurance is not displayed in the figure. This figure excludes special-needs plans since their bids are not included in the calculation of the NAMBA.

Source: CMS's annual release of Part D NAMBA and other Part C and Part D bid information.

Finally, plans' bid projections may differ from actual spending, particularly given the uncertainty as beneficiaries and plans adjust to the benefit redesign. These figures represent averages, and variation exists across plans.

Higher bids would increase beneficiary premiums if not for substantial premium “buydowns”

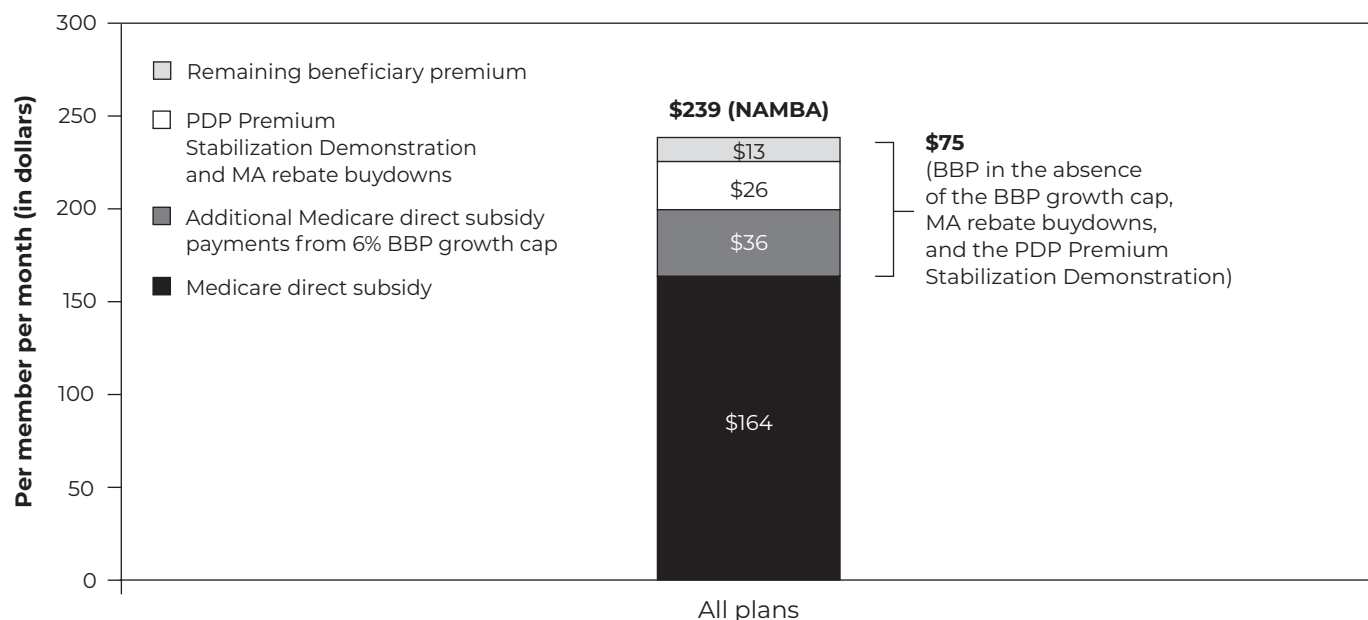
Before 2024, the national average basic premium (or BBP) was set so that it composed 25.5 percent of Medicare's total expected basic-benefit costs. These costs increased substantially after the IRA redesign (see Figure 13-A2, p. 523), partly because the IRA change shifted drug-spending liabilities away

from enrollee cost sharing. This shift would have increased beneficiary premiums, as shown in Figure 13-A5. Here, we show what the BBP would have been without additional policies to lower enrollees' share of Medicare's total expected basic benefit costs: The NAMBA increased from 2024 to 2026, which increased both the BBP (historically set at 25.5 percent) and the capitated direct-subsidy amount (Figure 13-A5).

However, since 2024, a provision in the IRA and policies implemented under CMS's Part D Premium Stabilization Demonstration have reduced the BBP's share of total expected basic-benefit costs. For example, in 2026, the average expected premium that enrollees actually paid for the basic Part D benefit (\$13 PMPM) is substantially lower than the historically set BBP (Figure 13-A6).⁸⁵ This reduction resulted from several mechanisms aimed at lowering the premium

**FIGURE
13-A6**

Basic beneficiary premiums are substantially lowered through IRA provisions and buydowns, 2026



Note: IRA (Inflation Reduction Act of 2022), PDP (prescription drug plan), MA (Medicare Advantage), NAMBA (national average monthly bid amount), BBP (base beneficiary premium). Excludes special-needs plans since their bids are not included in the calculation of the NAMBA. "MA rebate buydowns" refers to MA plans' use of Part C rebates to lower Part D premiums for their enrollees.

Source: Part D and MA bid pricing tool data and Part D landscape files from CMS.

that enrollees pay. First, the IRA capped year-over-year growth in the BBP at no more than 6 percent. For 2026, this requirement resulted in a BBP of \$39 instead of \$75 PMPM. The difference of \$36 PMPM (\$75 minus \$39) was covered by an increase in Medicare's direct subsidy, which increased program costs (Figure 13-A6). The additional \$26 PMPM of the basic premium is lowered through mechanisms that differ for PDPs and MA-PDs (Figure 13-A7, p. 528).

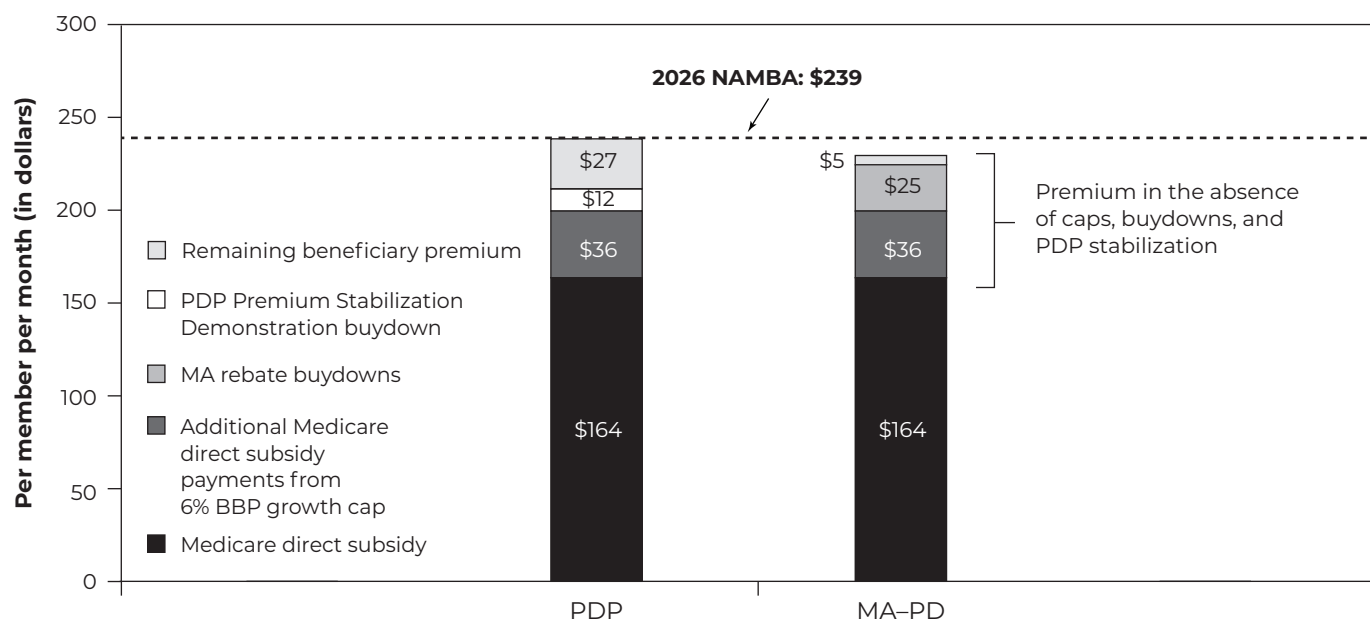
MA plans have long been able to use their MA rebates to buy down Part D premiums for their enrollees. These buydowns can be substantial—on average, covering over 90 percent of the basic MA-PD premium in recent years. The MA buydowns further reduced the basic premiums for MA-PD enrollees by \$25 PMPM, resulting in a remaining premium of \$5 PMPM, on average (Figure 13-A7, p. 528). The Part D Premium Stabilization

Demonstration targeted PDPs. This three-year demonstration lowered the BBP, capped year-over-year PDP total premium growth, and narrowed risk corridors. In 2026, the impact of this demonstration was to lower basic premiums by \$12 PMPM for PDPs, on average, to \$27 PMPM (Figure 13-A7).⁸⁶

As shown in Figure 13-A7 (p. 528), the remaining basic premiums differed for PDPs and MA-PDs because MA-PDs, on average, had lower bids and because MA rebate buydowns have been sizable in recent years.⁸⁷ The Part D Premium Stabilization Demonstration, in contrast, is temporary (lasting for up to three years beginning in 2025) and has lowered the PDP basic premiums by about half the amount of MA rebates that are used to buy down basic premiums. This differential has important implications for setting Medicare's premium subsidy for LIS enrollees (called the low-income premium-subsidy amount (LIPSA)) and

**FIGURE
13-A7**

Basic premiums differed between PDPs and MA-PDs, 2026



Note: PDP (prescription drug plan), MA-PD (Medicare Advantage Prescription Drug [plan]), NAMBA (national average monthly bid amount), BBP (base beneficiary premium). Excludes special-needs Part D plans since their bids are not included in the calculation of the NAMBA. "MA rebate buydowns" refers to MA plans' use of rebates to lower Part D premiums for their enrollees as a supplemental benefit.

Source: Part D and MA bid pricing tool data and Part D landscape files from CMS.

PDP benchmark-plan designations (see text box, pp. 530–531).

Many plans offer supplemental coverage, which is also affected by MA buydowns and the Premium Stabilization Demonstration. The sizable MA buydowns mean that many MA-PDs have a zero-dollar total premium, while all PDPs must charge supplemental premiums that reflect the value of the enhanced benefits. The premium gap between PDPs and MA-PDs is expected to widen as the Part D Premium Stabilization Demonstration and the BBP cap on year-over-year growth are phased out. We plan to continue to examine the sources of these differences and monitor changes in Part D bids and spending as plans and enrollees adjust to the IRA Part D redesign.

Interviews with actuaries

Between August 2025 and December 2025, Commission staff conducted five interviews with 11 actuaries, all with experience preparing Part D bids or with expertise in the Part D market. Some actuaries were employees of insurers that participate in Part D (PDP and MA-PD markets), including both for-profit and nonprofit plans, and operating either in a single PDP region or across multiple regions. The interviews focused on four main topics related to recent trends in the NAMBA, the state of the PDP market, LIS benchmark plans, and risk adjustment, and were conducted in a semistructured format. While we made efforts to learn about broader perceptions among their actuarial colleagues working in the Part D market, some of the findings may not necessarily reflect the perspectives of all Part D plans.

In this section, we summarize key themes and takeaways from these interviews.

Interviews point to possible underbidding for 2025, contrary to earlier assessments

After CMS announced the NAMBA increase of nearly 180 percent for 2025 (see Table 13-A2, p. 522), interviewees agreed that there was a general consensus that plan bids were likely too conservative (i.e., too high), reflecting greater uncertainty as the IRA's benefit redesign became effective (Cline and Liner 2024). However, in the first quarter of 2025, use of brand-name and specialty drugs, including GLP-1s, may have exceeded plan expectations. Referring to the general consensus that plans may have “overbid” in 2025, one interviewee noted, “The Q1 2025 data has [sic] shown that that view was wrong.” Additionally, one interviewee observed that, beyond the lower annual OOP limit and the elimination of cost sharing above that limit, the change in TrOOP calculation—whereby the value of supplemental benefits is now counted as TrOOP—is likely having a bigger impact than plans expected. As a result, in preparing their bids for 2026, plans, on average, appear to have corrected upward, responding to the actual utilization and cost trends. As one interviewee observed, in retrospect, the 33 percent increase in the NAMBA for 2026 “makes sense given the increased utilization that have [sic] already exceeded expectation in the first half of the year [2025].”

Variation in 2026 bids and premiums reflects continued uncertainty and different approaches to bidding

Interviewees generally agreed that 2026 bids continued to exhibit large variation in part due to the continued uncertainty with respect to the impact of the IRA redesign, particularly as it relates to the accelerated spending trends among beneficiaries without the LIS. At the same time, many also agreed that the effectuation of MFPs for selected drugs under the Medicare Drug Price Negotiation Program as well as other drug-pricing policies was also an important factor contributing to uncertainty. Some interviewees highlighted divergent bidding strategies taken by carriers as contributing to the variation in bids and premiums.

MFPs are a major source of uncertainty

Interviewees emphasized that the application of MFPs beginning in 2026 contributes to uncertainty; they also

noted that the effects of maximum fair prices (MFPs) will not be uniform across plans. This uncertainty is due to variation across plans in the use of selected drugs and in the rebates plans received for selected drugs before the MFPs went into effect. That is, plans with higher baseline utilization of selected drugs or greater reliance on rebates on those drugs face more unpredictability in how MFPs will affect their benefit costs. Some interviewees expressed concerns that lower OOP costs for MFP drugs would likely increase utilization, but the magnitude of the increase was difficult to predict. In addition, the expected loss of rebates on selected drugs complicates the bid preparation as plans must anticipate both the loss of rebate revenue that historically has lowered their bids (and premiums) and potential shifts in member behavior. Some interviewees noted that MFPs being implemented alongside other significant policy changes further complicate efforts to predict the impact of these policies. Referring to impacts of other drug-pricing policies, one interviewee noted that “plans took different approaches, with some trying to factor this in while others did not.”

Aggressive, low-premium versus conservative or opportunistic approaches to bidding

In 2026, some actuaries noted that bidding strategies were more varied than in 2025, likely adding to the large variation in bids and premiums. For example, they noted cases in which insurers were evaluating region by region, looking at expected membership and weighing “the tradeoff between the margin target versus having low premiums and being under the benchmark,” while other plans took a more financially conservative approach, increasing premiums to hedge against uncertainty in utilization trends and the impact of MFPs and other drug-pricing policies. Some plans intentionally bid above the benchmark, accepting loss of enrollees who receive the LIS in exchange for higher margins on other members. One interviewee explained, “If you are going to be over [the benchmark] . . . you might as well be over by a lot to make some margins.” In markets with high SNP penetration or less attractive opportunities to gain low-cost enrollees who receive the LIS, plans were more likely to bid above the benchmark or exit the market entirely. As one interviewee observed, “Florida is particularly an unattractive market for benchmark plans because of growth of SNPs.” Continued uncertainty may have

LIS benchmark plans and the low-income premium-subsidy amount

Medicare subsidizes the premiums for beneficiaries who are eligible for Part D's low-income subsidy (LIS). To determine the regional low-income premium-subsidy amount (LIPSA)—the maximum amount of premium subsidy Medicare pays to Part D plans on behalf of an LIS beneficiary—CMS calculates a “benchmark” premium amount separately for each of the 34 Part D regions.

The benchmark amount for a region is based on the premiums of all stand-alone prescription drug plans (PDPs) and Medicare Advantage Prescription Drug

plans (MA-PDs) serving those regions that had any LIS enrollment in the previous year. To calculate a region's benchmark, CMS computes the average basic premium in the region, weighted by LIS enrollment.⁸⁸ Plans that offer both basic and enhanced coverage have only the portion of their premium attributable to basic coverage included in the calculation. If at least one basic PDP has a premium at or below the benchmark, the region's LIPSA is equal to the benchmark amount.⁸⁹ If no basic PDP in the region has a premium below that amount, the LIPSA is equal to the lowest beneficiary premium for a basic PDP offered in the region. The premium subsidy

(continued next page)

**FIGURE
13-A8**

Illustrative example of determining LIPSA and benchmark plans in two PDP regions

Region A			
Plan	Premium	LIS member count	Weighted average premium (benchmark)
MA-PD 1	\$50	50	\$42
PDP 2	\$45	35	
PDP 3	\$40	40	
PDP 4	\$25	25	

Region A has two benchmark plans:

PDP 3 and PDP 4 premiums are lower than the benchmark
Benchmark and LIPSA amount = \$42

Region B			
Plan	Premium	LIS member count	Weighted average premium (benchmark)
MA-PD 1	\$25	50	\$35
PDP 2	\$45	35	
PDP 3	\$40	40	

Region B has one benchmark plan:

No PDP plans have premiums less than the benchmark.
PDP 3 has the lowest premium.

Benchmark amount = \$35
LIPSA amount = \$40

Note: LIPSA (low-income premium-subsidy amount), PDP (prescription drug plan), LIS (low-income subsidy), MA-PD (Medicare Advantage Prescription Drug [plan]). In this illustrative example, we assume that the PDPs that qualify as benchmark plans are basic PDPs. The benchmark amount is calculated as the average premium across the plans listed for each region weighted by the LIS member counts shown.

Source: MedPAC illustration of hypothetical LIS benchmark calculations.

LIS benchmark plans and the low-income premium-subsidy amount (cont.)

paid by Medicare is the lower of a plan's premium or the LIPSA.⁹⁰ Basic PDPs that have a beneficiary premium that is less than or equal to their LIPSA are known as "benchmark plans." Benchmark plans have their premiums for LIS enrollees fully subsidized by Medicare. Figure 13-A8 illustrates how LIPSA and benchmark plans are determined in two hypothetical PDP regions.

As more LIS beneficiaries have enrolled in MA-PDs (especially special-needs plans), the premiums of MA-PDs have greater weight in determining each region's benchmark premium amount and LIPSA. When MA-PD premiums are, on average, lower than PDP premiums, benchmark amounts decline. This

situation, in turn, can reduce the number of PDPs that qualify as benchmark plans.

Benchmark plans play an important role for fee-for-service (FFS) beneficiaries who receive the LIS. Individuals who enroll in benchmark plans do not pay a premium, and those who do not select a plan on their own are automatically enrolled in benchmark plans (auto-enrollees), thereby ensuring the beneficiary has drug coverage. If there is more than one benchmark plan in a region, CMS randomly assigns auto-enrollees equally among benchmark plans.⁹¹ Auto-enrollees have historically composed a substantial share of LIS beneficiaries in FFS Medicare (Medicare Payment Advisory Commission 2020a). ■

contributed to market consolidation, with several insurers exiting or reducing their PDP offerings. As one interviewee summarized, "Carriers are looking to be profitable, not [to gain] more membership . . . the PDP market is essentially down to five major carriers."

Competition in the PDP market is shaped by policy and plan strategies

We asked interviewees to discuss how recent policy changes, market incentives, and plan strategies have affected the PDP market. Interviewees emphasized that uncertainty related to the implementation of the IRA policies was a key factor affecting the structure and functioning of the PDP market. However, they also discussed other factors that affect the structure and stability of the PDP market: the persistence of risk selection—the differences in the risk profiles of enrollees across plans that are not accounted for by risk scores—among PDPs, benchmark-plan dynamics, and the influence of recent changes to risk adjustment.

National insurers may see less value in operating in the PDP market

Several interviewees noted that, historically, the PDP market provided national carriers (insurers)

with scale and leverage in negotiating rebates with pharmaceutical manufacturers, as well as access to a pool of enrollees who could be converted to their MA products (i.e., MA-PDs). Interviewees explained that these large insurers benefited from comparatively large rebates, which provided them with a financial advantage under Part D's risk-adjustment model that was built based on gross benefit costs (before accounting for rebates) (see text box on Part D's risk-adjustment model on pp. 210–211 in the June 2025 report to the Congress). However, the effectuation of MFPs is expected to lessen the use of rebates as a tool to lower benefit costs and as revenue streams for pharmacy benefit managers (PBMs) and their vertically integrated pharmacies. Interviewees noted that as more drugs become subject to MFPs, the financial advantage will likely continue to diminish.

Several interviewees highlighted the potential need for large investment to operate and grow market share in the PDP market, where plans face more restrictions and limited ability to revamp their offerings compared with the MA-PD market. For example, Part D regulations prohibit insurers that terminate or do not renew a contract from entering or expanding into the PDP region(s) from which they exited for two years.⁹²

One interviewee noted that, unlike MA-PDs, “PDPs do not have a lot of room to absorb margin pressures” that arose from the policy change on pharmacy direct and indirect remuneration (DIR) in 2024 and now from the IRA redesign and the effectuation of MFPs.

Furthermore, changes in the MA market may also affect how these insurers view the PDP market. One interviewee observed that “MA margins have been squeezed quite a bit, so the value of conversions from the PDP market has gone down.” As a result, “investment in [the] PDP [market] has gone down,” and several large carriers may be reassessing their participation in the PDP market, with some choosing to exit or consolidate their offerings.

Selection effects within the PDP market remain strong

Several interviewees noted that risk profiles of enrollees vary widely across PDPs and that the selection effects tend to persist due to structural and behavioral factors. Because most enrollees do not switch plans, existing members “heavily impact plan premiums,” and the inability to “start over” in the PDP market contributes to the persistence of selection effects. Selection effects may also persist through CMS’s auto-assignment process, which assigns beneficiaries with the LIS to benchmark PDPs that are premium free. Auto-enrollees tend to have lower utilization and more predictable claims experience. One interviewee explained that auto-enrollees consistently have a better risk profile, creating an incentive to capture them over “switchers,” referring to beneficiaries with the LIS who have switched to a different plan from the one to which they were originally assigned. This difference in risk profiles between auto-enrollees and switchers means that plans with a substantial auto-enrollee population have a competitive advantage, allowing them to bid more aggressively to maintain zero-premium benchmark status.

Plans, particularly those operated by large national insurers with in-house PBMs, may be able to select favorable risk by strategically setting prices paid to pharmacies. For example, by setting higher prices for specific high-cost drugs, plans can increase enrollee cost sharing and potentially discourage enrollment by individuals who rely on those medicines (doing so would make the plan look more expensive to those individuals when they compare prices on Plan Finder to select a plan). An interviewee noted, “Plans may

use benefit design and pharmacy pricing strategies to influence their enrollee mix,” further reinforcing selection effects.

Benchmark-plan dynamics may drive both competition and market instability

In the PDP market, plans that have premiums below the regional benchmark are rewarded with auto-enrollees (see text box on the low-income premium amount and the determination of benchmark plans, pp. 530–531). This process gives plans incentives to bid aggressively in order to qualify as a benchmark plan to receive auto-enrollees, who typically have lower and more predictable drug costs. This competitive pressure can lead to lower premiums, benefiting both Part D beneficiaries and Medicare, which subsidizes program costs. However, the same dynamics may also contribute to market instability: If a benchmark plan’s premium rises above the benchmark, it loses a significant portion of its LIS enrollees, resulting in abrupt shifts in enrollment with major implications for their revenues. As one interviewee noted, “If you accidentally go over the benchmark, you lose the auto-assigned members, and it costs a lot of money to try and get back to benchmark status, and you don’t get back all the auto-assigned members you lost.” This dynamic also means that small changes in premiums or risk scores can have outsized effects on membership mix and financial outcomes. Some interviewees suggested that this instability in the benchmark-plan dynamics can lead to changes in plan offerings, market exits, and plan consolidations. However, one interviewee noted that losing benchmark status does not necessarily create barriers to reentry into the LIS market, describing it as primarily a business decision rather than an operational limitation.

Limited differentiation and “commoditization” of PDP offerings

The IRA changes dramatically reduced cost-sharing liability through the redesign of the benefit as well as new coverage and cost-sharing requirements. As a result, many enrollees without the LIS are expected to pay less cost sharing than before the redesign took effect. Multiple interviewees noted that, as a result of these changes, Part D has become a “commoditized” market, limiting their ability to differentiate their plans from competitors through the use of formulary tiers

and copays. In 2025, more plans are using coinsurance, in part to avoid adverse selection but also because of the change in the TrOOP calculation that effectively lowers the annual OOP limit when plans use generous copays. As a result, decisions about formulary and benefit designs now have less impact on beneficiaries' OOP costs and on their utilization and plan choice. The commoditized market also means that there is limited ability to offer enhanced-benefit plans in the PDP market. Interviewees noted that attempts to offer richer benefits or lower cost sharing can attract higher-risk enrollees, increasing plan liability.

As the PDP market becomes more commoditized, with limited differentiation in benefits and cost sharing, selection effects can become even more pronounced. For example, plans with the lowest premiums may be able to attract healthier, lower-utilization members, which, in turn, may enable them to maintain lower premiums than competitors. This dynamic was described by one interviewee as a situation in which “the lowest premium gets you the best members and mix, particularly members who don’t utilize or those that take few generics and so are low cost, and the risk-adjustment model overpays even on low-cost members because of the dynamics of not reflecting [postsale rebates and fees] and the [data] lag.” Additionally, several interviewees observed that the narrowing of options to manage utilization or to distinguish themselves in the market encourages plans to compete primarily on premium, reinforcing selection effects and contributing to wide variation in risk profiles and financial outcomes across PDPs. One interviewee suggested that commoditization may reduce “frictions” for beneficiaries switching plans by ensuring a baseline level of coverage while enabling them to seek plans that offer lower cost sharing for specific drug(s), potentially increasing selection effects.

Separate normalization and other “enhancements” to risk adjustment have made the PDP market more attractive

Separate normalization and the “enhancements” that CMS implemented under the new risk-adjustment model may have improved the attractiveness of the PDP market. Interviewees explained that the application of separate normalization factors for PDPs and MA-PDs allows risk scores to better reflect the average differences in utilization patterns between the

two markets. In turn, these changes have resulted in higher risk scores for PDPs—and thus higher (capitated) payments—particularly for LIS members in PDPs, allowing some plans to offer lower premiums and remain competitive. An interviewee noted that insurers who previously found the LIS population in PDPs difficult to serve may now find it “more financially viable to try to get back in under the benchmarks.”

However, while interviewees generally agreed that the use of separate normalization factors has improved the short-term attractiveness of the PDP market, some cautioned that “mathematical underpinnings are not sound.” Instead, interviewees argued that long-term sustainability of the PDP market will depend on continued refinement of risk adjustment and market-stabilization policies. As one interviewee put it, “using separate normalization as a way to drive revenue to PDP doesn’t seem sustainable. . . . To stabilize the PDP market, coming up with a way to drive revenue that isn’t reliant on separate normalization factor [sic] is something worth considering.”

Improving the accuracy of risk adjustment is key for the long-term stability of the PDP market

Interviewees consistently emphasized that improving the accuracy of risk adjustment is fundamental to the stability of the PDP market. By compensating plans fairly for differences in enrollees’ average expected costs, risk adjustment has the potential to neutralize the financial impact of selection effects and to promote competition. Nearly all interviewees expressed concern that the current model is not keeping pace with actual utilization trends, particularly for beneficiaries without the LIS. Some interviewees noted that the situation has resulted in misvalued hierarchical condition categories (HCCs) where “certain HCCs are undervalued in a way that lowers risk scores for non-low income population.” However, there was less consensus on the best approach to improve the accuracy of Part D’s risk-adjustment model. Some suggested using a separate model for PDPs and MA-PDs, though some also expressed reservations about using separate models as a long-term solution, noting that it could create artificial incentives and potentially distort competition between the two markets. Others discussed the need to reflect prices net of DIR or actual drug use rather than rely solely on diagnoses.

Interviewees also suggested other ideas as the market continues to adjust to changes, though there was less consensus. For example, one interviewee suggested that tighter risk-corridor protection for PDPs would be valuable to plans as they face greater uncertainty in predicting enrollees' utilization and pricing during this period of market transition. While this protection could be temporary, interviewees noted that, with the large increase in bids, risk corridors are no longer providing the same level of protection as before the IRA changes. That is, the current initial threshold of 5 percent (above the expected costs in plan bids) can mean major losses for plans before any payment protection is triggered. Another interviewee suggested that a policy change to allow insurers to “revamp” their PDP offerings and start anew could improve the attractiveness of the PDP market, encourage innovation, and allow PDPs to adapt to the changing market conditions. Currently, PDPs that exit from a region are not allowed to reenter the market for two years, which limits PDPs' ability to change their offerings.⁹³

Finally, when we asked whether there was any reason to exclude SNPs from the calculation of the NAMBA, interviewees generally agreed that there was no compelling reason for their exclusion. Given SNPs' growing market share, interviewees generally agreed that this exclusion (in law) no longer made sense. However, there was less clarity on how including bids submitted by SNPs would affect the NAMBA and what the broader implications would be on the PDP market. Several interviewees suggested that the effects on the NAMBA would likely vary from year to year, “though theoretically, it shouldn't have that much impact.”

“Steady state” may still be a few years away

Interviewees broadly agreed that a “steady state”—a return to normal variability and predictability in Part D utilization and costs—is still several years away, citing multiple sources of uncertainty and ongoing policy changes. They pointed to data lags in risk adjustment and continued volatility in utilization, especially for high-cost and specialty drugs.

Compounding these challenges are policy changes, including the effectuation of MFPs, other policies that could affect drug prices, and modifications to CMS's Premium Stabilization Demonstration, all of which make it difficult for plans to predict costs and the premiums for their enrollees. Interviewees also noted manufacturer responses, such as reduced availability of patient-assistance programs, which have shifted more cost onto Part D and increased financial pressure on plans.

