

MedPAC Holds January 2026 Meeting

On January 15 and 16, 2026, the Medicare Payment Advisory Commission (MedPAC) held a public meeting, which included the following sessions:

By law, the Commission reviews Medicare's fee-for-service (FFS) payment policies each year and makes payment update recommendations. MedPAC's recommendations are typically informed by four indicators: beneficiaries' access to care, quality of care, access to capital, and provider revenues and costs. In this month's meeting, commissioners voted on draft recommendations originally presented in December 2025, which included:

- Assessing payment adequacy and updating payments: Physician and other health professional services;
- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; and,
- Assessing payment adequacy and updating payments: Skilled nursing facility services; home health agency services; inpatient rehabilitation facility services; outpatient dialysis services; and hospice services.

Other sessions included:

- Mandated report: The impact of recent changes to the home health prospective payment system;
- Analyzing recent increases in Part D bids;
- Medicare Part D: status report;
- Ambulatory Surgical Centers: status report;
- The Medicare Advantage program: status report; and,
- Mandated report: Dual-eligible special-needs Plans.

The full agenda for the meeting and presentations for the sessions are available [here](#).



MEDPAC RECOMMENDS BUMP TO PHYSICIAN AND OTHER HEALTH PROFESSIONAL SERVICES ABOVE CURRENT LAW

This session followed MedPAC's December meeting, where staff provided an in-depth look at spending under Medicare's Physician Fee Schedule (PFS), and presented their draft recommendation. MedPAC staff highlighted that beneficiaries continue to have good access to clinician services, that quality of care remains difficult to assess, and that clinician revenues and costs remain somewhat positive. PFS spending has grown substantially faster since 2000 than the Medicare Economic Index (a measure of inflation in the sector) at 104 percent versus 56 percent, though has significantly outpaced payment updates over the same period (14 percent). Staff also briefly touched on changes expected to increase total payments to primary care providers. For a more detailed discussion on MedPAC staff research and commissioner discussion, see our December MedPAC summary.

In the follow-up discussion, several Commissioners raised concerns that the recommended update would represent a net negative payment update relative to clinician cost growth and could contribute to consolidation and workforce pressures. Commissioners also questioned whether existing access measures fully capture emerging access challenges, particularly for primary care and specialty services, and discussed trends such as the growth of concierge and corporate-affiliated practices. Other Commissioners expressed support for the recommendation, noting the need to balance beneficiary access with the financial burden that higher payment rates could impose on beneficiaries and taxpayers, and emphasizing that overall access indicators remained strong.

The draft recommendation presented to the Commission stated that, for Calendar Year (CY) 2027, Congress should increase payment rates for physician and other health professional services by 0.5 percent more than current law. A majority of Commissioners voted in favor.

COMMISSION RECOMMENDS NO CHANGE FOR HOSPITAL INPATIENT AND OUTPATIENT SERVICES, AND CONTINUES RECOMMENDING ITS MEDICARE SAFETY-NET INDEX

In a second follow-up session from their December meeting, the Commission returned to its prior assessment of payment adequacy for hospital inpatient and outpatient services. Staff briefly summarized the framework used to evaluate payment adequacy for general acute care hospitals, noting that beneficiary access to hospital care remained strong in FY 2024, quality of care was mixed, hospital access to capital was

positive and improved, and FFS margins (though still low) have continued to increase. The Commission also highlighted its standing recommendation, established in 2023, to better target Medicare payments to hospitals serving large shares of low-income beneficiaries through the Medicare Safety-Net Index (MSI). For a more detailed discussion on MedPAC staff research and commissioner discussion, see our December MedPAC summary.

The draft recommendation presented was: 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.*

The recommendation was approved by a strong majority of Commissioners, with one abstention. Commissioners supporting the recommendation emphasized that it balances maintaining beneficiary access to hospital care, preserving fiscal pressure for efficiency, and better targeting additional resources to safety-net hospitals serving vulnerable populations.

MEDPAC APPROVES RECOMMENDATIONS TO REDUCE OR ELIMINATE PAYMENT INCREASES FOR SNFS, IRFS, HOME HEALTH, OUTPATIENT DIALYSIS SERVICES, AND HOSPICE SERVICES

In the third and final follow-up session from the December meeting, the Commission briefly revisited payment adequacy indicators for skilled nursing facility (SNF) services, home health agency (HHA) services, inpatient rehabilitation facility (IRF) services, outpatient dialysis services, and hospice services. For a more detailed discussion on MedPAC staff research and commissioner discussion, see our December MedPAC summary.

