Executive summary

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

By law, the Medicare Payment Advisory Commission reports to the Congress each March on the Medicare fee-for-service (FFS) payment systems. We evaluate the adequacy of FFS Medicare's payments and make recommendations for how those payments should be updated for the policy year in question (in this report, 2026). 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. The spending implications are presented as ranges over one-year and five-year periods. Unlike official budget estimates used to assess the impact of legislation, these estimates do not consider the complete package of policy recommendations or the interactions among them. 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 the following FFS payment systems: acute care hospital inpatient and outpatient services, physicians and other health professional services, 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 Part D prescription drug program. In this report, we provide a status report on MA, including recent trends in enrollment, plan offerings, and Medicare's payment to plans, and we discuss issues such as MA coding intensity, favorable selection, and market concentration. We also provide a status report on Part D that, in addition to providing information on recent trends in enrollment and plan offerings, describes the expected effects of significant changes happening in 2025, as implementation of the Inflation Reduction Act of 2022 continues.

In this year's report, we also include a status report on ambulatory surgical centers and a chapter that describes our recommendation to improve beneficiaries' access to inpatient psychiatric care by eliminating both the 190-day lifetime limit on covered days in freestanding inpatient psychiatric facilities and the reduction in the number of covered inpatient psychiatric days available to some beneficiaries during their initial benefit period.

In Appendix A, we list all of this year's recommendations and the commissioners' votes. The Commission's full inventory of recommendations, with links to relevant reports, is available at medpac.gov/recommendation/.

Context for Medicare payment policy

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

Both national health care spending and Medicare spending tend to grow more quickly than the U.S. gross domestic product (GDP)—causing spending in both sectors to consume growing shares of GDP over time. In 2023, $4.9 trillion was spent on health care in the U.S. (equivalent to 17.6 percent of GDP); Medicare spending made up about $1.0 trillion of this spending (equivalent to 3.7 percent of GDP).

Total Medicare spending grew at a slower-than-usual pace during the first year of the coronavirus pandemic in 2020. Although Medicare spending increased on COVID-19 testing and treatment and on services that were made more widely available through waivers of Medicare's usual payment rules, this increase was more than offset by decreased spending on non-COVID-19 care. Since then, Medicare beneficiaries' health care spending has generally returned to more typical levels.

Looking ahead, CMS expects Medicare spending to grow by about 4 percent per year between now and the early 2030s, after accounting for economy-wide price inflation. This increased spending is driven by Medicare enrollment growth and growth in the volume and intensity of services that clinicians deliver per beneficiary. FFS Medicare prices are not a significant driver of spending growth since they are projected to grow more slowly than inflation. The shift in beneficiary enrollment from traditional FFS Medicare to MA also contributes to Medicare spending growth since the program pays an estimated 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare.

Despite this projected spending growth, the Medicare program finds itself in a better position financially than it was a few years ago. After an initial economic slowdown at the start of the pandemic, the U.S. economy subsequently experienced strong growth, yielding higher-than-expected Medicare payroll tax revenues. At the same time, Medicare beneficiaries used a lower volume of Part A services than expected during the pandemic, and future Part A spending (on hospital inpatient and skilled nursing facility care) is now projected to be lower than previously estimated. As a result, the balance in Medicare's Hospital Insurance Trust Fund is now projected to be able to pay for its share of Part A services for a decade longer than was projected before the pandemic—until 2036 according to the Medicare Board of Trustees, or until 2035 according to the Congressional Budget Office.

Yet pressure to restrain the growth in Medicare's overall spending remains. A growing share of general federal revenues must be transferred to Medicare's Supplementary Medical Insurance (SMI) Trust Fund to help pay for Part B clinician and outpatient services and Part D prescription drug coverage. For example, the share of personal and corporate income taxes collected by the federal government that was transferred to the SMI Trust Fund to pay for Part B and Part D was 17 percent in 2023 and is projected to increase to 22 percent by 2030, according to the Medicare Trustees. Further, Medicare's current rate of spending growth causes beneficiaries to face higher premiums and cost sharing over time. The Medicare Trustees estimate that spending by FFS beneficiaries on Medicare Part B and Part D premiums and cost sharing consumed 26 percent of the average Social Security benefit in 2024—up from 17 percent 20 years earlier, in 2004. It is important for policymakers to consider the effect of raising Medicare's payments to providers and plans on beneficiaries' premiums and cost-sharing liabilities. Restraining the annual growth in Medicare payments to providers and plans can help beneficiaries afford their health care.

One way the Medicare program has kept spending growth relatively low is by setting payment rates in certain sectors. Our annual March report recommends updates to FFS Medicare payment rates for various types of providers, which can be greater than, less than, or equivalent to current law, depending on our assessment of Medicare payment adequacy for each sector. Our annual June report typically offers broader recommendations aimed at restructuring the way Medicare's payment systems work.

Assessing payment adequacy and updating payments in FFS Medicare

As required by law, the Commission annually recommends payment updates 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 for all providers in a payment system is changed relative to the prior year. As explained in Chapter 2, we determine updates by first assessing the adequacy of FFS Medicare payments for providers in the current year (2025), by considering beneficiaries' access to care, the quality of care, providers' access to capital, and how Medicare payments compare with providers' costs. As we detail in Chapter 2, we consider several different types of provider margins, in combination with other metrics, when assessing these domains. As part of that process, we examine whether FFS payments will support access to high-quality care and the efficient delivery of services, consistent with our statutory mandate. Finally, we make a recommendation about what, if any, update is needed for the policy year in question (in this report, 2026).

This year, we consider recommendations in the following sectors: acute care hospital inpatient and outpatient services, physicians and other health professional services, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and hospice providers. The Commission's goal is to use consistent criteria

across settings, but because data availability, conditions at baseline, differences in the external pressures on each sector, and anticipated changes between baseline and the policy year may vary, we do not have a standard formula for producing recommendations based on these criteria, and our recommended updates vary. We use the best available data to examine indicators of payment adequacy and reevaluate any assumptions from prior years, to make sure our recommendations for 2026 accurately reflect current conditions. Because of standard data lags, the most recent complete data we have are generally from 2023. We use preliminary data from 2024 when available.