Interviewees cautioned that lower average premiums for PDPs observed in 2026 relative to 2025 are not a sign of market stability but rather a reflection of how the use of separate normalization for PDPs and MA-PDs has, on average, increased the risk scores for PDPs, resulting in lower risk-standardized bids and premiums.⁹⁴ One interviewee noted that the lower premiums for PDPs were “a result of higher NAMBA and increased direct subsidy, not intentional efforts by plans to lower bids.” While separate normalization and other changes to Part D's risk adjustment may have improved near-term financial prospects for PDPs, on average, interviewees emphasized that the risk-adjustment model needs further refinement. ■

Endnotes

- 1 Plans receive prospective payments for reinsurance that are reconciled with actual spending (net of postsale rebates and discounts) after the end of the benefit year for enrollees who reached the annual OOP threshold.
- 2 For example, the Commission has recommended establishing higher copayment amounts for nonpreferred and nonformulary drugs under the LIS benefit and giving plans greater flexibility regarding coverage of drugs in the protected classes, though these proposals have not yet been adopted (Medicare Payment Advisory Commission 2020b, Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2016).
- 3 For example, in 2023, on average, MA-PD risk scores were an estimated 7.6 percentage points higher than PDP risk scores due to differences in coding intensity. Unlike in the MA program, higher coding intensity in Part D does not, by itself, increase program spending; rather, it affects relative payments between the two markets.
- 4 The changes adopted in the IRA are also likely to affect revenues of pharmaceutical manufacturers and may influence decisions related to future investment in research and development (R&D) as well as strategies for new product launches. However, estimates of these potential effects vary widely, reflecting significant uncertainty (Avalere 2022, Congressional Budget Office 2022, Gassull et al. 2023, Philipson et al. 2023). As noted in our previous reports to the Congress, the price paid by Medicare and other entities for drugs represents just one of many factors that influence investment in biopharmaceutical R&D (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2022a).
- 5 Before 2025, TrOOP spending excluded beneficiary cost sharing paid by most sources of supplemental coverage, though it included the 70 percent discount that manufacturers of brand-name drugs were required to pay in the coverage gap.
- 6 CMS requires plans to adjust their bids to remove any insurance effect of enhanced (supplemental) benefits on basic-benefit costs by applying an induced utilization factor to the expected basic benefit costs. However, the effects of enhanced benefits on TrOOP that increase basic-benefit costs are not treated as insurance effects and are excluded from the induced utilization factor.
- 7 For the applicable periods beginning October 1, 2022, and October 1, 2023, approximately 1,500 national drug codes (nine-digit national drug codes) experienced price increases exceeding inflation and owed more than \$1.2 billion in inflation rebates. By law, inflation rebates are deposited in the Federal Supplementary Medical Insurance Trust Fund (Centers for Medicare & Medicaid Services 2026).
- 8 Previously, a small share of LIS enrollees with slightly higher levels of income or assets received a partial subsidy; beginning in 2024, all beneficiaries who previously would have been eligible for a full or partial LIS receive full subsidy benefits.
- 9 Before the 2025 bids were submitted, CMS estimated that the IRA changes would roughly double gross plan liability, and many, including CMS, expect Part D's risk adjustment to take on much greater importance (Centers for Medicare & Medicaid Services 2023a, Robb et al. 2024).
- 10 The MDP discount during the initial coverage phase for negotiated drugs is covered instead by Medicare through the Selected Drug Subsidy Program.
- 11 In 2030, the IRA requires that the BBP cover at least 20 percent of expected basic benefit costs, which may necessitate an annual increase of more than 6 percent.
- 12 If the BBP were set to be 25.5 percent of the total expected benefit (as originally set in law), it would have been \$75.38 in 2026 (this number was \$55.98 in 2025). Capping the BBP growth results in a BBP of \$38.99 (lower than the BBP without the cap by \$36.39). In contrast, applying the cap last year decreased the BBP by \$19.20.
- 13 All average premium information in this chapter is enrollment weighted (unless otherwise stated). For all years before 2026, we used same-year enrollment to weight premiums across plans (e.g., Part D plan enrollment from 2025 was used to calculate average 2025 premiums). Since 2026 enrollment was unknown at the time the analysis was conducted, we used April 2025 plan members as weights for 2026. We used CMS's crosswalk files to match 2025 plans to 2026 plans to account for plans that consolidated. Because we used 2025 enrollment as weights, plans that are new in 2026 are not included in the analysis of 2026 average premiums.
- 14 CMS reported that the average PDP total premium was expected to decrease in 2026 to \$34; this calculation was based on an assumption that some beneficiaries would switch to lower-premium plans. While switching to lower cost plans is supported by historical data, our estimate does not make such an assumption, but rather assumes all beneficiaries

- remain in the same plan as in 2025. Other researchers have also reported that average PDP premiums are expected to increase in 2026 among non-LIS enrollees (Collin et al. 2025, Stengel et al. 2025).
- 15 Beneficiaries who receive the LIS do not pay the full premium amounts because Medicare's low-income premium subsidy pays most or all of their premiums.
 - 16 SNPs are specialized types of MA plans that limit their enrollment to specific categories of individuals with unique needs or conditions, including dual eligibility, severe chronic conditions, or institutionalization, to provide targeted care and tailored benefit packages.
 - 17 The LIS benchmark is the average basic premium for PDPs and MA-PDs (including SNPs) in each of the 34 PDP regions, weighted by LIS enrollment.
 - 18 Dental, vision, hearing, and fitness benefits are the most common non-Medicare services, though policy changes have expanded the types of benefits that plans may offer, and plans have gradually covered a larger number of non-Medicare services (Medicare Payment Advisory Commission 2025c).
 - 19 As with the income-related premium for Part B, higher Part D premiums apply to individuals with an annual adjusted gross income greater than \$106,000 and to couples filing jointly with an adjusted gross income greater than \$212,000 in 2025; these thresholds are updated annually.
 - 20 The LEP amount depends on the length of time an individual goes without coverage as generous as Part D and is calculated by multiplying 1 percent of the BBP by the number of full uncovered months an individual was eligible but was not enrolled in a Part D plan and went without other creditable coverage.
 - 21 These additional late-enrollment premiums are paid into the Part D account of the Supplementary Medical Insurance Trust Fund.
 - 22 Fewer than half of the regions (14 out of 34) have six insurers offering PDPs; these regions have a local organization offering a plan in addition to the national carriers. Hawaii is the only region with just four insurers offering PDPs. Nearly half of all PDP beneficiaries were enrolled in a plan offered by the leading national carrier in 2025, while enrollment among the other four was roughly evenly split. The plan sponsor with nearly half of PDP enrollment is the only one to have a benchmark plan in every region, though another organization significantly increased its footprint in the benchmark market from 17 regions in 2025 to 30 in 2026.
 - 23 Enrollment among the 48 PDPs that fully terminated averaged 10,000, with roughly 480,000 beneficiaries in such plans.
 - 24 When the Part D program was created, the Congress contemplated such a scenario and included in the legislation a contingency plan to ensure beneficiaries would always have a minimum of two options for prescription drug coverage (see CFR Sec. 423.859.). If that minimum requirement is not met, the law allows the Secretary to approve a plan(s) that administers Part D's prescription drug benefit without taking insurance risk (or only assuming limited insurance risk). In 2025, however, all regions continued to meet the minimum number of required plans, with all enrollees having at least five qualifying PDPs.
 - 25 The four regions with just one benchmark plan available in 2025 included Florida, Illinois, Nevada, and Texas.
 - 26 The remainder qualified either because they received benefits through the Medicare Savings Program or Supplemental Security Income program or because they were eligible after they applied directly to the Social Security Administration.
 - 27 During the coronavirus public health emergency, the Congress required states to pause eligibility checks for Medicaid enrollees. This requirement expired in April 2023, and at that time states began the process of once again checking eligibility during renewal periods, which took up to one year to complete. Thus, by mid-2024, disenrollment of individuals no longer eligible for Medicaid was complete. Because beneficiaries who are dually eligible for Medicare and Medicaid automatically receive the LIS, disenrollments from Medicaid lead to decreases in the number of people automatically receiving the LIS.
 - 28 The retiree drug subsidy is paid to employers that provide prescription drug coverage to their retirees that is comparable with or more generous than Part D's defined standard benefit.
 - 29 Medicare's Trustees noted an "unexpected surge in the use of antidiabetic drugs" that began in 2023 (Boards of Trustees 2025). The use of GLP-1s has risen across all payers, driven in part by the drugs' effectiveness in treating Type 2 diabetes and, more recently, by FDA approvals for additional indications, such as the treatment of cardiovascular disease and weight loss. Growing public awareness of GLP-1s through direct-to-consumer advertising has also likely contributed to the uptick in their use (Greenwalt and Glass 2025, Rad and Melendez-Torres 2025).
 - 30 Between 2023 and 2024, Medicare's spending for the LICS subsidy declined from \$25.7 billion to about \$21 billion, while

- cost sharing paid by beneficiaries who did not receive the LIS declined from \$5.4 billion to \$3.8 billion, likely due in large part to the IRA change. Part D spending in the catastrophic phase of the benefit in 2024 indicates that this provision may have added as much as \$6 billion to plan liability.
- 31 Before 2024, Part D program payments increasingly shifted from capitated direct-subsidy payments to cost-based reinsurance. By 2023, reinsurance accounted for 93 percent of Part D program spending on basic benefits, up from less than 50 percent a decade earlier. In 2024, this trend was reversed, with reinsurance accounting for 76 percent of basic-benefit costs.
 - 32 The total net pharmacy DIR payments used by Part D plans to offset benefit costs grew from less than \$1 billion before 2015 to more than \$21 billion by 2023, accounting for nearly a quarter of all DIR received by plans, primarily used to lower benefit costs. Rebates received by plans from pharmaceutical manufacturers accounted for the other three-quarters.
 - 33 In 2023, on average, pharmacy DIR fees amounted to about 8 percent of the gross (or list) prices at the POS, up from less than 5 percent before 2020 (MedPAC's analysis of the Part D prescription drug event and DIR data from CMS).
 - 34 To examine growth in prices, the Commission contracted with Acumen to construct a series of volume-weighted price indexes that reflect total amounts paid to pharmacies for Part D prescriptions (i.e., POS prices) as well as prices for single-source brand-name drugs net of postsale manufacturer discounts. The indexes reflect prices (of existing products) measured at the median of the distribution for each grouping of products associated with a specific drug or biologic. The price index measures changes in the prices of products that existed in both the measurement period and the preceding period.
 - 35 In 2023, pharmacy DIR fees lowered the prices of generic drugs by 12 percent, on average, compared with 7 percent and 8 percent for brand-name drugs and biologics, respectively (Medicare Payment Advisory Commission 2025a).
 - 36 Medicare's LICS subsidy continues to count toward the annual OOP threshold after 2024. However, starting in 2025, the new MDP that replaced the Coverage-Gap Discount Program will no longer count toward the annual OOP threshold.
 - 37 In 2024, high-cost enrollees without the LIS paid, on average, about \$2,250 OOP in cost sharing. Discounts paid by pharmaceutical manufacturers for prescriptions filled in the coverage gap accounted for the remainder of the annual OOP threshold amount (\$8,000).
 - 38 The TA is equal to the plan bid minus administrative costs and profits assumed in bids. The profits that are recouped under Part D's risk corridors are a portion of "excess" profits that plans made above and beyond the amounts assumed in bids.
 - 39 In 2020, the annual OOP threshold increased by \$1,250 as it reverted to the level that would have applied if the provision in the Affordable Care Act of 2010 (ACA) to temporarily slow growth from 2014 to 2019 had not been implemented.
 - 40 Expected average plan liability used in risk-corridor calculation—plan bid minus administrative costs and profits—is referred to as the "target amount." Between 2023 and 2024, the TA across all plan types rose from \$27 to over \$50 PMPM. The increase, in both dollar and percentage terms, was greater for PDPs and SNPs compared with conventional MA-PDs.
 - 41 To examine growth in prices, the Commission contracted with Acumen to construct a series of volume-weighted price indexes that reflect total amounts paid to pharmacies for Part D prescriptions (i.e., POS prices) as well as prices for single-source brand-name drugs net of postsale manufacturer discounts. The indexes are calculated using chain-weighted Fisher price indexes and are measured at the median of the distribution relative to prices as of the first quarter of 2014. Indexes reflect changes in the prices of products that existed in both the measurement period and the preceding period. They do not reflect the effect of new products' launch prices.
 - 42 To account for generic substitution, Acumen groups NDCs that are pharmaceutically identical, aggregating prices across drug trade names, manufacturers, and package sizes. As a result, brand-name drugs are grouped with their generics if they exist, and this price index more closely reflects the degree to which market share has moved across products.
 - 43 The decrease in POS prices in 2024 reflects the new DIR policy requiring pharmacy fees to be reflected at the POS. Pharmacy fees, on average, accounted for a larger share of spending for generic drugs compared with brand-name drugs and biologics. As a result, the impact of the DIR policy was greater on the generic price index (a decrease of 34.2 percent) than on the overall index including brand-name drugs and biologics (a decrease of 11.3 percent).
 - 44 The decrease in POS prices in 2024 was driven primarily by the new policy requiring pharmacy fees to be reflected at the POS.
 - 45 MedPAC calculations based on data from CMS.

- 46 MedPAC calculations based on analysis by Acumen for MedPAC.
- 47 In the case of Fiasp/Novolog, our expenditure index decreased in 2024 as prices, measured by our price index, decreased between the fourth quarter of 2023 and the first quarter of 2024.
- 48 These estimates reflect use for an expanding set of FDA-approved indications—including Type 2 diabetes and cardiovascular risk management—but exclude weight loss, implying utilization likely remains highly constrained relative to the full scope of approvals. CMS’s planned Better Approaches to Lifestyle and Nutrition for Comprehensive Health (BALANCE) Model would allow Medicare Part D plans to cover GLP-1 drugs for weight loss at negotiated prices, potentially lowering plan costs and beneficiary OOP costs, though overall federal spending could still rise due to voluntary plan-participation incentives and expanded utilization.
- 49 See also Chart 10-24 in our July 2025 data book for the average rebates negotiated by plans for drugs in protected classes compared with other drug classes (Medicare Payment Advisory Commission 2025a).
- 50 To be selected for the negotiation program, the product must have been on the market for at least 7 years if it is a small-molecule drug and 11 years if it is a biological product. The IRA included a provision to exempt certain single-source drugs that would otherwise qualify for negotiation. For example, the law specifically excludes plasma-derived products and drugs that are approved and designated for only one rare disease (“orphan drugs”). The original law exempted from price negotiation only orphan drugs that treat exactly one rare disease. A subsequent law change expanded that exemption to include any drug that treats one or more rare diseases (see Sec. 71203 of P.L. 119-21).
- 51 There will be 15 drugs selected from either program in 2028 and 20 in 2029 and subsequent years.
- 52 The applicable percentage ranges from 40 percent for drugs that have been on the market for more than 16 years to 75 percent for drugs that have been on the market for 9 years to 12 years.
- 53 Manufacturers are asked to submit information related to research and development costs, prior federal financial support, unit costs of production and distribution, revenue and sales data, and information on patents and market exclusivity granted by the Food and Drug Administration (Centers for Medicare & Medicaid Services 2024c).
- 54 The difference in discounts paid by manufacturers of selected drugs under the Coverage Gap Discount Program were higher for the 2026 cohort than for the 2027 cohort, which also contributed to the lower savings for the 2026 cohort.
- 55 Under Part D’s protected-class policy, plans must cover all or substantially all drugs in six protected classes, which include antineoplastics (cancer drugs). This coverage requirement has limited Part D plans’ ability to negotiate lower prices or rebates for drugs used for cancer treatment. Because the Medicare Drug Price Negotiation Program sets a ceiling price that requires mandatory discounts based on the number of years the drug has been on the market, prices negotiated under the program could provide substantial discounts relative to the prices negotiated by Part D plans.
- 56 Some of the reduction in gross spending for Novo Nordisk’s insulin products may have been due to the \$35 cap on insulin products that was in place for certain Part D plans under a demonstration, the Senior Savings Model, and subsequently mandated across all Part D plans as a result of the IRA.
- 57 For example, the administration’s agreements with two manufacturers of GLP-1s, two of which are selected drugs for 2027 (Ozempic and Wegovy), announced on November 6, 2025, set GLP-1 prices at \$245, an amount below the \$274 negotiated under the program (The White House 2025). Given that Ozempic and Wegovy account for a disproportionate share of projected savings, the impact of these agreements could be substantial.
- 58 The agency displays other Part D quality measures on the CMS website, including some metrics that are either being removed from or evaluated for addition to the star-rating system.
- 59 The definition of a unit can vary across drug products. CMS lists solid oral dosage forms as an example of a unit for formulation in its pricing-data submission guidance (Centers for Medicare & Medicaid Services 2021).
- 60 The extent of variation in unit costs across network pharmacies vary by contract and by NDC. We used simple averages (i.e., not weighted by volume or price) to assign a single-unit cost for each contract–NDC combination. Our analysis included 796 contracts, each with up to 3,774 distinct NDCs.
- 61 To the extent that unit costs and unit-cost changes vary across pharmacies within network pharmacies, individual beneficiary experiences may differ from these average unit-cost changes. In our analysis of unit costs of a few oral medications including both brand-name and generic drugs within the same contract, we found that unit costs for some

- drugs varied widely across pharmacies, while unit costs for other drugs were identical across all network pharmacies. This finding was true at the annual enrollment period, in January, and in August of the 2024 benefit year.
- 62 CAHPS surveys generate standardized and validated measures of patient experience. MA organizations and Part D plan sponsors are required to contract with a third-party survey vendor to collect CAHPS survey responses from a random sample of each contract's enrollees.
 - 63 Due to the nature of focus-group research, our sample size was limited, so findings are not generalizable to the broader Part D population.
 - 64 For example, in the initial months of the policy in 2024, there was an expectation that some pharmacies could experience cash-flow challenges as they simultaneously faced obligations to pay price concessions (pharmacy DIR) from 2023 while also receiving lower reimbursement for prescriptions filled in 2024, consistent with the new definition of negotiated prices under the policy (see text box, p. 416–417, on the regulatory change affecting prices paid at the POS in the March 2025 report to the Congress).
 - 65 The Commission has recommended, for example, establishing a higher copayment amount under the low-income subsidy for nonpreferred and nonformulary drugs and giving plans greater flexibility regarding coverage of drugs in the protected classes (Medicare Payment Advisory Commission 2020b, Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2016).
 - 66 Medicare's basic benefit cost is net of rebates, discounts, and fees paid by pharmaceutical manufacturers and pharmacies and does not include cost sharing paid by beneficiaries or any benefits covered under enhanced (supplemental) benefits.
 - 67 There are some differences between our recommendation and the IRA design. For instance, by adding a more generous cost-sharing protections, such as the \$2,000 annual limit on out-of-pocket costs, than those envisioned under our recommendation, the redesign substantially shifted liabilities for drug spending from cost sharing paid by beneficiaries at the point of sale to plans (which increases both enrollee premiums and the premium subsidies paid by Medicare) while limiting some of plans' ability to apply formulary tools to manage enrollees' spending.
 - 68 Part D plans can and often do offer alternative coverage structures to provide the basic Part D benefit. For example, a plan can offer a deductible that is lower than the deductible under the standard benefit or use tiered copayments rather than 25 percent coinsurance as long as the alternative benefit meets certain tests of actuarial equivalence.
 - 69 In addition, the IRA lowered the catastrophic threshold to \$2,000 from \$8,000 in 2024. Manufacturers of drugs selected for the Medicare Drug Negotiation Program ("selected drugs") are exempt from manufacturer discount programs, including the 20 percent discount for prescriptions filled in the catastrophic phase of the benefit. For these selected drugs, Medicare provides a higher reinsurance protection (40 percent of catastrophic spending).
 - 70 CMS requires plans to adjust their bids to remove any insurance effect of enhanced (supplemental) benefits on basic-benefit costs by applying an induced utilization factor to the expected basic-benefit costs. However, the effects of enhanced benefits on TrOOP that increase basic-benefit costs are not treated as insurance effect and are excluded from the induced utilization factor.
 - 71 The income limit for the LIS is 150 percent of the federal poverty level, and the asset limit in 2026 is \$16,590 if single and \$33,100 if married. Enrollees qualifying for Medicaid or Supplemental Security Income are also eligible for the LIS. In 2026, individuals receiving the LIS pay up to \$5.10 per prescription for generics and up to \$12.65 for brand-name prescriptions.
 - 72 Since Medicare does not subsidize benefits beyond basic Part D coverage, enrollees are responsible for paying the full cost of supplemental benefits charged by plans in supplemental premiums.
 - 73 In a given year, plan sponsors might discontinue some or all plans, and data from these plans would not be included in the BPT for that year. For example, plans that are not offered in 2026 will not appear in the 2026 BPT data even if the plan was offered in 2024. Likewise, plan sponsors may put together a bid for a new plan they intend to offer in the upcoming year; in this case, the plan's projections would be included in our analysis, but the plan would lack any historical data. However, CMS does require plans to crosswalk from prior plans to new ones since members of the prior plans would be expected to enroll in new plans. Thus, plans' projections of members in new plans will include some members previously enrolled in plans that terminated.
 - 74 We exclude Medicare Medical Savings Account plans, MA private fee-for-service plans, Program of All-Inclusive Care for the Elderly plans, plans established through reasonable-cost reimbursement contracts under Section 1876(h) of the Social Security Act ("cost plans"), and employer group waiver plans. Special-needs plans (SNPs) submit bids, but these bids are excluded from the calculation of the direct subsidy and the national average premium. However, SNPs still receive direct-subsidy and premium payments based on those amounts. Unless otherwise noted, we include information from SNPs in our analysis.

- 75 We use projected member months from the bids to compute weighted averages because using enrollment from the previous June requires dropping any plans that were not in existence then (or that could not be cross walked).
- 76 Beginning in 2030, the BBP is required to compose at least 20 percent of the total basic-benefit cost (meaning that the year-over-year increase in the BBP may exceed 6 percent).
- 77 If an enrollee selects a plan that includes supplemental coverage, the enrollee must pay the full price (i.e., any supplemental premiums charged by plans) for the additional coverage (i.e., Medicare does not subsidize it).
- 78 Risk corridors kick in if costs deviate from a plan's bid by more than 5 percent. If the deviation is between 5 percent and 10 percent, Medicare shares the losses/gains equally. If the deviation is greater than 10 percent, Medicare incurs 80 percent of losses and recoups 80 percent of gains.
- 79 In 2025, CMS began applying separate normalization factors for PDPs and MA-PDs to adjust for the diverging risk-score trends in these two markets and to “more accurately reflect Part D costs in each of these two sectors” (Centers for Medicare & Medicaid Services 2024a). The agency noted that Part D's risk-adjustment model has historically overpredicted costs for MA-PDs and underpredicted costs for PDPs. The separate normalization factors are intended to fix these prediction errors by increasing PDP risk scores and decreasing MA-PD risk scores while maintaining a 1.0 risk score across all enrollees.
- 80 For these selected drugs, Medicare provides higher reinsurance protection (40 percent of catastrophic spending). The IRA also introduced the Selected Drug Subsidy Program whereby CMS provides a subsidy to plans of 10 percent of the negotiated price under the catastrophic threshold for drugs selected for negotiation.
- 81 To estimate the amount of change by payer source between 2025 and 2026, we applied the 2026 payer-source shares to 2025 spending (net of rebates and supplemental cost sharing). We then compare these simulated amounts with 2025 amounts from 2025 payer-source shares. The difference is our estimate of the amount attributable to each payer source that was shifted into (or out of) the bid. The residual difference after accounting for all the payer sources is our estimate of the growth in overall spending that increased the bid. The same method is used to estimate the change by payer source between 2024 and 2025.
- 82 On average in 2024, spending net of rebates and supplement cost sharing was \$309 PMPM (Figure 13-A3, p. 524). However, based on 2022 experience, plans had projected \$270 PMPM. This difference suggests that plans, on average, underpredicted 2024 spending by approximately \$39 PMPM. Note that the bid data do not include information from plans that are not participating in the upcoming years (plans that terminated).
- 83 Manufacturers of drugs selected that are subject to the maximum fair price (MFP) under the Medicare Drug Price Negotiation Program are not subject to the new MDP. CMS will make separate payments to plans for the MDP below the annual OOP limit, while Medicare's reinsurance payments will be increased to pay for the portion of the MDP above the annual OOP limit. As a result, some of the increase in the expected reinsurance reflects the increase in reinsurance payments from the effectuation of MFPs in 2026.
- 84 Before 2025, TrOOP spending excluded beneficiary cost sharing paid by most sources of supplemental coverage, though it included the 70 percent discount that manufacturers of brand-name drugs were required to pay in the coverage gap.
- 85 Medicare's premium subsidy pays for most or all premiums for low-income beneficiaries.
- 86 CMS's Part D Premium Stabilization Demonstration lowered premiums by up to \$15 in 2025 and up to \$10 in 2026 for PDPs. It also capped total (basic plus supplemental) premium growth by \$35 in 2025 and \$50 in 2026. The \$12 reflects the effects of both components of the demonstration on the basic premiums for PDPs.
- 87 Our June 2025 report to the Congress discusses trends in the PDP and MA-PD markets leading to differences in premiums and risk-standardized costs (Medicare Payment Advisory Commission 2025c).
- 88 Enrollment weights are based on June enrollment for the year when bids are submitted; for example, June 2025 enrollment is used for plan year 2026 benchmark calculations, based on each plan's LIS enrollment relative to all LIS-eligible individuals in the region. While SNPs are not included in the calculation of the national average monthly bid amount (NAMBA), they are included for purposes of calculating regional benchmarks. Bids submitted by MA private-fee-for-service plans, the Program for All-Inclusive Care for the Elderly plans, and cost plans are excluded from this calculation; employer group waiver plans do not submit bids and therefore do not affect the calculation of the benchmark.
- 89 The LIS-weighted premiums are calculated before the application of the Part D Premium Stabilization Demonstration and any MA rebate buydowns.

- 90 The lower of the LIPSA or plans' premiums after the application of the Part D Premium Stabilization Demonstration or Part C rebate buydowns is the premium subsidy paid by Medicare on behalf of the LIS enrollee.
- 91 Auto-enrollment only applies to FFS beneficiaries because any LIS beneficiary enrolled in MA has actively chosen an MA plan.
- 92 This two-year ban applies when an insurer terminates all plan benefit packages in a PDP region and is intended to promote market stability. (See CFR Sec. 423.507(a)(3) and 423.508(e) for more detail.)
- 93 See Endnote 92.
- 94 Interviewees were referring to CMS's projection that the average total premium for PDPs would decrease from \$38.31 in 2025 to \$34.50 in 2026 (a decrease of \$3.81) (Centers for Medicare & Medicaid Services 2025e).

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CHAPTER 14

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

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

Chapter summary

Before 2020, fee-for-service (FFS) Medicare's home health prospective payment system (PPS) paid for services using a 60-day episode as the unit of payment and applied a case-mix system that included the number of therapy visits as a payment factor, with more visits resulting in higher payments. The Commission and others raised concerns over many years that increasing payments based on the number of therapy visits created financial incentives that distorted provider decision-making about the types of cases admitted to home health care and the types of services provided. The Commission first recommended removing the number of therapy visits as a factor in payment in March 2011.

The Bipartisan Budget Act (BBA) of 2018 required CMS to shift to a 30-day period for payment and eliminate therapy visits from the case-mix adjustment. 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

In this chapter

- Analytic framework for estimating the impact of the PDGM
- PDGM not associated with a substantial difference in probability of FFS home health care use
- Fewer visits per FFS stay associated with the PDGM
- PDGM not associated with a substantial difference in measures of FFS quality
- PDGM not associated with a substantial difference in FFS Medicare margins
- Discussion

for home health stays. Our analysis uses an interrupted time series (ITS) methodology that relies on pre-PDGM trends from 2016 to 2019 as a baseline to assess differences. We use the ITS model to produce two estimates: the “with PDGM” estimate, which reflects the observed postimplementation period, and the “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.

No substantial difference associated with the PDGM in FFS Medicare beneficiaries’ probability of home health use or in the number of periods per user—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. 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. These results suggest that the PDGM did not

impact the likelihood that a FFS Medicare beneficiary received home health or the duration of home health care.

Fewer home health visits per FFS stay associated with the PDGM, especially therapy visits—The PDGM was associated with fewer home health visits per stay in 2023. 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).

While the removal of therapy visits from the case-mix system may account for some of the decline in therapy associated with the PDGM, given the limitations of our methods it is also possible that other factors—such as broader changes in the delivery system or shifts in care delivery practices—played a role in the reduction of therapy visits. For example, our results indicate that the PDGM was associated with 0.7 fewer skilled nursing visits per stay even though the PDGM did not change how the case-mix system paid for these services (under the PDGM and the predecessor case-mix system the number of nursing visits provided during home health care did not increase payments for most stays). It is not clear why skilled nursing visits would decline as a result of the PDGM, and our findings could reflect non-PDGM factors influencing care, such as staffing challenges or other effects from the disruption of the pandemic. Similarly, since many of the non-PDGM factors potentially impacting skilled nursing may affect other aspects of home health care, our reported results for the difference in therapy visits associated with the PDGM may, at least in part, similarly reflect non-PDGM factors.

It is also important to recognize that, prior to the implementation of the PDGM, the case-mix system used in 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. Although the provision of therapy is no longer a factor in determining payment for home health services, Medicare's coverage rules for therapy services remained unchanged under the PDGM, and CMS has emphasized that therapy should still be provided based on patient needs. The decline in therapy visits may reflect better alignment of home health care services with beneficiary needs.

No substantial difference associated with the PDGM in outcomes for most measures we examined—Our analysis found that beneficiary quality-of-care outcomes associated with the PDGM were not substantially different for most

measures in 2023. For all FFS beneficiaries who received home health care, we found that the rate of potentially preventable hospitalization during the home health stay 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.

PDGM not associated with substantial difference in FFS Medicare margins—

The PDGM was not associated with a substantial difference in overall FFS Medicare margins, with the results indicating a 0.6 percentage point lower FFS Medicare margin for home health stays associated with the PDGM in 2023 that was not statistically significant. The average FFS Medicare margin among all home health stays in 2023 was 24.1 percent, and almost all categories that we examined had margins over 20 percent, indicating that payments continued to exceed costs after the PDGM implementation. 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 re-aligned 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. ■

Medicare home health care services consist of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to beneficiaries in their homes. For home health care to be covered by Medicare, it must be required because the individual is homebound and needs skilled nursing care on an intermittent basis or physical or speech therapy or an ongoing need for occupational therapy.¹ In contrast to coverage for skilled nursing facility services, Medicare does not require a preceding hospital stay to qualify for home health care, nor are deductibles or copayments applied. In 2024, Medicare spent \$16.0 billion on home health care services for about 2.7 million fee-for-service (FFS) Medicare beneficiaries using the benefit.

Before 2020, FFS Medicare's home health prospective payment system (PPS) paid for home health care services with a 60-day episode as the unit of payment and a case-mix system that included the number of therapy visits provided as a payment factor (with additional therapy visits yielding higher payments). The Balanced Budget Act (BBA) of 2018 required CMS to make two changes: to implement a 30-day period as the unit of payment and to eliminate the number of therapy visits provided during home health care as a payment factor in the case-mix system. On January 1, 2020, CMS implemented the Patient-Driven Groupings Model (PDGM), which implemented the required statutory changes and implemented a revised case-mix system with new measures of clinical and functional severity.

The BBA of 2018 requires that the Commission assess the application of the 30-day unit of payment for home health care (see text box on the congressional mandate, p. 554) and submit its findings in two reports. The Commission submitted an interim report in March 2022; this chapter satisfies a BBA of 2018 requirement for a final report by March 15, 2026.

This chapter begins by reviewing the policy history that led to the changes enacted in the BBA of 2018, summarizes how CMS implemented those changes in 2020, and reviews the findings from our interim report. We then outline the technical approach we applied to assess the trends in home health care associated with the BBA of 2018 reforms for our final report. Finally, we present findings assessing the effects on utilization,

quality of care provided, and financial performance associated with the PDGM.