For SNFs, indicators of beneficiary access to care, quality of care, access to capital, and FFS Medicare payments and costs were positive or stable. *The Commission voted unanimously to recommend reducing the 2026 Medicare base payment rates for skilled nursing facilities by 4 percent for fiscal year 2027.*

For HHAs, MedPAC staff assessed beneficiary access to care, quality of care, access to capital, and Medicare payment and cost data as positive or stable. In a follow-up discussion, Commissioners addressed delays in initiating home health care and differences between fee-for-service Medicare and Medicare Advantage, though generally agreed that the indicators supported a reduction in payment rates. *The*

Commission voted unanimously to recommend reducing the 2026 Medicare base payment rates for home health agencies by 7 percent for Calendar Year (CY) 2027.

For IRFs, MedPAC staff reported that beneficiary access to care, quality of care, access to capital, and FFS Medicare payments and costs indicators were positive or stable. *The Commission voted unanimously to recommend reducing the 2026 Medicare base payment rates for IRFs by 7 percent for CY2027.*

For outpatient dialysis services, access to capital and FFS Medicare payments and costs were assessed as adequate, while beneficiary access to care was stable, and quality of care was mixed. *The Commission recommends that Congress eliminate the 2026 update to the Medicare base payment rate in CY2027, with the majority of Commissioners voting in favor and two abstentions.*

Finally, staff summarized payment adequacy indicators for hospice services. Overall, beneficiary access to care, quality of care, access to capital, and FFS Medicare costs and payments were positive or stable. *Despite some Commissioner concerns regarding oversight and quality variation, the Commission recommended eliminating the 2026 update to hospice base payment rates for FY2027. The Commission voted unanimously in support of the recommendation.*

COMMISSION'S FINAL REVIEW OF MANDATED REPORT ON HOME HEALTH PATIENT-DRIVEN GROUPINGS MODEL SHOWS LARGELY POSITIVE FINDINGS

The Bipartisan Budget Act of 2018 mandates that the Commission report on the impact of recent changes to the home health prospective payment system (PPS). This session was the final public discussion of the report before its March 15, 2026, due date and builds on work from the October 2024 and December 2025 meetings.

The analysis focuses on the effects of shortening the unit of payment from 60 days to 30 days and removing therapy visit thresholds as payment adjusters through the implementation of the Patient-Driven Groupings Model (PDGM), which measures patient severity through five dimensions, and began in 2020. Staff emphasized that its implementation during the onset of the COVID-19 pandemic presents implementation challenges.

Staff reported that PDGM was associated with changes in utilization patterns but had little effect on overall access, quality, or profitability. From 2016 to 2023, the share of fee-for-service (FFS) beneficiaries receiving home health services declined modestly (from 9.8 percent to 8.6 percent), while total visits per stay declined substantially (from

19.6 to 15.9). Staff ascribed this primarily to a reduction in therapy visits, while nursing visits declined to a lesser extent. Staff noted that the reduction in therapy visits is consistent with the policy goal of removing incentives to furnish therapy based on payment thresholds rather than patient need. Staff highlighted that the probability of an FFS beneficiary receiving home health care remained almost unchanged in 2023 (8.8 percent versus 8.6 percent), though estimated a slight increase in the probability of a post-institutional stay (+0.3 percent), and a lower probability of at least one community-admitted stay (-0.8 percent)

With respect to quality, staff found little change across most measures. Rates of potentially preventable hospitalizations declined, discharge-to-community rates remained stable, and there were no substantial changes in measures of improvement in self-care or mobility. A newly added quality measure reviewed at the January meeting similarly did not indicate deterioration in care following PDGM implementation. Staff emphasized that these findings suggest that reductions in visit volume were not accompanied by widespread declines in measured quality.

Staff also reviewed financial performance and found that PDGM was not associated with a statistically significant change in Medicare margins across demographic, clinical, or service-use groups in 2023. Regardless of PDGM's effects, staff reiterated that FFS Medicare payments for home health remain well above costs. Medicare margins for freestanding home health agencies were approximately 21 percent in 2024, consistent with prior findings discussed in earlier sessions.