In considering updates to FFS payment rates, we may make recommendations that redistribute payments within a payment system to correct biases that may make treating patients with certain conditions or in certain areas financially undesirable, make certain procedures relatively more profitable, or otherwise result in differences that could undermine access to care for some beneficiaries. We may also recommend changes to improve program integrity.

Payment rates set to cover the costs of relatively efficient delivery of care help induce all providers to control their costs. Furthermore, FFS Medicare rates have broader implications for health care spending because they are used in setting payments for other government programs and private health insurance. Thus, while setting prices intended to support efficient provision of care directly benefits the Medicare program, it can also affect health care spending across payers.

Hospital inpatient and outpatient services

General acute care hospitals (ACHs) primarily provide inpatient medical and surgical care to patients needing an overnight stay, as well as 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 2023, the FFS Medicare program and its beneficiaries spent nearly $180 billion on IPPS and OPPS services, including $6.7 billion in uncompensated-care payments made under the IPPS.

As described in Chapter 3, indicators of hospital payment adequacy were mixed. Beneficiary access to care remained good overall, and hospitals' all-payer margin was positive and improved. However, quality indicators were mixed, and aggregate FFS Medicare payments remained well below hospitals' costs.

Beneficiaries' access to care—Indicators of beneficiaries' access to hospital inpatient and outpatient services suggest that FFS Medicare beneficiaries maintained good access to care. From fiscal year (FY) 2022 to FY 2023, hospital employment and the number of inpatient beds increased. The aggregate hospital occupancy rate of ACH beds remained at 69 percent, and the median percentage of emergency department patients who left without being seen remained near 2 percent. The supply of hospitals was relatively steady, though about 10 more hospitals closed than opened in both 2023 and 2024, and others converted to rural emergency hospitals. The volume of both inpatient and outpatient services per FFS Medicare beneficiary increased from 2022 to 2023 (by 1 percent and 2 percent, respectively). We estimate that hospitals' FFS Medicare marginal profit on IPPS and OPPS services—an indicator of whether hospitals with excess capacity have an incentive to treat more Medicare beneficiaries—remained positive in FY 2023.

Quality of care—Hospital quality indicators were mixed. In FY 2023, FFS beneficiaries' risk-adjusted hospital mortality rate was 7.6 percent, an improvement relative to the 2019 and 2022 level of 7.9 percent. FFS Medicare beneficiaries' risk-adjusted readmission rate was 15.0 percent, worse than the previous year (14.6 percent), but improved relative to the rate in 2019 (15.5 percent). Most patient-experience measures improved in 2023 but remained below prepandemic levels by at least 1 percentage point.

Providers' access to capital—From FY 2022 to FY 2023, hospitals' 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) increased from 2.7 percent to 5.1 percent. However, within this aggregate, there continued to be substantial variation: A quarter of hospitals had an all-payer operating margin greater than 10 percent, and a quarter had an all-payer operating margin less than −4 percent. In addition,

the all-payer operating margin continued to be lower among hospitals with higher values of the Commission-developed Medicare Safety-Net Index (MSNI). Other measures of hospitals' access to capital were positive in 2023: Hospitals' all-payer total margin (the percentage of revenue from all payers, sources, and lines of business that is left as profit after accounting for all costs) increased over 4 percentage points, hospitals' borrowing costs increased by less than the general market, and mergers and acquisitions continued. Preliminary data suggest further improvement in hospitals' access to capital in FY 2024.

FFS Medicare payments and providers' costs—FFS Medicare payments for inpatient and outpatient services continued to be below hospitals' costs in FY 2023. From 2022 to 2023, exclusive of coronavirus relief funds, hospitals' FFS 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) was stable (from −13.1 percent to −13.0 percent). Nonetheless, some hospitals—which we refer to as "relatively efficient"—consistently achieved much lower costs while still performing relatively well on a specified set of quality metrics. The 2023 median FFS Medicare margin among these relatively efficient hospitals was −2 percent, exclusive of coronavirus relief funds. For 2025, we project that hospitals' FFS Medicare margin will remain stable at about −13 percent. Similarly, we project that the median FFS Medicare margin among relatively efficient hospitals will remain stable at about −2 percent.

Recommendation—The current-law updates to payment rates for 2026 will not be finalized until summer 2025, but CMS's current 2024 forecasts and other required updates are projected to increase the IPPS and OPPS base rates by over 2 percent.

The Commission recommends that the Congress should (1) for 2026, update the 2025 Medicare base payment rates for general ACHs by the amount reflected in current law plus 1 percent and (2) redistribute existing disproportionate-share-hospital and uncompensated-care payments to hospitals through the Commission's MSNI and increase the MSNI pool by $4 billion (which would be distributed to hospitals for both their FFS and MA patients). This recommendation would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing particularly significant financial challenges.

Rural emergency hospitals—The Consolidated Appropriations Act (CAA), 2021, requires the Commission to report annually on payments to rural emergency hospital (REHs). In 2023, 21 hospitals converted to REHs. FFS Medicare paid about $10 million for outpatient hospital services at these REHs and about $30 million in fixed monthly payments to cover standby costs. FFS Medicare's monthly fixed payments are three times as high as claims-based payments, which underscores the importance of fixed payments for the viability of REHs.

Physician and other health professional services

Medicare's physician fee schedule pays for about 9,000 types of medical services—ranging from office visits to surgical procedures, imaging, and tests—that are delivered in physician offices, hospitals, nursing homes, 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, podiatrists, physical therapists, psychologists, and other types of health professionals. In 2023, the Medicare program and its beneficiaries paid $92.4 billion for services billed by about 1.4 million clinicians and delivered to 28.2 million FFS beneficiaries, accounting for just under 17 percent of FFS spending. As described in Chapter 4, most physician payment-adequacy indicators have remained stable or improved in 2023 and 2024, but clinicians' input costs are estimated to have grown faster than the historical trend.