Background

In the years before the BBA of 2018, the Congress, the Commission, and CMS expressed concerns about the incentives embedded in the home health PPS. The case-mix system used before 2020 had a series of nine payment thresholds that increased payment as the number of therapy visits in an episode increased; in effect, providing more therapy visits increased payments.² The Commission raised concerns about the incentives of these thresholds in our 2010 report to the Congress and recommended eliminating the thresholds in 2011 (Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2010). An investigation by the U.S. Senate Committee on Finance found that many home health agencies were providing therapy services based on financial incentives, and the committee called for Medicare to move away from using therapy visits as a payment factor (U.S. Senate Committee on Finance 2011).

A 2011 CMS-sponsored study of the home health PPS found that the average FFS Medicare margin (a measure of profitability) varied across the case-mix system's payment groups and that the margin for a 60-day episode was sometimes related to particular beneficiary characteristics (L & M Policy Research 2011). The report also found higher margins for 60-day episodes with more therapy.

Because of these concerns, CMS began a research effort that identified new clinical, functional, and service-use categories for a home health case-mix system that did not rely on the provision of therapy (Plotzke et al. 2016). These new categories were intended to better measure the case mix of home health care beneficiaries, minimize the potential for patient selection, and better align provision of services with patient needs. The research also found that dividing a 60-day episode into two 30-day periods would more accurately align payments with costs since the first 30 days of home health care had higher costs compared with the second 30 days. In June 2017, CMS proposed a new design for the home health PPS that included a 30-day unit of payment, revised case-mix

Mandate for the Commission to assess the impact of changes to the home health prospective payment system

Section 51001 of the Bipartisan Budget Act of 2018 (BBA of 2018):

the REPORTS.—

(1) INTERIM REPORT.—Not later than March 15, 2022, the Medicare Payment Advisory Commission shall submit to Congress an interim report on the application of a 30-day unit of service as the unit of service applied under section 1895(b)(2) of the Social Security Act (42 U.S.C. 1395fff(b)(2)), as amended by subsection (a), including an analysis of

- the level of payments provided to home health agencies as compared to the cost of delivering home health services, and
- any unintended consequences, including with respect to behavioral changes and quality.

(2) FINAL REPORT.—Not later than March 15, 2026, such Commission shall submit to Congress a final report on such application and any such consequences. ■

factors, and the elimination of therapy from the case-mix system for implementation in 2019. However, CMS withdrew this proposal in November 2017 (Centers for Medicare & Medicaid Services 2017).

In February 2018, the Congress enacted the BBA of 2018 with a mandate to implement the 30-day unit of payment and remove the number of therapy visits as a factor in the case-mix system, policies similar to CMS's proposed revision from 2017. On January 1, 2020, CMS implemented the statutorily mandated changes along with the new case-mix factors for clinical and other patient attributes, similar to its 2017 proposal.

The PDGM categorizes periods into 432 payment groups based on the following characteristics (Figure 14-1):

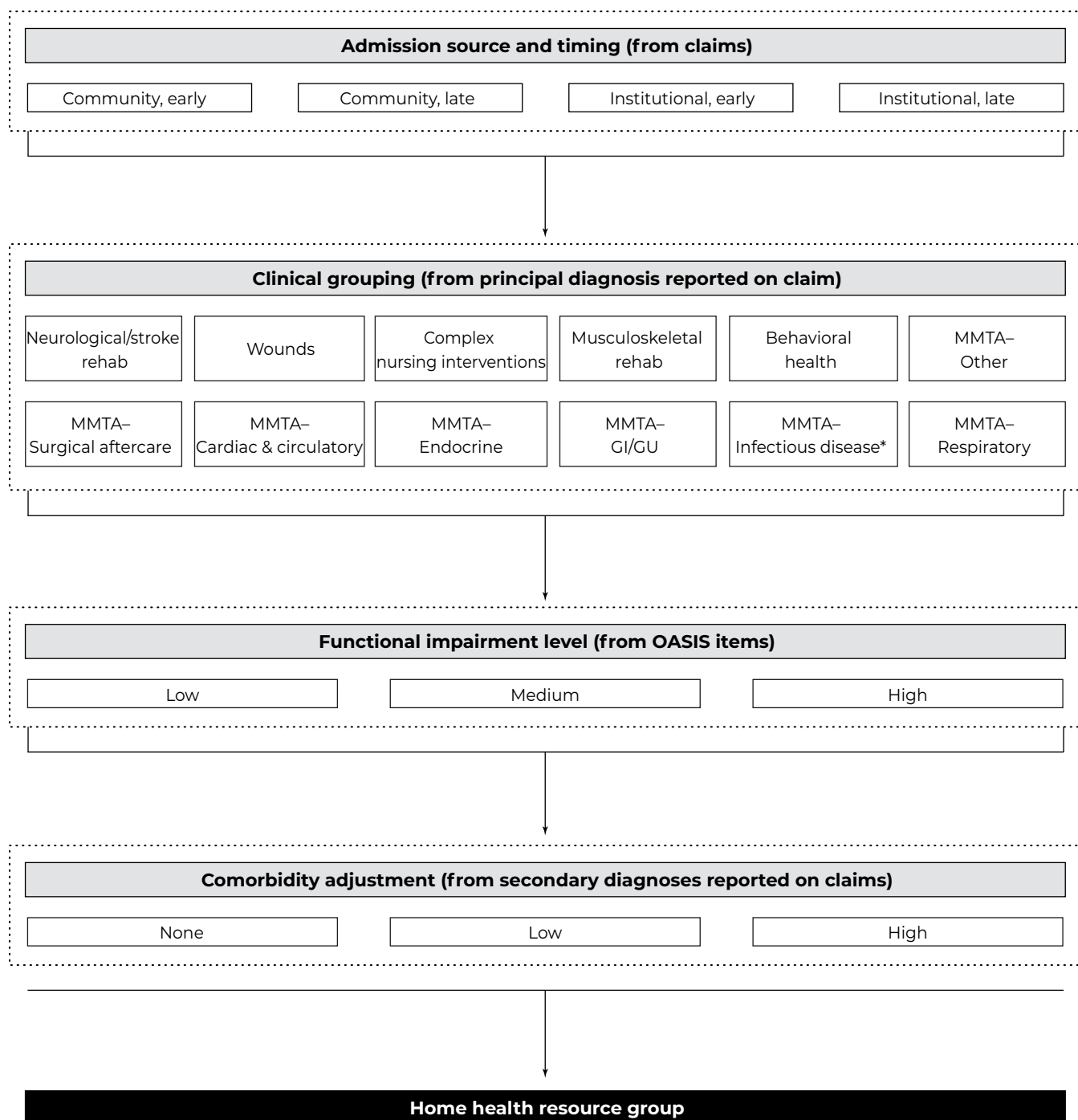
- *Timing of the 30-day period*—Newly initiated home health services (those with no prior home health services) are classified as “early,” while 30-day periods that follow an initial 30-day period are classified as “late.” For example, if a beneficiary has four consecutive 30-day home health periods, the first 30-day period is classified as early, while the three subsequent 30-day periods are classified as late 30-day periods. Thirty-day periods initiated

more than 60 days after the end of a previous 30-day period are classified as “early.”

- *Beneficiary referral source*—Early 30-day periods that are preceded by a discharge from an inpatient hospital, long-term care hospital (LTCH), inpatient rehabilitation facility (IRF), inpatient psychiatric facility (IPF) or skilled nursing facility (SNF) are classified as institutional 30-day periods. Early 30-day periods that are not preceded by these services are classified as community-admitted 30-day periods. Late 30-day periods are classified as institutional when immediately preceded by an acute care hospital stay (stays at a SNF, IRF or LTCH do not result in an institutional classification for late 30-day periods, in contrast to early periods). Late 30-day periods without a prior acute care hospital stay are classified as community admitted.
- *Clinical grouping*—The PDGM has 12 clinical categories. The categories are defined by a primary diagnosis for selected medical conditions: need for musculoskeletal rehabilitation, neurological/stroke rehabilitation, wound care, behavioral health care, complex care, or one of seven medication management, teaching, and assessment (MMTA) categories: cardiac and circulatory conditions, endocrine conditions, infectious diseases,

**FIGURE
14-1**

Home health payment groups under the PDGM



Note: PDGM (Patient-Driven Groupings Model), MMTA (medication management, teaching, and assessment), GI/GU (gastrointestinal tract/genitourinary system), OASIS (Outcome and Assessment Information Set).

* Includes neoplasms and blood-forming diseases

Source: Centers for Medicare & Medicaid Services 2025.

respiratory conditions, gastrointestinal and genitourinary conditions, surgical aftercare, and other conditions.

- *Functional impairment level*—The PDGM classifies patients' cognitive and physical functioning using information from the Outcome and Assessment Information Set (OASIS) home health patient assessment.
- *Comorbidity adjustment*—The PDGM adjusts payments for comorbidities reported on home health care claims, with a two-tiered adjustment system for selected conditions that indicate greater severity.

MedPAC's March 2022 interim report found no negative impacts from the PDGM

The Commission's interim report on the impact of the changes to the home health PPS found that the disruption caused by the coronavirus pandemic limited our ability to assess the impact of the PDGM, though we determined that the PDGM itself did not substantially disrupt access to care for beneficiaries. Despite the onset of the coronavirus pandemic, the number of HHAs declined only slightly in 2020, and most beneficiaries continued to have access to multiple providers in their area. We noted that the BBA of 2018 did not require reductions to FFS Medicare's aggregate payments for home health care and, indeed, in 2020, the financial performance of HHAs remained strong, with the FFS Medicare margin increasing from 15.8 percent in 2019 to 20.2 percent in 2020. The total number of 30-day periods declined in the months immediately after the onset of the pandemic in March 2020. Though volume rebounded in July, overall home health utilization in 2020 was lower than in the prior year.

Most indicators of patient severity under the PDGM were unchanged. The distribution of 30-day periods in the beneficiary referral source groups and clinical groups in 2020 was similar to the distribution for these categories in 2019. The share of 30-day periods in higher-paying functional impairment groups and comorbidity groups did increase in 2020, but these measures may be more sensitive to HHA coding practices.

The Commission also assessed the CMS-hierarchical condition category (CMS-HCC) scores for beneficiaries who received home health care in 2019 and 2020. These scores are calculated by CMS for each beneficiary independent of clinical data provided by HHAs. The average CMS-HCC scores were about the same in 2019 and 2020, indicating that the average severity of illness of beneficiaries using home health care did not change significantly in the first year of the PDGM. This finding suggests that HHAs did not avoid higher-acuity beneficiaries in the first year of the PDGM.

After the Commission's interim report, Prusynski et al. reached similar findings that the PDGM did not negatively affect home health care access (Prusynski et al. 2025). The study assesses changes to skilled nursing facility and home health care using an interrupted time series model.³ The model estimated changes in the monthly share of IPPS discharges to SNF and HHA in 2018 to 2021, and included controls for beneficiary clinical conditions, length and severity of the IPPS hospital stay, and county level COVID-19 rates during the study period (the study did not examine home health services for beneficiaries admitted from the community). Their findings indicated that the PDGM was associated with a 1.04 percentage point increase in home health use relative to the pre-pandemic trend. The study did not examine other aspects of home health utilization, quality, or financial performance, and did not examine changes for home health care services that were not preceded by a hospitalization.

Analytic framework for estimating the impact of the PDGM

For the Commission's final report on the impact of the PDGM, we have expanded on the analyses presented in our March 2022 interim report in several important ways. More data are available for analysis of the post-PDGM period, so we can examine years less likely to be directly affected by the coronavirus pandemic. For the final report, we also use trends from the pre-PDGM period (2016 to 2019) as a baseline for estimating the impact of the change. In addition, we measure a broader range of metrics, including quality of care outcomes, than we assessed in the March 2022

**TABLE
14-1****Outcomes examined to assess the impact of the PDGM**

Domain	Metric (FFS beneficiaries)
Utilization	Probability of receiving any home health care services in a year
	Probability of a postinstitutional home health stay in a year
	Probability of a community-admitted home health stay in a year
	Length of home health stay
	Average 30-day periods per user in a year
	Total visits per home health stay
	Skilled nursing visits per home health stay
	Therapy visits per home health stay
Quality	Aide visits per home health stay
	Potentially preventable hospitalization or observation stay during home health stay
	Discharge to community
	Change in mobility at discharge relative to admission based on six patient-assessment items (grooming, upper-body dressing, lower-body dressing, bathing, toilet hygiene, and eating)
	Change in self-care at home health discharge relative to admission based on three OASIS items (toilet transferring, bed transferring, and ambulation/locomotion)
Financial performance	FFS Medicare margin for home health stay

Note: PDGM (Patient-Driven Groupings Model), FFS (fee-for-service), OASIS (Outcome and Assessment Information Set).

Source: MedPAC.

interim report. We also examine outcomes for home health care services regardless of whether they were preceded by a hospitalization.

Data sources for this analysis

Our population includes FFS beneficiaries who were enrolled in Medicare Parts A and B for all twelve months of a given year (from 2016 through 2023) and for the six months prior to that year.⁴ They did not need to meet this criterion for all eight years in our study—only for the specific year being analyzed. We use Medicare enrollment data, FFS claims, and OASIS data to construct utilization and quality measures discussed below. We use Medicare HHA cost reports to calculate FFS Medicare margins for each stay.

Domains examined to assess the impact of the PDGM

Our analysis examines the effects of the PDGM on outcomes in three domains: the use of home health care by FFS beneficiaries, the quality of the home

health care received by FFS beneficiaries, and the profitability of FFS home health stays for HHAs (see Table 14-1, for the measures included in each domain).⁵

Other factors that could affect home health care during the study period

In assessing the effect of the PDGM on the outcomes listed in Table 14-1, we must recognize that the PDGM was implemented nationwide concurrent with a substantial shock to health care use and amid important longer-term shifts in the FFS Medicare landscape. These changes included:

- Reduced demand for home health care and other health care services during the coronavirus public health emergency. HHAs saw declines in the use of services due in part to beneficiaries' reluctance to allow HHA staff into their homes during the early months of the pandemic; although, the substantial reduction in SNF use during this time partially offset this decline as some beneficiaries who would

**TABLE
14-2**

Control variables that may have influenced FFS Medicare home health care use during 2016 to 2023 that were incorporated into the analysis

Type	Variable
Beneficiary demographic and health factors	Age
	Sex
	Race/ethnicity
	CMS-HCC indicators
	Low-income subsidy/Medicare and Medicaid dual-eligibility status
	Prior use of inpatient services (count)
	Prior use of outpatient hospital services (count)
	Prior use of SNF, IRF, or LTCH care (count)
County-level supply and economic factors	Prior physician office visit (count)
	Number of hospitals
	Number of SNFs
	Share of Medicare beneficiaries enrolled in Medicare Advantage
	Unemployment rate
	Per capita personal income
	Area Deprivation Index
State level	Elective service utilization per 1,000 enrolled beneficiaries
	Administrative actions in effect to prevent fraud and abuse

Note: FFS (fee-for-service), CMS-HCC (CMS hierarchical condition category), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). Indicator variables for 79 CMS-HCCs were used in the model. Administrative actions to prevent fraud and abuse include two policies that were in effect for portions of 2016 to 2023: moratoriums on the enrollment of new home health agencies in certain areas and the pre-claims review demonstration that has been implemented in selected states. Stay-based outcomes include clinical groups and functional groups based on the PDGM to account for beneficiary acuity.

Source: MedPAC.

have been admitted to SNFs shifted toward home health care (Inloes et al. 2023, Office of Inspector General 2022).

- A continuing decline in the aggregate and per capita number of FFS Medicare hospital inpatient discharges. Hospital stays are common precursors to home health care (although not required to receive covered services), so a decline in hospital use would be expected to reduce demand for home health care.
- A growing share of Medicare beneficiaries enrolling in Medicare Advantage (MA). This shift may affect both the mix of beneficiaries in FFS Medicare and how HHAs provide care as they navigate MA plans' management of care.

- Workforce supply constraints (particularly nurses) reported by home health care agencies and other medical providers (National Alliance for Care at Home 2025, Office of Inspector General 2022). These constraints may have reduced the amount of 30-day periods or visits per stay for FFS Medicare beneficiaries.

As shown in Table 14-2, our analysis incorporates a wide range of beneficiary-level variables that are likely to affect home health care use, including demographics and health factors. Variables also include county-level supply and economic indicators, such as provider supply and the use of elective services, which may help account for some of the impact of the coronavirus pandemic (particularly in areas where elective procedures declined more sharply). Additionally,

**TABLE
14-3****Characteristics of FFS Medicare beneficiaries who used home health care in 2023**

Category	All FFS Medicare beneficiaries	FFS Medicare beneficiaries with at least one home health stay
Total (in millions)	24.1	2.1
Geography		
Urban	78.4%	82.8%
Nonfrontier rural	20.2	16.6
Frontier rural	1.4	0.6
Race		
White	84.5	85.1
Black	6.7	7.6
Other	8.8	7.3
Age		
80 or over	22.2	44.9
Under 80	77.8	55.1
LIS/dual-eligibility status		
LIS/dually eligible	15.5	20.7
Not LIS/dually eligible	84.5	79.3
Clinical condition group		
Knee	0.3	0.8
Dementia	4.7	14.4
Chronic obstructive pulmonary disease	4.6	7.5
Congestive heart failure	5.9	12.9
Diabetes	22.5	34.1
Stroke	1.2	2.3
Schizophrenia/major depressive	8.4	12.0
Neurodegenerative (Parkinson's/ALS/MS/muscular dystrophy)	1.6	4.1
None of the conditions above	59.7	35.9

Note: FFS (fee-for-service), LIS (low-income subsidy), ALS (amyotrophic lateral sclerosis), MS (multiple sclerosis). Components may not sum to totals due to rounding.

Source: Acumen analysis of 2023 data of CMS risk-score files and home health standard analytic file.

we control for annual changes in county-level MA enrollment to reflect shifts in the composition of the FFS population.

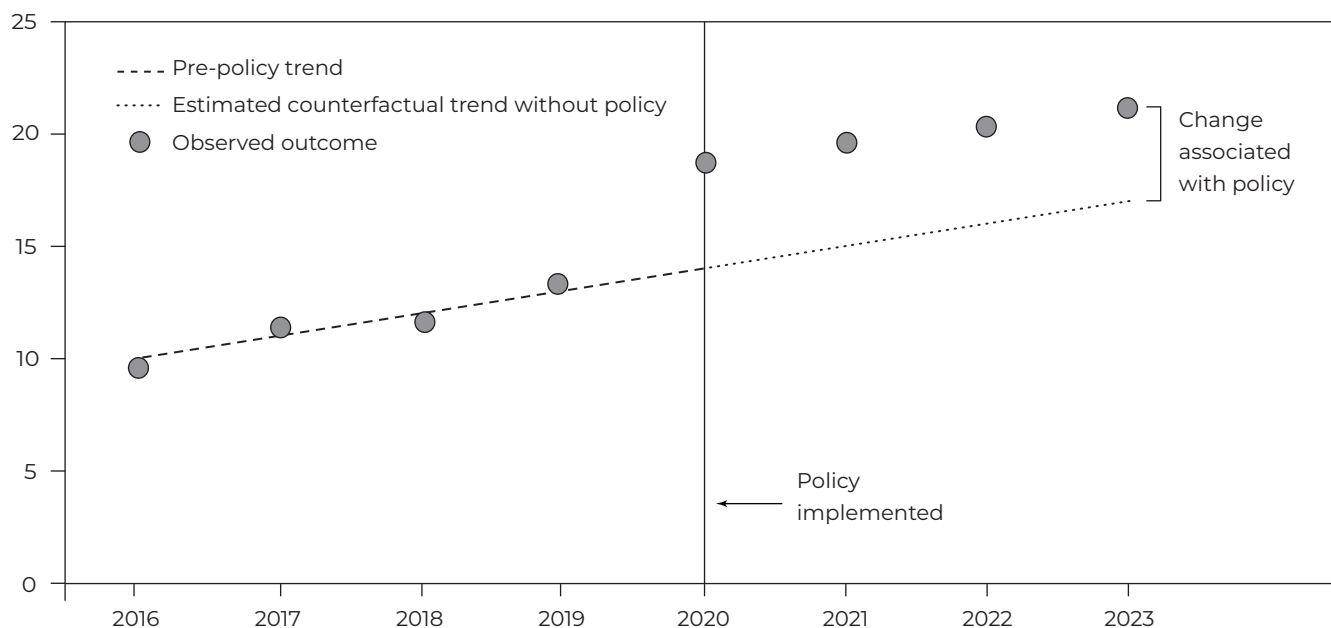
Assessing the impact for selected FFS populations

We identified subpopulations of beneficiaries to assess the effects of the PDGM across selected demographic,

socioeconomic, and clinical characteristics. We selected patient groups based on characteristics that are common in home health care and cover different aspects of use (Table 14-3). For example, the geographic categories will capture differences in the PDGM effects for beneficiaries who reside in urban and rural counties, with the latter subdivided into frontier and nonfrontier areas (frontier counties

FIGURE
14-2

Illustrative example of an interrupted time series measuring the impact of a policy



Source: MedPAC.

have a population density of fewer than six people per square mile). Outcomes may also differ for beneficiaries depending on whether they were admitted to home health care from the hospital or from the community. Analyzing differences across these populations helps us understand how the PDGM impacted different beneficiary groups.

Methodology for assessing the association of the PDGM with measures of FFS Medicare home health care use, quality, and financial performance

We use an interrupted time series (ITS) approach to construct our estimates of the impact of the PDGM. An ITS is an appropriate methodology for evaluating the effect of the PDGM because it allows researchers to construct a counterfactual when no control group is available. In an ITS, the data from the period before a policy's implementation are used to estimate preexisting trends in the outcomes of interest. The approach generally assumes that those trends would have continued had the policy change not occurred (Figure 14-2). The estimated counterfactual trend can

also be adjusted by including control variables in the model. The impact of the policy is then estimated as the difference between the actual outcomes in the period after the policy's implementation and the estimated counterfactual trend line. However, as discussed later in this section, caution is warranted in attributing the model-identified impacts to the implementation of the PDGM.

An ITS assumes that trends for the outcome from the pre-PDGM period (2016 to 2019) would have continued in 2020 and later years in the absence of the PDGM, after adjusting for available control variables. In other words, it assumes that any difference between the estimated counterfactual and the measured outcome identified in the post-PDGM period are due to the new payment system and not to other factors that we are unable to fully control for. Given the start of the coronavirus pandemic in 2020, we focus our assessment of the impact of the PDGM on the estimate for 2023 because it is less likely to be affected by the pandemic.

The base model specification is as follows. Each outcome y for beneficiary i in county j in year t is estimated using the following linear regression model with county fixed effects:

$$(y_{ijt}) = \beta_0 + \beta_1 T + \beta_2 X_{ijt} + \beta_3 P_{T=t} + \beta_4 P_{T=t} \times H_{ijt} + C_i$$

where

y : outcome of interest listed in Table 14-1 (p. 557)

T : year

X : beneficiary and county characteristics listed in Table 14-2 (p. 558)

H : Indicators for subgroups listed in Table 14-3 (p. 559) which are interacted with PDGM coefficients to allow for differing policy effects

P : a set of annual indicators that equal 1 for each year after the PDGM starts (2020 to 2023)

C : county fixed effect

We estimated a county fixed-effects linear regression to assess the association between the Patient-Driven Groupings Model (PDGM) and beneficiary outcomes (standard errors are clustered at the county level). For each beneficiary-year observation, the model relates outcomes listed in Table 14-1 to a set of post-PDGM year indicators (2020–2023), controlling for beneficiary and county characteristics. County fixed effects account for time-invariant differences across counties, while year indicators capture secular trends common across areas. To examine whether PDGM effects differ across populations, the post-PDGM indicators are interacted with subgroup indicators defined in Table 14-3, allowing the estimated policy effects to vary by beneficiary subgroup.⁶ For each category, we estimated the mean outcome with and without PDGM in 2020 to 2023, and the magnitude and statistical significance of the difference in the means is our measure of the change attributable to the PDGM.

Sensitivity analyses

We estimated several alternative specifications to assess the sensitivity of our estimates. We first estimated a base model that included only the year trend T and annual indicators for the post-PDGM years P , and then we estimated four additional specifications that sequentially added the control variables and county

fixed effects. We also estimated a version of the full model omitting data from 2020 and 2021, the years in which the pandemic would be expected to have affected the outcomes the most. We conducted these sensitivity analyses for four outcomes: the probability of any home health care use, the probability of any postinstitutional home health care use, the probability of any community-admitted home health care use, and the average number of visits per stay. Lastly, we also tested whether using a linear versus binary logit specification changed results for the probability of any home health care use. In each case, the estimates of the PDGM's impact on those outcomes in 2022 and 2023 under the alternative specifications were broadly consistent with our main specification.

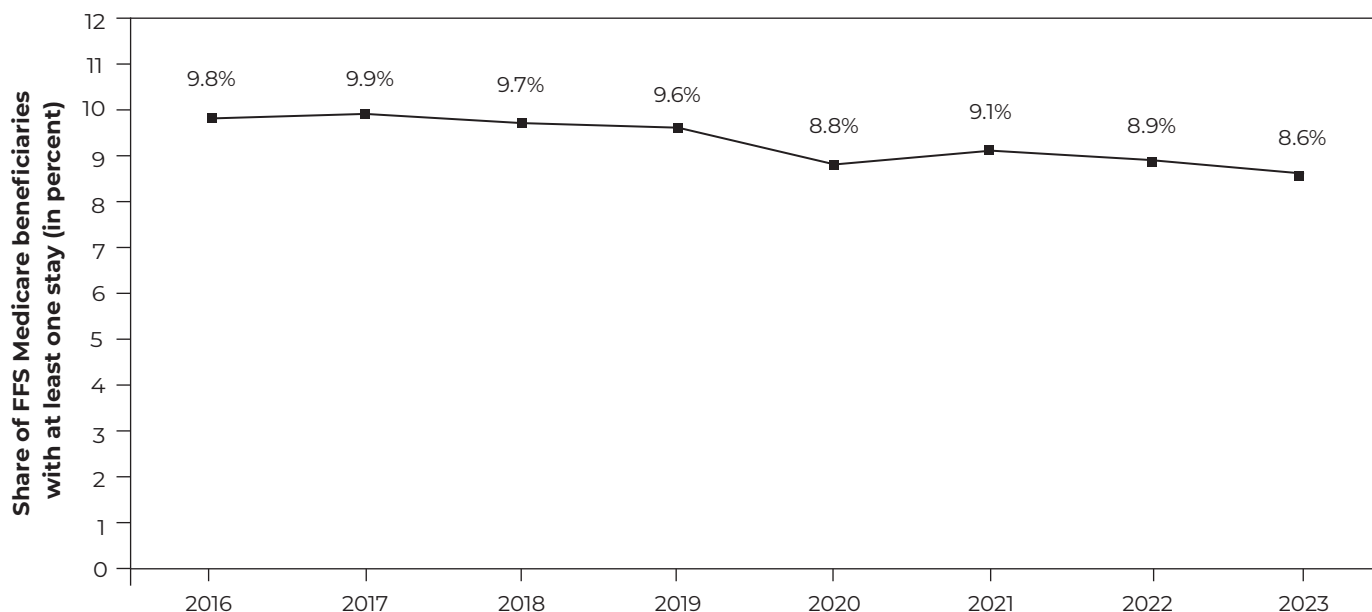
Appropriate caution in interpreting the estimates from the ITS models

We urge caution in interpreting the effects estimated in this analysis as solely the causal effects of the PDGM on the use of home health care, quality of care, and financial performance. Our ITS regressions use preexisting trends in home health outcomes and controls for certain time-varying factors to estimate the impact of the PDGM. The key assumption is that the preexisting trend, after adjusting for available control variables, would have continued had the PDGM not been implemented in 2020. However, since the coronavirus pandemic coincided with the implementation of the PDGM and because widespread changes to the health care landscape occurred following the start of the pandemic, our methods cannot fully account for all relevant changes that occurred since the start of the PDGM. As discussed above, we apply some techniques (such as controlling for local-market employment factors and the rate of elective procedures) to control for other factors that were changing in the post-PDGM period. However, those control variables are unlikely to fully capture non-PDGM changes to the health care system after the pandemic.

As a result, the effects attributed to the PDGM by our models could be due, at least in part, to other factors, resulting in conflated results. If our control variables do not fully account for the ongoing effects of the pandemic on utilization, our estimates may incorrectly attribute to the PDGM a decrease or increase in the probability or the amount of home health care services that beneficiaries receive. To minimize the impact of the disruptions associated with the coronavirus

**FIGURE
14-3**

Share of FFS Medicare beneficiaries with at least one home health stay has declined since 2016



Note: FFS (fee-for-service). Data include Medicare beneficiaries enrolled in FFS Medicare for the 12 months of a calendar year and the 6 months preceding it. Home health stays are constructed by linking consecutive home health claims with less than or equal to 60 days between the end of an initial claim and the beginning of the next claim.

Source: Acumen analysis of home health claims, 2016–2023.

pandemic, we report results from the model for 2023 as our measure of the changes in home health care use associated with the PDGM. By 2023, the PDGM had been in place for four years, and observed utilization patterns likely reflect how HHAs have adapted to the incentives of the new payment system. However, even in 2023, some impacts of the pandemic may persist; stakeholders have raised concerns about tight labor markets after the pandemic, and a lack of staff could also impact home health care use and outcomes (LeadingAge 2025). As a result, the results we report for post-2020 years may, in part, reflect other factors.