Commissioner Discussion

Commissioner discussion focused on the analytic challenges inherent in evaluating a nationwide payment reform implemented during the pandemic and generally expressed support for the rigor and transparency of the approach used. Commissioners raised questions about differences between community-admitted and post-hospital patients, the role of functional status data collected through Outcome and Assessment Information Set (OASIS) assessments, and the reliability of those data for comparative quality analysis. Several commissioners also discussed the limited use of home health aide and social work visits and whether greater availability of supportive services in the home could reduce reliance on more costly post-acute settings, though staff noted that these issues were largely outside the scope of the mandated analysis.

Commissioners emphasized that the report provides important evidence that recent payment system changes were associated with reductions in visit volume—particularly therapy visits—without clear adverse effects on access, quality, or provider profitability. Findings will inform future policy discussions as the Commission continues to monitor

utilization patterns, quality measurement, and the role of home health care within the broader post-acute care continuum.

MEDPAC EXAMINES IMPLICATIONS OF THE INFLATION REDUCTION ACT PROVISIONS ON PART D PLAN BIDS

In this session, the Commission reviewed its assessment of recent increases in Medicare prescription drug (Part D) plan bids, focusing on changes following implementation of the Inflation Reduction Act (IRA) of 2022 and subsequent shifts in benefit design. Commissioners then discussed drivers of bid growth, implications for Medicare costs and beneficiary premiums, and factors affecting plan stability.

The IRA introduced a redesigned Medicare Part D benefit, lowering beneficiary cost sharing, imposing caps on premium growth, and shifting the role of the capitated monthly direct subsidy as the primary mechanism for subsidizing Part D premiums rather than Medicare's cost-based reinsurance payments. Under the redesigned benefit, cost-sharing changes include removal of the coverage gap, elimination of cost sharing once enrollees reach the out-of-pocket limit, and a new out-of-pocket cap that was lowered from \$8,000 under 2024 rules to \$2,000 in 2025 (updated annually for inflation), with cost sharing and liability structures further evolving in 2026. Additionally, in 2026, negotiated prices for the first 10 drugs under the Medicare Drug Price Negotiation Program became effective, further shifting Part D financing dynamics.

The Commission reviewed Part D plan bid data through 2026, noting the definition and role of the National Average Monthly Bid Amount (NAMBA), which is the enrollment-weighted average of plan bids for basic Part D benefits used to calculate Medicare's capitated direct subsidy to plans. NAMBA increased substantially in recent years, rising by approximately 180 percent in 2025 relative to 2024 and by 33 percent in 2026 relative to 2025. The NAMBA reflects shifts in both plan liability and expected drug spending. Medicare's total subsidy for basic benefits, including the capitated direct subsidy and expected reinsurance, increased by 53 percent in 2025 and 40 percent in 2026.

Staff highlighted the drivers of bid growth. In 2025, most of the increase was related to a shift in benefit financing that increased plan liability through reductions in beneficiary cost sharing and Medicare reinsurance, including a lower share of benefits covered by Medicare's expected reinsurance and a greater role of direct subsidy. In 2026, bid growth was primarily related to higher expected drug spending and continued uncertainty about utilization and pricing under the redesigned benefit.

Preliminary bid data show that plans' average expected basic benefit costs and national bid amounts continued to rise from 2024 through 2026. Analyses decomposed growth into relative contributions from shifts in financing to plan liability (such as reductions in beneficiary cost sharing and Medicare reinsurance) and higher overall expected drug spending, including utilization trends for high-cost products like GLP-1s.

The effects of Medicare policies aimed at limiting premium increases for beneficiaries were also discussed. Without policies such as the Inflation Reduction Act's 6 percent cap on base beneficiary premium growth and the Part D Premium Stabilization Demonstration, MedPAC staff estimated that average premiums could have grown by 18 percent in 2024 and 44 percent in 2025. In 2026, the average expected basic premium was \$13 per member per month, compared with \$75 in a hypothetical scenario without stabilization policies, with the difference financed in large part by higher Medicare direct subsidies and stabilization demonstration payments. These effects varied by plan type.

Staff also reviewed findings from interviews with CMS actuaries regarding Part D plan bids and underlying cost projections. Actuaries highlighted the challenges plans face in projecting costs under the redesigned benefit, noting that limited historical data and the introduction of new provisions, such as lower out-of-pocket caps and drug price negotiation, have increased uncertainty. They observed that while plan bids include margins to account for financial risk, preliminary data suggest these margins remain relatively small. Actuaries also emphasized the difficulty of separating cost growth due to policy-induced shifts in financing from growth driven by higher expected drug spending, particularly for high-cost drugs and specialty products. These findings informed the Commission's consideration of plan stability and the implications for Medicare spending and beneficiary premiums.