Beneficiaries' access to care—In the Commission's 2024 survey, Medicare beneficiaries continued to report access to clinician services that was comparable with or, in most cases, better than that of privately insured people. In response to a request from the House Committee on Appropriations, our survey began asking respondents to quantify wait times this year. We found that the number of weeks Medicare beneficiaries reported waiting for appointments with new clinicians was comparable with or better than the wait times reported by privately insured people. Our findings are consistent with those 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 and that Medicare beneficiaries of any age are more likely than privately insured people to rate their insurance coverage positively. Surveys also indicate that the share of clinicians accepting Medicare is comparable with the share accepting private insurance, despite private health insurers paying higher rates. Almost all clinicians who bill Medicare accept physician fee schedule amounts as payment in full and do not seek higher payments from patients for fee schedule services. The supply of most types of clinicians billing FFS Medicare has been growing in recent years, although the composition of the clinician workforce continues to change, with a rapid increase in the number of APRNs and PAs, a steady increase in the number of specialists, and a slow decline in the number of primary care physicians. For each year between 2016 and 2021, the number of clinicians who began billing the fee schedule for the first time was larger than the number who stopped billing the physician fee schedule.

The number of clinician encounters per beneficiary has increased over time, with faster growth from 2022 to 2023 (4.3 percent) compared with the average annual growth rate from 2018 to 2022 (0.5 percent). Growth rates varied by clinician specialty and type of service. From 2022 to 2023, the number of encounters per beneficiary with primary care physicians declined by 0.1 percent while encounters per beneficiary with specialist physicians increased by 2.7 percent and encounters with APRNs and PAs increased by 10.1 percent.

Quality of care—We report three population-based measures of the quality of clinician care: risk-adjusted ambulatory care–sensitive (ACS) hospitalization rates, risk-adjusted ACS emergency department (ED) visits, and patient-experience measures. In 2023, risk-adjusted rates of ACS hospitalizations and ED visits remained below (that is, better than) prepandemic levels and continued to vary across health care markets. Between 2022 and 2023, 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. Instead, we rely on indirect measures of how Medicare payments compare with the costs of providing services.

In 2023, payment rates paid by private preferred provider organization (PPO) health plans for clinician services were 140 percent of FFS Medicare's payment rates, up from 136 percent in 2022. Survey data suggest 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).

Physician fee schedule spending per FFS beneficiary grew for most types of services in 2023, despite declines in payment rates for many types of services from 2022 to 2023. Among broad service categories, growth rates were 4.2 percent for evaluation and management services, 4.2 percent for imaging, 3.7 percent for other (i.e., nonmajor) procedures, 7.2 percent for treatments, and 4.9 percent for tests. Spending per FFS beneficiary declined by 0.1 percent for major procedures. Growth in clinicians' input costs as measured by the Medicare Economic Index (MEI) has moderated from recent highs reached during the coronavirus pandemic and is expected to moderate further in the coming years. MEI growth is projected to be 3.3 percent in 2024 and 2.8 percent in 2025.

Recommendation—Under current law, in 2026, payment rates are expected to increase by 0.75 percent for clinicians in advanced alternative payment models (e.g., accountable care organization models that involve some financial risk) and 0.25 percent for all other clinicians. Given recent high inflation, cost increases in 2026—which are currently projected to be 2.3 percent—could be difficult for clinicians to absorb. Yet current payments to clinicians appear to be adequate, based on many of our indicators.

Given these mixed findings, for calendar year 2026, the Commission recommends that the Congress replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the MEI minus 1 percentage point. Based on CMS's MEI projections at the time of this publication, the update recommendation would be equivalent to 1.3 percent. Our recommendation would be built into subsequent years' payment rates, in contrast to the temporary updates specified in current law for 2021 through 2024, which have each increased payment rates for one year only and then expired.

To promote adequate access to care for all Medicare beneficiaries, the Commission also reiterates its March 2023 recommendation that the Congress also should establish new, permanent safety-net add-on payments for clinician services furnished to FFS Medicare beneficiaries with low incomes. The amount of the add-on payments would differ by clinician specialty. We estimate that the recommended safety-net add-on policy would increase the average clinicians' fee schedule revenue by 1.7 percent.

We estimate that the combination of the recommended update and safety-net policies would increase fee schedule revenue for the average clinician by 3.0 percent above current law, but the effects would differ by provider specialty and share of services furnished to low-income beneficiaries. We estimate that the combined effect of the two policies would increase fee schedule revenue by an average of 5.7 percent for primary care clinicians and by an average of 2.5 percent for other clinicians.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2023, about 262,000 beneficiaries with ESRD and on dialysis were covered under FFS Medicare and received dialysis from more than 7,700 dialysis facilities. In 2023, the FFS Medicare program and its beneficiaries spent $8.1 billion for outpatient dialysis services. As described in Chapter 5, measures of the capacity and supply of outpatient dialysis providers, beneficiaries' ability to obtain care, and changes in the volume of services suggest that Medicare payments are adequate.

Beneficiaries' access to care—The capacity of dialysis facilities appears to exceed demand. Between 2022 and 2023, the number of in-center treatment stations was steady, while the number of FFS and MA dialysis beneficiaries declined (due to several factors, including the excess mortality among ESRD patients during the public health emergency, the decline in the adjusted rate of new ESRD cases during the last decade, and the increase in treatments furnished in-home). The 11 percent decline in FFS treatments in 2023 was largely due to ending the statutory provision that prevented most dialysis beneficiaries from enrolling in MA plans. The share of beneficiaries on dialysis enrolled in FFS Medicare fell by 18 percent in 2021—the first year of the statutory change—and by about 12 percent annually between 2021 and 2023. An estimated 17 percent FFS marginal profit in 2023 suggests that dialysis providers with excess capacity have a financial incentive to continue to serve Medicare beneficiaries.