Given these limitations, in this analysis we describe the differences identified by our models as the change in outcomes associated with the PDGM, rather than the change caused by it. This distinction is critical since the impact of the PDGM on the outcomes these models estimate may reflect other factors. Small estimated effects are particularly difficult to attribute

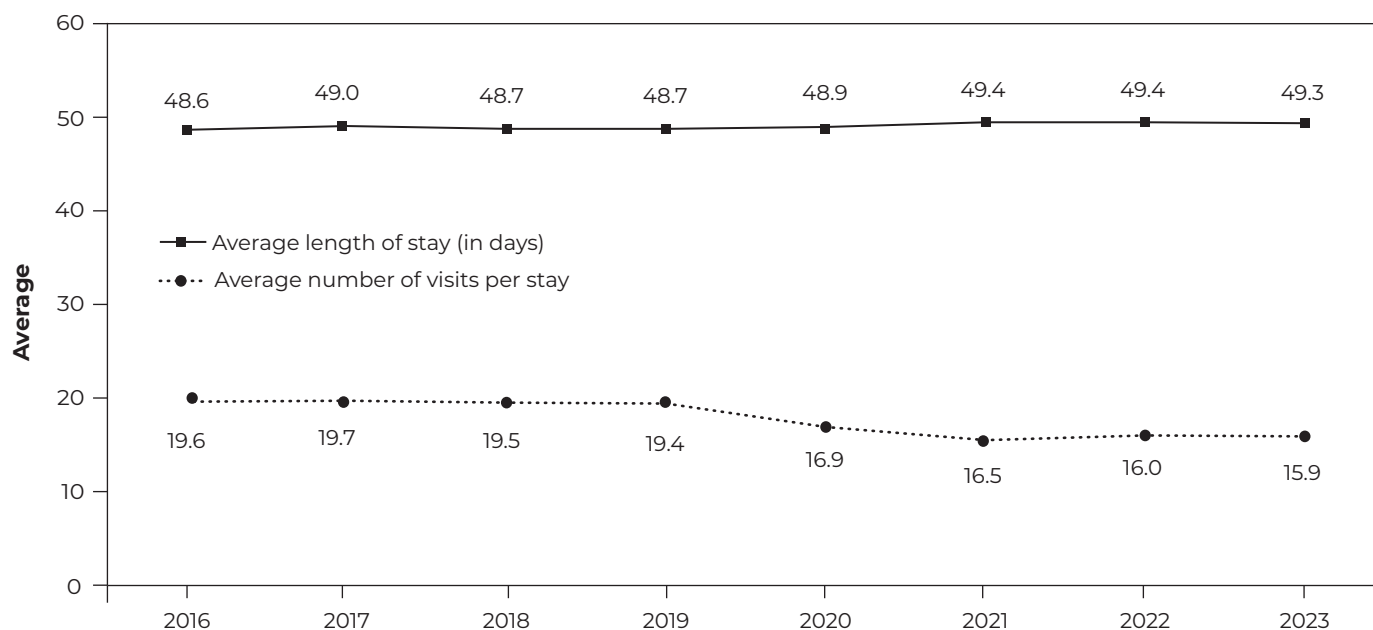
to the causal effect of the PDGM, even when they are statistically significant. Small estimated effects may primarily reflect other changes over time that are difficult to control for in our models.

PDGM not associated with a substantial difference in probability of FFS home health care use

Before applying the ITS methodology to assess the impact of the PDGM, we first examined unadjusted trends in home health care utilization before and after the policy's implementation. The figures below examine the annual trends for three of our measures: the share of FFS Medicare beneficiaries with at least one stay (Figure 14-3), the average visits per stay (Figure 14-4), and the average length of a home health stay (Figure 14-4).

**FIGURE
14-4**

Average length of FFS home health stays did not change substantially, while the average number of visits per FFS stay decreased, 2016–2023



Note: FFS (fee-for-service). Data include Medicare beneficiaries enrolled in FFS Medicare for the 12 months of a calendar year and the 6 months preceding it. Home health stays are constructed by linking consecutive home health claims with less than 60 days between the end of an initial claim and the beginning of the next claim.

Source: Acumen analysis of home health claims, 2016–2023.

Between 2016 and 2023, the proportion of FFS Medicare beneficiaries with at least one home health stay declined from 9.8 percent to 8.6 percent (Figure 14-3). In the same period, the average number of visits per stay fell from 19.6 to 15.9—a decrease of nearly 20 percent (Figure 14-4). The sharpest annual drop occurred in 2020, when the share of beneficiaries with a home health stay fell from 9.6 percent in 2019 to 8.8 percent, and the average number of visits declined from 19.4 to 16.9. By contrast, the average length of stay remained relatively stable at about 49 days (Figure 14-4).

Assessing differences in FFS home health care use associated with the PDGM

To identify differences in use associated with the PDGM, we apply the ITS methodology described above. We use the ITS models to produce two sets of estimates. The with-PDGM estimate reflects what actually occurred during each year of the

postimplementation period.⁷ The without-PDGM estimate is a counterfactual of what would have happened in the absence of the changes. The tables in this report focus on the difference between the with-PDGM values and without-PDGM values in 2023, the most recently available year of data. (Unless otherwise noted, effects discussed in text are statistically significant at $p < .05$.)

FFS Medicare beneficiaries' probability of home health care use was not substantially affected

Overall, the results in Table 14-4 (p. 564) indicate that the PDGM was not associated with a substantial difference in the probability of home health use in 2023 for most categories. Among all FFS Medicare beneficiaries, the probability of having at least one home health stay in 2023 was 8.6 percent under the with PDGM estimate compared with the 8.8 percent counterfactual without the PDGM, a difference of -0.2 percentage points, or -2.0 percent (Table 14-4).

**TABLE
14-4****No substantial difference associated with the PDGM
in probability of home health use in 2023**

Category	Probability of any home health use		Percentage point difference	Percent difference (difference as a share of without PDGM)
	With PDGM	Without PDGM		
Any home health care during year (all referral sources)	8.6%	8.8%	-0.2	-2.0%
By source of referral				
Postinstitutional stay starting in 2023	4.7	4.5	0.3	6.0
Community admitted stay starting in 2023	3.0	3.9	-0.8	-21.8
Any home health stay during year by beneficiary characteristics:				
Geography				
Urban	9.0	9.2	-0.2	-2.4
Nonfrontier rural	7.1	7.1	<0.1	-0.1
Frontier rural	3.9	3.6	0.3	7.0
Race				
White	8.7	8.8	-0.1	-1.4
Black	9.7	10.8	-1.2	-10.8
Other	7.2	7.1	0.1	0.8
Age				
80 or over	17.4	15.2	2.2	14.4
Under 80	6.1	6.9	-0.8	-12.3
LIS/dual-eligibility status				
LIS/dually eligible	11.5	11.7	-0.2	-1.9
Not LIS/dually eligible	8.1	8.2	-0.2	-2.0
Clinical condition group				
Knee	24.2	24.7	-0.4	-1.8
Dementia	26.2	27.1	-0.9	-3.2
Chronic obstructive pulmonary disease	14.1	14.9	-0.8	-5.2
Congestive heart failure	18.7	19.9	-1.1	-5.7
Diabetes	13.0	13.9	-0.9	-6.4
Stroke	17.4	18.6	-1.2	-6.4
Schizophrenia/major depressive	12.3	12.5	-0.2	-1.9
Neurodegenerative (Parkinson's/ALS/MS/muscular dystrophy)	22.7	23.7	-1.0	-4.3
None of the conditions above	5.2	5.0	0.2	3.2

Note: PDGM (Patient-Driven Groupings Model), FFS (fee-for-service), LIS (low-income subsidy), ALS (amyotrophic lateral sclerosis), MS (multiple sclerosis). Shaded cells are statistically significant at $p < .05$.

Source: Acumen analysis of 2023 data of CMS hierarchical condition category files, Medicare Provider Analysis and Review, census data, CMS market-saturation and utilization file, and the standard analytic files for outpatient hospitals, physician services, home health, skilled nursing facilities, and inpatient rehabilitation facilities.

There were small differences in results for FFS Medicare beneficiaries by the geographic classification for their county (urban, nonfrontier rural, and frontier

rural). Among beneficiaries in frontier rural counties, the probability of at least one home health stay in 2023 was 3.9 percent with the PDGM, compared

with 3.6 percent without the PDGM, a difference of 0.3 percentage points, or 7.0 percent (Table 14-4). For FFS Medicare beneficiaries in urban counties, the probability with the PDGM was 0.2 percentage points lower, on par with the difference for all home health users. The PDGM was not associated with any difference in the probability of use for FFS Medicare beneficiaries in nonfrontier rural counties, as the difference between the with-PDGM values and without-PDGM values was less than 0.1 percentage point and not statistically significant.

The PDGM was associated with greater differences in the probability of home health use for certain groups of beneficiaries. Among Black FFS Medicare beneficiaries, the PDGM was associated with a 10.8 percent lower probability of home health use (Table 14-4). Black FFS Medicare beneficiaries experienced a higher probability of a postinstitutional 30-day period under the PDGM, but this was offset by a lower probability of community-admitted 30-day periods (data not shown). Differences for the other racial groups were relatively small and not statistically significant. For FFS Medicare beneficiaries ages 80 and over, there was a 14.4 percent higher probability of home health use associated with the PDGM, while for those under the age of 80 the PDGM was associated with a 12.3 percent lower probability of use. The PDGM policy was associated with a 0.2 percentage point lower probability of service use for beneficiaries who were not dually eligible or enrolled in the low-income subsidy (LIS).

The PDGM was associated with different patterns of likelihood of use for postinstitutional and community-admitted stays in 2023: The PDGM was associated with a 0.3 percentage point higher likelihood of a postinstitutional stay and a 0.8 percentage point lower likelihood of a community-admitted stay.⁸ The effects associated with the PDGM are small, and as noted earlier, our model may not be fully accounting for all the factors influencing home health utilization during this period, but the increase in the likelihood of postinstitutional stays may reflect other factors, such as stronger demand for home health care services after hospitalization compared with demand from community referral sources. HHAs can be an important alternative to other more costly sites of post-acute care, and this may encourage the post-hospital use of home health. Our finding of higher postinstitutional

use is consistent with that of Prusynski et al., who found slightly higher shares of IPPS discharges to HHAs after the implementation of the PDGM (Prusynski et al. 2025).

No substantial difference associated with the PDGM in the number of 30-day periods per FFS home health user in 2023

Medicare's FFS payment systems can create incentives for higher volume, and shifting the payment unit from 60 days to 30 days raised concerns that HHAs might add extra 30-day periods. If this occurred, we would expect an increase in the number of 30-day periods per home health user. However, the PDGM was not linked to a substantial increase: In 2023, users averaged 2.7 30-day periods under the PDGM compared with 2.6 without the PDGM (Table 14-5, p. 566). This small, statistically significant difference does not suggest a material difference in volume. Across beneficiary categories, effects associated with the PDGM were small—generally 0.1 periods per year or less—with the largest difference being 0.3 periods for LIS/dually eligible beneficiaries.

The PDGM was not associated with a substantial change in FFS length of stays across beneficiary groups

The PDGM was associated with limited differences in average length of stay across nearly all beneficiary groups. In 2023, the average length of stay under the PDGM was 2.1 days longer than it would have been without the PDGM, a 4.4 percent difference (Table 14-6, p. 567). Across stay categories, the differences in the lengths of stay for the with the PDGM and the without the PDGM estimates were not substantial, ranging from 1.0 to 4.2 days. Slightly larger percentage differences were observed among FFS Medicare beneficiaries who were LIS or dually eligible, ages 80 and over, and in the “other” racial category, for whom the PDGM was associated with somewhat longer lengths of stay. Average lengths of stay for both postinstitutional and community-admitted stays were longer by 2.1 days, corresponding to differences of 4.9 percent and 3.8 percent, respectively.

Fewer visits per FFS stay associated with the PDGM

Overall, we found that the PDGM was associated with fewer home health visits per stay in 2023, stemming in large part from a lower number of therapy visits. The

**TABLE
14-5**

**No substantial change associated with the PDGM in
30-day periods per FFS home health user in 2023**

Category	30-day periods per FFS user		Difference	Percent difference (difference as a share of without PDGM)
	With PDGM	Without PDGM		
Any home health stay during year	2.7	2.6	0.1	4.7%
Any home health stay during year by beneficiary characteristics:				
Geography				
Urban	2.7	2.6	0.1	5.1
Nonfrontier rural	2.9	2.9	0.1	3.3
Frontier rural	2.9	2.8	0.1	2.6
Race				
White	2.7	2.5	0.1	4.8
Black	3.2	3.2	0.0	0.2
Other	3.2	2.9	0.3	9.1
Age				
80 or over	2.9	2.7	0.2	6.9
Under 80	2.6	2.5	0.1	2.8
LIS/dual-eligibility status				
LIS/dually eligible	3.7	3.4	0.3	7.3
Not LIS/dually eligible	2.5	2.4	0.1	3.8
Clinical condition group				
Knee	2.6	2.5	0.1	4.4
Dementia	3.4	3.3	0.1	3.9
Chronic obstructive pulmonary disease	2.9	2.8	0.1	1.9
Congestive heart failure	3.1	3.0	>0.1	1.5
Diabetes	3.1	3.0	0.1	2.9
Stroke	3.0	2.9	0.1	2.7
Schizophrenia/major depressive	3.0	2.8	0.1	4.7
Neurodegenerative (Parkinson's/ALS/MS/muscular dystrophy)	3.4	3.4	0.1	2.4
None of the conditions above	2.3	2.1	0.2	7.9

Note: PDGM (Patient-Driven Groupings Model), FFS (fee-for-service), LIS (low-income subsidy), ALS (amyotrophic lateral sclerosis), MS (multiple sclerosis). Shaded cells are statistically significant at $p < .05$.

Source: Acumen analysis of 2023 data of CMS hierarchical condition category files, Medicare Provider Analysis and Review, census data, CMS market-saturation and utilization file, and the standard analytic files for outpatient hospitals, physician services, home health, skilled nursing facilities, and inpatient rehabilitation facilities.

difference in visits was roughly proportionate across most of the categories we examined, indicating that the drop in visits was, on a percentage basis, similar for most groups. To the extent that the case-mix system prior to the PDGM increased payment when

additional therapy visits were provided, the difference in visits under the PDGM could, at least in part, be a correction that reflects plans of care under the PDGM better reflecting clinical needs. However, it is notable that even though the payment methodology for skilled

**TABLE
14-6****No substantial change associated with the PDGM in average length of stay per FFS home health user in 2023**

Category	Average length of stay (in days)		Difference	Percent difference (difference as a share of without PDGM)
	With PDGM	Without PDGM		
All FFS stays	49.3	47.2	2.1	4.4%
Stay by source of home health referral:				
Postinstitutional	44.5	42.5	2.1	4.9
Community admitted	56.5	54.5	2.1	3.8
Any home health stay during year by beneficiary characteristics:				
Geography				
Urban	48.7	46.6	2.1	4.6
Nonfrontier rural	52.2	50.4	1.8	3.5
Frontier rural	51.2	49.3	1.8	3.7
Race				
White	48.4	46.5	2.0	4.3
Black	53.7	52.7	1.0	1.9
Other	53.9	49.7	4.2	8.4
Age				
80 or over	52.6	49.3	3.3	6.8
Under 80	46.5	45.4	1.0	2.3
LIS/dual-eligibility status				
LIS/dually eligible	59.1	55.5	3.7	6.6
Not LIS/dually eligible	46.6	45.0	1.6	3.7
Clinical condition group				
Knee	46.8	45.3	1.6	3.5
Dementia	55.5	52.4	3.1	6.0
Chronic obstructive pulmonary disease	51.0	49.1	1.9	3.8
Congestive heart failure	52.0	50.2	1.9	3.7
Diabetes	53.0	50.5	2.5	4.9
Stroke	52.3	50.2	2.0	4.1
Schizophrenia/major depressive	51.7	49.4	2.3	4.6
Neurodegenerative (Parkinson's/ALS/MS/muscular dystrophy)	55.8	53.5	2.3	4.4
None of the conditions above	44.6	42.9	1.7	4.0

Note: PDGM (Patient-Driven Groupings Model), FFS (fee-for-service), LIS (low-income subsidy), ALS (amyotrophic lateral sclerosis), MS (multiple sclerosis). A postinstitutional stay occurs when a FFS Medicare beneficiary had a hospitalization or skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital stay within the 14 days before the start of the current stay; a community-admitted stay is not preceded by these services in the 14 days before the start of the current stay. Home health stays are constructed by linking consecutive home health claims with less than or equal to 60 days between the end of an initial claim and the beginning of the next claim. Shaded cells are statistically significant at $p < .05$. Absolute and relative change values have been rounded to the nearest tenth.

Source: Acumen analysis of 2023 data of CMS hierarchical condition category files, Medicare Provider Analysis and Review, census data, CMS market-saturation and utilization file, and the standard analytic files for outpatient hospitals, physician services, home health, skilled nursing facilities, and inpatient rehabilitation facilities.

**TABLE
14-7****PDGM was associated with fewer total visits per FFS stay across all categories of beneficiaries, 2023**

Category	Total visits per stay			Percent difference (difference as a share of without PDGM)
	With PDGM	Without PDGM	Difference	
All FFS stays	15.9	18.8	-2.9	-15.3%
Stay by source of home health referral:				
Postinstitutional	15.6	18.3	-2.7	-14.7
Community admitted	16.4	19.6	-3.1	-16.1
Any home health stay during year by beneficiary characteristics:				
Geography				
Urban	15.8	18.7	-2.8	-15.2
Nonfrontier rural	16.4	19.4	-3.0	-15.6
Frontier rural	16.8	19.2	-2.4	-12.6
Race				
White	15.8	18.8	-2.9	-15.6
Black	16.2	19.5	-3.2	-16.7
Other	16.4	18.4	-2.0	-10.8
Age				
80 or over	17.1	20.0	-2.9	-14.6
Under 80	15.0	17.8	-2.8	-15.9
LIS/dual-eligibility status				
LIS/dually eligible	17.5	19.8	-2.3	-11.6
Not LIS/dually eligible	15.5	18.5	-3.0	-16.4
Clinical condition group				
Knee	16.5	20.4	-3.9	-19.1
Dementia	18.1	21.5	-3.5	-16.0
Chronic obstructive pulmonary disease	15.9	18.8	-2.9	-15.4
Congestive heart failure	16.8	19.9	-3.1	-15.6
Diabetes	17.1	20.0	-2.9	-14.3
Stroke	17.8	21.8	-4.0	-18.2
Schizophrenia/major depressive	16.5	19.6	-3.2	-16.1
Neurodegenerative (Parkinson's/ALS/MS/muscular dystrophy)	18.8	22.9	-4.1	-18.1
None of the conditions above	14.4	17.0	-2.6	-15.4

Note: PDGM (Patient-Driven Groupings Model), FFS (fee-for-service), LIS (low-income subsidy), ALS (amyotrophic lateral sclerosis), MS (multiple sclerosis). A postinstitutional stay occurs when a FFS Medicare beneficiary had a hospitalization or skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital stay within the 14 days before the start of the current stay; a community-admitted stay is not preceded by these services in the 14 days before the start of the current stay. Home health stays are constructed by linking consecutive home health claims with less than or equal to 60 days between the end of an initial claim and the beginning of the next claim. Shaded cells are statistically significant at $p < .05$. Values have been rounded to the nearest tenth.

Source: Acumen analysis of 2023 data of CMS hierarchical condition category files, Medicare Provider Analysis and Review, census data, CMS market-saturation and utilization file, and the standard analytic files for outpatient hospitals, physician services, home health, skilled nursing facilities, and inpatient rehabilitation facilities.

**TABLE
14-8**

Change associated with the PDGM was largest for FFS therapy visits, 2023

Visit discipline	Visits per FFS stay		Difference	Percent difference (difference as a share of without PDGM)
	With PDGM	Without PDGM		
Nursing	6.4	7.1	-0.7	-9.8%
Therapy	8.8	11.2	-2.4	-21.3
Home health aide	0.6	0.3	0.2	75.6

Note: PDGM (Patient-Driven Groupings Model), FFS (fee-for-service). Home health stays are constructed by linking consecutive home health claims with less than or equal to 60 days between the end of an initial claim and the beginning of the next claim. Shaded cells are statistically significant at $p < .05$. Values have been rounded to the nearest tenth of a percent.

Source: Acumen analysis of 2023 data of CMS hierarchical condition category files, Medicare Provider Analysis and Review, census data, CMS market-saturation and utilization file, and the standard analytic files for outpatient hospitals, physician services, home health, skilled nursing facilities, and inpatient rehabilitation facilities.

nursing services did not change, there were also fewer visits for these services associated with the PDGM – which raises questions as to whether other factors account for some of the difference in therapy visits that the model attributed to the PDGM.

Table 14-7 shows the with-PDGM and without-PDGM estimates of the average number of visits per stay for FFS Medicare beneficiaries in 2023. Overall, the number of visits per stay averaged 15.9 with the PDGM compared with 18.8 without the PDGM, a difference of 2.9 visits or 15.3 percent. The relative difference in total visits per stay associated with the PDGM was generally of the same magnitude across beneficiary groups and sources of referral, with percentage differences for most categories in the -10.8 percent to -19.1 percent range, all statistically significant.

The difference in visits associated with the PDGM in 2023 appeared to be smaller for beneficiaries with lower incomes than for other beneficiaries. The PDGM was associated with 11.6 percent fewer visits among beneficiaries who were dually eligible or who had the LIS, compared with 16.4 percent fewer visits for other beneficiaries. The impact associated with the PDGM was about the same for stays regardless of referral source: The PDGM was associated with 14.7 percent fewer visits per stay for postinstitutional stays and 16.1 percent fewer visits per stay for community-admitted stays.

PDGM associated with 2.4 fewer therapy visits per FFS stay

Table 14-8 compares the average number of visits per stay by visit discipline (nursing, therapy, or home health aide) for the with-PDGM group and the without-PDGM group. The PDGM was associated with 0.7 fewer nursing visit per stay, a difference of -9.8 percent, and 2.4 (or 21.3 percent) fewer therapy visits per stay. At the same time, the PDGM was associated with 0.2 more home health aide visits per stay, but this finding is hard to interpret because of the low frequency of home health aide visits.⁹ Because the PDGM implementation coincided with the pandemic and other systemic changes, our results may not fully account for all non-PDGM factors influencing utilization. Even in 2023, lingering effects such as staffing shortages could contribute to the differences in visits per stay for nursing and therapy. As a result, the changes associated with the PDGM in Table 14-8, as with other results in this evaluation, should be interpreted cautiously.

The fewer therapy visits observed under the PDGM is directionally consistent with the removal of therapy volume as a payment factor, and may, in part, reflect changes in agency behavior in response to the new payment system. However, given the limitations of the analysis, it is also possible that broader changes in the health care system or shifts in care delivery

practices influenced these results. As mentioned earlier, if our control variables do not fully account for reduced utilization during the pandemic and subsequent changes to health care delivery, the models could incorrectly measure the change associated with the PDGM.

Although the PDGM removed therapy volume as a payment factor and was expected to reduce incentives to provide therapy based on financial considerations, the fewer visits associated with the PDGM was not limited to therapy services. We also found 0.7 fewer visits per stay in skilled nursing visits per stay associated with the PDGM, even though the PDGM did not change how nursing services are paid; under both the prior case-mix system and the PDGM, payments for nursing were based on patient clinical and functional characteristics rather than visit counts. The absence of a clear incentive in the PDGM for reduced nursing visits suggests that broader, non-PDGM factors—such as labor market pressures or post-pandemic operational changes—may have influenced visit intensity for skilled nursing, and it is reasonable to expect that therapy also could have been affected. Accordingly, while the PDGM may have contributed to the decline in therapy visits, the concurrent decline in nursing visits suggests that not all of the observed reduction in therapy can be attributed solely to the payment model's incentive changes.

The lower amount of therapy visits per stay associated with the PDGM may also reflect HHAs better aligning therapy regimens with beneficiaries' clinical needs. As noted earlier, there were concerns that the previous case-mix system incentivized higher therapy volumes, potentially distorting the services delivered and beneficiaries served. Removing therapy from the case-mix system was viewed as correcting a distortion in the home health PPS (Centers for Medicare and Medicaid Services 2019). Medicare's coverage rules and other criteria for therapy were not changed with the implementation of the PDGM (Centers for Medicare & Medicaid Services 2021). The PDGM was designed to more accurately align payment with patient characteristics, thereby encouraging providers to deliver care based on patient needs, not financial incentives. CMS has cautioned against inappropriate reductions in therapy services.

The change in therapy visits per stay associated with the PDGM in 2023 was relatively uniform across the categories, varying from 17.2 percent to 24.0 percent

(Table 14-9). In relative terms, the difference appeared to be smaller for beneficiaries in frontier rural areas and for those age 80 and over. The PDGM was associated with 17.2 percent fewer therapy visits among beneficiaries living in frontier rural areas, compared with about 21 percent fewer therapy visits for beneficiaries living in other areas; and the PDGM was associated with 19.5 percent fewer therapy visits among beneficiaries who were age 80 and over compared with 23.0 percent fewer therapy visits for younger beneficiaries. By contrast, the association between the PDGM on therapy visits appeared to be greater for community-admitted stays than for postinstitutional stays (24.0 percent fewer therapy visits vs. 19.5 percent fewer therapy visits). The effect associated with the PDGM on therapy visits also appeared to be marginally greater for LIS/dually eligible beneficiaries than for other beneficiaries (23.9 percent fewer therapy visits vs. 20.7 percent fewer therapy visits).

PDGM not associated with a substantial difference in measures of FFS quality

Measuring differences in home health care quality associated with the PDGM is important because it provides an assessment of how the quality of care delivered to FFS beneficiaries may have been affected by the PDGM. Further, the lower visits per stay associated with the PDGM, particularly for therapy visits, may raise concerns about stinting on care. However, for most of our quality measures the differences associated with the PDGM were small in 2023 (Table 14-10).

Our analysis of two claims-based quality measures under the PDGM shows mixed results. For FFS beneficiaries receiving home health care, the rate of potentially preventable hospitalizations during the home health stay was about 2.1 percentage points lower with the PDGM, indicating better outcomes. By contrast, the PDGM was associated with a slightly lower share of stays ending in discharge to the community, suggesting slightly more transitions to hospitals or other post-acute care settings after home health. As mentioned earlier, these findings should be interpreted cautiously due to methodological limitations that restrict the ability to establish a causal association between the PDGM and the observed

**TABLE
14-9****Change in FFS therapy visits associated with the PDGM
was relatively uniform across stay categories, 2023**

Category	Therapy visits per stay		Difference	Percent difference (difference as a share of without PDGM)
	With PDGM	Without PDGM		
All FFS stays	8.8	11.2	-2.4	-21.3%
Stay by source of home health referral:				
Postinstitutional	8.9	11.1	-2.2	-19.5
Community admitted	8.7	11.4	-2.7	-24.0
Any home health stay during year by beneficiary characteristics:				
Geography				
Urban	8.8	11.2	-2.4	-21.3
Nonfrontier rural	9.0	11.4	-2.4	-21.1
Frontier rural	8.8	10.7	-1.8	-17.2
Race				
White	9.0	11.4	-2.4	-21.2
Black	8.6	11.0	-2.3	-21.3
Other	7.6	9.9	-2.3	-23.0
Age				
80 or over	9.8	12.2	-2.4	-19.5
Under 80	8.0	10.4	-2.4	-23.0
LIS/dual-eligibility status				
LIS/dually eligible	7.6	10.0	-2.4	-23.9
Not LIS/dually eligible	9.2	11.5	-2.4	-20.7
Clinical condition group				
Knee	11.4	14.7	-3.4	-22.9
Dementia	10.6	13.5	-2.9	-21.6
Chronic obstructive pulmonary disease	8.5	10.9	-2.4	-21.9
Congestive heart failure	9.0	11.4	-2.4	-20.7
Diabetes	8.8	11.2	-2.4	-21.4
Stroke	11.4	14.7	-3.3	-22.3
Schizophrenia/major depressive	9.6	12.3	-2.6	-21.6
Neurodegenerative (Parkinson's/ALS/MS/muscular dystrophy)	12.4	15.5	-3.1	-19.9
None of the conditions above	8.2	10.4	-2.2	-21.4

Note: PDGM (Patient-Driven Groupings Model), FFS (fee-for-service), LIS (low-income subsidy), ALS (amyotrophic lateral sclerosis), MS (multiple sclerosis). A prior-hospital stay occurs when a FFS Medicare beneficiary had a skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital stay within the 14 days before the start of the current stay; a community-admitted stay is not preceded by these services in the 14 days before the start of the current stay. Home health stays are constructed by linking consecutive home health claims with less than or equal to 60 days between the end of an initial claim and the beginning of the next claim. Shaded cells are statistically significant at $p < .05$. Values have been rounded to the nearest tenth.

Source: Acumen analysis of 2023 data of CMS hierarchical condition category files, Medicare Provider Analysis and Review, census data, CMS market-saturation and utilization file, and the standard analytic files for outpatient hospitals, physician services, home health, skilled nursing facilities, and inpatient rehabilitation facilities.

**TABLE
14-10**

Changes in FFS quality outcomes associated with the PDGM were small for most measures, 2023

Measure	With PDGM	Without PDGM	Difference	Percent difference (difference as a share of without PDGM)
Rate of potentially preventable hospitalization during home health stay (percent)	8.2%	10.3%	-2.1	-20.0%
Rate of stays discharged to the community after home health care (percent)	82.8	85.2	-2.5	-2.9
Change in composite mobility at discharge	0.89	0.86	0.03	3.7
Change in composite self-care at discharge	2.50	2.46	0.04	1.6

Note: FFS (fee-for-service), PDGM (Patient-Driven Groupings Model). Functional quality measures measure care through episodes that begin with an Outcome and Assessment Information Set (OASIS) start-of-care assessment and end with an OASIS end-of-care assessment. Rate of discharge to the community measures care in the period after a home health claim indicating discharge. Changes in the composite measures of function show how much function improved by discharge, with higher values meaning greater improvement. Shaded cells are statistically significant at $p < .05$. Values have been rounded to the nearest tenth of a percent.

Source: Acumen analysis of 2023 data of CMS hierarchical condition category files, Medicare Provider Analysis and Review, census data, CMS market-saturation and utilization file, and the standard analytic files for outpatient hospitals, physician services, home health, skilled nursing facilities, and inpatient rehabilitation facilities.

2023 outcomes. Overall, the estimates suggest that the PDGM was associated with fewer preventable hospitalizations but slightly worsened post-stay outcomes for home health users.

FFS beneficiaries had slightly higher rates of improvement in functional status under the PDGM, though data considerations limit analysis

We assessed differences in patient functional status using two measures developed by CMS: change in mobility and change in self-care (Centers for Medicare & Medicaid Services 2022). An important consideration for functional measures is that they are based on patient-assessment data, which may be influenced by agency coding practices. For example, the Commission has found discrepancies in functional status reporting between discharge and admission across post-acute care settings, often favoring higher payments (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2019). A study by the Department of Health and Human Services Office of Inspector General documented

underreporting of falls with major injuries in the patient assessments completed by HHAs (Office of Inspector General 2023). Since the change in self-care and change in mobility measures use patient-assessment data that may have inaccuracies, the results in Table 14-10 should be interpreted cautiously.

The PDGM was associated with slightly higher improvement in patient functional status at discharge compared with the without-PDGM estimate for both self-care and mobility (Table 14-10). Though these differences were statistically significant, the magnitudes of the effect associated with the PDGM represent small amounts of function gain.

The result for improvement in self-care at discharge provides an example of the small difference associated with the PDGM. For this measure, beneficiaries are assessed on a scale that measures self-care ability from a range of -6 (lowest function) to +6 (highest function) at admission and discharge from home health care. For a patient admitted with a self-care score of 0, the estimated average improvement translates to self-care

score at discharge of 2.46 without the PDGM versus 2.50 with the PDGM—a difference that is small relative to the 13-point functional scale (Table 14-10).