The background analysis emphasized that the Part D bid increases are driven by a combination of policy-induced changes in benefit design and financing, expected growth in drug spending, and uncertainty for plans in projecting costs under the redesigned benefit. Medicare's share of basic benefit costs increased significantly under current policies, while beneficiaries' share declined.

Commissioner Discussion

During the Commission's discussion, members focused on clarifying the drivers of the steep increase in plan bids and the implications for beneficiaries' premiums and Medicare's costs. Commissioners expressed interest in the relative contributions of shifts in financing versus underlying drug spending to recent bid growth. Several members emphasized the role of changes in cost sharing and liability structures, particularly the lower out-of-pocket cap and shifting responsibility from Medicare

reinsurance to plan liability, and they sought clarity on how these elements are incorporated into bid projections. Commissioners also discussed uncertainty in bidding due to limited historical data under the redesigned benefit and the effects of the Drug Price Negotiation Program on rebate patterns and plan expectations.

Members questioned how the bid increases translate into actual premiums paid by beneficiaries, noting that stabilization policies and Medicare direct subsidies have moderated premium growth relative to unadjusted bid increases. Commissioners asked about the sustainability of policies such as the premium stabilization demonstration and the 6 percent base beneficiary premium cap beyond their current temporary status, and the potential effects on beneficiary premiums and plan participation once those policies expire. External pressures on plan margins and actuarial uncertainty were also listed as concerns, with members noting that plans may adjust strategies differently in 2026 and beyond, given persistent uncertainty about utilization, pricing trends for high-cost drugs, and the full effects of negotiated prices under the IRA.

The Commission also discussed broader market implications, including competitive dynamics in the PDP and MA PD markets, risk adjustment, and potential policies to support long-term stability of standalone PDPs given the changing bidding environment. Commissioners highlighted the need for ongoing monitoring of bid trends, plan behavior, and the implications of benefit design changes for beneficiaries, particularly those with high drug spending. Most members acknowledged that while policies to stabilize premiums have helped mitigate near-term volatility for enrollees, continued evaluation of long-term impacts on premiums, Medicare spending, and plan stability is needed.

MEDPAC PROVIDES A STATUS REPORT ON MEDICARE PART D

In this session, the Commission reviewed the status of the Medicare Part D prescription drug program, including enrollment, plan availability, beneficiary access and quality, program spending, and the effects of recent policy changes on the structure of the Part D market. Staff noted that while enrollment remained strong, the total number of available plans declined, and Medicare program spending increased significantly.

In 2025, 56 million Medicare beneficiaries, or 80 percent, were enrolled in Part D, including 13.6 million beneficiaries receiving the low-income subsidy (LIS). Enrollment in standalone prescription drug plans (PDPs) totaled 23 million, representing 42 percent of all Part D enrollees, while enrollment in conventional Medicare Advantage prescription drug plans (MA-PDs) reached 25 million. Enrollment in Special Needs Plans (SNPs) reached 7 million, driven by growth in C-SNPs and enrollment by non-LIS beneficiaries. Staff noted that continued growth in MA-PD and SNP enrollment reflects

an ongoing shift in the Part D market toward integrated plan designs, with PDP enrollment falling from 60 percent to 42 percent over the last decade.

Plan availability declined notably in 2026, with the total number of plans falling to 5,030. The number of PDPs declined by 22 percent, largely due to a 34 percent reduction in the number of enhanced plans. Despite these declines, beneficiaries in every region have access to an average of 11 PDPs and 32 MA-PDs in 2026, and every region has at least one premium-free benchmark PDP. Average total beneficiary premiums for 2026 differ significantly between plan types, with PDPs at \$60 and MA-PDs at \$11 after accounting for MA buydowns.

Staff reviewed the most recent complete spending and utilization data, noting that total Medicare program spending reached \$132.1 billion in 2024, an 18 percent increase from the prior year. This growth was driven by a 389 percent increase in the capitated direct subsidy. Beneficiary spending remained relatively stable at \$34.4 billion, though basic premiums grew by 6 percent while cost-sharing decreased by 6 percent. Single-source drugs continue to affect costs significantly; while generics account for 90 percent of prescriptions, single-source drugs accounted for over 83 percent of gross Part D spending in 2024, up from 70 percent in 2014. Additionally, Medicare's net risk-corridor payments to plans totaled \$3.6 billion in 2024, the largest such payments since 2006.