Quality of care—FFS dialysis beneficiaries' rates of all-cause hospitalization, ED use, and mortality held relatively steady between 2022 and 2023, as did measures of their experience receiving in-center hemodialysis. 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. Under the ESRD prospective payment system (PPS), the two largest dialysis organizations have grown through acquisitions of and mergers with midsize dialysis organizations. In 2023 and 2024, facility closures and consolidations by each of the two largest dialysis organizations aimed to reduce overcapacity related to the increasing use of home dialysis and the decline in patient census in some markets.

FFS Medicare payments and providers' costs—FFS Medicare payment per treatment in freestanding dialysis facilities (which provide the vast majority of FFS dialysis treatments) grew by 3 percent, while cost per treatment rose by 2 percent between 2022 and 2023. In 2023, a decline in cost growth was observed across most cost categories, including capital, ESRD drugs, and labor. Consequently, the FFS 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) rose from −1.1 percent in 2022 to −0.2 percent in 2023. We project a 2025 aggregate Medicare margin of 0 percent. This projection does not account for the add-on payments for new ESRD drugs and phosphate binders in 2024 and 2025, which may increase FFS Medicare payments relative to facilities' costs and thus increase the margin.

Recommendation—Under current law, the Medicare FFS base payment rate for dialysis services is projected to increase by 1.7 percent in 2026. Though the FFS Medicare margin is low, other indicators of payment adequacy are generally positive. Thus, the Commission recommends that, for calendar year 2026, the Congress

update the 2025 base payment rate for outpatient dialysis services by the amount determined under current law.

Skilled nursing facility services

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 furnish long-term care services not covered by Medicare. In 2023, about 14,500 freestanding SNFs furnished about 1.6 million Medicare-covered stays to 1.2 million FFS beneficiaries. In that year, the FFS Medicare program and its beneficiaries spent $30 billion on SNF services. As described in Chapter 6, the indicators of Medicare payment adequacy for SNF care are mostly positive, indicating sufficient beneficiary access to SNF care.

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, but given that Medicare is a small share of most nursing homes' business and that its payment rates are high relative to costs, it is unlikely that the closures reflect the adequacy of Medicare's payments. In 2023, 88 percent of Medicare beneficiaries lived in a county with three or more SNFs or swing-bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds), and this share has remained the same since 2018. Between 2022 and 2023, Medicare-covered SNF admissions per 1,000 FFS beneficiaries decreased by 12 percent, and Medicare-covered SNF days per 1,000 FFS beneficiaries decreased by 8 percent. In 2023, FFS Medicare marginal profit (an indicator of whether SNFs have an incentive to treat more Medicare beneficiaries) averaged 31 percent for freestanding facilities. This profit is a strong positive indicator of beneficiary access to SNF care, though factors other than the level of payment (such as bed availability or staffing shortages) could challenge access.

Quality of care—In fiscal years 2022 and 2023, the mean facility risk-adjusted rate of successful discharge to the community from SNFs was 50.9 percent, similar to the rate for the 2021 and 2022 two-year period (50.7 percent). The mean facility risk-adjusted rate of hospitalizations was 10.4 percent, similar to the rate in the 2021 and 2022 period. 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. In the first six months of 2024, there were 144 publicly announced merger and acquisition transactions, on pace for record transaction volume. In 2023, the all-payer total margin—the percentage of revenue from all payers, sources, and lines of business that is left as profit after accounting for all costs—improved from –1.3 percent in 2022 to 0.4 percent in 2023. Total margins may be understated, given the complex arrangements many nursing homes have with third parties.

FFS Medicare payments and providers' costs—From 2022 through 2023, FFS Medicare payments per day to freestanding SNFs increased 2.4 percent, while growth in costs per day increased 3.8 percent. The FFS Medicare margin for freestanding SNFs (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) was 22 percent in 2023. Margins varied greatly across facilities, reflecting differences in costs per day, economies of scale, and cost growth. We project a FFS Medicare margin for freestanding SNFs of 23 percent for 2024.

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. However, some uncertainty remains about the impact of new nurse staffing requirements on SNF costs in 2026. The Commission therefore proposes a modest reduction to the payment rates and recommends that, for fiscal year 2026, the Congress reduce the 2025 Medicare base payment rates for SNFs by 3 percent.

Medicaid trends—As required by the Affordable Care Act of 2010, we report 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. Between December 2023 and October 2024, the number of Medicaid-certified facilities declined 1.1 percent, to about 14,300 facilities. In 2023, FFS Medicaid spending (federal and state) was $42.5 billion, 5.6 percent more than in 2022. The average non–FFS Medicare margin (the percentage of

revenue from all payers, sources, and lines of business except FFS Medicare SNF services that is left as profit after accounting for costs) was −4.1 percent, an improvement from 2022. The improvement reflects the increases in Medicaid base payment rates made by many states.

Home health care services

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2023, about 2.7 million Medicare FFS beneficiaries received care, and the program spent $15.7 billion on home health care services. In that year, over 12,000 HHAs were certified to participate in Medicare. As described in Chapter 7, the indicators of Medicare payment adequacy for home health care are generally positive.

Beneficiaries' access to care—Supply and volume indicators show that FFS beneficiaries have good access to home health care. The number of HHAs participating in the Medicare program increased by 3.4 percent in 2023. However, this increase was due almost entirely to growth in the number of HHAs in Los Angeles County, California. Excluding this county, the number of participating HHAs declined by 2.8 percent. Still, in 2023, over 98 percent of Medicare beneficiaries lived in a ZIP code served by at least two HHAs, and 88 percent lived in a ZIP code served by five or more HHAs. The number of 30-day periods per FFS Medicare beneficiary declined by 1.8 percent in 2023. This decline was driven by a decrease in the use of home health care after acute care hospital discharge, which increased in 2020 and then began to decline, although it remained higher in 2023 than in prepandemic years. 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 has declined since 2020, but the decline slowed in 2023. (Due to anomalies related to cost allocation on the home health cost report, we were unable to compute the FFS Medicare marginal profit for 2023.)