PDGM not associated with a substantial difference in FFS Medicare margins

Assessing profitability of home health stays, measured by aggregate FFS margin at the level of the home health stay, is essential for understanding how financial incentives may influence home health care utilization and outcomes. A shift in the margin can signal whether providers are being paid more or less generously relative to their costs.¹⁰ The PDGM was not associated with a substantial change in financial performance, with a 0.6 percentage point decrease in the FFS Medicare margin in 2023 that was not statistically significant (Table 14-11, p. 574). Overall FFS Medicare profitability was 24.1 percent, with almost all categories having margins over 20 percent, indicating that payments continued to exceed costs after the PDGM implementation.

Comparing the changes by source of admission, the community-admitted stays were 2.1 percent lower under the PDGM, while postinstitutional stays were slightly higher (though not statistically significant). The difference between the margins for community-admitted stays and postinstitutional was smaller for the with the PDGM estimate, indicating that the PDGM was associated with narrowing the difference in profitability between these two categories. Even with the profitability changes associated with the PDGM, margins for community-admitted stays were over 24 percent.

The findings likely reflect the myriad of factors that can affect costs and payments that determine financial margins. For example, in the post-PDGM era HHAs could have expanded their use of lower-cost staff, such as by using licensed practical nurses or therapy assistants in the place of registered nurses or physical, occupational and speech therapists, respectively. In addition, FFS Medicare's payment policies are updated annually, reflecting the market basket and other policies that can affect the average payment per stay. However, given the many disruptions influencing the sector during this period, it is notable that FFS

Medicare margins remained relatively high with no substantial change associated with the PDGM.

Discussion

Assessing the impact of the PDGM on access and quality of care is important for Medicare, but interpretation of these findings requires caution because our methods cannot fully account for all factors that may affect these measures. In addition to the factors mentioned previously, the high payment levels under the PDGM are important context for interpreting our results. The BBA of 2018 was not designed to reduce FFS Medicare's payments for home health care services, which have substantially exceeded costs since the PPS was implemented in 2001. The high payment levels before and after the implementation may have been a stabilizing factor during the pandemic and the implementation of the PDGM (Figure 14-5, p. 575). The BBA of 2018 required that the base rate for the PDGM be set at a level that was budget neutral relative to 2019, a year when the Commission reported high FFS Medicare margins (over 15 percent) for freestanding agencies. FFS Medicare margins for HHAs were high before and after the implementation of the PDGM, equaling 19.8 percent in 2023. Though there is variation across providers in average FFS Medicare margins, the Commission has generally found that they are substantially above cost, and FFS Medicare margins in 2024 were 21.2 percent for freestanding HHAs (see Chapter 8). This analysis also found that the FFS Medicare margins for home health payments under the PDGM were well in excess of cost (Table 14-11, p. 574).

Within these limitations, our findings suggest that the PDGM did not substantially affect overall access to home health care, the duration of care, or the profitability of home health stays for fee-for-service beneficiaries. Measures of home health use and length of stay were largely stable, quality of care outcomes were generally similar or better, and FFS Medicare margins remained high and well above costs. These results indicate that the transition to a 30-day unit of payment and revised case-mix system did not result in adverse effects on beneficiaries. Importantly, despite fewer visits per stay, the quality-of-care outcomes were generally stable or potentially improved with the PDGM, suggesting that agencies were able

**TABLE
14-11****No substantial change associated with the PDGM in average FFS Medicare margin per home health stay, 2023**

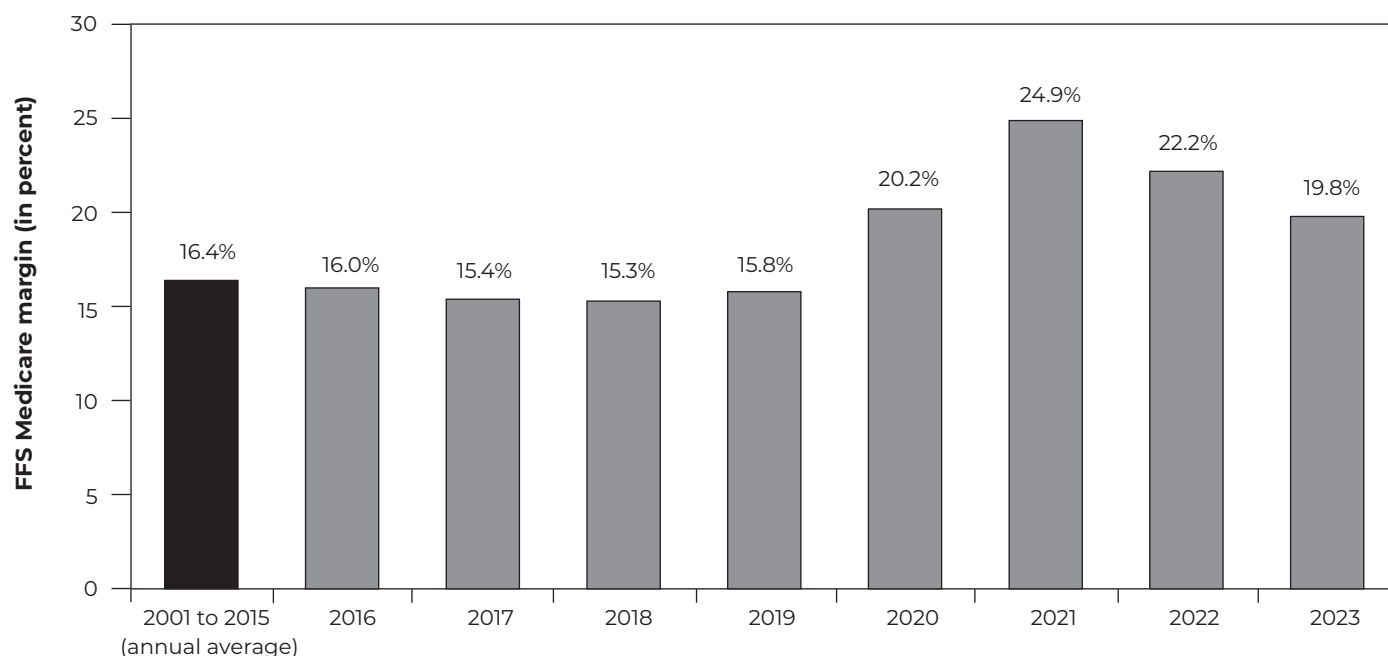
Category	With PDGM	Without PDGM	Percent difference
All FFS stays	24.1%	24.7%	-0.6%
Stay by source of home health referral:			
Postinstitutional	23.9	23.6	0.3
Community admitted	24.5	26.6	-2.1
Any home health stay during year by beneficiary characteristics:			
Geography			
Urban	24.7	25.4	-0.7
Nonfrontier rural	20.4	20.6	-0.2
Frontier rural	14.3	18.3	-4.0
Race			
White	23.9	24.8	-0.9
Black	25.8	23.7	2.1
Other	24.6	24.6	-0.1
Age			
80 or over	22.1	23.6	-1.5
Under 80	25.8	25.6	0.2
LIS/dual-eligibility status			
LIS/dually eligible	24.9	22.8	2.1
Not LIS/dually eligible	23.9	25.1	-1.2
Clinical condition group			
Knee	20.1	25.8	-5.7
Dementia	22.2	22.8	-0.7
Chronic obstructive pulmonary disease	22.9	23.4	-0.6
Congestive heart failure	22.0	21.3	0.6
Diabetes	23.7	22.6	1.1
Stroke	20.9	24.4	-3.6
Schizophrenia/major depressive	23.7	24.9	-1.2
Neurodegenerative (Parkinson's/ALS/MS/muscular dystrophy)	23.2	24.6	-1.3
None of the conditions above	25.4	26.8	-1.4

Note: PDGM (Patient-Driven Groupings Model), FFS (fee-for-service), LIS (low-income subsidy), ALS (amyotrophic lateral sclerosis), MS (multiple sclerosis). A postinstitutional stay occurs when a Medicare beneficiary had a skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital stay within the 14 days before the start of the current stay; a community-admitted stay is not preceded by these services in the 14 days before the start of the current stay. Home health stays are constructed by linking consecutive home health claims with less than or equal to 60 days between the end of an initial claim and the beginning of the next claim. Shaded cells are statistically significant at $p < .05$. Values have been rounded to the nearest tenth.

Source: Acumen analysis of 2023 data of CMS hierarchical condition category files, Medicare Provider Analysis and Review, census data, CMS market-saturation and utilization file, and the standard analytic files for outpatient hospitals, physician services, home health, skilled nursing facilities, and inpatient rehabilitation facilities.

**FIGURE
14-5**

FFS Medicare margins for freestanding home health agencies were high before, during, and after the implementation of the PDGM in 2020



Note: FFS (fee-for-service), PDGM (Patient-Driven Groupings Model).

Source: MedPAC analysis of Medicare home health cost-report files, 2001 to 2023.

to maintain or improve outcomes under the new payment structure.

We did observe fewer therapy visits per stay associated with the PDGM, which is directionally consistent with the PDGM's removal of number of therapy visits as a payment factor and with longstanding concerns that the prior payment system encouraged therapy provision based on financial incentives rather than patient need. To the extent that the PDGM reduced these incentives, the fewer therapy visits observed may reflect a correction of a distortion in the prior system and a closer alignment of therapy use with clinical need. At the same time, the fewer skilled nursing visits observed—despite

no comparable change in payment incentives for nursing—also suggests that broader factors, such as pandemic-related workforce challenges and operational adjustments, also influenced service delivery, including therapy visits.

Taken together, these findings indicate that the PDGM did not negatively affect FFS Medicare beneficiaries, but continued monitoring is warranted. Future Commission work will examine the PDGM payment groups to assess their relative profitability under current utilization patterns and costs, and to better understand how agency characteristics, labor mix, and other factors interact with the payment system over time. ■

Endnotes

- 1 Medicare has two criteria for homebound status. In the first, the beneficiary must have difficulty leaving the home unassisted because of an illness or injury, or leaving the home is medically contraindicated. In addition, a beneficiary must have “a normal inability to leave the home” and leaving must require “considerable and taxing effort.” Absences from the home for medical treatment, attendance at adult day care centers, and other absences that are infrequent or for relatively short duration are generally excepted when applying the criteria.
- 2 The therapy thresholds in the home health PPS evolved over time. From October 1, 2000, to December 31, 2007, the PPS had a threshold at 10 therapy visits, with 60-day periods that had 10 or more therapy visits qualifying for higher payment. In 2008, CMS implemented a revised case-mix system that had nine thresholds, which remained in effect until the PDGM went into effect in January 1, 2020.
- 3 In October 2019 the SNF PPS implemented the Patient-Driven Payment Model, which eliminated the use of therapy services from the case-mix model.
- 4 This population definition differs from the population used in the March report to the Congress on payment adequacy in home health. We require beneficiaries to have Part A and Part B continuously in the calendar year and the six months prior so that we have adequate data for our regression models (discussed further below).
- 5 For utilization metrics, home health stays are calculated as claims separated by no more than 60 days. This definition was used to promote comparability between 60-day payment episodes and 30-day payment periods before and after the PDGM. For the claims-based quality measures (preventable hospitalizations and discharge to community), stays were composed of claims separated by no more than three days (per CMS specifications of these measures). The change in self-care and change in mobility measures are based on patient-assessment data collected at the beginning and end of home health care.
- 6 Our stay-level models also included additional variables to examine the changes associated with the PDGM for the postinstitutional and community-admitted stays.
- 7 More precisely, the with-PDGM estimates are predicted values from the ITS regression models, meaning that they reflect the observed values in 2023 after adjusting for the control variables included in the model. Those with-PDGM predicted values are very close to the unadjusted observed values in 2023 (data not shown).
- 8 A postinstitutional stay occurs when a Medicare beneficiary had a hospitalization or institutional post-acute care stay within the 14 days before the start of the current stay; a community-admitted stay does not have these services in the 14 days before the start of the current stay.
- 9 The PDGM did not alter the payment methodology for home health aide services, so it is unclear why use of the model would increase or decrease the provision of home health aide visits. The costs of aide visits are included in the case-mix-adjusted base rate, and the number of visits provided does not affect payment. But aide visits are infrequently provided, which may make them harder to model accurately.
- 10 The FFS Medicare margins for 2023 in this chapter reflect the stays for FFS Medicare beneficiaries that met our inclusion criteria for this evaluation. As a result, the overall average we report in this chapter does not match the margins we report for freestanding HHAs in 2023 in Chapter 8 of this report. These FFS Medicare margins are computed at the stay level, not the provider level as in our payment adequacy work. In addition, the provider margins are weighted by agency payments in Chapter 8; the margins reported in this chapter are not weighted.

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CHAPTER 15

Mandated report: Dual-eligible special-needs plans

Mandated report: Dual-eligible special-needs plans

Chapter summary

Individuals who qualify for both Medicare and Medicaid—known as dually eligible beneficiaries—may receive care that is fragmented or poorly coordinated because of the challenges of navigating two distinct and complex programs. Given these concerns, policymakers have taken steps to develop programs that better integrate care for these beneficiaries. These programs have largely focused on the creation of health plans that provide both Medicare and Medicaid benefits and thus have incentives to better manage and coordinate care than either program has when acting on its own. These plans also 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.

However, there are several types of Medicare managed care plans that serve the dually eligible population and their level of integration with Medicaid varies. Many of these plans are particular variations of the dual-eligible special-needs plan (D-SNP), which is a specialized Medicare Advantage (MA) plan that limits its enrollment to dually eligible beneficiaries. In an effort to better understand the relative performance of plans that serve dually eligible beneficiaries, the Bipartisan Budget Act (BBA) of 2018 directs

In this chapter

- Nearly half of dually eligible beneficiaries are enrolled in D-SNPs
- Available data provide limited insight into relative performance of D-SNPs
- The growing use of chronic-condition special-needs plans as D-SNP “look-alike” plans
- Appendix: Scores on HEDIS clinical quality measures

the Commission to periodically compare the performance of these plans. This report is our third under the BBA of 2018 mandate.

As required by the mandate, we compared plans' performance using 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 Consumer Assessment of Healthcare Providers and Systems (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 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. ■

Individuals who qualify for both Medicare and Medicaid—known as dually eligible beneficiaries—may receive care that is fragmented or poorly coordinated because of the challenges of navigating two distinct and complex programs.¹ Given these concerns, policymakers have taken steps to develop programs that better integrate care for these beneficiaries. These programs have largely focused on the creation of health plans that provide both Medicare and Medicaid benefits and thus have incentives to better manage and coordinate care than either program has when acting on its own.

However, there are several types of Medicare managed care plans that serve the dually eligible population and their level of integration with Medicaid varies. Many of these plans are particular variations of the dual-eligible special-needs plan (D-SNP), which is a specialized Medicare Advantage (MA) plan that limits its enrollment to dually eligible beneficiaries. In an effort to better understand the relative performance of plans that serve dually eligible beneficiaries, the Bipartisan Budget Act (BBA) of 2018 directs the Commission to periodically compare the performance of these plans. In 2013, the Commission recommended that D-SNPs should be required to have a high level of integration with Medicaid (Medicare Payment Advisory Commission 2013).

The BBA of 2018 requires the Commission to provide a report every two years, starting in 2022 and continuing through 2032 (see text box, p. 584, for the legislative language of the mandate). After that, the schedule changes, with another report due in 2033 and updates required every five years. This chapter is our third report under the mandate, which we are required to submit to the Congress by March 15, 2026.

In this chapter, we provide background information on the dually eligible population and then compare plans' performance using 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 Consumer Assessment of Healthcare Providers and Systems (CAHPS) beneficiary survey. We then examine efforts by MA insurers to develop products known as “look-alike plans” that are not D-SNPs but target dually eligible beneficiaries.

Background

Individuals must separately qualify for both Medicare and Medicaid coverage to become dually eligible beneficiaries. For these individuals, the federal Medicare program covers medical services such as hospital care, post-acute care, physician services, durable medical equipment, and prescription drugs. The federal-state Medicaid program covers a variety of long-term services and supports (LTSS), such as custodial nursing home care and community-based care, and wraparound services, such as dental benefits and transportation. Medicare is the primary payer for any services that are covered by both programs, such as inpatient care and physician services.

Roughly half of dually eligible beneficiaries first qualify for Medicare based on disability (compared with 15 percent of beneficiaries who are not dually eligible) and roughly half qualify when they turn 65. Medicaid's eligibility rules vary somewhat across states, but most dually eligible beneficiaries qualify because they receive Supplemental Security Income benefits, need nursing home care or have other high medical expenses, or meet the eligibility criteria for the Medicare Savings Programs, in which Medicaid provides assistance with Medicare premiums and cost sharing (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2025). Not all individuals who are eligible for Medicaid participate in the program. In July 2024, about 12.1 million Medicare beneficiaries (18 percent of all Medicare beneficiaries) were dually eligible.

Dually eligible beneficiaries can be divided into two broad groups—“full benefit” and “partial benefit”—based on the Medicaid benefits they receive. Full-benefit dually eligible beneficiaries qualify for the full range of Medicaid services covered in their state, while partial-benefit dually eligible beneficiaries receive assistance only with Medicare premiums and, in some cases, with cost sharing. In July 2024, there were 8.7 million full-benefit dually eligible beneficiaries and 3.4 million partial-benefit beneficiaries. Unless noted otherwise, all references in this chapter to “dually eligible beneficiaries” include both full-benefit and partial-benefit dually eligible beneficiaries.

Legislative language for mandated report

Section 50311(b)(1)(E) of the Bipartisan Budget Act of 2018 reads:

(E) STUDY AND REPORT TO CONGRESS.—

(i) IN GENERAL.—Not later than March 15, 2022, and, subject to clause (iii), biennially thereafter through 2032, the Medicare Payment Advisory Commission established under section 1805, in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900, shall conduct (and submit to the Secretary and the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on) a study to determine how specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) perform among each other based on data from Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, reported on the plan level, as required under section 1852(e)(3) (or such other measures or data sources that are available and appropriate, such as encounter data and Consumer Assessment of Healthcare Providers and Systems data, as specified by such Commissions as enabling an accurate evaluation under this subparagraph). Such study shall include, as feasible, the following comparison groups of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii):

(I) A comparison group of such plans that are described in subparagraph (D)(i)(I).

(II) A comparison group of such plans that are described in subparagraph (D)(i)(II).

(III) A comparison group of such plans operating within the Financial Alignment Initiative demonstration for the period for which such plan is so operating and the demonstration is in effect, and, in the case that an integration option that is not with respect to specialized MA plans for special needs individuals is established after the conclusion of the demonstration involved.

(IV) A comparison group of such plans that are described in subparagraph (D)(i)(III).

(V) A comparison group of MA plans, as feasible, not described in a previous subclause of this clause, with respect to the performance of such plans for enrollees who are special needs individuals described in subsection (b)(6)(B)(ii).

(ii) ADDITIONAL REPORTS.—Beginning with 2033 and every five years thereafter, the Medicare Payment Advisory Commission, in consultation with the Medicaid and CHIP Payment and Access Commission, shall conduct a study described in clause (i). ■

Given the role that factors such as disability and functional impairment play in becoming a dually eligible beneficiary, it is not surprising that the dually eligible population is more likely than other Medicare beneficiaries to report that they are in poor health (12 percent vs. 3 percent) or need help performing three or more activities of daily living (ADLs) (23 percent vs. 5 percent) (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment

and Access Commission 2025).² The poorer health of this population leads in turn to higher costs for both programs (Table 15-1). Measured on a per capita basis, the average annual Medicare cost for a dually eligible beneficiary in 2022 was almost \$26,000, more than twice the corresponding figure for other Medicare beneficiaries. Within the dually eligible population, those eligible for full Medicaid benefits had higher Medicare costs and much higher Medicaid costs than

**TABLE
15-1****Dually eligible beneficiaries had much higher per capita annual spending in 2022 than other Medicare beneficiaries**

	Medicare	Medicaid	Total
Dually eligible beneficiaries			
All dually eligible	\$25,871	\$14,535	\$40,405
Full-benefit dually eligible	26,947	19,413	46,360
Partial-benefit dually eligible	22,831	763	23,594
All other Medicare beneficiaries	11,834	N/A	11,834

Note: N/A (not applicable). Figures include all Medicare (Part A, Part B, and Part D) and Medicaid spending except Medicare or Medicaid spending on Part A, Part B, or Part D premiums. Figures for both programs include all fee-for-service payments and all payments made to health plans. The Medicaid spending for partial-benefit dually eligible beneficiaries is for coverage of Medicare cost sharing. Components may not sum to totals due to rounding.

Source: MedPAC analysis of linked Medicare-Medicaid enrollment and spending data.

those eligible for partial Medicaid benefits only. In 2022, Medicare and Medicaid together spent more than \$46,000 per capita, on average, on full-benefit dually eligible beneficiaries; Medicare accounted for about 58 percent of the combined spending and Medicaid the other 42 percent.

The high Medicare costs for dually eligible beneficiaries are driven by a combination of higher utilization of all major types of services and higher per user spending for those who receive care. For example, based on beneficiaries with fee-for-service (FFS) coverage in both programs, in 2022, full-benefit dually eligible beneficiaries were more likely than other Medicare beneficiaries to use inpatient care (22 percent vs. 13 percent), and those who were hospitalized had higher inpatient costs (\$28,317 vs. \$22,717). The Medicaid costs for full-benefit dually eligible beneficiaries were largely for LTSS, such as nursing home care and home- and community-based waiver programs. Less than half of the full-benefit dually eligible population with FFS coverage in both programs (43 percent) used LTSS in 2022, but spending on those services accounted for almost 80 percent of this population's total Medicaid costs (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2025).

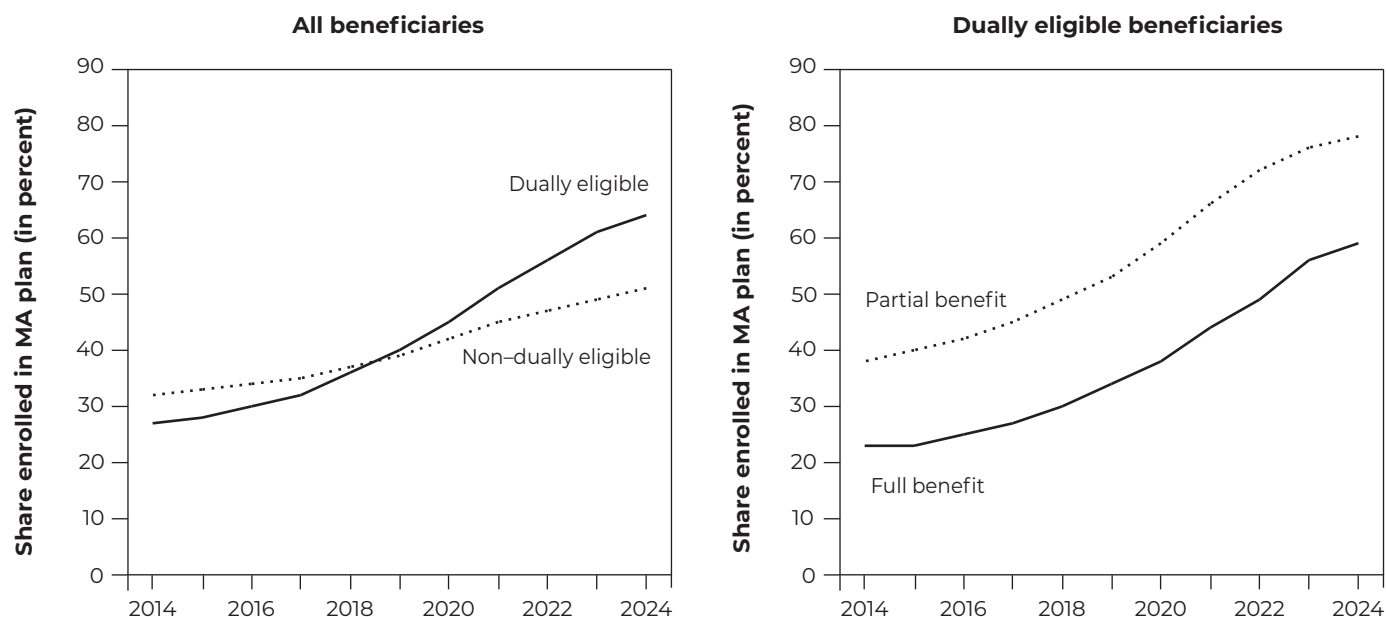
The share of dually eligible beneficiaries enrolled in MA has grown rapidly

As with other beneficiaries, the share of dually eligible beneficiaries enrolled in MA plans has grown rapidly in recent years. The left half of Figure 15-1 (p. 586) shows the share of dually eligible and non-dually eligible beneficiaries enrolled in MA from 2014 to 2024. Dually eligible beneficiaries were historically less likely than other beneficiaries to enroll in managed care plans, but that pattern reversed during this period, and the share of the dually eligible population enrolled in MA is now higher than that of non-dually eligible beneficiaries (64 percent vs. 51 percent in 2024). Within the dually eligible population, as shown on the right half of Figure 15-1, partial-benefit dually eligible beneficiaries have consistently been more likely than full-benefit dually eligible beneficiaries to enroll in MA plans. Between 2014 and 2024, the MA participation rate for both groups more than doubled, and a substantial majority are now enrolled in MA. The participation rate for partial-benefit dually eligible beneficiaries is particularly high (78 percent).

It is worth noting that Figure 15-1 does not include enrollment in plans that are not part of the MA program, such as cost plans, Medicare-Medicaid Plans (MMPs), and the Program of All-Inclusive Care for

FIGURE
15-1

The share of dually eligible beneficiaries enrolled in MA plans more than doubled between 2014 and 2024



Note: MA (Medicare Advantage). Figures are based on enrollment in July of each year. Full-benefit dually eligible beneficiaries qualify for the full range of Medicaid services covered in their state, while partial-benefit dually eligible beneficiaries receive assistance only with Medicare premiums and, in some cases, with Medicare cost sharing. Figures do not include beneficiaries who did not have both Part A and Part B coverage or lived in the U.S. territories. Figures do not include beneficiaries who were enrolled in health plans that are not part of the MA program (stand-alone Part D plans, cost plans, Medicare-Medicaid Plans, and the Program of All-Inclusive Care for the Elderly).

Source: MedPAC analysis of Medicare enrollment and eligibility data.

the Elderly. In 2024, about 3 percent of dually eligible beneficiaries were enrolled in those plans (largely in MMPs, which were capitated, highly integrated plans for full-benefit dually eligible beneficiaries that operated under a Center for Medicare & Medicaid Innovation demonstration between 2013 and 2025), compared with less than 1 percent of non-dually eligible beneficiaries.

Integration requirements for D-SNPs

D-SNPs are based on the rationale that dually eligible beneficiaries will receive better care from a specialized MA plan that is tailored to meet their distinct care needs than they would from a conventional MA plan. The extent to which D-SNPs must integrate the delivery of Medicare and Medicaid services has

evolved over time. When D-SNPs were first authorized in 2003, they did not have to meet any specific requirements for integration. The Congress enacted the first requirements in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Since 2010, MIPPA has required D-SNPs to have Medicaid contracts that meet certain minimum requirements, such as specifying the plan's service area, the Medicaid services the plan provides (if any), and the plan's responsibility to coordinate the delivery of Medicaid services for its enrollees.

Later, with the Affordable Care Act of 2010, the Congress added requirements for plans that wanted to qualify as a fully integrated dual-eligible SNP (FIDE-SNP). These plans must be offered by an entity that has a capitated Medicaid contract to provide

both institutional and community-based LTSS, and they can receive higher Medicare payments if their enrollees have high levels of functional impairment.

The BBA of 2018 built on the MIPPA standards by requiring D-SNPs, starting in 2021, to meet one of three additional criteria for integration:

- The plan meets a minimum set of requirements, determined by the Secretary, to coordinate the delivery of LTSS, behavioral health, or both for plan enrollees. CMS specified through regulation that these plans must notify the state about admissions to inpatient hospitals and skilled nursing facilities for at least one group of “high-risk” full-benefit dually eligible beneficiaries, which is defined by the state. CMS refers to these plans as coordination-only D-SNPs; they have the lowest level of integration because they do not have to provide any Medicaid services (plan enrollees instead receive those services through a Medicaid fee-for-service (FFS) program or a separate Medicaid managed care plan).
- The plan qualifies as either (1) a highly integrated dual-eligible SNP (HIDE-SNP) by having a capitated Medicaid contract to provide LTSS, behavioral health, or both; or (2) a FIDE-SNP. HIDE-SNPs fall somewhere in the middle in terms of their integration with Medicaid: They are more integrated than coordination-only plans because they provide some Medicaid services, but less integrated than FIDE-SNPs because their Medicaid contracts may not be as extensive and they can use a wider variety of contracting arrangements with states. FIDE-SNPs have the highest level of integration because they provide a broad range of Medicaid services, including substantial LTSS coverage.
- The plan assumes “clinical and financial responsibility” for both Medicare and Medicaid benefits provided to its enrollees. CMS has defined these plans as HIDE-SNPs or FIDE-SNPs that have exclusively aligned enrollment, which means that enrollment in the D-SNP is limited to dually eligible beneficiaries who receive their Medicare and Medicaid benefits from the same insurer. Based on a separate BBA of 2018 provision, these plans must have a unified process for handling appeals

and grievances (instead of separate processes for Medicare-covered and Medicaid-covered services).³ The use of exclusively aligned enrollment also allows plans to integrate other aspects of the enrollee experience, such as member materials.

In addition to the requirements for Medicaid integration, D-SNPs must complete annual health risk assessments for their enrollees, have an approved evidence-based model of care, and report certain additional quality measures. Otherwise, they are largely subject to the same rules as conventional MA plans. For example, they can require enrollees to receive care from in-network providers, employ utilization-management tools like prior authorization, and offer supplemental benefits that FFS Medicare does not cover.

Nearly half of dually eligible beneficiaries are enrolled in D-SNPs

Like conventional MA plans, D-SNPs are now widely available. In 2026, they are offered in 47 states and the District of Columbia, and we estimate that 98 percent of beneficiaries live in counties where at least one D-SNP is available. The only states without D-SNPs are Alaska, New Hampshire, and Vermont.

Table 15-2 (p. 588) shows the enrollment distribution for dually eligible beneficiaries (both full benefit and partial benefit) in 2024. Overall, 33 percent of these beneficiaries were enrolled in FFS Medicare, 64 percent were enrolled in MA plans, and 3 percent were enrolled in non-MA plans. (See text box, pp. 590–591, for a summary of important recent and upcoming changes to health plans that serve dually eligible beneficiaries.)

Nearly half of dually eligible beneficiaries (46 percent) were enrolled in D-SNPs. Most of those enrollees (27 percent of all dually eligible beneficiaries) were in coordination-only D-SNPs, followed by 15 percent in HIDE-SNPs and 3 percent in FIDE-SNPs. The majority of D-SNP enrollees were thus in plans with the lowest level of integration with Medicaid, while the share enrolled in FIDE-SNPs, which have the highest level of integration, was low. Although overall D-SNP enrollment has grown substantially in recent years, the relative shares enrolled in the different types of D-SNPs have been fairly stable.

