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MedPAC Releases March 2026 Report to Congress

Each March, the Medicare Payment Advisory Commission (MedPAC) is required to report to Congress on the Medicare fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare prescription drug program (Medicare Part D). This report also includes chapters on trends and issues in post-acute care, a status report on Ambulatory Surgical Centers (ASCs), the home health prospective payment system, and dual-eligible special needs plans. The report was released on March 12, 2026, and can be found here.

MEDPAC PROVIDES CONTEXT FOR MEDICARE PAYMENT POLICY

National healthcare spending in the United States continues to surpass economic growth. In 2024, U.S. healthcare spending reached $5.3 trillion (18 percent of the GDP), with recent years showing rapid growth driven by increased service volume, medical prices, and high insurance coverage, with the share of the U.S. population with health insurance reaching an all-time high (of 92 percent in 2022 through 2024). Spending growth in 2023 and 2024 was 7 percent annually, reversing pandemic-related declines, and is expected to continue at similar rates in 2025.

Drivers of Medicare 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 resulted in a shift of the cost of prescription drugs from beneficiaries to the federal government. By the mid-2030s, Medicare spending is expected to equal more than 5 percent of GDP.

- Continued growth in Medicare enrollment over the next decade, as correlated to more of the baby-boom generation reaching Medicare's eligibility age, contributes to increased Medicare spending.

- Growth in volume and intensity of the services and items delivered to patients and growth in the average price of Part B drugs are also projected to drive up Medicare spending.

- Medicare draws an increasing share of tax revenues, with Medicare spending per beneficiary growing more quickly for items and services covered under Part B than under Part A or Part D.

Medicare Spending and Revenue Trends

- Medicare spending per beneficiary has grown faster for Part B than for Parts A and D, driven by increased outpatient services and drug utilization. In 2024, an amount equivalent to 16 percent of federal income taxes was used for Parts B and D.

- Projections indicate that the Medicare Trust fund will be insolvent by 2033.

Beneficiary Costs and Affordability

- Rising Medicare spending increases premiums and cost sharing, affecting beneficiaries with modest resources and especially those with low income or FFS beneficiaries enrolled without supplemental coverage.

- Certain groups, such as disabled and low-income beneficiaries, face higher affordability issues.

- The proportion of beneficiaries qualifying due to disability has declined, and overall health status has improved, with more beneficiaries reporting being in "very good" health.

- In 2024, 67 million beneficiaries were enrolled in Medicare. By 2029, all members of the Baby-boom generation will have reached age 65, and Medicare enrollments will reach 75 million, up from 49 million in 2011 when the generation first began to reach Medicare's eligibility age.

Impact of Consolidation on Healthcare Spending

- Provider consolidation has increased, in part due to hospital mergers, physician practice acquisitions, and cross-market mergers, leading to higher bargaining power and payment rates. While consolidation can improve care coordination, it often results in higher payments and greater market concentration, particularly in inpatient hospital markets.

- Private insurers, including UnitedHealth, Humana, and CVS Health are acquiring or contracting with hospitals, physician groups, and pharmacies, controlling significant market shares.

- Non-provider organizations like private equity (PE) firms are increasingly investing in physician practices, especially high-revenue specialties, with PE ownership rising from 4.5 percent in 2022 to 6.5 percent in 2024. This has

resulted in significant price increases, with some studies reporting up to 7.8 percent rise in prices and higher charges per case.

- Consolidation enhances bargaining power for higher payment rates with private insurers and Medicare, often exploiting site-based payment differentials to increase Medicare reimbursements.

MEDPAC RECOMMENDS PAYMENT UPDATES

MedPAC assesses payment adequacy using the most recently available data, considering beneficiaries' access to care, the quality of care provided, providers' access to capital, and how Medicare payments compare with providers' costs. Recommendations for Medicare fee-for-service (FFS) payment updates for 2027 are based on the most recent available data, which is from 2024 in most cases. The table below summarizes MedPAC's payment update recommendations and rationale.