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—Access to capital is a less important indicator of Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors; still, with an all-payer margin for freestanding HHAs of 8.2 percent in 2023, many HHAs yield positive financial results that could appeal to capital markets. Recent years have seen substantial interest in HHAs by private-equity and health insurance companies. 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 in prior years.

FFS Medicare payments and providers' costs—HHAs' cost growth exceeded payment growth in 2023, but FFS Medicare margins for freestanding agencies (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) remained high, averaging 20.2 percent. In aggregate, FFS Medicare's payments have always been substantially more than costs under prospective payment: From 2001 to 2022, the FFS Medicare margin for freestanding HHAs averaged 17.1 percent. The projected FFS Medicare margin for 2025 is 19 percent.

Recommendation—The Commission's review of payment adequacy for Medicare home health services indicates that FFS Medicare payments are substantially in excess of costs. Home health care can be a high-value benefit when it is appropriately and efficiently delivered. However, FFS Medicare's current payment rates far exceed the cost of delivery, and that cost is largely borne by taxpayers and beneficiaries paying Part B premiums. On this basis, the Commission recommends that, for calendar year 2026, the Congress should reduce the 2025 base payment rate for home health agencies by 7 percent.

Inpatient rehabilitation facility services

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after illness, injury, or surgery. Inpatient, interdisciplinary 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 2023, the FFS Medicare program and its beneficiaries spent $9.6 billion on 404,000 IRF stays in about 1,200 IRFs nationwide. The FFS Medicare program accounted for about 51 percent of all IRF discharges. As described in Chapter 8, IRF payment-adequacy indicators were positive in 2023.

Beneficiaries' access to care—Between 2022 and 2023, the number of IRF beds increased by 3 percent. Similar to the previous year, the aggregate IRF occupancy rate was 69 percent in 2023, indicating that, in markets with IRFs, capacity is more than adequate to meet demand. From 2022 to 2023, the number of FFS Medicare stays in IRFs increased by about 7 percent, and stays per FFS beneficiary increased by about 10 percent. Marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was 18 percent for hospital-based IRFs and 40 percent for freestanding IRFs—a very strong indicator of access.

Quality of care—For the two-year period of 2022 through 2023, the median facility risk-adjusted rate of successful discharge to the community from IRFs was 67.2 percent, essentially stable from the prior period of 2021 through 2022. The median facility risk-adjusted rate of potentially preventable readmissions was also relatively stable at 8.8 percent and was higher (worse) for freestanding and for-profit providers than hospital-based and nonprofit providers.

Providers' access to capital—Between 2022 and 2023, freestanding IRFs' all-payer total margin (the percentage of revenue from all payers, sources, and lines of business that is left as profit after accounting for all costs) rose from 8 percent to about 10 percent. For-profit corporations continued to open new IRFs and enter joint ventures with other organizations, suggesting strong access to capital. Hospital-based IRFs access capital through their parent hospitals.

FFS Medicare payments and providers' costs—In 2023, IRFs' average payment per stay increased by less than 1 percent, while average cost per stay declined slightly after several years of higher growth. As a result, IRFs' FFS 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) rose to 14.8 percent, up from 13.7 percent in 2022.

Recommendation—FFS Medicare's payments to IRFs must be reduced to more closely align aggregate payments with aggregate costs. The Commission recommends that, for fiscal year 2026, the 2025 base payment rate for IRFs be reduced by 7 percent.

Hospice services

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill with a life expectancy of six months or less if the illness runs its normal course. When beneficiaries elect to enroll in the Medicare hospice benefit, they agree to forgo Medicare coverage for conventional treatment of their terminal illness and related conditions. FFS Medicare pays for hospice care for beneficiaries enrolled in either traditional FFS Medicare or MA. In 2023, more than 1.7 million Medicare beneficiaries (including more than half of decedents) received hospice services from about 6,500 providers, and Medicare hospice expenditures totaled $25.7 billion. As described in Chapter 9, the indicators of Medicare payment adequacy for hospice services are positive.

Beneficiaries' access to care—In 2023, indicators of beneficiaries' access to hospice were positive. In 2023, the number of hospice providers increased by more than 10 percent as more for-profit hospices entered the market, a trend that has extended for more than a decade. The overall share of Medicare decedents using hospice services increased from 49.1 percent in 2022 to 51.7 percent in 2023, similar to the prepandemic high of 51.6 in 2019. The number of hospice users and total days of hospice care also increased. For decedents, average lifetime length of stay increased by about 1 day in 2023 to 96.2 days. Between 2022 and 2023, median length of stay was stable at 18 days. In 2023, Medicare payments to hospice providers exceeded marginal costs by 14 percent. This rate of marginal profit suggests that providers have a strong incentive to treat Medicare patients and is a positive indicator of patient access.

Quality of care—Scores on the Hospice Consumer Assessment of Healthcare Providers and Systems were stable in the most recent period. Scores on a composite of seven processes of care at admission were very high and topped out for most providers (meaning scores are so high and unvarying that meaningful distinctions and improvement in performance can no longer be made). The provision of in-person visits at the end of life was

stable or increased slightly between 2022 and 2023, but the frequency of nurse visits remained lower than the prepandemic level.

***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 more than 10 percent in 2023) and reports of strong investor interest in the sector suggest that capital is available to these providers. Less is known about access to capital for nonprofit freestanding providers, for which capital may be more limited. 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 2022 because of the data lag required to calculate cap overpayment amounts. Between 2021 and 2022, average cost per day increased by 3.8 percent. The FFS 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) for 2022 was 9.8 percent, down from 13.3 percent in 2021. If Medicare's share of pandemic-related relief funds is included, the aggregate FFS Medicare margin was about 10.4 percent. Cost growth slowed in 2023, with hospices' average cost per day increasing by 3.0 percent. We project a FFS Medicare margin for hospices of about 8 percent in 2025.