**TABLE
15-2**

Enrollment of dually eligible beneficiaries, by type of coverage and the comparison groups specified in the Bipartisan Budget Act of 2018, July 2024

Type of coverage	Beneficiaries (thousands)	Share	Comparison group
Fee-for-service	3,832	33%	
Medicare Advantage plans:			
Dual-eligible special-needs plans			
Coordination-only	3,205	27	Group A
HIDE-SNPs	1,771	15	See below
FIDE-SNPs	<u>402</u>	<u>3</u>	See below
Subtotal, D-SNPs	5,378	46	
Conventional plans	1,835	16	Group E
All other Medicare Advantage plan types	323	3	Group E
Subtotal, all Medicare Advantage plans	7,536	64	
Non-Medicare Advantage plans:			
Medicare-Medicaid Plans	256	2	Group D
Program of All-Inclusive Care for the Elderly	60	1	
Cost plans	<u>6</u>	<u><1</u>	
Subtotal, all non-Medicare Advantage plans	323	3	
Total dually eligible beneficiaries	11,691	100	
Detail on HIDE-SNPs and FIDE-SNPs			
Without aligned enrollment			
HIDE-SNPs	1,748	15	Group B
FIDE-SNPs	67	1	Group B
With aligned enrollment			
HIDE-SNPs	23	<1	Group C
FIDE-SNPs	335	3	Group C

Note: HIDE-SNP (highly integrated dual-eligible special-needs plan), FIDE-SNP (fully integrated dual-eligible special-needs plans), D-SNP (dual-eligible special-needs plan). Figures are based on July 2024 enrollment. Figures do not include beneficiaries who did not have both Part A and Part B coverage or beneficiaries who lived in the U.S. territories. Components may not sum to totals due to rounding. Groups A through E correspond with the five plan types, as shown from left to right, in Tables 15-3, 15-4, 15-5, 15-6, and 15-A1.

Source: MedPAC analysis of Medicare enrollment and eligibility data and health plan data.

Aside from D-SNPs, another 16 percent of dually eligible beneficiaries were enrolled in conventional MA plans, while 3 percent were enrolled in other MA

plan types, such as institutional special-needs plans, chronic-condition special-needs plans, or employer-sponsored plans.

Available data provide limited insight into relative performance of D-SNPs

The BBA of 2018 directs the Commission to periodically examine how D-SNPs “perform among each other” using Healthcare Effectiveness Data and Information Set (HEDIS) quality measures or other data sources, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) beneficiary survey or plan encounter data, as appropriate.

To the extent feasible, these reports must compare five types of plans that serve dually eligible beneficiaries. Table 15-2 shows which plans are in each comparison group. The first three groups, referred to as Groups A, B, and C, are made up of D-SNPs that have been divided based on the BBA of 2018’s integration criteria. These comparison groups differ somewhat from the coordination-only, HIDE-SNP, and FIDE-SNP categories because they also account for whether HIDE-SNPs and FIDE-SNPs have exclusively aligned enrollment. As shown at the bottom of Table 15-2, in 2024, the differences between the two methods for categorizing D-SNPs were relatively modest since nearly all HIDE-SNP enrollees were in plans that did not have exclusively aligned enrollment and most FIDE-SNP enrollees were in plans that did have exclusively aligned enrollment. The fourth group (Group D) are MMPs, while the fifth group (Group E) are other MA plans (looking only at the dually eligible beneficiaries in those plans). Most beneficiaries in Group E are enrolled in conventional MA plans.

Another logical comparison group would be dually eligible beneficiaries who are enrolled in FFS Medicare, although the mandate does not require this comparison. However, the Commission has previously noted that efforts to compare FFS and MA performance are hindered by several data limitations (such as a lack of clinical data for FFS enrollees and discrepancies between plans’ HEDIS data and encounter data) and the challenges of adjusting for differences between the FFS and MA populations (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019b). Given these challenges, we determined in our March 2023 report to the Congress that rigorous comparisons of quality and outcomes between MA and FFS could not be made at this time (Medicare Payment Advisory Commission 2023).

For this report, we analyzed two types of HEDIS measures—clinical quality measures and risk-adjusted utilization measures—and CAHPS patient experience measures.

- On the clinical quality measures, we found that each plan type performed better on some measures and worse on others. While the differences between the scores on a given measure were often relatively small, HIDE-SNPs and FIDE-SNPs with exclusively aligned enrollment had the best overall performance of the five plan types, while other MA plans had the worst overall performance.
- On the risk-adjusted utilization measures, HIDE-SNPs and FIDE-SNPs that did not have aligned enrollment had the best overall performance, while MMPs had the worst overall performance.
- As for the CAHPS measures, we found that the five comparison groups had very similar scores, with coordination-only D-SNPs performing slightly better than the other plan types.

Drawing broader conclusions about plan performance from this analysis is challenging because other factors, such as differences in the characteristics of the dually eligible beneficiaries who enroll in each plan type, may contribute to the variation in scores. Table 15-3 (p. 592) illustrates some of those differences. For example, the share of enrollees who were under age 65 was relatively low for HIDE-SNPs and FIDE-SNPs with aligned enrollment (20 percent) because some FIDE-SNPs were available only to beneficiaries who are 65 or older or need LTSS. Two plan types (HIDE-SNPs and FIDE-SNPs with aligned enrollment and MMPs) were limited to full-benefit dually eligible beneficiaries, while partial-benefit dually eligible beneficiaries accounted for a substantial share of the enrollment in the other three plan types. The share of enrollees who lived in urban versus rural areas and the racial/ethnic composition of enrollees also varied across the five plan types due to the fact that some plan types are offered only in certain states.

As a group, dually eligible beneficiaries are also quite heterogeneous and include subgroups that may have very distinct care needs, such as beneficiaries who are under age 65 and have a behavioral health condition versus beneficiaries who are in their 80s and have multiple functional impairments. This variation

Important recent and upcoming changes to the landscape of health plans that serve dually eligible beneficiaries

The figures in Table 15-2 (p. 588) do not reflect the impact of several important changes that will affect the landscape of health plans that serve dually eligible beneficiaries:

Additional requirements for plans to qualify as fully integrated dual-eligible special-needs plans (FIDE-SNPs)

Before 2025, FIDE-SNPs were required to have capitated Medicaid contracts to provide primary care, acute care, and long-term services and supports. Starting in 2025, CMS added new requirements aimed at ensuring that all FIDE-SNPs have a high level of integration with Medicaid. CMS now requires that the Medicaid contracts for FIDE-SNPs cover a broader set of services and that FIDE-SNPs have exclusively aligned enrollment. Some plans that had been FIDE-SNPs did not meet these new requirements and were reclassified as highly integrated dual-eligible special-needs plans (HIDE-SNPs) in 2025. These plans had about 110,000 enrollees.

Changes to special enrollment periods

Medicare largely prohibits beneficiaries from changing their coverage (switching from fee-for-service (FFS) to Medicare Advantage (MA), from MA to FFS, or changing their MA or stand-alone Part D plan) outside of an annual enrollment period. However, before 2025, dually eligible beneficiaries could use a special enrollment period (SEP) to make

any change to their coverage once per calendar quarter during the first nine months of the year.⁴

Starting in 2025, CMS replaced this SEP with a pair of new SEPs: the first SEP allows dually eligible beneficiaries to switch from an MA plan to a stand-alone Part D plan or change their stand-alone Part D plan on a monthly basis, while the second SEP allows full-benefit dually eligible beneficiaries to enroll in certain integrated dual-eligible special-needs plans (D-SNPs) on a monthly basis.⁵ These changes limit the ability of dually eligible beneficiaries to enroll in or change MA plans outside of the annual enrollment period, and they may lead to slower enrollment growth in coordination-only D-SNPs (which are largely ineligible for the new integrated-care SEP) relative to HIDE-SNPs and FIDE-SNPs (which are eligible).

Closure of Medicare–Medicaid Plans (MMPs)

The MMPs were part of a demonstration in which CMS and certain states tested the use of capitated, highly integrated plans for full-benefit dually eligible beneficiaries. At their peak, MMPs operated in 10 states and had between 400,000 and 450,000 enrollees, making the demonstration one of the largest specifically aimed at the dually eligible population.⁶

CMS ended the demonstration in 2025, and this year most MMPs converted into D-SNPs. CMS

(continued next page)

makes it challenging for health plans to manage this population and to assess plan performance.

External researchers who have studied integrated plans have found some evidence that they produce better outcomes, but their findings have been limited and inconsistent. One recent literature review surveyed

all evaluations of FIDE-SNPs, MMPs, and the Program of All-Inclusive Care for the Elderly (PACE) that were published between 2010 and 2023 (Roberts et al. 2024).⁷ According to the review, those studies have found some evidence that FIDE-SNPs and MMPs have positive effects on certain metrics, such as reductions in long-term nursing home stays and greater use of outpatient

Important recent and upcoming changes to the landscape of health plans that serve dually eligible beneficiaries (cont.)

tied its decision to end the demonstration to such factors as Congress's decision to make D-SNPs a permanent part of the MA program, greater flexibility for MA plans in offering supplemental benefits, and regulatory changes that incorporate some MMP features into D-SNPs. The Commission's review of evaluations of the demonstrations found that they tended to result in statistically significant increases in Medicare spending and had mixed effects on service use (Medicare Payment Advisory Commission 2024b). Based on July 2025 enrollment, we estimate that 66 percent of MMP enrollees (about 160,000 people) were moved into FIDE-SNPs and 18 percent (about 45,000 people) were moved into HIDE-SNPs. The remaining 16 percent (about 40,000 people) were in MMPs that closed without converting into D-SNPs; most of these enrollees will likely switch to D-SNPs offered by other insurers, which in many cases include HIDE-SNPs or FIDE-SNPs. The transition from MMPs to D-SNPs will thus increase the share of beneficiaries enrolled in more highly integrated D-SNPs relative to the less-integrated coordination-only plans.

Implementation of requirements to more closely align D-SNPs and Medicaid managed care plans

Many states now have Medicaid managed care programs that serve dually eligible beneficiaries, making it feasible to use health plans to provide integrated care (either by enrollment in a single plan that covers both Medicare and Medicaid benefits or enrollment in separate Medicare and Medicaid plans

offered by the same insurer). In 2024, CMS finalized a new policy that aims to more closely align the D-SNP and Medicaid managed care markets.

Under this policy, starting in 2027, insurers that have a Medicaid plan that serves full-benefit dually eligible beneficiaries will be limited to offering a single D-SNP for those beneficiaries in the Medicaid plan's service area. Insurers that now offer multiple D-SNPs for full-benefit dually eligible beneficiaries in those areas will need to consolidate their plans. In addition, any new enrollment in these D-SNPs will be limited to beneficiaries who are also enrolled in the insurer's companion Medicaid plan. In 2030, these D-SNPs must disenroll any remaining beneficiaries who are not also enrolled in the insurer's companion Medicaid plan. At that point, all of these D-SNPs will have exclusively aligned enrollment with their companion Medicaid plan.

This policy will apply only in states with Medicaid managed care programs that serve full-benefit dually eligible beneficiaries, and there are some exceptions that would allow insurers to offer more than one D-SNP. For example, a state could require an insurer to offer more than one D-SNP if the state has multiple Medicaid managed care programs that serve distinct populations (such as one for beneficiaries under 65 and another for beneficiaries who are 65 and older). States can also allow insurers to offer a separate D-SNP for partial-benefit dually eligible beneficiaries.⁸ ■

care, but found "limited and inconclusive" effects on other metrics, such as hospital admissions and emergency department visits. Another review of the literature on integrated care programs concluded that "findings across all domains tended to be mixed," and noted that one particular challenge for researchers was controlling for the effects of selection (which results

from the fact that these programs are not available in all areas and may target certain subsets of the dually eligible population, and from the fact that enrollment in these programs is typically voluntary) (Smith et al. 2021). However, one recent study found that full-benefit dually eligible beneficiaries enrolled in FIDE-SNPs had lower disenrollment rates (voluntary changes

**TABLE
15-3**

The dually eligible beneficiaries enrolled in the five plan types specified in the Bipartisan Budget Act of 2018 differed in several respects, 2024

Beneficiary characteristic	Coordination-only D-SNPs	HIDE-SNPs and FIDE-SNPs		MMPs	Other MA plans
		Unaligned	Aligned		
Number of enrollees (in thousands)	3,622	2,042	412	301	2,760
Age					
Under 65	35%	27%	20%	46%	24%
65 and older	65	73	80	54	76
Sex					
Female	60	60	63	56	60
Male	40	40	37	44	40
Race/ethnicity					
White, non-Hispanic	48	37	35	50	56
Black	30	19	20	25	18
Hispanic	14	29	27	15	17
Asian	6	9	12	5	6
Other/unknown	3	6	6	5	3
Type of Medicaid eligibility					
Full benefits	68	69	98	99	54
Partial benefits	32	31	2	1	46
Residence					
Urban area	76	90	92	90	82
Rural area	24	10	8	10	18
Nursing home resident	2	1	4	10	10
Died during the year	4	4	5	5	6

Note: D-SNP (dual-eligible special-needs plan), HIDE-SNP (highly integrated dual-eligible special-needs plan), FIDE-SNP (fully integrated dual-eligible special-needs plan), MMP (Medicare–Medicaid Plan), MA (Medicare Advantage). Enrollment figures are based on beneficiaries who had at least one month during 2024 where they were both (1) dually eligible for Medicare and Medicaid, and (2) enrolled in one of the five plan types shown in the table. Figures do not include beneficiaries in the U.S. territories. Beneficiaries were counted as nursing home residents if there was at least one month where they had been in a nursing home for 90+ days. Components may not sum to 100 due to rounding.

Source: MedPAC analysis of Medicare enrollment and eligibility data and health plan data.

to another type of coverage) than full-benefit dually eligible beneficiaries enrolled in other types of D-SNPs or in other types of MA plans, suggesting that enrollees in more highly integrated plans may be more satisfied with their care (Meyers et al. 2025). Better data and more research are needed on the effects of integrated plans on quality and outcomes.

HEDIS measures

For this report, we analyzed person-level HEDIS data for measurement year 2024, the most recent available. HEDIS is a set of quality measures that has been developed by the National Committee for Quality Assurance (NCQA) to evaluate health plans. For 2024, CMS required both MA plans and MMPs to collect

and report data for a subset of HEDIS measures. The person-level HEDIS data have both beneficiary and plan identifiers, which we used to identify beneficiaries enrolled in D-SNPs, MMPs, and other MA plans and to determine which beneficiaries were dually eligible. We divided the D-SNP enrollees into three groups based on the BBA integration criteria that each plan met in 2024.

We analyzed two types of HEDIS measures: clinical quality measures and risk-adjusted utilization measures. We examined clinical quality measures in our previous mandated reports, while the analysis of risk-adjusted utilization measures is new. While HEDIS measures are often used to assess health plans, they do have some limitations. For example, the clinical quality measures are largely process measures that do not directly measure actual outcomes, and many measures exclude beneficiaries who live in nursing homes, who account for about 10 percent of all full-benefit dually eligible beneficiaries. Similarly, the specifications for the utilization measures may exclude a significant amount of service use.⁹

Clinical quality measures

For each comparison group, we calculated scores for 28 HEDIS measures with a total of 56 associated rates. Some measures have more than one associated rate: For example, a measure on follow-up after an emergency department visit for substance abuse has two rates, one for 7-day follow-up and one for 30-day follow-up. The number of observations that were used to calculate each rate varied depending on the enrollment in each plan type and the demographic and clinical specifications for each measure. We did not include four measures—blood pressure control for patients with diabetes, controlling high blood pressure, glycemic status assessment for patients with diabetes, and transitions of care—where some plans report administrative data and some plans report data collected from a sample of enrollee medical records.

Each plan type performed better on some measures and worse on others. In many cases, the differences between the scores on a given measure were relatively small and may not be very meaningful to beneficiaries, even if they are statistically significant. (See Table 15-A1, pp. 606-608, in this chapter's appendix, for the scores on each measure we used in our analysis.)

We tested our results for statistical significance by comparing each plan type's score on a given rate with the unweighted average of the scores for the five plan types and found that 83 percent of the scores were significant at the 95 percent confidence level. CMS has addressed this challenge in some analyses by requiring scores to differ by at least 3 percentage points to have "practical significance" (Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2023b).

We applied the concept of practical significance to our analysis by looking for cases where a plan type's score on a rate differed from the unweighted average of the scores for the five plan types by at least 3 percentage points. Table 15-4 (p. 594) groups the 56 rates that we analyzed into three care domains—access/availability of care, effectiveness of care, and measures reported using electronic clinical data systems (ECDS)—and shows the number of rates where each plan type had better performance (top half of the table) or worse performance (bottom half of the table). All of the differences shown in Table 15-4 were statistically significant at the 95 percent confidence level. Using this approach, we found the following:

- HIDE-SNPs and FIDE-SNPs with exclusively aligned enrollment had the best overall performance, doing better on 14 rates and worse on only 1 rate. For effectiveness of care, they performed better on four rates related to behavioral health. Among the ECDS measures, they performed better on three rates related to screening for social needs and two rates related to immunizations.
- Other MA plans had the worst overall performance of the five plan types, doing better on 4 rates and worse on 15 rates. For effectiveness of care, they performed better on two rates related to care for osteoporosis and worse on six rates related to behavioral health. Among the ECDS measures, they performed worse on six rates related to screening and intervention for social needs.
- MMPs had the greatest variation in performance of the five plan types, doing better on 17 rates and worse on 11 rates. In the area of access/availability of care, they performed better on four rates related to initiation of and engagement with treatment

**TABLE
15-4**

**Relative performance on HEDIS clinical quality measures
for measurement year 2024, by plan type**

Measure domain	Coordination-only D-SNPs	HIDE-SNPs and FIDE-SNPs		MMPs	Other MA plans
		Unaligned	Aligned		
Number of rates where the score for the plan type was <u>better</u> than the overall average and the difference was practically significant:					
Access/availability of care (7 rates)	1	0	1	4	0
Effectiveness of care (35 rates)	2	3	6	8	3
Measures reported using electronic clinical data systems (14 rates)	4	4	7	5	1
Total (56 rates)	7	7	14	17	4
Number of rates where the score for the plan type was <u>worse</u> than the overall average and the difference was practically significant:					
Access/availability of care (7 rates)	0	3	0	1	1
Effectiveness of care (35 rates)	7	4	0	6	7
Measures reported using electronic clinical data systems (14 rates)	3	4	1	4	7
Total (56 rates)	10	11	1	11	15

Note: HEDIS (Healthcare Effectiveness Data and Information Set), D-SNP (dual-eligible special-needs plan), HIDE-SNP (highly integrated dual-eligible special-needs plan), FIDE-SNP (fully integrated dual-eligible special-needs plan), MMP (Medicare-Medicaid Plan), MA (Medicare Advantage). Figures do not include plans in the U.S. territories. Figures indicate the number of rates where the score for the plan type was better or worse than the unweighted average of the scores for all five plan types and the difference was 3+ percentage points. All differences were statistically significant at the 95 percent confidence level.

Source: MedPAC analysis of HEDIS person-level data for measurement year 2024 and D-SNP integration data for 2024.

for substance use disorder. For effectiveness of care, they performed better on six rates related to behavioral health, but worse on three rates related to diabetes care and two rates related to care for osteoporosis. Among the ECDS measures, they performed better on three rates related to interventions for enrollees with social needs, but worse on two rates related to breast cancer and colorectal cancer screening and on two rates related to screening for social needs.

- Coordination-only D-SNPs performed better on a total of 7 rates and worse on a total of 10 rates. In the area of effectiveness of care, these plans performed worse on six rates related to behavioral health, such as follow-up after a hospitalization for mental illness. Among the ECDS measures, these

plans performed better on three rates related to screening for enrollees' social needs (food, housing, and transportation) but worse on three rates related to providing assistance for those identified with social needs.

- HIDE-SNPs and FIDE-SNPs without exclusively aligned enrollment performed better on 7 rates and worse on 11 rates. In the area of access/availability of care, these plans performed worse on three rates related to initiation of and engagement with treatment for substance use disorder. For effectiveness of care, they performed better on two rates related to screening for and management of osteoporosis and worse on two rates related to behavioral health. Among the ECDS measures, they performed better on rates related to screening for

breast cancer, colorectal cancer, and some social needs, but performed worse on two rates related to immunizations.

Drawing broader conclusions about plan performance from this analysis is challenging because other factors may contribute to the variation in scores. For example, in 2024, over 99 percent of beneficiaries lived in counties where at least one MA plan was available and 95 percent lived in counties where at least one D-SNP was available, but some plan types were not widely available. The most highly integrated plans in particular had more limited availability: MMPs and FIDE-SNPs were available in only 8 states and 14 states, respectively. Thus, differences in HEDIS scores across the five comparison groups could be influenced by factors such as regional differences in state Medicaid eligibility requirements, disease prevalence, access to care, and physician practice patterns.

Another factor could be structural differences between MMPs and MA plans. MMPs were part of a demonstration and operated outside of the MA program. The two plan types differed in many ways, and differences in their enrollment models and quality incentives could have affected their relative performance on HEDIS measures. In MA, almost all beneficiaries enroll voluntarily, while in MMPs, many beneficiaries were passively enrolled by states. MMPs might have had more difficulty engaging with passive enrollees, which could have contributed to their poor performance on some measures. Both types of plans had quality incentives, but the incentive for MA plans was structured as a bonus (higher payments for plans with a rating of 4 stars or better), while the incentive for MMPs was structured as a quality withhold (lower payments for plans that do not meet performance thresholds), and they were not evaluated on the same HEDIS measures. Seven measures that we included in our analysis (breast cancer screening, colorectal cancer screening, eye exam for patients with diabetes, follow-up after emergency department visit for people with multiple high-risk conditions, kidney health evaluation for patients with diabetes, osteoporosis management in women who had a fracture, and statin therapy for patients with cardiovascular disease) were used in the MA star ratings but not the MMP quality withhold, and MA plans performed noticeably better than MMPs on six of the eight rates associated

with those measures. Conversely, two measures (depression screening and follow-up, follow-up after hospitalization for mental illness) were used in the MMP quality withhold but not the MA star ratings, and MMPs performed noticeably better than MA plans on three of the four rates associated with those measures. Some of the differences in HEDIS scores may thus reflect differences in plans' financial incentives to focus on certain measures over others.

The challenges of using HEDIS measures to assess performance also reflect larger difficulties in assessing the quality and performance of MA plans (both in terms of how well individual plans perform compared with each other and how well MA plans perform compared with the FFS program). Most HEDIS measures are process measures that are not tied to clinical outcomes, but the Commission holds that measures tied to clinical outcomes and patient experience are more suitable for quality payment programs (Medicare Payment Advisory Commission 2018). CMS includes some process measures in the calculation of the MA star ratings, accounting for about 25 percent of a plan's overall star rating for 2026, but it gives more weight to outcomes and patient-experience measures (Centers for Medicare & Medicaid Services 2025b).

Risk-adjusted utilization measures

The NCQA has developed several utilization measures that focus on services provided by hospitals. CMS required MA plans and MMPs to report four of those measures: acute hospital discharges, emergency department visits, all-cause 30-day readmissions, and hospitalizations for potentially preventable conditions. The measure for potentially preventable hospitalizations has two rates: one for certain acute conditions (bacterial pneumonia, urinary tract infections, cellulitis, and severe pressure ulcers) and one for certain chronic conditions (short-term and long-term complications from diabetes, uncontrolled diabetes, diabetic patients who have had a lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, and heart failure).

When plans report these measures, they report both actual service use and an estimate of expected service use for enrollees who meet the measure's HEDIS specifications. Plans calculate the expected service use by applying a set of risk-adjustment models that are

**TABLE
15-5**

Performance on HEDIS risk-adjusted utilization measures for measurement year 2024, by plan type

	Coordination-only D-SNPs	HIDE-SNPs and FIDE-SNPs		MMPs	Other MA plans
		Unaligned	Aligned		
Acute hospital discharges					
Observed amount	406,845	240,327	64,044	37,093	362,777
Risk-adjusted expected amount	346,004	224,529	49,351	29,729	297,862
Observed-to-expected ratio	1.18	1.07	1.30	1.25	1.22
Emergency department visits					
Observed amount	999,221	542,046	118,724	77,299	642,117
Risk-adjusted expected amount	679,958	414,432	85,096	67,415	514,478
Observed-to-expected ratio	1.47	1.31	1.40	1.15	1.25
All-cause readmissions					
Observed amount	63,461	35,373	9,190	6,240	57,844
Risk-adjusted expected amount	60,872	34,622	8,476	5,603	54,811
Observed-to-expected ratio	1.04	1.02	1.08	1.11	1.06
Hospitalizations for potentially preventable conditions:					
Acute conditions					
Observed amount	19,288	11,561	3,933	1,505	20,968
Risk-adjusted expected amount	13,602	10,893	2,620	929	14,041
Observed-to-expected ratio	1.42	1.06	1.50	1.62	1.49
Hospitalizations for potentially preventable conditions:					
Chronic conditions					
Observed amount	38,961	23,867	7,673	2,994	35,676
Risk-adjusted expected amount	25,875	19,077	4,567	1,755	25,019
Observed-to-expected ratio	1.51	1.25	1.68	1.71	1.43

Note: HEDIS (Healthcare Effectiveness Data and Information Set), D-SNP (dual-eligible special-needs plan), HIDE-SNP (highly integrated dual-eligible special-needs plan), FIDE-SNP (fully integrated dual-eligible special-needs plan), MMP (Medicare–Medicaid Plan), MA (Medicare Advantage). Figures do not include plans in the U.S. territories. We tested these results for statistical significance by comparing the score for each plan type to the unweighted average of the scores for all five plan types and using a *t*-test; we found that all but two scores (the scores for coordination-only D-SNPs on the two rates related to hospitalizations for potentially preventable conditions) were significant at the 95 percent confidence level.

Source: MedPAC analysis of HEDIS person-level data for measurement year 2024 and D-SNP integration data for 2024.

developed by NCQA and predict an enrollee's service use based on such factors as age, sex, and the presence of various clinical comorbidities. (These models are different from the risk-adjustment models that CMS uses to adjust payments to MA plans to account for differences in enrollees' health status.)

Table 15-5 shows the observed and risk-adjusted expected amounts for each measure plus the ratio

of the two amounts. An observed-to-expected ratio lower than 1 means the plan type had lower utilization than expected given the demographics and clinical conditions of their enrollees, while a ratio greater than 1 means plans had higher utilization than expected. However, the ratios for every measure and plan type shown in Table 15-5 are greater than 1, which suggests that the underlying risk-adjustment models for these measures have some limitations. Those models

are calibrated on a broad sample of MA enrollees—meaning that the observed-to-expected ratio across the entire sample should equal 1.0—and may not be as accurate for a subset of enrollees such as dually eligible beneficiaries. For example, the ratio of 1.47 for emergency department visits for coordination-only D-SNPs may suggest that the expected utilization for that service is underestimated. If the inaccuracies of the risk adjustment models affect all plan types equally, then comparing the ratios across the five plan types is still meaningful. However, if the models are more accurate for some plan types than others, the comparisons will not provide an accurate picture of relative plan performance.

Notwithstanding this limitation, HIDE-SNPs and FIDE-SNPs that did not have aligned enrollment had the best performance (lowest observed-to-expected ratio) on four of the five utilization metrics, including both rates for potentially avoidable hospitalizations. Conversely, MMPs had the poorest performance on three of the five metrics, although the differences between their scores and the scores for other plan types were relatively small. As with the clinical quality measures, drawing broader conclusions from this analysis is challenging because other factors (such as differences in plan availability, inaccuracies in risk adjustment, and structural differences between MMPs and MA plans) may contribute to the variation in scores.¹⁰

CAHPS patient experience measures

We also analyzed results from the CAHPS beneficiary survey, which was developed by the Agency for Healthcare Research and Quality (AHRQ) to assess patient experience with the health care system. Patient experience measures are an important source of information about overall quality because they measure enrollees' perspectives on the services provided by their health plan.

How we analyzed the survey results

Each year, CMS requires MA plans (and MMPs when they were in operation) to administer a version of the survey to a sample of enrollees. The agency selects the sample and requires plans to hire an approved outside vendor to conduct the surveys. The surveys are usually conducted in the spring of each year and ask enrollees about their experience during the previous six months. For this report, we analyzed results from the

surveys conducted in 2024, the most recent available. The responses to the survey thus refer to care that enrollees received in late 2023 and early 2024. Across all MA plans, about 33 percent of the enrollees who were selected for the 2024 survey responded (Centers for Medicare & Medicaid Services 2025a).

The MA version of the CAHPS survey has more than 60 questions, which makes it impractical to report the results for each question. We instead focused on scores for six composite measures, which combine the scores on groups of closely related individual measures, and on scores for five measures for which enrollees give an overall rating (from 0 to 10) of a key feature of their health care experience. For example, the composite measure for “how well doctors communicate” is based on four individual questions that ask if the enrollee's personal doctor explained things in a way that was easy to understand, listened carefully to the enrollee, showed respect for what the enrollee had to say, and spent enough time with the enrollee. We also present scores for one individual measure—the share of enrollees who received a flu shot—that is part of both the MA and MMP quality incentives. Our focus on a limited number of measures is consistent with AHRQ guidance and similar to the approach CMS uses to incorporate CAHPS scores in the MA star ratings (Agency for Healthcare Research and Quality 2015, Centers for Medicare & Medicaid Services 2024).¹¹

We used beneficiary and plan identifiers, as we did with the HEDIS data, to determine which CAHPS respondents were dually eligible beneficiaries and to assign them to the five comparison groups specified in the BBA mandate. We divided the D-SNP enrollees based on the integration criteria that each plan met in 2024. We also adjusted survey responses to account for differences in case mix, using the same factors that CMS applies when it adjusts CAHPS responses to calculate the MA star ratings. Finally, we converted the scores on each measure to a scale of 0 to 100 (from low to high) for ease of interpretation.