Payment System	Payment Update Recommendation *Italicized text quotes MedPAC's recommendations*	Rationale and Expected Changes
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.*	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 (to be distributed across hospitals' FFS and MA patients), less than the recommendation of prior years. MedPAC's analysis indicates that the combination of both recommendations would maintain beneficiary access, move hospital payments closer to the cost of efficiently delivering high-quality care, and better target resources to hospitals serving large groups of low-income Medicaid beneficiaries.
Physician and other health	*For calendar year 2027, the Congress should increase payment rates for physician and other health*	Based on the Commission's indicators, current payments to clinicians appear to be adequate to ensure access to care, yet it is projected that clinicians will face moderate rates of input cost growth which

professional services	*professional services by 0.5 percentage points more than current law.*	could exceed payment rate updates and be difficult to absorb. The recommendation would increase payment rates in 2027 by a total of 1.25 percent for qualifying clinicians participating in Advanced Alternative Payment Models (A-APMs) and by a total of 0.75 percent for other clinicians, while net payment rates for 2027 would be 1.2 percent and 1.7 percent lower, respectively, than in 2026.
Outpatient dialysis services	*For the calendar year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rate for outpatient dialysis services.*	The Commission found payment adequacy indicators for outpatient dialysis services to be generally favorable. The capacity of dialysis facilities appeared to be aligned with demand from Medicare beneficiaries on dialysis. Between 2023 and 2024, there was an 8 percent decline in FFS treatments, primarily due to a shift of beneficiaries on dialysis from FFS Medicare to MA. In terms of quality of care, fluid and anemia management for FFS beneficiaries on dialysis were steady in the same time frame. Furthermore, access to capital for dialysis providers remained strong, and the FFS Medicare payment per treatment in freestanding dialysis facilities grew by 2 percent, while the cost per treatment declined by 3 percent. Under current law, the FFS Medicare base payment for dialysis services is projected to increase by 1.6 percent. Given the positive trend in most payment adequacy indicators, this recommendation would eliminate the update to the 2026 base payment rate.
Skilled nursing facility services	*For fiscal year 2027, the Congress should reduce the 2026 base payment rates for skilled nursing facilities by 4 percent.*	MedPAC recommends other approaches, such as replacing the VBP program with a program that includes large incentive payments to redistribute FFS Medicare payments. This recommendation is to accommodate providers that do not perform well under the SNF PPS.

		Current law is expected to increase payment rates by 2.3 percent in FY 2027. This recommendation is expected to lower spending relative to current law by $2-$5 billion over a year and $10-$25 billion over five years. Impacts on patient access to SNF care and on provider willingness and ability to provide care are not expected.
Home health care services	*For fiscal year 2027, the Congress should reduce the 2026 Medicare base payment rate for home health agencies by 7 percent.*	The FFS Medicare margin was 21.2 percent in 2024 and is expected to be 19 percent in 2026. This recommendation is not intended to be additive to the BBA of 2018 adjustments. Current law is expected to increase payment rates by 2.3 percent in 2027. The recommendation would decrease federal program spending by $750 million-$2 billion over one year and by $10-$25 billion over five years.
Inpatient rehabilitation facility (IRF) services	*For fiscal year 2027, the Congress should reduce the 2026 Medicare base payment rate for inpatient rehabilitation facilities by 7 percent.*	The Medicare margin for IRFs rose more than 2 percentage points to 17.1 percent in FY 2024, and the Commission projects that it will increase to 18 percent in FY 2026. The high FFS Medicare margin indicates that the IRF PPS exerts too little pressure on providers to control costs. The recommendation would lower spending relative to current law by between $2-$5 billion in one year, and between $10-$15 billion over five years. IRFs would still receive sufficient revenue to maintain FFS Medicaid beneficiaries' access to IRF care while bringing IRF prospective payment system payment rates closer to the cost of efficiently delivering high-quality care.
Hospice services	*For fiscal year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rates for hospice.*	In 2024, the number of providers increased by 2.6 percent, following an increase in for-profit hospices. Access to capital appears to remain adequate, as suggested by continued investor interest. The 2023

		aggregate FFS Medicare margin was 8.0 percent, and the projected 2026 margin is about 9 percent. This recommendation would decrease federal program spending relative to current law by $250-$750 million over one year and by $1-$5 billion over five years.

MEDPAC EXAMINES TRENDS AND KEY ISSUES IN POST-ACUTE CARE

Post-acute care (PAC), including skilled nursing facilities (SNFs), home health agencies (HHAs), and inpatient rehabilitation facilities (IRFs), accounts for a substantial share of Medicare spending following hospitalizations. In 2024, Medicare fee-for-service (FFS) PAC spending totaled $57.7 billion, with SNFs accounting for the largest share, followed by home health and IRFs.