***Recommendation*—**Based on the positive indicators of payment adequacy and strong margins, the Commission concludes that current payment rates are sufficient to support the provision of high-quality care without an increase to the payment rates in 2026. The Commission recommends that the Congress eliminate the update to hospice base payment rates for fiscal year 2026.

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 10's ASC status report, in 2023, about 6,300 ASCs treated 3.4 million FFS Medicare beneficiaries. FFS Medicare program spending and beneficiary cost sharing on ASC services was about $6.8 billion.

The supply of ASCs and volume of services continued to grow in 2023: The number of ASCs rose 2.5 percent, and the number of ASC surgical procedures per FFS beneficiary grew by about 5.7 percent. 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. The most common service in ASCs, which accounted for almost 19 percent of volume and 19 percent of spending in 2023, was extracapsular cataract removal with intraocular lens insertion.

Most ASCs are for profit, and geographic distribution is uneven. The vast majority are located in urban areas, and the concentration of ASCs varies widely across states. About 68 percent of the ASCs that billed Medicare in 2023 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 2018 to 2023, the ASC specialties that grew most rapidly were pain management and cardiology. Relative to hospital outpatient departments (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.

Medicare spending per FFS beneficiary on ASC services rose at an average annual rate of 7.8 percent from 2018 through 2022 and by 15.4 percent in 2023. However, policymakers know little about the costs ASCs incur in treating beneficiaries because Medicare does not require ASCs to submit cost data, unlike its cost-data requirements for other types of facilities. The Commission contends that ASCs could feasibly provide such information, as other small providers such as home health agencies and hospices do. Beginning in 2010 through 2022, the Commission recommended that the Congress require ASCs to submit cost data and reiterated this recommendation in 2023 and 2024. The Commission also encourages 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.

The Medicare Advantage program: Status report

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional FFS Medicare program. As described in Chapter 11, in 2024, the MA program included 5,678 plan options offered by 175 organizations; enrolled about 33.6 million beneficiaries (54 percent of Medicare beneficiaries with both Part A and Part B coverage); and paid MA plans an estimated $494 billion (not including payments for drug coverage offered by MA plans). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, plan generosity (including enhanced financial protections and supplemental benefits), and payments for MA plan enrollees relative to spending for beneficiaries enrolled in FFS Medicare. We also provide updates on risk adjustment, risk-coding practices, favorable selection of enrollees into MA, the structure of the MA market, and the current state of quality reporting in MA.

The Commission strongly supports the inclusion of 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, like reduced premiums and cost-sharing liability. As evidenced by rapid growth in enrollment, these additional benefits are attractive to beneficiaries. Because Medicare pays private plans a partially predetermined rate—risk adjusted per enrollee—rather than a per service rate, plans should have greater incentives than FFS providers to deliver more efficient care.

The MA program is quite robust, with growth in enrollment, increased plan offerings, and a near record-high level of supplemental benefits. From 2018 to 2024, the share of eligible Medicare beneficiaries enrolled in MA rose from 37 percent to 54 percent. In 2025, the average Medicare beneficiary has a choice of 42 plans offered by an average of eight organizations.

In 2025, we estimate that Medicare will spend about 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected $84 billion. These higher payments vary significantly across MA parent organizations and are not an estimate of plan profits and administrative expenses. However, they are the primary source of funding for supplemental benefits, which include coverage of non-Medicare services (services not covered by Part A and Part B) and better financial protection for MA enrollees relative to beneficiaries in FFS Medicare without supplemental coverage. The rebates that plans use to finance these benefits have nearly doubled since 2018 and account for a projected 17 percent of payments to all MA plans in 2025, equaling $2,255 annually per enrollee in conventional plans (including $180 per enrollee for plan administrative expenses and profit). However, CMS lacks information about beneficiaries' use of many of these benefits.

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; the Commission estimates that Part B premium payments will be about $13 billion higher in 2025 because of higher Medicare payments to MA plans (equivalent to roughly $198 per beneficiary per year).

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 lower actual spending relative to their risk score tend to enroll in MA; it is the extent to which risk-standardized spending of MA enrollees would be lower than the FFS average without any intervention from MA plans. "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 if they were in FFS Medicare. Both favorable selection and coding intensity lead to pricing errors that cause CMS's risk-adjustment system to set the payment rate too high for a given MA enrollee.

Favorable selection may stem from a variety of factors, including differences in enrollees' propensities for using care for reasons unrelated to their health, differences in enrollees' health status that are not accounted for by risk scores, and differences in provider practice styles, among other reasons. Similarly, MA coding intensity is driven by several factors, including MA plans documenting diagnoses

more comprehensively than providers in FFS Medicare and, in some cases, submitting fraudulent diagnostic data. Separately identifying all of these factors is challenging and in many cases is not possible given available data. However, regardless of the causes, higher MA coding intensity and favorable selection of enrollees in MA increase Medicare's payments to plans. Higher payments to MA plans fund more generous benefits, but those higher payments increase Medicare spending and create an imbalance between the MA and FFS programs such that policymakers must weigh the added cost with the unmeasured value of the added benefits. Past experience with reductions in MA payments has demonstrated that plans can adjust their bidding behavior and lessen effects on plan participation and beneficiary enrollment while achieving program savings.

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 level of Medicare payments to MA plans. Relatively higher levels of payment stem largely from coding intensity and favorable selection. Second, the program that is used to reward plans for better quality is administratively burdensome, adds significantly to program costs, and does not meaningfully improve quality, nor does it provide meaningful quality information for beneficiaries choosing among MA plans. Third, MA benchmarks generate a number of inequities, including "cliff" effects from dividing 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, Medicare must address the challenges, burdens, and care disruptions for beneficiaries that stem from the process of choosing between plans and from changes to provider networks. Finally, the Commission finds that plan-submitted data about enrollees' 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.