There was little variation in CAHPS scores across the five comparison groups

The CAHPS scores for each comparison group are shown in Table 15-6 (p. 598). Instances in which the difference between the score for a given plan type and the average score for all plan types were statistically significant using a t-test are marked with a plus sign (+) when the

**TABLE
15-6**

CAHPS scores from 2024 surveys, by plan type

	Overall average for all plan types	Coordination- only D-SNPs	HIDE-SNPs and FIDE-SNPs			
			Unaligned	Aligned	MMPs	Other MA plans
Composite measures						
Getting care quickly	82	83 (+)	83 (+)	79 (–)	82	82
Getting needed care	78	80 (+)	79 (+)	76 (–)	78	78
How well doctors communicate	90	91 (+)	90	89	89	89
Customer service	83	84 (+)	84	83	83	83
Care coordination	85	86 (+)	85	83	85	85
Getting needed prescription drugs	89	89 (+)	89	87	88	89
Enrollee ratings						
All health care	84	85	85 (+)	84	84 (–)	84
Personal doctor	90	91 (+)	91 (+)	90	90 (–)	90
Specialist	89	89	89	89	88	90 (+)
Health plan	89	90 (+)	90 (+)	89	87 (–)	87 (–)
Drug plan	90	92 (+)	91 (+)	91	90	89 (–)
Individual measure						
Received annual flu shot	65	62 (–)	64	71 (+)	64	66

Note: CAHPS (Consumer Assessment of Healthcare Providers and Systems), D-SNP (dual-eligible special-needs plan), HIDE-SNP (highly integrated dual-eligible special-needs plan), FIDE-SNP (fully integrated dual-eligible special-needs plan), MMP (Medicare–Medicaid Plan), MA (Medicare Advantage). All scores have been converted to a 0-to-100 scale (from low to high) for ease of interpretation and, except for the flu-shot measure, have been case-mix adjusted for response bias. Figures do not include plans in the U.S. territories.
(+) Score is better than overall average and difference is statistically significant ($p < 0.05$).
(-) Score is worse than overall average and difference is statistically significant ($p < 0.05$).

Source: MedPAC analysis of CAHPS person-level data and D-SNP integration data for 2024.

plan type performed better and a minus sign (-) when the plan type performed worse.¹² We found that two plan types—coordination-only D-SNPs and HIDE-/FIDE-SNPs that do not have aligned enrollment—had higher scores on many measures. In particular, the coordination-only D-SNPs had higher scores on all of the composite measures and three of the five enrollee ratings. In contrast, the other three plan types had lower scores on two or more measures, with MMPs having lower scores on three of the five enrollee ratings.

However, the differences between the scores for the various plan types were often small in absolute terms—only a few percentage points for most measures—and may not be very meaningful for beneficiaries.

As discussed above, CMS has used a difference of 3 percentage points, as it has with HEDIS scores, as a threshold for “practical significance” in some analyses (Centers for Medicare & Medicaid Services 2023b). Using this threshold, there were only six measures with meaningful differences between the highest-scoring and lowest-scoring plans (getting care quickly, getting needed care, care coordination, health plan rating, drug plan rating, and the flu-shot measure), with the coordination-only D-SNPs performing better on four of those measures, and only one measure with a meaningful difference between the highest-scoring plan and every other plan type (the flu-shot measure, where HIDE-/FIDE-SNPs with aligned enrollment performed better).

Other analyses have also found that CAHPS scores for many measures vary relatively little. For example, the Commission identified the lack of variation as one weakness of the MA star-rating system and noted that the minimal differences in scores may not provide a reasonable basis for deciding which plans should receive a quality bonus (Medicare Payment Advisory Commission 2019b). Similarly, a study that used CAHPS data from 2015 to 2019 found relatively small differences in the scores for dually eligible beneficiaries enrolled in D-SNPs versus other MA plans (Haviland et al. 2021). Another study that used CAHPS data from 2015 to 2018 to compare the experience of dually eligible beneficiaries in FIDE-SNPs, other D-SNPs, and other MA plans found relatively small differences in the scores for those plan groupings (Meyers et al. 2023).

The growing use of chronic-condition special-needs plans as D-SNP “look-alike” plans

The MA program allows insurers to offer three types of special-needs plans: D-SNPs, which enroll beneficiaries who have both Medicare and Medicaid; institutional special-needs plans (I-SNPs), which enroll beneficiaries who need the level of care provided in a nursing home; and chronic-condition special-needs plans (C-SNPs), which enroll beneficiaries with certain chronic conditions, such as diabetes, chronic lung disease, or chronic kidney disease.

Enrollment in all three types of SNPs has grown in recent years, but the increase for C-SNPs has been particularly rapid. Between 2021 and 2025, total enrollment more than tripled, rising from about 394,000 to 1.3 million beneficiaries. (For comparison, total enrollment in D-SNPs increased from 3.6 million to 6.2 million during the same period.) In this section, we discuss how some of this growth—about 10 percent—appears to be due to the growing use of C-SNPs as look-alike plans, which are MA plans that are not D-SNPs but still target dually eligible beneficiaries. Other factors, such as increased interest among MA insurers in using C-SNPs rather than conventional plans as a vehicle to offer extra benefits that are tailored to beneficiaries with specific diseases

or conditions, may play a larger role in explaining the overall growth in C-SNPs.

The rationale for offering look-alike plans is that MA insurers find it profitable to enroll dually eligible beneficiaries. The growth in the D-SNP market provides a clear indicator of their attractiveness to insurers: Between 2020 and 2025, the number of plans increased from 539 to 903, and enrollment more than doubled, rising from 3.0 million to 6.2 million beneficiaries. This year, the number of D-SNPs will reach a new high—a total of 1,019 plans are being offered—and 98 percent of beneficiaries have access to at least one D-SNP.

While insurers might prefer to target dually eligible beneficiaries using D-SNPs, states’ efforts to develop integrated care programs can limit the ability of some insurers to offer these plans. As noted earlier, all D-SNPs must have a state Medicaid contract, but states are not obligated to sign contracts with every insurer that wants to offer a D-SNP. States can thus control access to their D-SNP markets by contracting selectively with insurers. Several states have used this flexibility to promote integrated care by limiting the ability to offer D-SNPs to insurers that also offer Medicaid managed care plans that serve the dually eligible population. This approach promotes greater integration by developing a group of insurers that have the capacity to provide both Medicare and Medicaid benefits.

However, these restrictions give insurers that do not have access to the D-SNP market an incentive to find other ways to enroll this population. One strategy has been to use other types of MA plans (traditionally conventional plans but increasingly C-SNPs) as look-alike plans, which have some of the same features as D-SNPs. Based on the annual focus groups that the Commission conducts with dually eligible beneficiaries, D-SNPs are appealing largely due to their coverage of extra benefits rather than their ability to offer a product that integrates Medicare and Medicaid coverage. These extra benefits are financed using the rebates that plans receive under the MA payment system—Medicaid funding plays no role—so insurers can develop look-alike plans with coverage similar to that offered by D-SNPs. And since look-alike plans do not have to meet the extra requirements that apply to D-SNPs (such as the statutory requirement that all D-SNPs must have a state Medicaid contract), insurers

**TABLE
15-7****Impact of restrictions on use of conventional MA plans as look-alike plans, 2023–2026**

	2023	2024	2025	2026
Look-alike threshold	80%	80%	70%	60%
Number of affected plans (closed at end of prior year because they exceeded the threshold)	47	12	23	21
Enrollment in affected plans (thousands)	206	20	51	52
Postclosure coverage for enrollees in affected plans				
Other MA plans/MMPs	98%	97%	N/A	N/A
Fee-for-service	2	3	N/A	N/A

Note: MA (Medicare Advantage), MMP (Medicare–Medicaid Plan), N/A (not available). Figures for enrollment in affected plans are for January of the prior year, when CMS determines whether plans are complying with the look-alike threshold. Figures for shares of enrollees who were subsequently enrolled in MA or fee-for-service are based on January enrollment (i.e., the month after the look-alike plan closed).

Source: CMS data on look-alike plans and MedPAC analysis of Medicare enrollment data.

can use look-alike plans to circumvent any restrictions that states might apply to their D–SNP markets as part of their efforts to develop integrated care programs.

The prevalence of look-alike plans began to increase in the mid-2010s; much of the initial growth occurred in California as a response to the state’s MMP demonstration but then spread to other states.¹³ The Commission examined the growth of look-alike plans and expressed concern that they could undermine states’ efforts to enroll more dually eligible beneficiaries in integrated care (Medicare Payment Advisory Commission 2019a, Medicare Payment Advisory Commission 2018).

CMS has since issued regulations aimed at limiting the ability of MA insurers to use conventional plans as look-alike plans. Starting in 2023, insurers were not allowed to operate a conventional plan if dually eligible beneficiaries accounted for more than 80 percent of the plan’s total enrollment. The look-alike threshold has since been lowered, to 70 percent in 2025 and 60 percent starting in 2026. CMS enforces this requirement by calculating, for each plan, the share of enrollees who are dually eligible in January of each year; plans that exceed the look-alike threshold are required to close at the end of the year. When

a look-alike plan is closed, the insurer can transfer its enrollees to another MA plan that meets certain requirements (such as having Part D drug coverage and a \$0 premium for enrollees who receive the Part D low-income subsidy). Depending on the other plans an insurer offers, a closure may result in enrollees being transferred to another conventional plan, a D–SNP, a C–SNP, or (if the insurer does not have any plans that meet the requirements) to FFS Medicare.

Since 2023, these restrictions have cumulatively resulted in the closure of 103 look-alike plans (second row, Table 15-7). The largest number of closures—47 plans with a total of 206,000 enrollees—occurred in 2023, when the restrictions first took effect. Following these closures, nearly all of the beneficiaries in the affected plans have switched to other health plans (either because they were automatically transferred to another plan offered by the same insurer or because they affirmatively chose a new plan).

In response to these restrictions, insurers have begun using C–SNPs as a vehicle for offering look-alike plans. Table 15-8 shows the number of conventional plans and C–SNPs offered between 2019 and 2024, stratified by the share of enrollees who were dually eligible. The share of enrollees who were dually eligible was

**TABLE
15-8****Conventional MA plans and C-SNPs, stratified by the share of enrollees who were dually eligible, 2019–2024**

	2019	2020	2021	2022	2023	2024
Conventional MA plans						
0%–20%	2,237	2,571	2,868	3,148	3,414	3,485
21%–40%	287	311	392	377	373	317
41%–60%	43	52	82	103	111	103
61%–80%	27	46	56	68	73	45
81%–100%	<u>63</u>	<u>66</u>	<u>74</u>	<u>60</u>	<u>17</u>	<u>11</u>
Total	2,657	3,046	3,472	3,756	3,988	3,961
C-SNPs						
0%–20%	94	119	143	169	200	202
21%–40%	18	26	35	55	52	44
41%–60%	3	4	7	9	11	15
61%–80%	4	6	6	8	9	12
81%–100%	<u>8</u>	<u>8</u>	<u>11</u>	<u>17</u>	<u>26</u>	<u>31</u>
Total	127	163	202	258	298	304

Note: MA (Medicare Advantage), C-SNP (chronic-condition special-needs plan). Enrollment figures are for July of each year. We calculated the share of enrollees who were dually eligible using both full-benefit and partial-benefit dually eligible beneficiaries.

Source: MedPAC analysis of Medicare enrollment and plan data.

relatively low in most plans—less than 20 percent, which is roughly in line with the overall figure for the Medicare population—but much higher for a subset of plans. As the number of conventional plans with a high share of dually eligible enrollees (60 percent or more) has decreased due to the restrictions on look-alike plans, the number of C-SNPs with a high share of dually eligible enrollees has increased, from 17 plans in 2021 to 43 plans in 2024.¹⁴

The fact that a large share of the enrollees in a particular C-SNP are dually eligible does not, by itself, mean that the plan is a look-alike plan. In some C-SNPs, the share of enrollees who are dually eligible is likely to be high due to the characteristics of the beneficiaries targeted by the plan. For example, in 2024, 10 of the 43 C-SNPs in which more than 60 percent of enrollees were dually eligible were plans that targeted beneficiaries who

have end-stage renal disease (ESRD). About half of the ESRD population is dually eligible, so C-SNPs that target them may often be close to or above the look-alike threshold. However, given the small size of the ESRD population (about 1 percent of all beneficiaries), these C-SNPs will not attract a significant number of enrollees.

However, for C-SNPs overall, the vast majority of enrollees (about 95 percent) are in plans that target three conditions that are relatively common among Medicare beneficiaries: cardiovascular disease (CVD), chronic heart failure (CHF), and diabetes. The C-SNPs that target these conditions are typically open to beneficiaries who have any one of the three conditions. The higher prevalence of these conditions, combined with the fact that insurers can target all three conditions with the same C-SNP, makes these C-SNPs

better suited to serve as look-alike plans. In 2024, most C-SNPs that exceeded the look-alike threshold (31 of 43) targeted CVD, CHF, and diabetes.

Another indication that some C-SNPs are being used as look-alike plans is the fact that most plans with a large share of enrollees who are dually eligible are clustered in certain states. In 2024, among the 31 plans that (1) exceeded the look-alike threshold and (2) targeted beneficiaries with CVD, CHF, and diabetes, 29 plans were offered in six states (Arizona, California, Idaho, Illinois, Indiana, and New Mexico) that limit participation in their D-SNP market to insurers that also offer a Medicaid managed care plan for dually eligible beneficiaries in their state.

The C-SNPs that target dually eligible beneficiaries also appear to have distinctive benefit designs. Figure 15-2 shows the relationship in 2024 between the share of C-SNP enrollees who were dually eligible and three important plan features—the MA out-of-pocket limit on Part A and Part B cost sharing (top left panel), the deductible for Part D drug coverage (top right panel), and the monthly Part D premium (lower left panel).¹⁵ These scatterplots are based on C-SNPs that targeted beneficiaries with CVD, CHF, or diabetes and exclude plans that had fewer than 100 enrollees; each dot is an individual C-SNP. The figure shows clear differences between C-SNPs that had a high share of dually eligible beneficiaries (above the 60 percent look-alike threshold) and other C-SNPs:

- Most C-SNPs with a high share of dually eligible beneficiaries had the highest possible out-of-pocket limit (\$8,850), while other C-SNPs tended to have much lower limits, often \$4,000 or less. Most dually eligible beneficiaries do not benefit from a lower limit because Medicaid covers their Part A and Part B cost sharing, so insurers that seek to attract them have an incentive to have a higher out-of-pocket limit and focus instead on offering other features such as richer coverage of non-Medicare supplemental benefits. At the same time, a higher out-of-pocket limit will be unattractive to many non-dually eligible beneficiaries, who can typically enroll in other MA plans (including conventional plans) that have lower limits.
- Every C-SNP with a high share of dually eligible beneficiaries had the highest possible Part D deductible (\$545), while the other C-SNPs largely

did not have a deductible. The C-SNPs that primarily serve non-dually eligible beneficiaries face competitive pressure to reduce or eliminate the deductible to attract enrollment, but the same does not hold true for C-SNPs that target the dually eligible because the Part D low-income subsidy covers the deductible for them.

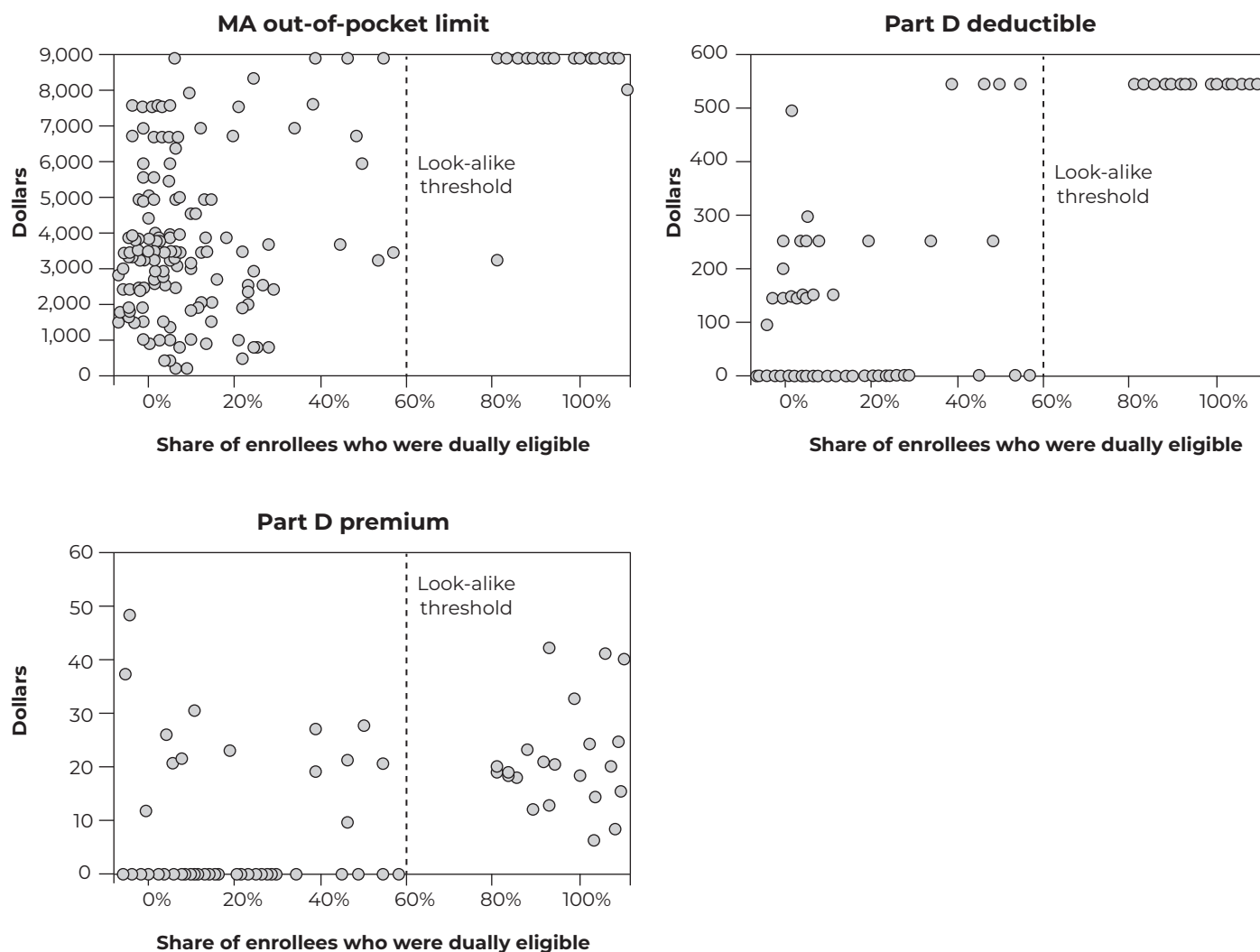
- Every C-SNP with a high share of dually eligible enrollees charged a premium for Part D coverage, while most other C-SNPs had a \$0 premium. Zero-premium drug coverage is one of the most popular features in MA plans, so many conventional plans and C-SNPs use a portion of their MA rebates to cover the premium that enrollees would otherwise pay. However, C-SNPs that target the dually eligible do not have the same incentive because the low-income subsidy covers premiums up to a benchmark amount. These plans simply need to ensure that their premium is less than or equal to the benchmark amount, rather than eliminate it entirely.

We can use beneficiary-level enrollment data to identify C-SNPs with high shares of dually eligible enrollees through 2024 (the most recent year available), but we cannot provide precise figures for 2025 and 2026. For those two years, we instead estimated the number of C-SNPs that may be functioning as look-alike plans by identifying plans with features similar to those highlighted in Figure 15-2. We counted C-SNPs as potential look-alike plans if they targeted beneficiaries with CVD, CHF, or diabetes and had (1) a high out-of-pocket limit for Part A and Part B cost sharing, (2) the maximum Part D deductible, (3) a nonzero Part D premium, and (4) a Part D premium that was fully covered by the low-income subsidy.

Using this approach, we estimate that the number of C-SNPs that may be functioning as look-alike plans has grown from 5 plans in 2021 to 92 plans in 2026, with a particularly large increase in 2026 (Table 15-9, p. 604). Overall enrollment in these plans has increased as well, from 70,000 in 2021 to 113,000 in 2025. The growth in enrollment is larger than those figures would suggest because the 2021 figure includes three C-SNPs that operate as regional preferred provider organization (RPPO) plans. Enrollment in RPPO-style plans has declined rapidly in recent years, largely because other MA plans tend to offer more generous extra benefits.

**FIGURE
15-2**

C-SNPs that largely served dually eligible beneficiaries had different features than other C-SNPs, 2024



Note: C-SNP (chronic-condition special-needs plan), MA (Medicare Advantage). Figures are based on C-SNPs that targeted beneficiaries with one or more of the following conditions: cardiovascular disease, chronic heart failure, and diabetes. Figures do not include C-SNPs in Puerto Rico. The share of enrollees who were dually eligible is based on July enrollment. The MA out-of-pocket limit applies to in-network care; the maximum limit in 2024 was \$8,850. The maximum Part D deductible for 2024 was \$545. *N* = 198 plans.

Source: MedPAC analysis of Medicare enrollment, plan landscape, and MA bid data.

Total enrollment in the three RPPO plans fell from 61,000 in 2021 to 16,000 in 2024, and the share of enrollees that were dually eligible declined as well, from 80 percent to 47 percent. By 2023, none of the plans exceeded the look-alike threshold of 60 percent. If these three plans were excluded from Table 15-9 (p.

604), the overall increase in enrollment between 2021 and 2025 would be larger, about 100,000 beneficiaries. CMS has also expressed concern about the recent growth in C-SNPs where a large share of enrollees are dually eligible beneficiaries (Centers for Medicare & Medicaid Services 2025c).

**TABLE
15-9**

The number of C-SNPs that appear to function as look-alike plans has grown substantially, 2021-2026

	2021	2022	2023	2024	2025	2026
Number of C-SNPs that may function as look-alike plans	5	17	21	31	41	92
Annual growth rate		240%	24%	48%	32%	124%
Enrollment (thousands)	70	62	51	89	113	N/A
Annual growth rate		-11%	-18%	76%	27%	N/A

Note: C-SNP (chronic-condition special-needs plan), N/A (not available). Figures are based on C-SNPs that targeted beneficiaries with one or more of the following conditions: cardiovascular disease, chronic heart failure, and diabetes. Figures do not include C-SNPs in Puerto Rico. For 2021-2024, we counted C-SNPs as potential look-alike plans if dually eligible beneficiaries represented more than 60 percent of their overall enrollment. For 2025-2026, we counted C-SNPs as potential look-alike plans if their benefit designs had four features: (1) a Medicare Advantage out-of-pocket limit that was within \$1,000 of the maximum allowed amount, (2) a Part D deductible equal to the maximum allowed amount, (3) a Part D premium that was greater than \$0, and (4) a Part D premium that was fully covered by the Part D low-income subsidy. Enrollment figures are for July of each year.

Source: MedPAC analysis of Medicare enrollment and plan benefit data.

Interest in using C-SNPs as a new type of look-alike plan may continue to grow due to regulatory changes that should increase the number of dually eligible beneficiaries who receive integrated care but will also, to some degree, limit the ability of MA insurers to offer and market D-SNPs. Like conventional plans, C-SNPs that target dually eligible beneficiaries undermine state efforts to develop integrated care programs.

Policymakers may thus want to consider broadening the current restrictions on look-alike plans to cover C-SNPs. As part of this change, policymakers could include limited exceptions for C-SNPs that target conditions such as ESRD, HIV/AIDS, and chronic and disabling mental health conditions, where a very high share of the affected beneficiaries are dually eligible. ■

15-APPENDIX A

Scores on HEDIS clinical quality measures

**TABLE
15-A1**

Scores on HEDIS clinical quality measures for measurement year 2024, by plan type

Measure	Coordination- only D-SNPs	HIDE-SNPs and FIDE-SNPs		MMPs	Other MA plans
		Unaligned	Aligned		
Access/availability of care					
Adults' access to preventive/ambulatory health services	96.3%	96.2%	97.3%	91.6%	95.6%
Initiation and engagement of substance use treatment					
Alcohol use disorder					
Initiation	43.7	41.0	40.4	47.2	44.3
Engagement	6.5	5.9	6.0	8.7	5.9
Opioid use disorder					
Initiation	35.4	31.8	37.3	44.6	35.6
Engagement	9.0	6.7	14.7	14.0	7.1
Other substance use disorder					
Initiation	39.9	27.9	34.2	43.6	35.1
Engagement	5.5	3.5	6.5	8.1	4.3
Effectiveness of care: Behavioral health					
Adherence to antipsychotic medications for individuals with schizophrenia	78.3	79.2	83.7	82.8	79.8
Antidepressant medication management					
Effective acute phase treatment	79.3	79.8	79.6	77.4	82.1
Effective continuation phase treatment	62.9	63.3	65.1	64.1	66.6
Follow-up after emergency department visit for mental illness					
7-day follow-up	31.4	32.7	49.4	55.5	32.3
30-day follow-up	48.5	51.1	65.5	69.6	47.9
Follow-up after emergency department visit for substance use					
7-day follow-up	23.9	28.8	31.3	34.2	24.6
30-day follow-up	38.9	43.5	47.4	50.2	39.3
Follow-up after hospitalization for mental illness					
7-day follow-up	27.1	31.5	35.0	40.9	26.0
30-day follow-up	47.7	52.1	57.6	61.7	45.4
Pharmacotherapy for opioid use disorder	34.0	31.7	32.7	35.6	30.7
Effectiveness of care: Cardiovascular conditions					
Cardiac rehabilitation					
Attended 2+ sessions within 30 days	4.1	2.7	4.3	3.7	4.2
Attended 12+ sessions within 90 days	5.3	3.7	4.2	5.3	5.5
Attended 24+ sessions within 180 days	4.9	3.6	4.2	5.6	5.1
Attended 36+ sessions within 180 days	2.1	1.7	1.8	3.1	2.3
Persistence of beta-blocker treatment after a heart attack	65.7	66.3	63.4	68.0	65.4
Statin therapy for patients with cardiovascular disease					
Received statin therapy	86.5	87.4	87.8	85.4	86.6
Statin adherence 80%	84.5	85.9	84.5	81.0	85.1

**TABLE
15-A1**

Scores on HEDIS clinical quality measures for measurement year 2024, by plan type *(cont.)*

Measure	Coordination- only D-SNPs	HIDE-SNPs and FIDE-SNPs			Other MA plans
		Unaligned	Aligned	MMPs	
Effectiveness of care: Care coordination					
Follow-up after emergency department visit for people with multiple high-risk chronic conditions	57.1	61.7	63.4	59.8	56.6
Effectiveness of care: Diabetes					
Eye exam for patients with diabetes	79.4	75.9	77.6	64.3	75.7
Kidney health evaluation for patients with diabetes	59.3	66.3	57.9	46.3	62.8
Statin therapy for patients with diabetes					
Received statin therapy	80.3	81.9	82.9	76.8	80.7
Statin adherence 80%	83.5	84.4	82.9	80.5	84.0
Effectiveness of care: Musculoskeletal conditions					
Osteoporosis screening in older women	52.9	55.9	53.5	40.2	54.8
Osteoporosis management in women who had a fracture	39.4	42.2	37.0	19.6	40.8
Effectiveness of care: Overuse/appropriateness (lower scores indicate better performance)					
Nonrecommended PSA-based screening in older men	30.0	37.8	27.5	24.4	28.0
Potentially harmful drug-disease interactions in older adults					
Chronic kidney disease	13.6	14.8	13.6	11.1	9.9
Dementia	45.7	48.7	44.9	40.6	41.8
History of falls	47.6	43.8	43.0	41.3	44.5
Use of high-risk medications in older adults	23.8	23.3	24.3	19.5	20.0
Use of opioids at high dosage	5.0	7.3	7.6	4.3	5.5
Use of opioids from multiple providers					
Multiple pharmacies	1.9	1.7	2.0	2.3	1.6
Multiple prescribers	15.7	14.5	17.3	18.6	15.9
Multiple prescribers and pharmacies	1.0	0.9	1.2	1.4	0.8
Effectiveness of care: Respiratory conditions					
Pharmacotherapy management of COPD exacerbation					
Bronchodilator	87.2	87.7	89.9	88.3	85.5
Systemic corticosteroid	76.0	73.8	74.0	76.0	74.8
Measures reported using electronic clinical data systems					
Adult immunization status					
Herpes zoster	19.6	19.0	22.4	18.7	19.8
Influenza	37.4	35.2	44.2	37.4	37.4
Pneumococcal	56.1	50.0	58.6	56.2	55.4
TDAP	35.3	33.3	37.3	40.5	33.8
Breast cancer screening	71.8	73.8	72.6	60.8	71.0
Colorectal cancer screening	69.5	71.8	70.0	54.6	68.4

**TABLE
15-A1**

Scores on HEDIS clinical quality measures for measurement year 2024, by plan type *(cont.)*

Measure	Coordination- only D-SNPs	HIDE-SNPs and FIDE-SNPs			Other MA plans
		Unaligned	Aligned	MMPs	
Depression screening and follow-up					
Screening	19.5	9.4	13.1	23.8	11.7
Follow-up on positive screen	66.3	70.3	63.8	68.1	72.2
Social need screening and intervention					
Food screening	17.5	22.0	19.2	9.4	3.7
Food intervention	2.3	18.4	18.0	29.8	12.6
Housing screen	19.1	13.2	21.2	16.3	9.0
Housing intervention	1.0	6.4	19.6	28.9	8.2
Transportation screen	22.0	23.5	22.6	12.3	7.3
Transportation intervention	2.7	15.5	15.3	35.2	6.4

Note: HEDIS (Healthcare Effectiveness Data and Information Set), D-SNP (dual-eligible special-needs plan), HIDE-SNP (highly integrated dual-eligible special-needs plan), FIDE-SNP (fully integrated dual-eligible special-needs plan), MMP (Medicare–Medicaid Plan), MA (Medicare Advantage), PSA (prostate-specific antigen), COPD (chronic obstructive pulmonary disease), TDAP (tetanus, diphtheria, and acellular pertussis). Figures do not include plans in the U.S. territories.

Source: MedPAC analysis of HEDIS person-level data for measurement year 2024 and D-SNP integration data for 2024.