While total FFS PAC spending has declined modestly due in part to the shift toward Medicare Advantage (MA), per-beneficiary spending has increased, particularly for IRFs. From 2015 to 2024, SNF use declined by 35 percent, home health use declined modestly, and IRF use increased by 31 percent, contributing to a 56 percent increase in IRF spending. These trends reflect changes in provider supply, payment incentives, and fewer hospitalizations, as well as ongoing workforce shortages that may constrain capacity and affect access.

Overlap in the Types of Patients Treated in Different PAC Settings

- **Overlap in patient populations:** MedPAC finds that beneficiaries treated in SNFs, HHAs, and IRFs often have similar clinical characteristics and care needs, indicating that multiple settings may be clinically appropriate.
- **Site-of-care decisions influenced by nonclinical factors:** Placement decisions are influenced by provider availability, local supply, and caregiver support, in addition to clinical considerations.
- **Implications for efficiency:** Overlap suggests opportunities to furnish care in lower-cost settings when clinically appropriate, particularly shifting from institutional care to home-based care.
- **Limitations in data comparability:** Differences in patient assessment tools and reporting across settings limit the ability to compare outcomes and evaluate the appropriateness of placement.

Concerns About Measuring and Improving Quality in Nursing Homes

- **Wide variation in SNF quality and outcomes:** MedPAC identifies substantial variation in readmissions, functional improvement, and other outcomes across facilities.
- **Limitations of current quality measures:** Quality measurement is constrained by incomplete data, inconsistent reporting, and limited measures of patient experience.
- **Challenges in comparing quality across PAC settings:** Differences in case mix and measurement systems make cross-setting comparisons difficult.
- **Policy implications:** These limitations hinder Medicare's ability to link payment to quality and promote high-value care.

High FFS Medicare Payments, FFS Incentives, and Medicare Benefits May Encourage Inefficient Care

- **Financial incentives vary across settings:** Differences in payment rates and beneficiary cost-sharing across SNFs, IRFs, and home health create incentives that may not align with efficient site-of-care decisions.
- **Substantial variation in cost by setting:** IRFs have the highest cost per stay, followed by SNFs, while home health episodes are lower cost but may span longer durations.
- **Incentives for greater use or longer stays:** FFS payment structures may encourage longer lengths of stay or higher utilization, without clear evidence of improved outcomes.
- **Core finding:** MedPAC indicates that current FFS incentives do not consistently promote efficient use of PAC services across settings.

Alternative Payment Models (APMs) and PAC Use

- **Lower PAC use under APMs:** Accountable Care Organizations (ACOs) and bundled payment models are associated with reduced use of PAC services compared to FFS Medicare.
- **Shifts toward lower-cost settings,** so providers participating in APMs are more likely to: 1) use home health instead of SNFs and 2) use SNFs instead of IRFs.
- **Shorter lengths of stay:** APMs are associated with reductions in duration of PAC use, reflecting incentives to manage total episode spending.

- **Implications for efficiency:** These patterns suggest that some PAC use under FFS Medicare may be avoidable or substitutable.
- **Quality impacts remain mixed:** Evidence on quality outcomes is inconclusive, and MedPAC emphasizes continued monitoring.

MA and PAC Use

- **Stronger incentives to control PAC spending:** MA plans receive capitated payments and have incentives to limit PAC use and manage costs.
- **Observed utilization differences:** Compared to FFS, MA enrollees tend to have fewer SNF days and greater use of lower-cost settings such as home health
- **Potential tradeoffs:** While these approaches may improve efficiency, they may also raise concerns about access to care, including delays or restricted provider choice.
- **Implications for the PAC market:** Continued growth in MA enrollment is likely to influence overall PAC utilization patterns and provider behavior.

MedPAC highlighted the need for continued policy attention to improve alignment between payment and care delivery. Areas of focus include developing more site-neutral payment approaches, strengthening quality measurement systems, and improving care coordination across PAC settings to support more efficient and appropriate use of services.

MEDPAC PROVIDES UPDATE ON AMBULATORY SURGICAL CENTERS

MedPAC provided an update on Ambulatory Surgical Centers (ASCs), which provide outpatient surgical procedures for patients not requiring an overnight stay. This report evaluates industry growth, Medicare payment trends, and the Commission's ongoing policy recommendations.