Measures of beneficiary experience remained generally positive with high CAHPS ratings on satisfaction and value, although average star ratings declined in 2024. Staff also presented an analysis of the Medicare Plan Finder, finding that prices during the Annual Enrollment Period (AEP) generally aligned with those at the start of the 2024 benefit year, with most oral drug products experiencing price changes of \$0.10 or less.

Commissioner Discussion

During the discussion, Commissioners focused on the implications of recent trends for program stability, affordability, and beneficiary protection. Members emphasized the sharp reduction in PDP availability and expressed concern about the concentration of enrollment among fewer plans, particularly in regions with only one benchmark PDP. Commissioners discussed how declining PDP participation could affect beneficiary choice, competition, and long-term market viability, especially for beneficiaries who are not eligible for Medicare Advantage or SNPs. Several members linked these concerns to declining PDP participation and increased market concentration, noting potential downstream effects on pharmacy contracting and beneficiary access.

Commissioners also examined spending trends driven by high-cost drugs, including single-source drugs and biologics, and noted the growing number of beneficiaries

reaching the out-of-pocket threshold. Members discussed how changes in benefit design may alter beneficiary behavior, manufacturer incentives, and plan strategies, particularly for beneficiaries with very high drug spending.

Pharmacy access and market structure were recurring themes. Commissioners raised concerns about the role of vertically integrated plans and pharmacy benefit managers and their implications for pharmacy networks, independent pharmacies, and beneficiary access. Members discussed the need for additional analysis of network adequacy, pharmacy participation, and the potential effects of consolidation on medication access and safety.

Several Commissioners highlighted limitations in beneficiaries' awareness of the true prices of prescription drugs and discussed the challenges this creates for cost-conscious decision-making. Members emphasized the importance of medication therapy management and coordination of care, noting concerns about medication safety when beneficiaries obtain prescriptions from multiple sources.

The Commission concluded that while Part D continues to provide essential prescription drug coverage to a large share of Medicare beneficiaries, ongoing monitoring and evaluation are needed to assess the effects of recent policy changes on enrollment, plan participation, spending, access, and beneficiary experience, particularly as the Part D market continues to evolve.

MEDPAC REVIEWS AMBULATORY SURGICAL CENTER STATUS REPORT

In this session, MedPAC staff presented their annual status update on Ambulatory Surgical Centers (ASCs). These facilities offer outpatient surgical procedures and are paid based on Outpatient Prospective Payment System (OPPS) rates, adjusted by an ASC conversion factor. On average, ASC payment rates are 44 percent lower than OPPS rates. ASCs have certain advantages over a traditional outpatient setting, including lower cost-sharing and easier scheduling for patients, as well as opportunities to improve physician efficiency through customized surgical environments and the ability to hire specialized staff.

In 2024, 6,436 ASCs served 3.4 million Medicare beneficiaries across 6.4 million surgical procedures, generating \$7.5 billion in FFS payments. The average FFS Medicare payment per beneficiary receiving ASC services increased by 13.1 percent from 2023 to 2024, from \$1,954 to \$2,211. The sector has shown steady growth over the last five years, with the number of facilities increasing by 2.3 percent annually between 2019 and 2023 and by 2.2 percent in 2023-2024. ASCs are also primarily clustered in certain states (e.g., Maryland) and are almost exclusively found in urban areas (94 percent in 2025). Responding to a commissioner's question, MedPAC staff noted that one reason

for this geographic discrepancy is insufficient patient concentration in rural areas. ASC volume has also continued to expand, though it remains highly concentrated in a small number of procedures. Extracapsular cataract removal with Intraocular Lens (IOL) insertion alone accounted for 18 percent of total ASC volume in 2024, and 50 percent of total volume was concentrated in only 7 procedures. The volume of total hip, knee, and shoulder replacements is rapidly increasing. ASCs also treat fewer dual-eligible, disabled, and 85+ beneficiaries than HOPDs, and outcome measures from the ASC Quality Reporting (ASCQR) program have remained largely static over the last three years. Previously, MedPAC recommended that ASCs collect and submit cost report data, citing that the lack of available information limits CMS's ability to tailor payment rates.