Endnotes

- 1 Throughout this chapter, we use the term “dually eligible” to refer to beneficiaries who are actually enrolled in both Medicare and Medicaid. There are some Medicare beneficiaries who are eligible for Medicaid in the sense that they meet the program’s eligibility requirements but have not actually enrolled, either because they are unaware of their eligibility or because they do not want to enroll.
- 2 ADLs include eating, using the toilet, personal hygiene, and transferring (being able to move from one setting to another, such as getting in and out of a chair). Most states require Medicaid beneficiaries to need help with two or three ADLs to qualify for nursing home care or community-based forms of long-term care.
- 3 CMS also requires coordination-only D-SNPs to have a unified process for handling appeals and grievances if they have exclusively aligned enrollment and provide a minimum set of Medicaid-covered services. The various types of D-SNPs that are required to have a unified process for handling appeals and grievances are collectively referred to as “applicable integrated plans.”
- 4 The quarterly SEP was in effect from 2019 through 2024. Prior to 2019, dually eligible beneficiaries had a different SEP that allowed them to change their coverage on a monthly basis.
- 5 The new integrated-care SEP can only be used to enroll in FIDE-SNPs, HIDE-SNPs, or coordination-only plans that qualify as applicable integrated plans (meaning that the plan provides at least a limited set of Medicaid services and has aligned enrollment). In addition, the new SEP can only be used to align a beneficiary’s enrollment between their D-SNP and their Medicaid managed care plan.
- 6 We examined the MMP demonstrations in depth in our June 2016 and June 2018 reports (Medicare Payment Advisory Commission 2018, Medicare Payment Advisory Commission 2016).
- 7 PACE plans serve beneficiaries who are age 55 or older and need the level of care provided in a nursing home. The program aims to keep people living in the community instead of going into nursing homes, and it uses a distinctive model of care based on adult day-care centers that are staffed by interdisciplinary teams that provide therapy and medical services. PACE plans provide all Medicare- and Medicaid-covered services. The program is relatively small, covering about 63,000 Medicare beneficiaries in 2024.
- 8 Many such plans already exist. As of July 2025, about 10 percent of all D-SNPs (88 out of 903) were limited to partial-benefit dually eligible beneficiaries; those plans had nearly 250,000 enrollees.
- 9 In an earlier analysis, the Commission found that, across all MA enrollees, the specifications for one of the utilization measures (all-cause readmissions) excluded 45 percent of index hospitalizations and 71 percent of readmissions (Medicare Payment Advisory Commission 2024a).
- 10 One type of variation that we investigated was the share of enrollees who qualify for full or partial Medicaid benefits. In 2024, partial-benefit dually eligible beneficiaries accounted for about 50 percent of the dually eligible beneficiaries enrolled in other MA plans and about 30 percent of HIDE-SNP and coordination-only D-SNP enrollees, but only 2 percent of FIDE-SNP enrollees and less than 1 percent of MMP enrollees (see Table 15-3, p. 592). When we calculated scores for the HEDIS risk-adjusted utilization measures using data for full-benefit dually eligible beneficiaries only, the effects on our findings were relatively modest.
- 11 As part of the MA star ratings, CMS uses five of the six composite measures, three of the five measures in which enrollees rate their health care experience, and the flu shot measure.
- 12 We measured statistical significance by comparing the score for each plan type with the unweighted average of the scores for all plan types. As a sensitivity test, we also measured statistical significance using the enrollment-weighted average of the scores for all plan types. Using this approach, the number of measures where coordination-only D-SNPs and HIDE-/FIDE-SNPs without aligned enrollment performed better decreased and the number of measures where MMPs and HIDE-/FIDE-SNPs with aligned enrollment performed worse increased.
- 13 California’s demonstration had several features that spurred insurers to offer look-alike plans. First, participation in the demonstration was limited to insurers that had Medi-Cal managed care contracts. Second, the state froze enrollment in its D-SNPs to encourage dually eligible beneficiaries to enroll in MMPs. (Insurers that offered both MMPs and D-SNPs had to transfer any D-SNP enrollees who were eligible for the demonstration to their MMP.) Third, the state did not allow any new insurers to enter the D-SNP market. Fourth, MMPs were not allowed to pay commissions, so efforts to shift enrollment from D-SNPs (which, like all MA plans, could pay commissions) to MMPs reduced incomes for agents and brokers.

14 As shown in Table 15-8, there can still be situations where conventional plans exceed the look-alike threshold. For example, in 2024, there were 11 plans in which the share of enrollees who were dually eligible was greater than 80 percent (the threshold in effect at the time). Conventional plans can still exceed the threshold in three situations. First, a plan that complied with the threshold in earlier years may later exceed the threshold if the share of enrollees who are dually eligible increases. Second, the restrictions on look-alikes include an exception for new plans, which are defined as plans that are in their first year of operation and have fewer than 200 enrollees. Third, the restrictions on look-alikes do not apply to plans offered in states that do not have

any D-SNPs or MMPs (in 2024, there were five such states). Plans in the first situation must close at the end of the plan year, while plans in the second situation will be closed at the end of their second year of operation if they continue to exceed the threshold. Plans in the third situation can continue to operate as long as their state does not have any D-SNPs.

15 This approach is similar to the one we used in our June 2019 report to examine the growth in the number of conventional plans that were being used as look-alike plans (Medicare Payment Advisory Commission 2019a).

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A P P E N D I X

A

**Commissioners' voting
on recommendations**



Commissioners' voting on recommendations

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 requires MedPAC to call for individual commissioner votes on each recommendation and to document the voting record in our reports. The information below satisfies that mandate.

Chapter 1: Context for Medicare payment policy

No recommendations

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

No recommendations

Chapter 3: Hospital inpatient and outpatient services

The Congress should:

- for 2027, update the 2026 Medicare base payment rates for general acute care hospitals by the amount specified in current law, and
- implement the Medicare Safety-Net Index (MSNI) described in our March 2023 report, with \$1 billion added to the MSNI pool.

Yes: Barr, Casale, Chernew, Cherry, Damberg, Diller, Dusetzina, Konetzka, Liao, Metan, Poulsen, Rambur, Riley, Sarraan, Upchurch

Abstain: Kan, Miller

Chapter 4: Physician and other health professional services

For calendar year 2027, the Congress should increase payment rates for physician and other health professional services by 0.5 percentage points more than current law.

Yes: Barr, Casale, Chernew, Cherry, Damberg, Diller, Dusetzina, Konetzka, Liao, Metan, Poulsen,
Rambur, Riley, Sarran, Upchurch
No: Kan, Miller

Chapter 5: Outpatient dialysis services

For calendar year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rate for outpatient dialysis services.

Yes: Barr, Casale, Chernew, Cherry, Damberg, Diller, Dusetzina, Kan, Konetzka, Liao, Metan, Miller,
Poulsen, Rambur, Riley, Sarran, Upchurch

Chapter 6: Post-acute care: Trends and key issues

No recommendations

Chapter 7: Skilled nursing facility services

For fiscal year 2027, the Congress should reduce the 2026 Medicare base payment rates for skilled nursing facilities by 4 percent.

Yes: Barr, Casale, Chernew, Cherry, Damberg, Diller, Dusetzina, Kan, Konetzka, Liao, Metan, Miller,
Poulsen, Rambur, Riley, Sarran, Upchurch

Chapter 8: Home health care services

For calendar year 2027, the Congress should reduce the 2026 Medicare base payment rate for home health agencies by 7 percent.

Yes: Barr, Casale, Chernew, Cherry, Damberg, Diller, Dusetzina, Kan, Konetzka, Liao, Metan, Miller,
Poulsen, Rambur, Riley, Sarran, Upchurch

Chapter 9: Inpatient rehabilitation facility services

For fiscal year 2027, the Congress should reduce the 2026 Medicare base payment rate for inpatient rehabilitation facilities by 7 percent.

Yes: Barr, Casale, Chernew, Cherry, Damberg, Diller, Dusetzina, Kan, Konetzka, Liao, Metan, Miller,
Poulsen, Rambur, Riley, Sarran, Upchurch

Chapter 10: Hospice services

For fiscal year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rates for hospice.

Yes: Barr, Casale, Chernew, Cherry, Damberg, Diller, Dusetzina, Kan, Konetzka, Liao, Metan, Miller, Poulsen, Rambur, Riley, Sarrao, Upchurch

Chapter 11: Ambulatory surgical center services: Status report

No recommendations

Chapter 12: The Medicare Advantage program: Status report

No recommendations

Chapter 13: The Medicare prescription drug program (Part D): Status report

No recommendations

Chapter 14: Mandated report: The impact of recent changes to the home health prospective payment system

No recommendations

Chapter 15: Mandated report: Dual-eligible special-needs plans

No recommendations

Acronyms

Acronyms

A-APM	advanced alternative payment model	CMG	case-mix group
ACA	Affordable Care Act of 2010	CMI	case-mix index
ACG	ambulatory care group	CMS	Centers for Medicare & Medicaid Services
ACH	acute care hospital	CMS-HCC	CMS hierarchical condition category
ACO	accountable care organization	CON	certificate of need
ACS	ambulatory care sensitive	COPD	chronic obstructive pulmonary disease
ADL	activity of daily living	COVID-19	coronavirus disease 2019
AEP	annual enrollment period	CPCP	corporate primary care practice
AHRQ	Agency for Healthcare Research and Quality	CPL	covered-procedure list
AIDS	acquired immunodeficiency syndrome	CPT	Current Procedural Terminology
ALS	amyotrophic lateral sclerosis	C-SNP	chronic-condition special-needs plan
AMA	American Medical Association	CT	computed tomography
APC	ambulatory payment classification	CVD	cardiovascular disease
APCM	advanced primary care management	CY	calendar year
APM	alternative payment model	DECI	demographic estimate of coding intensity
APRN	advanced practice registered nurse	DIR	direct and indirect remuneration
ASCQR	ASC Quality Reporting	DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
ASP	average sales price	DO	doctor of osteopathic medicine
BBA	Balanced Budget Act	DOJ	Department of Justice
BBA	Bipartisan Budget Act	DRG	diagnosis-related group
BBP	base beneficiary premium	DSH	disproportionate share
BLS	Bureau of Labor Statistics	D-SNP	dual-eligible special-needs plan
BMI	body mass index	E&M	evaluation and management
BCPI	Bundled Payments for Care Improvement	ECDS	electronic clinical data systems
BCPI-A	Bundled Payments for Care Improvement-Advanced	ECP	endoscopic cyclophotocoagulation
BPT	bid pricing tool	ED	emergency department
CAA	Consolidated Appropriations Act	eGFR	estimated glomerular filtration rate
CAH	critical access hospital	EGWP	employer group waiver plan
CAHPS	Consumer Assessment of Healthcare Providers and Systems	EMTALA	Emergency Medical Treatment and Labor Act
CBO	Congressional Budget Office	ESA	erythropoiesis-stimulating agent
CC	complication or comorbidity	ESRD	end-stage renal disease
CCP	coordinated-care plan	ETC	ESRD Treatment Choices
CEO	chief executive officer	FDA	Food and Drug Administration
CFR	Code of Federal Regulations	FFS	fee-for-service
CGDP	Coverage-Gap Discount Program	FIDE-SNP	fully integrated dual-eligible special-needs plan
CHC	continuous home care	FPL	federal poverty level
CHF	congestive heart failure	FQHC	federally qualified health center
CHIP	Children's Health Insurance Program	FTC	Federal Trade Commission
CJR	Comprehensive Care for Joint Replacement	FY	fiscal year
CKD	chronic kidney disease	g/dL	grams per deciliter
		GAF	geographic adjustment factor

GAO	Government Accountability Office	LDS	Limited Data Set
GASB	Government Accounting Standards Board	LEP	late-enrollment penalty
GDP	gross domestic product	LICS	low-income cost sharing
GIP	general inpatient care	LIP	low-income patient
GLP-1	glucagon-like peptide-1 receptor agonist	LIPSA	low-income premium-subsidy amount
GME	graduate medical education	LIS	low-income subsidy
H-CAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems	LLC	limited liability corporation
HCC	hierarchical condition category	LTCH	long-term care hospital
HCPCS	Healthcare Common Procedure Coding System	LTSS	long-term services and supports
HEDIS	Healthcare Effectiveness Data and Information Set	LUPA	low utilization payment adjustment
HH	home health	LVH	low-volume hospital
HHA	home health agency	LVI	low-volume and isolated
HH-CAHPS	Home Health Care Consumer Assessment of Healthcare Providers and Systems	LVPA	low-volume payment adjustment
HHI	Herfindahl-Hirschman Index	M3P	Medicare Prescription Payment Plan
HHS	Department of Health and Human Services	MA	Medicare Advantage
HI	Hospital Insurance (Medicare Part A)	MACPAC	Medicaid and CHIP Payment and Access Commission
HIDE-SNP	highly integrated dual-eligible special-needs plan	MACRA	Medicare Access and CHIP Reauthorization Act of 2015
HIV	human immunodeficiency virus	MAGI	modified adjusted gross income
HMO	health maintenance organization	MAO	Medicare Advantage organization
HOPD	hospital outpatient department	MA-PD	Medicare Advantage Prescription Drug [plan]
HOPE	Hospice Outcomes & Patient Evaluation	MA-VIP	Medicare Advantage value-incentive program
HPRD	hours per resident day	MCBS	Medicare Current Beneficiary Survey
HSA	hospital service area	MCCM	Medicare Care Choices Model
HUD	Department of Housing and Urban Development	MD	doctor of medicine
HVHDF	high-volume hemodiafiltration	MDP	Manufacturer Discount Program
HVIP	hospital value-incentive program	MDH	Medicare-dependent hospital
ICD	International Classification of Diseases	MDS	Minimum Data Set
ICH-CAHPS	In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems	MedPAC	Medicare Payment Advisory Commission
IME	indirect medical education	MedPAR	Medicare Provider Analysis and Review
IOL	intraocular lens	MEI	Medicare Economic Index
IPF	inpatient psychiatric facility	MEPS	Medical Expenditure Panel Survey
IPO	inpatient only	MFP	maximum fair price
IPPS	inpatient prospective payment systems	MIPS	Merit-based Incentive Payment System
IQR	interquartile range	MIPPA	Medicare Improvements for Patients and Providers Act of 2008
IRA	Inflation Reduction Act of 2022	MLR	medical loss ratio
IRC	inpatient respite care	MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
IRF	inpatient rehabilitation facility	MMP	Medicare-Medicaid Plan
I-SNP	institutional special-needs plan	MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007
KFF	(formerly) Kaiser Family Foundation	MOOP	maximum out of pocket
LDO	large dialysis organization	MPF	Medicare Plan Finder

MRI	magnetic resonance imaging	PLI	professional liability insurance
MS	multiple sclerosis	PMPM	per member per month
MSA	Medicare Savings Account	POS	point of sale
MSA	metropolitan statistical area	PPEO	provisional period of enhanced oversight
MSNI	Medicare Safety-Net Index	PPI	Producer Price Index
MSSP	Medicare Shared Savings Program	PPO	preferred provider organization
MTM	medication therapy management	PPS	prospective payment system
N/A	not applicable	PT	physical therapist
N/A	not available	QMB	qualified Medicare beneficiary
NAMBA	national average monthly bid amount	QPP	Quality Payment Program
NCQA	National Committee for Quality Assurance	QRP	Quality Reporting Program
NDC	national drug code	R&D	research and development
NH	nursing home	RADV	risk-adjustment data validation
NHIS	National Health Interview Survey	RAND	(formerly) RAND Corporation
NORC	(formerly) National Opinion Research Center	RCD	Review Choice Demonstration
NP	nurse practitioner	REH	rural emergency hospital
OASIS	Outcome and Assessment Information Set	REIT	real estate investment trust
OIG	Office of Inspector General	RHC	routine home care
OON	out of network	RHC	rural health clinic
OOP	out of pocket	RN	registered nurse
OPPS	outpatient prospective payment system	RPM	remote physiologic monitoring
OQR	Outpatient Quality Reporting	RPPO	regional preferred provider organization
OR	operating room	RVU	relative value unit
OREC	original reason for entitlement code	RxHCC	prescription drug hierarchical condition category
OT	occupational therapy	SCHIP	State Children's Health Insurance Program
PA	physician assistant	SDOH	social determinants of health
PAC	post-acute care	SEP	special enrollment period
PACE	Program of All-Inclusive Care for the Elderly	SLP	speech-language pathology
Part B-ID	Part B Immunosuppressive Drug Benefit	SMI	Supplementary Medical Insurance
PBJ	Payroll Based Journal	SNF	skilled nursing facility
PBM	pharmacy benefit manager	SNP	special-needs plan
PBP	plan benefits package	SSBCI	special supplemental benefits for the chronically ill
PCP	primary care provider	SSI	Supplemental Security Income
PD	peritoneal dialysis	SSI	surgical-site infection
PDGM	Patient-Driven Groupings Model	TA	targeted amount
PDP	prescription drug plan	TBD	to be determined
PDPM	Patient-Driven Payment Model	TCOC	total cost of care
PE	private equity	TDAP	tetanus, diphtheria, and acellular pertussis
PFFS	private fee-for-service	TDAPA	transitional drug add-on payment adjustment
PFS	physician fee schedule	TPNIES	transitional payment adjustment for new and innovative equipment and supplies
PHC4	Pennsylvania Health Care Cost Containment Council	TrOOP	true out of pocket
PHE	public health emergency	UIC	urban influence code
P.L.	Public Law		

U.S.	United States	VBID	value-based insurance design
USPCC	U.S. per capita cost	VBP	value-based purchasing
USRDS	U.S. Renal Data System	VIP	value-incentive program
VA	Department of Veterans Affairs	WISeR	Wasteful and Inappropriate Services Reduction

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Commissioners' biographies

Lynn Barr, MPH, is the director of the Barr-Campbell Family Foundation, which focuses on rural health, the underserved, education, and the environment. Previously, she recruited and organized small rural hospitals across three states to form the first National Rural accountable care organization (ACO). To manage the ACO's services, she founded and led Caravan Health and was awarded a \$30 million Transformation of Clinical Practice Initiative grant from CMS to provide similar services to rural providers and small practices who were not yet ready to participate in value-based payments. In March 2022, Ms. Barr sold Caravan Health to Signify, a division of CVS Health. Prior to forming Caravan Health, Ms. Barr shepherded four start-up companies and 12 medical inventions through the Food and Drug Administration and worldwide markets. Prior to that, she led the group purchasing of electronic medical records for California's rural hospitals, including individual needs assessments, vendor selection, negotiations, contracting assistance, and financing. Ms. Barr earned her master of public health degree from the University of California, Berkeley.

Paul N. Casale, MD, MPH, is a professor of population health sciences in the Division of Health Policy and Economics, a professor of clinical medicine in the Division of Cardiology at Weill Cornell Medical College, and an adjunct professor of Medicine at Columbia University Vagelos College of Physicians and Surgeons. He previously served as the executive director of NewYork Quality Care, an accountable care organization that is a joint initiative of NewYork-Presbyterian, Columbia University, and Weill Cornell Medical College. Dr. Casale has served on many national committees, including the chair of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and a member of the advisory council of the Agency for Healthcare Research and Quality. Dr. Casale's research focuses on clinical cardiology, value-based care, and payment reform. He has held multiple leadership positions in various health care settings including a rural private practice, a regional health system, and a large urban academic medical center. Dr. Casale earned his medical degree from Weill Cornell Medical College, completed training in cardiology at Massachusetts General Hospital/

Harvard Medical School, and earned his master of public health from the Harvard School of Public Health.

Michael E. Chernew, PhD, is the Leonard D. Schaeffer Professor of Health Care Policy and the director of the Healthcare Markets and Regulation Lab in the Department of Health Care Policy at Harvard Medical School. Dr. Chernew's research examines several areas related to improving the health care system, including studies of novel benefit designs, Medicare Advantage, alternative payment models, low-value care, and the causes and consequences of rising health care spending. He is also a member of the Congressional Budget Office's Panel of Health Advisors and a member of the Massachusetts Health Connector Board. Dr. Chernew is a member of the National Academy of Sciences, a research associate at the National Bureau of Economic Research, and a MITRE fellow. He is currently a coeditor of the *American Journal of Managed Care*. He has served on a number of CMS technical advisory panels reviewing the assumptions used by Medicare actuaries to assess the financial status of the Medicare trust funds. Dr. Chernew previously served on the Commission from 2008 to 2014 and was vice chair from 2012 to 2014. He earned his undergraduate degree from the University of Pennsylvania and his PhD in economics from Stanford University.

Robert A. Cherry, MD, MS, is the associate vice president for clinical affairs and chief health officer at University of California Health and is the chief medical and quality officer at UCLA Health in Los Angeles, CA. Dr. Cherry has extensive experience in quality and safety improvements and value-based care in health systems located in different parts of the U.S. He has coordinated innovative analytical methods to increase clinical quality of care, improve patient experience, and provide value to patients. He also has served on the board of many organizations, including the California Community Foundation, and he was appointed to the California Health Facilities Financing Authority, which helps nonprofit organizations with financing, construction, and remodeling of health facilities. A trauma and critical care surgeon, Dr. Cherry earned his medical degree from Columbia University and a

master's degree in health care management from the Harvard T.H. Chan School of Public Health.

Cheryl L. Damberg, PhD, is director of the RAND Center of Excellence on Health System Performance, distinguished chair in health care payment policy, and a principal senior economist at RAND. Her research explores the impact of strategies to drive cost and quality improvements in health care and the effects of health care consolidation on health care spending and quality performance. She also studies how providers are redesigning health care delivery in response to alternative payment models and has developed strategies to improve the design of value-based payment systems to address disparities in care and improve health equity. Dr. Damberg is an international expert in value-based payment reforms and Medicare payment policy, and she regularly advises the Congress and federal agencies on these and other issues. Dr. Damberg has served on many federal and state committees and currently is a member of the California Healthcare Payments Database Committee that oversees the state's all-payer claims database and the California Department of Managed Care's Quality and Equity Committee. She is an editorial board member of *Health Services Research*. She received her PhD in public policy from the RAND Graduate School of Public Policy and her master of public health degree from the University of Michigan School of Public Health.

Thomas Diller, MD, MMM, is vice president and chief medical officer for the AdventHealth Population Health Services Organization (PHSO) and serves as the president for the AdventHealth Provider Network (AHPN), a clinical integration network. In this role, he oversees clinical operations for the PHSO, including quality and bundles, as well as health and care management. He also has oversight of clinically integrated network governance and leads physician engagement across the network. Dr. Diller has more than two decades of medical management experience with demonstrated expertise in population health, quality and safety, hospital operations, clinical informatics, academics and research. Before joining AdventHealth, he served as vice president of population health and quality transformation for Blue Cross and Blue Shield of Louisiana. Before that, he held various senior clinical leadership roles at entities that include the University of North Texas Health Science Center, CHRISTUS Health, and Greenville Health System.

A board-certified internist, Dr. Diller has practiced internal, emergency, and occupational and preventive medicine. He earned a medical degree from the Southern Illinois University School of Medicine, a master's degree in medical management from Carnegie Mellon University, and a bachelor's degree from Illinois Wesleyan University.

Stacie B. Dusetzina, PhD, is a professor of health policy and an Ingram Professor of Cancer Research at Vanderbilt University Medical Center in Nashville, TN. She has conducted extensive research on topics related to Medicare coverage for and patient access to prescription drugs. This includes studies focused on drug pricing, Medicare Part D benefit design, and Medicare formulary coverage policies. She received her PhD in pharmaceutical sciences from the Eshelman School of Pharmacy at the University of North Carolina at Chapel Hill and postdoctoral training in the Department of Health Care Policy at the Harvard Medical School.

Kenny Kan, FSA, CPA, CFA, MAAA, is vice president and chief actuary of Horizon Blue Cross Blue Shield (BCBS) of New Jersey in Newark, NJ, where he recently helped launch a Medicare Advantage plan. Before joining Horizon BCBS, Mr. Kan was chief actuary for two other large health plans, where he oversaw efforts to assess payment and delivery innovations designed to improve quality and reduce cost. He also served for six years on the Maryland Health Care Commission. He is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. Mr. Kan earned his master's degree in professional accounting from the University of Texas.

R. Tamara Konetzka, PhD, is the Louis Block Professor of Public Health Sciences at the University of Chicago, with a secondary appointment in the Department of Medicine, Section of Geriatrics and Palliative Medicine. She is the codirector of the Health Policy Data Lab and an associate director of the Center for Chronic Disease Research and Policy at the University of Chicago, and she serves as the editor-in-chief of *Medical Care Research and Review*. Her research addresses the incentives created by health care payment policy affecting the quality of post-acute and long-term care, including the effects of public reporting of quality and the costs and benefits of home-based care. She received her PhD in health economics from

the University of North Carolina at Chapel Hill and completed a postdoctoral fellowship at the University of Pennsylvania and the VA Philadelphia.

Joshua Liao, MD, MSc, is an internist, physician executive, and scholar whose work focuses on combining public and private policy with clinical transformation to improve health outcomes. Dr. Liao is the National Associate Vice President for Clinical Transformation at Ascension, one of the nation's largest nonprofit health systems, where he oversees enterprise programs using technology and capabilities, including remote patient monitoring, patient-reported outcomes, clinician decision support, and large-scale engagement campaigns, to engage patients and clinicians and ultimately improve outcomes across diverse communities. He is also a Professor of Medicine and Professor of Health Economics, Systems, & Policy at the University of Texas Southwestern Medical Center, where he founded the Program on Policy Evaluation and Learning. Dr. Liao earned his medical degree Alpha Omega Alpha from Baylor College of Medicine, completed his clinical training at Brigham & Women's Hospital/Harvard Medical School, and obtained his Master of Science in health policy research from the University of Pennsylvania, where he served as Senior Fellow at the Leonard Davis Institute of Health Economics in the Wharton School.

Gokhan Metan, MSc, PhD, NACD.DC, currently serves as the chief risk and technology officer at Catalight, a nonprofit organization providing care for individuals with developmental disabilities, and as cofounder and chairman of the board at WiseCare AI Inc., an AI startup focused on matching Medicare and Affordable Care Act (ACA) beneficiaries with the most suitable health care coverage through a proprietary intelligence platform. In addition, Dr. Metan is the founder and chief technology & analytics officer of Full Spectrum Insights, a consulting firm specializing in data infrastructure, cloud computing, machine learning, AI, and software delivery. Dr. Metan has served as an executive in organizations ranging in size from Fortune 100 companies to start-ups with the aim of creating reliable, high-impact technologies that improve health care access and outcomes. Before his current roles, Dr. Metan held executive positions at Centene Corporation, a publicly traded managed care company; SSM Health, a not-for-profit U.S. health care system; and Humana, the second-largest Medicare Advantage

insurer in the country. He is directorship certified by the National Association of Corporate Directors (NACD, DC). Dr. Metan holds dual master of science degrees in management and industrial engineering and earned his PhD in operations research with a minor in finance from Lehigh University.

Brian Miller, MD, MBA, MPH, is an associate professor of medicine at Johns Hopkins University and a nonresident fellow at the American Enterprise Institute. His research focuses on the Medicare Advantage program, the Food and Drug Administration's (FDA's) regulation of pharmaceutical products and medical devices, and competition in health care markets. His research leverages his previous experience at CMS, the FDA, Federal Communications Commission, and the Federal Trade Commission. Dr. Miller also serves as a trustee for the North Carolina State Health Plan, a \$4.5 billion health plan covering over 750,000 employees, dependents, and retirees. A practicing hospital medicine physician, Dr. Miller earned his medical degree from Northwestern University, a master of public health degree from Johns Hopkins University, and a master's degree in business administration from the University of North Carolina at Chapel Hill.

Gregory P. Poulsen, MBA, is senior vice president at Intermountain Healthcare, an integrated health system based in Salt Lake City, UT. He has vast experience in strategy and policy for providing higher-quality health care while reducing health care costs. In addition, Mr. Poulsen was a key architect of many innovations at Intermountain Healthcare, including offering a Medicare Advantage plan and assisting with the transition to a value-based integrated health care-delivery system. Mr. Poulsen was a founding member of the Commonwealth Fund Commission on a High Performance Health System, has been a board and executive committee member for the American Hospital Association, and trustee for the American Board of Internal Medicine Foundation, and is a national guest scholar at Stanford University. He has also been a member of several other value-focused boards and task forces. He earned his master of business administration degree from Brigham Young University.

Betty Rambur, PhD, RN, FAAN, is the Routhier Endowed Chair for Practice and professor of nursing in the College of Nursing at the University of Rhode

Island, where she has conducted research on such topics as alternative payment models, telehealth nursing, and value-based workforce redesigns. Before joining the University of Rhode Island, Dr. Rambur served on the Green Mountain Care Board—a five-member regulatory, innovation, and evaluation board that has broad responsibility for cost containment and oversight of Vermont's transition to post-fee-for-service provider reimbursement. Previously, Dr. Rambur served as dean of the College of Nursing and Health Sciences at the University of Vermont and was chairperson for the North Dakota Health Task Force, a statewide health care–financing reform initiative. Dr. Rambur received her PhD in nursing from Rush University.

Wayne J. Riley, MD, MPH, MBA, is president of the State University of New York (SUNY) Downstate Health Sciences University, tenured professor of internal medicine and of health policy and management, and the chair of the board of the New York Academy of Medicine. Immediately before joining Downstate, Dr. Riley served as clinical professor of medicine and adjunct professor of health care management at Vanderbilt University and as the 10th president and chief executive officer of Meharry Medical College. He began his career at Baylor College of Medicine, where he completed residency training in internal medicine and held several key administrative posts, including vice president and vice dean for health affairs and governmental relations, assistant dean for education, and assistant chief of medicine at Ben Taub Hospital—a leading public safety-net teaching hospital. Dr. Riley is a member of the National Academy of Medicine (NAM) of the National Academy of Sciences, where he served as vice chair and chair of the NAM section on the administration of health services, education, and research. He is also president emeritus of the American College of Physicians, the nation's largest medical specialty society representing internal medicine, and the president of the Society of Medical Administrators, an organization of 50 of the nation's leading physician-executives. He is an independent director of HCA Healthcare Inc., Compass Pathways PLC, and HeartFlow Group Inc. Dr. Riley earned a BA in anthropology from Yale University, an MPH in health systems management

from the Tulane University School of Public Health and Tropical Medicine, an MD from Morehouse School of Medicine, and an MBA from Rice University's Jesse H. Jones Graduate School of Business.

Scott Sarran, MD, MBA, is the founding chief medical officer of Harmonic Health, a start-up company solely focused on revolutionizing the dementia care journey for patients, caregivers, and providers. Dr. Sarran is also the principal at Triple Aim Geriatrics, where he provides consultative services to managed care entities (payers and providers) to improve systems of care and outcomes for Medicare and dually eligible beneficiaries. His leadership experience includes chief medical officer roles across the payer—both large (Blue Cross Blue Shield IL, Health Care Service Corporation) and small (MoreCare IL, Fidelis Senior Care)—and provider (Advocate Health Care, University of Chicago, Cook County Health) sectors. In all these roles, his focus has been the intersection of improving care for high-risk patients while enabling win-win payer-provider partnerships. Dr. Sarran received his MD from the Northwestern University Feinberg School of Medicine and his MBA from Northwestern's Kellogg School of Management.

Gina Upchurch, RPh, MPH, is the founder and executive director of Senior PharmAssist, a nonprofit organization that helps older adults obtain and manage medication and provides Medicare benefits counseling and tailored community referrals in Durham, NC. Ms. Upchurch is a registered pharmacist and has participated in various committees at the state and national levels, such as the American Geriatrics Society Public Policy Committee and several working groups for the North Carolina Institute of Medicine. She received her bachelor of science degree in pharmacy and her master of public health degree from the University of North Carolina at Chapel Hill, where she also completed her geriatric pharmacy practice residency and still holds adjunct positions. In 2001, she was named a Robert Wood Johnson Community Health Leader for her patient advocacy and health-literacy efforts. Ms. Upchurch began her career as a science teacher with the U.S. Peace Corps in Botswana.

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