Industry Overview and Growth

As of 2024, approximately 6,400 Medicare ASCs were in operation, serving 3.4 million FFS Medicare beneficiaries. The industry continues to expand steadily, with the number of facilities growing at an average annual rate of 2.2 percent from 2019 to 2024. More than 95 percent of ASCs are for-profit, and most have some level of physician or corporate ownership. ASCs are heavily concentrated in urban areas (93.7 percent), making rural beneficiaries less likely to access their services. About 68 percent of centers specialize in a single clinical area—most commonly gastroenterology or ophthalmology—while multispecialty centers, particularly those focused on orthopedics and pain management, represent the fastest-growing segment.

Site-of-Care Shifts and Quality Metrics

The growth of the ASC sector is driven by specialized, streamlined environments that offer greater efficiency and lower costs for both Medicare and its beneficiaries. However, research suggests this shift can lead to "cherry-picking," where ASCs treat lower-risk patients while higher-complexity cases remain in Hospital Outpatient Departments (HOPDs). This trend disproportionately affects dually eligible beneficiaries, those over 85, and patients eligible due to disability, who often face more complex cases and barriers to care.

Furthermore, performance is currently measured through the ASC Quality Reporting (ASCQR) Program, which relies on only 4 claims-based clinical outcome measures. The Commission discussed and suggested expanding claims-based measures across more ASC specialties and aligning ASCQR measures with the HOPD Quality Reporting Program for better comparisons.

Role in Medicare

In 2024, total FFS Medicare payments to ASCs reached $7.5 billion, consisting of $6 billion in program spending and $1.5 billion in beneficiary cost-sharing. Medicare spending per FFS beneficiary saw a significant jump of 15.9 percent in 2024. This represents a sharp acceleration compared to the 9.4 percent average annual growth rate observed between 2019 and 2023 —likely due to the 3.2 percent increase in the ASC conversion factor, a 0.8 percent rise in volume, and an 8.4 percent increase in the average relative weight of services.

Despite the ASC payment system covering over 3,700 surgical procedures, Medicare revenue remains highly concentrated, with just 12 procedures accounting for 50 percent of all FFS surgical revenue in 2024. However, Medicare does not currently require ASCs to submit cost data, making it difficult to analyze the financial standing of the industry nationwide.

Recommendation: Mandatory Cost Data Reporting

MedPAC's primary concern was that, unlike most Medicare-certified facilities, ASCs are not required to submit cost data. Without this information, policymakers cannot assess whether payment rates accurately reflect the cost of care, which raises concerns about payment accuracy and program integrity. As such, the Commission continues to recommend requiring ASCs to report cost data to CMS to ensure fiscal accountability and support more accurate payment updates.

COMMISSION PROVIDES UPDATE ON MEDICARE ADVANTAGE

MedPAC provided an update to Congress on the Medicare Advantage (MA) program, which offers beneficiaries an alternative to traditional Medicare through private plans.

The report addresses enrollment, plan availability, payment policies, and quality of care.

The MA program remains a robust and growing alternative to traditional FFS Medicare. In 2025, 55 percent of all eligible Medicare beneficiaries were enrolled in MA, a significant increase from 37 percent in 2018; enrollment reached approximately 34.9 million beneficiaries. Between 2024 and 2025, MA enrollment grew by 4 percent, while the eligible population grew by only 2 percent. This growth was driven by the appeal of supplemental benefits, cost-sharing reductions, and out-of-pocket spending limits. In terms of plan choice, Health Maintenance Organizations (HMOs) remained the most popular, enrolling 20 million beneficiaries; however, special-needs plans (SNPs) also saw rapid growth, particularly chronic-condition SNPs (C-SNPs), which grew by 69 percent in 2025.

In 2026, beneficiary access to MA plans remained very high, though the Commission noted concerns about choice overload. Approximately 99 percent of beneficiaries have access to at least one MA plan, and 98 percent have access to a zero-premium plan that includes drug coverage. On average, beneficiaries can choose from 39 plans—which the volume of options may be overwhelming and difficult to navigate effectively.

For these MA plans, rebates—the portion of the difference between a plan's bid and its benchmark that Medicare pays to the plan—are projected to reach record-high levels in 2026. The average monthly rebate across all non-employer group plans is expected to reach an all-time high of $222 per member per month. These rebates are then typically used to offer non-Medicare supplemental benefits, reduced cost sharing, and Part D enhancements. Some concerns about Part B-driven financing and increased costs, coding intensity, and increased rebates were also raised.