Medicare payments to plans—In 2025, Medicare's payments to MA plans will total a projected $538 billion (about $507 billion excluding projected payments for enrollees with ESRD). As noted above, we project that Medicare's payments to MA plans in 2025 (including rebates that finance supplemental benefits) will be $84 billion more, or about 20 percent higher, than if MA enrollees were enrolled in FFS Medicare. This estimate reflects higher MA coding intensity, even after the annual CMS coding adjustment; favorable selection of beneficiaries in MA; setting benchmarks—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—above FFS spending in low-FFS-spending counties; and payments associated with benchmark increases under the quality-bonus program, which the Commission contends does not effectively promote high-quality care.

Favorable selection—We estimate that favorable selection increased MA payments in 2022 by roughly 10 percent above what the program would have paid under FFS Medicare. We project that in 2025, favorable selection will increase MA payments by roughly 11 percent above what the program would have paid under FFS Medicare, or $44 billion of the $84 billion in higher total payments to MA plans. We found relatively little variation in favorable selection by MA market penetration; that is, we estimate that favorable selection persists as the share of MA enrollees in a market increases. In addition, there were larger favorable-selection effects in MA enrollees with higher risk scores, implying that selection persists even as beneficiaries with more expensive health conditions enroll in MA. In fact, beneficiaries with higher risk scores can exhibit greater selection because there is more potential for overprediction. The Commission's estimates of favorable selection are reasonably robust and in line with a growing body of research that also estimates substantial effects from favorable selection on Medicare payments to MA plans.

Risk adjustment and coding intensity—We estimate that in 2023, MA risk scores were about 17 percent higher than scores for similar FFS beneficiaries due to higher coding intensity. We project that in 2025, MA risk scores will be about 16 percent higher than scores for similar FFS beneficiaries after accounting for the phase-in of the V28 risk-adjustment model. CMS reduces all MA risk scores by the same 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 2025, the adjustment will reduce MA risk scores by

the minimum amount, 5.9 percent, resulting in MA risk scores that will remain about 10 percent higher than they would have been if MA enrollees were in FFS Medicare. In 2025, higher scores due to coding intensity will result in a projected $40 billion of the $84 billion in higher total payments to MA plans.

Coding intensity for MA and FFS beneficiaries can arise for several reasons. We previously identified mechanisms that contribute to coding differences, such as health risk assessments and chart reviews, and we continue to examine why coding practices differ. In response to a congressional request, we examined the differing incentives in MA and FFS Medicare to document diagnoses, and we estimated rates of documenting chronic conditions in subsequent years in MA and FFS Medicare. However, because the risk-adjustment model is calibrated on FFS claims, relatively higher MA coding intensity—regardless of the reason—increases payments to MA plans above FFS spending.

In addition, we continue to find that coding intensity varies significantly across MA plans; 15 percent of MA enrollees are in plans that have coding intensity that falls below the 5.9 percent reduction (and even below FFS levels), and others are in plans that code far above that amount, including 16 MA organizations with average coding intensity that is more than 20 percent higher than FFS levels. Higher coding intensity allows some plans to offer more supplemental benefits—and attract more enrollees—than other plans. That result distorts both the nature of plan competition in MA and plan incentives to improve quality and reduce costs.

The Commission previously recommended changes to MA risk adjustment that would exclude diagnoses collected from health risk assessments, use two years of MA and FFS diagnostic data, and apply an adjustment to MA risk scores to address any residual impact of coding intensity. The Commission expects that our recommendation, along with the exclusion of chart reviews from risk adjustment, would reduce the heterogeneity in estimated coding intensity across MA organizations.

Quality in MA—The MA quality-bonus program increases MA payments by about $15 billion annually. In 2025, 69 percent of MA enrollees are in a plan that received a quality-bonus increase to its benchmark. At the same time, beneficiaries in MA and FFS report similar satisfaction with their coverage. Enrollees in both MA and FFS tend to rate their coverage and access to care highly—a trend that has held over time. For example, scores for all MA and FFS Consumer Assessment of Healthcare Providers and Systems survey measures, except annual flu vaccine, were above 80 percent from 2018 to 2023.

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

As described in Chapter 12, in 2024, Part D paid for outpatient drug coverage on behalf of more than 54 million Medicare beneficiaries. In 2023, Medicare and beneficiaries enrolled in Part D made payments to stand-alone Part D plans (known as PDPs) and Medicare Advantage-Prescription Drug plans (MA-PDs) totaling $128.2 billion (about 12 percent of total Medicare expenditures). Of that amount, Medicare paid $68.2 billion in subsidies for basic benefit costs and $43.9 billion in extra financial support for enrollees who received the low-income subsidy (LIS), while Part D enrollees paid $16.1 billion in premiums for basic benefits. Not included in this total is an additional $18.8 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. Surveys and focus-group findings suggest high overall satisfaction with Medicare Part D.

Significant changes happening in 2025—The passage of the Inflation Reduction Act of 2022 (IRA) brought many changes to the Part D program. One of the most important changes, the redesign of the Part D benefit structure, occurs in 2025. The redesign includes key elements of the Commission's 2020 recommendations intended to restore the plan incentives to manage drug spending that were in place at the start of the program. Notably, the redesign reduces 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 capitated direct-subsidy payments.

By adding cost-sharing protections such as the $2,000 annual limit on out-of-pocket costs, the redesign also substantially shifts liability for drug spending from cost sharing paid by beneficiaries at the point of sale (POS) to plans (which increases both enrollee premiums and the premium subsidies paid by Medicare). By lowering POS costs and increasing premiums, the redesign spreads the cost of the prescription drug benefit more

broadly among enrollees. Because the IRA also places a limit on the annual increase in average premiums paid by enrollees, Medicare's share of program spending has automatically increased to just over 83 percent (from the original 74.5 percent) in 2025.

Changes taking place in 2025 and subsequent years are expected to have wide-ranging impacts on Part D plan sponsors and their enrollees as well as participants in the pharmaceutical supply chain. For 2025, the national average plan bid rose by nearly 180 percent. The redesign's increase in plan liability was expected to raise premiums and Medicare's upfront payments for capitated direct subsidies while decreasing the share of spending paid by Medicare's reinsurance and beneficiaries' costs at the POS. However, greater variation in bids submitted by Part D plans for 2025 compared with previous years was likely driven by plans' uncertainty regarding the effects of the IRA on benefit costs, for which plans now bear a substantial portion of the insurance risk.