Commissioner Discussion

Commissioners touched on several issues, including substitution effects from ASCs, reimbursement (including facility fees), state-level certificate-of-need requirements, and cherry-picking, among others. In response to a question on whether there was any existing research into the potential substitution effects of ASCs versus HOPDs or physician offices, MedPAC staff stated that the available evidence is limited and suggests it does occur, citing cataract removal with IOL insert as one example.

Commissioners had a broader discussion about reimbursement, with several noting that both HOPDs and ASCs can charge facility fees, unlike many physician offices, and some urging site-neutral payments. One commissioner highlighted that many ASCs are physician-owned and offer important efficiencies, another how some payors prefer ASCs, while a third raised concerns about the role of private equity in the ASC market. Some saw physician-owned ASCs as a positive market force, particularly for treating patients in the appropriate setting, while two commissioners raised concerns about cherry picking and referral incentives. This also coincided with the broader theme of ensuring patients are treated in the appropriate setting, with the Chairman noting the difficulty of quantifying this using available data. Several commissioners argued for more quality data, with some requesting that payment be linked to quality. Two commissioners presented opposing views on whether ASCs should be required to report cost data.

The discussion also touched on certificate of need laws, with commissioners offering mixed views. These laws, in effect in some states, require governmental approval through the issuance of a certificate of need to construct new healthcare facilities. A commissioner requested further investigation into the topic, particularly given that aspects of the Rural Health Transformation Program in the recently passed One Big Beautiful Bill Act of 2025 are set to reward states for suspending these laws.

The Chairman ended the session by raising two additional topics for future investigation: an analysis of whether ASCs increase volume inappropriately when introduced into a market, and whether MedPAC should recommend increased flexibility or accountability for Alternative Payment Models (APMs) that encourage entities to discern the appropriate location of care safely and efficiently.

MEDPAC PROVIDES STATUS UPDATE ON THE MEDICARE ADVANTAGE PROGRAM

In this session, MedPAC staff presented a status report on the Medicare Advantage (MA) program. The MA program allows beneficiaries to receive Medicare benefits through private health plans rather than the traditional Fee-for-Service (FFS) program. For 2025, MA enrollment continued to grow, with 55 percent of eligible beneficiaries enrolled in MA plans. At both the national and local levels, the market remains highly concentrated with 3 large Medicare Advantage Organizations (MAOs)—UnitedHealth Group, Humana, and CVS Health—enrolling over half of all enrolled beneficiaries. However, the Commission also found that general access to MA plans remains positive. In 2026, 99 percent of beneficiaries have access to an MA plan, and 98 percent have access to a \$0 premium plan with Part D coverage. While the average number of plan choices per beneficiary is projected to decrease slightly, the number of insurers remains stable at an average of 8.

The Commission continued with an examination of rebates and supplemental benefits. MA rebates are projected to reach an all-time high, averaging \$222 per enrollee per month across all non-employer plans in 2026. These rebates finance extra services, reduced premiums, Part D benefit enhancements, and reduced cost-sharing. In 2023, MAOs spent nearly \$24 billion on non-Medicare services, with dental benefits (28 percent) and non-medical supports such as food or housing (24 percent) comprising the majority of spending.

The Commission then examined the MA plan payment structure and its impact, with MedPAC staff estimating that MA payments remain significantly higher than what Medicare would spend for similar beneficiaries in FFS. Although reduced from prior years, for 2026, MA payments are projected to be 114 percent of FFS spending—or \$76 billion more than FFS spending. This 14 percent excess is driven primarily by the increased intensity and differing patterns of MA coding relative to FFS (4 percent), as well as favorable selection of beneficiaries by MA plans (11 percent). To bridge this gap, staff highlighted that the V28 risk model is being phased in from 2024 through 2026 to improve base rate comparisons, favorable selection, mapping, and reduce coding intensity.

Additionally, at the request of commissioners, the analysis was expanded to examine MA plans for those with End Stage Renal Disease (ESRD). Since the 21st Century Cures Act (2016) allowed ESRD beneficiaries to join MA in 2021, their enrollment has surged from 27 percent in 2020 to 55 percent of eligible beneficiaries in 2024. MA plans often pay more for dialysis than FFS (averaging 122 percent of FFS rates in 2022), while plan revenues for ESRD beneficiaries have grown faster than their medical costs. For 2026, payments for ESRD enrollees are projected to be 12 percent above FFS levels, though they represent only 6 percent of MedPAC's overall MA payment estimate.