Compared with traditional FFS Medicare, the Commission estimates that MA payments in 2026 will be 14 percent higher than FFS spending would have been for MA enrollees. The key drivers of this trend are favorable selection and differences in coding intensity. Favorable selection occurs when beneficiaries who enroll in MA have lower risk-adjusted spending than their risk scores would predict, contributing an estimated 11 percent ($57 billion) increase in MA payments in 2026. In addition, higher coding intensity—where MA plans document more diagnoses than FFS providers, resulting in elevated risk scores—accounts for an additional 4 percent ($22 billion) increase in payments. Although the new V28 risk model was designed to reduce coding-driven payment differences, it has slightly reduced the gap, leaving a significant disparity. This remains consistent with MA bids and rebates.

Regarding industry trends, there is increasing consolidation and market power amongst plan providers. Particularly at the national level, 3 major organizations (UnitedHealth

Group, Humana, and CVS Health) account for 58 percent of all national enrollment in 2025; this concentration is even more pronounced at the local level. Additionally, industry integration is accelerating through vertical arrangements, where insurers increasingly own provider groups and entities that administer supplemental benefits to more directly influence care delivery and outcomes.

MedPAC remains highly critical of how quality is currently measured and rewarded in the MA program. The Quality-Bonus Program (QBP) uses a 1-to-5-star rating system to increase benchmarks for high-performing plans, which is projected to cost Medicare $16 billion in 2026. While only 40 percent of contracts achieved the 4-star bonus threshold for 2026, those plans account for 64 percent of total enrollment, contributing to a national average star rating of 3.98. This system undermines performance, contract-level reporting that masks local performance and creates cliff effects in scoring, all within a non-budget-neutral framework—adding costs to the program. The Commission argues that the system is fundamentally flawed, making it difficult to make informed choices and assess the program's value. In turn, the Commission relied more on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to better understand; they found that MA enrollees generally rate their experience and plan quality favorably.

Lastly, since the 2021 statutory change allowed all beneficiaries with End-Stage Renal Disease (ESRD) to enroll in MA, enrollment has surged from 27 percent to 55 percent. This shift has significantly improved plan profitability, as Medicare payments for ESRD enrollees grew 22 percent between 2018 and 2023 while medical costs rose only 8 percent. This resulted in 93 percent of ESRD enrollees being on contracts where revenues exceed medical costs. However, approximately 90 percent of ESRD enrollees are still charged with the maximum 20 percent coinsurance for dialysis, though they benefit from the mandatory $9,250 out-of-pocket limit. Additionally, while MA plans still pay 22 percent more than traditional Medicare for dialysis services, these prices have decreased from 28 percent in 2020, likely due to greater negotiating leverage from the removal of network-adequacy requirements.

Based on their review, the Commission encouraged further investigation into coding intensity, improvements to encounter data, addressing the Quality Bonus Program, and establishing more accurate benchmarks.

MEDPAC PROVIDES A STATUS UPDATE ON THE MEDICARE PRESCRIPTION DRUG PROGRAM (PART D)

In 2025, Medicare Part D provided outpatient prescription drug coverage to over 55 million beneficiaries through stand-alone Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug plans (MA-PDs). Total program spending reached approximately $148.3 billion in 2024, with Medicare contributing $90.3 billion in basic

benefit subsidies and $41.3 billion for low-income subsidies (LIS). Beneficiaries paid $16.7 billion in premiums and $17.7 billion in cost sharing, while retiree drug subsidies totaled $0.5 billion.

The Inflation Reduction Act (IRA) continues to drive significant structural changes to Part D, with the full redesign implemented in 2025. These changes reduce beneficiary cost sharing, including through the $2,000 out-of-pocket cap (adjusted to $2,100 in 2026 due to inflation), but shift greater financial responsibility to plans and Medicare.

The redesign also fundamentally alters program financing by reducing reliance on cost-based reinsurance and increasing the role of capitated direct subsidies. These changes have introduced uncertainty in utilization, plan bidding, and overall program costs.