The Premium Stabilization Demonstration that CMS implemented for 2025 reduced some of the largest premium increases observed among the PDPs but will increase program spending by an estimated $5 billion in 2025; large variations in premiums remain. Over the coming years, we expect plan sponsors to adjust to the redesigned benefit as they gain claims experience while adapting to the new market dynamics.

Historical trends and concerns about the long-term stability of the PDP market—Historical data has continued to show Part D enrollment shifting from PDPs to MA–PDs. In 2024, PDPs accounted for less than 43 percent of all Part D enrollees, down from 53 percent in 2020. Trends through 2024 also showed stable average premiums but significant differences between PDPs and MA–PDs, in part due to MA–PDs' ability to use Part C rebates to lower Part D premiums: The average PDP premium in 2025, weighted by 2024 enrollment, is estimated at $44, while the average MA–PD premium (including both special-needs plans and conventional plans) is $14. In 2023, Medicare's spending on cost-based reinsurance and the LIS continued to grow.

Some of the recent trends have raised concerns about the long-term stability of the PDP market, which provides drug coverage for FFS beneficiaries and, critically, ensures that premium-free plan options are available for individuals with low income and assets. The shift in Part D's enrollment from PDPs to MA–PDs is consistent with the shift in enrollment from FFS to MA in the broader Medicare program. At the same time, however, MA–PDs' ability to offer more generous prescription drug coverage at lower premiums using Part C rebate dollars may affect insurers' willingness to participate in the PDP market. Misalignment between Medicare's payments to Part D plans and their enrollees' drug costs could also create disincentives for insurers to participate in the PDP market. Part D's risk adjustment has historically paid MA–PDs relatively more compared with their actual average costs while paying relatively less to PDPs compared with their actual average costs. Those inaccuracies may result from differences in management of drug spending, differences in coding behavior, or some combination of the two. To try to address the inaccuracy in Part D's risk-adjustment model, CMS is using a separate normalization factor for MA–PDs and PDPs in 2025. Despite a significant drop in PDP offerings across the country, in 2025 each beneficiary continues to have at least 12 PDPs from which to choose and roughly 30 MA–PDs.

Eliminating Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities

In Medicare, coverage of treatment in freestanding inpatient psychiatric facilities (IPFs) is subject to limitations—a 190-day lifetime limit on days in IPFs and a reduction of inpatient psychiatric benefit days available in the initial benefit period for beneficiaries who are in freestanding IPFs on their first day of Medicare entitlement. (Under Part A, a beneficiary's initial Medicare benefit period can span 150 days: 60 full-benefit days, 30 days with Part A coinsurance, and 60 lifetime reserve days.) These provisions were established in 1965 (with the implementation of Medicare), when most inpatient psychiatric care took place in state- and locally run freestanding facilities. However, the landscape has changed substantially in the last 60 years, and the provision of inpatient psychiatric services has shifted away from longer-term custodial-type care in government-run facilities to acute psychiatric care in privately owned facilities. In 2023, only 4 percent of Medicare-covered IPF days were in government-run freestanding IPFs, while 35

percent were in privately owned freestanding IPFs. The remaining 60 percent of Medicare inpatient psychiatric days took place in hospital-based IPFs, which are not subject to these limitations.

A small but highly vulnerable group of beneficiaries is affected by Medicare's coverage limits on freestanding IPFs. As of January 2024, since their initial enrollment in Medicare, about 40,000 Medicare beneficiaries had exhausted their coverage in freestanding IPFs. An additional 10,000 Medicare beneficiaries were within 15 days of the 190-day limit. In 2023, among the Medicare beneficiaries who were near or at the 190-day limit, over 70 percent were under 65 (disabled) and 84 percent had low incomes. Eighty percent of FFS Medicare beneficiaries near or at the limit had a diagnosis of schizophrenia in the prior year; these beneficiaries also were more likely than other IPF users to have "dual" diagnoses of schizophrenia or depressive order with substance abuse disorder.

Medicare beneficiaries reaching the limit may still obtain psychiatric care from hospital-based IPFs or general acute care hospitals, but an alternative setting may be difficult to find, be disruptive to care, and potentially be a less appropriate setting for the beneficiary. We compared beneficiaries who were near or at the 190-day limit with a group of beneficiaries who were further away from the limit but had a similar history of previous freestanding IPF use. We found that beneficiaries affected by the limit had an average of 2.4 covered days in a freestanding IPF compared with 7.6 covered days for the comparison group, suggesting that freestanding IPF days could increase by about 5 days on average if the limit were removed. However, beneficiaries affected by the limit had 5.0 covered days in a hospital-based IPF compared with 2.8 days for those in the comparison group, indicating that some substitution away from hospital-based IPFs would occur in the absence of the limit. Beneficiaries affected by the limit had an average of 2.2 fewer days of covered inpatient psychiatric care than beneficiaries in the comparison group, indicating that overall covered days for inpatient psychiatric services would likely increase if the limit were removed.

The Commission recommends that the Congress eliminate the 190-day lifetime limit on covered days in freestanding IPFs and the reduction of the number of covered inpatient psychiatric days available during the initial benefit period for new Medicare beneficiaries who received care from a freestanding IPF on and in the 150 days prior to their date of Medicare entitlement. Eliminating the limits on psychiatric services in freestanding IPFs would improve access to inpatient psychiatric care for some of the most vulnerable Medicare beneficiaries and would better align Medicare's coverage of inpatient psychiatric services with coverage for other types of medical care. Continued work to ensure that Medicare beneficiaries are receiving high-quality inpatient psychiatric care and are transitioned appropriately to the community upon discharge is critically important. The Commission will continue to monitor access and quality of care for beneficiaries who use IPF services. ■