Commissioner Discussion

During the discussion, Commissioners emphasized the persistent issue of MA overpayment, driven by favorable selection and coding intensity. Several members expressed concerns that the MA program remains "overfunded" despite the positive impact of the V28 risk model. A recurring theme was the lack of transparency and data surrounding supplemental benefits and rebates. The Commissioners noted that while these benefits are essential for low-income beneficiaries, the "dizzying array" of options creates confusion and limits full use, prompting discussion of a potential "flexible spending card". There was also a strong call for structural reforms, including standardizing plan choices to reduce complexity, implementing budget-neutral quality bonus payments, and addressing current incentives for intensive coding by MA plans. Overall, the discussion emphasized the need to rebalance the program's profitability and "clumsy" benefit delivery with taxpayer protections.

COMMISSION REVIEWS DUAL-ELIGIBLE SPECIAL NEEDS PLANS FOR MANDATED REPORT

In this session, MedPAC highlighted the challenges and performance of providing integrated care for the approximately 12 million individuals dually eligible for Medicare and Medicaid.

The Commission highlighted challenges in caring for dual-eligible populations, who tend to have poorer health and higher costs. Beneficiaries often experience fragmented and poorly coordinated care between Medicare and Medicaid. To address this, policymakers developed specialized Medicare Advantage (MA) plans known as D-SNPs to better integrate benefits.

Enrollment in D-SNPs has grown rapidly among eligible beneficiaries, from 14 percent in 2014 to 46 percent in 2024. However, the level of Medicaid integration varies significantly by level of D-SNP:

- Coordination-Only D-SNPs: Lowest integration; currently holds 27 percent of dually eligible beneficiaries.
- Highly Integrated Dual Eligible (HIDE) SNPs: Medium integration; holds 15 percent of dually eligible beneficiaries.
- Fully Integrated Dual Eligible (FIDE) SNPs: Highest integration; holds only 3 percent of dually eligible beneficiaries.

Statutory requirements for these plans have become more extensive over time, moving from no specific requirements to mandated coordination standards.

To assess D-SNPs, the Commission analyzed Healthcare Effectiveness Data and Information Set (HEDIS) clinical quality data, risk-adjusted utilization measures, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys across 5 plan types. In terms of clinical quality, HIDE and FIDE SNPs with aligned enrollment showed the best overall performance, whereas other plans performed the worst. For risk-adjusted utilization, HIDE and FIDE SNPs without aligned enrollment performed best, while Medicare-Medicaid Plans (MMPs) performed the worst. However, CAHPS scores showed very little variation across plan types, with most ratings between 87 and 90.

Finally, MedPAC identified a growing concern regarding "look-alike" plans, which are MA plans that target dually eligible individuals without meeting formal D-SNP requirements. While CMS has limited conventional look-alikes by closing plans with more than 60 percent dually eligible enrollees, insurers are increasingly using Chronic Condition Special-Needs Plans (C-SNPs) to bypass these restrictions. MedPAC estimates that C-SNPs functioning as look-alikes account for 10 percent of overall C-SNP growth in recent years, expanding from 400,000 beneficiaries in 2021 to 1.3 million in 2025. As a result, MedPAC suggests that CMS consider broadening restrictions to include C-SNPs to prevent them from undermining state efforts to promote truly integrated care.

Commissioner Discussion

In their discussion, Commissioners explored the complex relationship between plan integration and downstream outcomes. They noted that although highly integrated plans such as HIDE and FIDE SNPs generally show better clinical performance, the overall evidence remains mixed. They emphasized that integration is not the only way to create value for dually eligible beneficiaries, and some suggested shifting the focus toward holding all plans accountable for results rather than focusing on integration levels. A significant portion of the discussion also focused on "look-alike" plans and the

rapid growth of C-SNPs as alternatives to D-SNPs. Commissioners expressed concern that these plans might bypass integration requirements while "cherry-picking" healthier beneficiaries, thereby undermining state-led coordination efforts. Additionally, they highlighted the importance of user convenience and consumer-facing benefits—such as dental and vision—noting that beneficiaries often prioritize these immediate supplemental benefits over broader clinical coordination.

This Applied Policy® Summary was prepared by [Hugh O'Connor](#) with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact him at hoconnor@appliedpolicy.com or at (202) 558-5272.