Main Impacts of the IRA on Part D

- **Plan bids and expected costs increased:** The national average monthly bid amount (NAMBA) increased by nearly 180 percent in 2025 and an additional 33 percent in 2026. Total expected basic benefit costs increased by 35 percent in 2026, reflecting higher expected drug spending and utilization.
- **Changes in liability affect utilization and plan behavior:** The elimination of beneficiary cost sharing above the OOP threshold reduces financial barriers to drug use but may reduce plans' ability to manage utilization, particularly for high-cost drugs.
- **Medicare's share of program costs increased:** Medicare's share of total program financing rose to approximately 86.8 percent in 2026, in part due to provisions that limit premium growth and shift liability away from beneficiaries.
- **Premium stabilization policies limit observed premium growth:** Policies such as the 6 percent cap on base beneficiary premium growth and the Part D Premium Stabilization Demonstration reduce increases in beneficiary premiums but increase federal spending.
- **Drug pricing provisions have mixed effects on plan costs:** The Medicare Drug Price Negotiation Program established under the Inflation Reduction Act sets maximum fair prices (MFPs) for selected high-expenditure drugs. In addition, inflation rebate provisions require manufacturers to pay rebates when price increases exceed inflation. These policies reduce prices for certain drugs but also reduce manufacturer rebates, potentially affecting plan liability and premiums. The net effects on total program spending and plan bids remain uncertain.

Recent Trends

- **Continued shift from PDPs to MA–PDs:** Enrollment continues to shift toward MA-PDs, with PDPs now accounting for less than 42 percent of Part D enrollment, down from 53 percent in 2020. MA-PD enrollment has increased, and these plans often offer lower premiums and additional benefits, in part financed through Medicare Advantage rebates.

- **Growing concerns about PDP market stability:** The number of PDPs declined by 22 percent between 2025 and 2026, with sharper reductions in enhanced plans. At the same time, MA-PD offerings remain robust. Diverging trends in costs, premiums, and risk scores between PDPs and MA-PDs raise concerns about long-term viability and competition in the PDP market.

- **Risk adjustment misalignment persists:** Part D risk scores have historically overpredicted costs for MA-PDs and underpredicted costs for PDPs. CMS introduced separate normalization factors in 2025, but further refinements may be needed to ensure accurate payments and balanced competition.

- **Program spending growth accelerating:** Part D spending increased nearly 18 percent between 2023 and 2024, reflecting rising drug costs and utilization. High-cost brand-name drugs and biologics, specifically those without generic or biosimilar competition, account for 83 percent of gross Part D spending, despite representing only 10 percent of prescriptions.

- **Premium variation widening despite stabilization efforts:** While average premiums remain relatively stable due to policy interventions, variation across plans has increased significantly, reflecting uncertainty in utilization, pricing, and plan strategy.

Pharmacy and Plan Market Trends

- **Growth in special needs plans (SNPs):** The number of SNP offerings increased by 20 percent between 2025 and 2026, continuing a broader trend toward plans targeting high-need beneficiaries. A growing share of these plans offers enhanced benefits.

- **Reduced plan design flexibility under the redesigned benefit:** The Part D redesign standardizes key elements of the benefit structure, limiting plans' ability to vary cost sharing across phases of the benefit. As a result, plan offerings are more similar, and differentiation through benefit design is reduced for PDPs.

- **Changes in liability structure affecting plan strategy:** Increased plan liability in the catastrophic phase and reduced reinsurance payments change plan

incentives for managing high-cost enrollees and drugs. Plans may respond through formulary design, utilization management, and pharmacy network configuration, although the effects are still emerging.

- **Shift in pharmacy price concessions (DIR) to the point of sale**: CMS policy requires that pharmacy price concessions be reflected in negotiated prices at the point of sale rather than retrospectively. This change increases price transparency for beneficiaries at the pharmacy counter but may reduce revenue predictability and create cash flow challenges, particularly for independent pharmacies.
- **Pressure on pharmacy reimbursement and participation:** Changes in reimbursement structures and concession timing may affect pharmacy margins. MedPAC notes that these dynamics could influence pharmacy participation in plan networks, especially in rural or underserved areas.
- **Potential implications for pharmacy access and network adequacy:** As plans adjust networks and reimbursement, there may be effects on pharmacy availability and beneficiary access to medications. MedPAC highlights the importance of monitoring pharmacy closures and network adequacy standards.
- **Plan Finder and pricing accuracy considerations:** While prices displayed on the Medicare Plan Finder are generally consistent with negotiated prices, CMS has identified instances of discrepancies during the enrollment period, which may affect beneficiary plan selection.
- **Differences in MA-PD and PDP market dynamics:** MA-PD plans continue to offer more integrated benefits and may use rebate dollars to offset Part D costs, while PDPs have fewer tools to manage premiums and benefits under the redesigned structure. These differences contribute to diverging plan availability and enrollment trends.

MedPAC emphasizes that the full effects of the IRA and related policy changes are still emerging. Early data indicate significant shifts in plan structure and financing, but uncertainty persists about the long-term impacts on utilization, premiums, and stakeholder incentives.

The Commission will continue to monitor how these changes, like the Medicare Drug Price Negotiation Program and benefit redesign, shape the Part D program, with a focus on market stability, beneficiary access, and program financing sustainability.

COMMISSION REPORTS ON THE IMPACT OF HOME HEALTH PROSPECTIVE PAYMENT SYSTEM CHANGES

The Patient-Driven Groupings Model (PDGM) was introduced on January 1, 2020, as a major reform to Medicare's home health prospective payment system (PPS). MedPAC analyzes three main domains: the use of home health services, the quality of care received, and the payments and costs of home health stays. Findings presented reflect outcomes associated with confounding variables, including the COVID-19 pandemic and labor market shifts. The Commission compares modeled counterfactuals reflecting the prior system with observed outcomes under PDGM to draw findings.

MedPAC found that PDGM is associated with few changes in access and duration of home health care. The number of home health users and 30-day episodes per user remained largely stable since shifting to PDGM. However, PDGM significantly impacted the number of home health visits patients received per episode. The number of visits per episode declined, which was driven by the removal of volume-based financial incentives that has been a significant factor in the previous PPS model. Skilled nursing visits have been reduced since PDGM was introduced. Such patterns are believed to be consistent with a reallocation of services towards a need-based, rather than an incentive-based delivery model.

While service frequency has been reduced by PDGM, quality and financial performance remained stable. Slight improvements to preventable hospitalizations and minor declines in discharge-to-community rates were observed, although most other quality indicators showed negligible changes. Meanwhile, Medicare margins for home health agencies remained elevated, indicating continued provider profitability under PDGM. In summary, the Commission states that PDGM did not negatively affect FFS Medicare beneficiaries, although continued monitoring will be necessary.

Future Commission goals include examining PDGM payment groups to better interpret 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.

COMMISSIONS REPORTS ON DUAL-ELIGIBLE SPECIAL-NEEDS PLANS

Dual-eligible special needs plans (D-SNPs) are specialized Medicare Advantage (MA) plans available to beneficiaries who qualify for both Medicare and Medicaid. The Bipartisan Budget Act (BBA) of 2018 directs the Commission to assess the performance of the plans periodically for improved integration of Medicaid and Medicare. MedPAC finds that while all D-SNPs must meet minimum coordination requirements, they vary substantially in the extent to which they integrate Medicaid benefits, ranging from loosely coordinated plans to more fully integrated arrangements.

D-SNP enrollment has increased significantly over the past few years. Nearly half of all dually eligible beneficiaries are now enrolled in D-SNP plans. However, most enrollees

are concentrated in plans that offer limited integration, thus receiving Medicare and Medicaid services through partially aligned systems. The lack of integration and alignment in state Medicaid policies creates more geographic and organizational differences across the D-SNP system.

The Commission concluded that current measurements of D-SNP performance are not enough to be able to adequately evaluate D-SNP effectiveness. The analyses have relied primarily on HEDIS clinical quality measures and CAHPS patient experience surveys, both of which demonstrated limited variation across plan types and are not strongly aligned with outcomes most relevant to dually eligible patients. Therefore, distinguishing major differences between models of different levels of integration is challenging. External research data is also inconclusive, as some studies identified improvements in specific outcomes, such as reductions in long-term institutional use, while lacking consistent evidence of broad performance advantages.

The growth of "look-alike" plans, which are MA plans, including some chronic condition special needs plans (C-SNPs), that often enroll dually eligible beneficiaries without meeting D-SNP integration requirements, is another concern. There is concern that such plans will undermine efforts to promote integrated care models as they compete for similar enrollees and operate under less rigid coordination standards. The Commission recommends that policymakers consider broadening current restrictions on look-alike plans to cover C-SNPs and include limited exceptions for C-SNPs that target conditions most prevalent among dually eligible beneficiaries.

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