Medicare Payment Advisory Commission, December 2025 Public Meeting
December 4-5, 2025, Meeting Summary

[Meeting materials available at on the MedPAC website here.]

On December 4-5, 2025, the Medicare Payment Advisory Commission (MedPAC, or "the Commission") held its December public meeting. HFMA presents a summary of that meeting. Unless specifically attributed to MedPAC commissioners or staff, all forward-looking statements in this summary reflect a prognostication of the Commission's likely actions; such statements are not informed by any proprietary or inside information about MedPAC's future plans.

Thursday, December 4, 2025

1. ASSESSING PAYMENT ADEQUACY AND UPDATING PAYMENTS: PHYSICIAN AND OTHER HEALTH PROFESSIONAL SERVICES (Rachel Burton, Geoff Gerhardt, Ledia Tabor, and Brian O'Donnell; 11:15 AM - 12:45 PM)

ISSUE: By law, each year the Commission reviews Medicare's fee-for-service (FFS) payment policies and makes payment update recommendations. For its March 2026 report to the Congress, in this session, the Commission considers whether payments to physicians and other health professionals are adequate and how they should be updated in 2027. The staff presentation includes information on beneficiaries' access to clinician care, quality of care, and the relationship between Medicare's payments and clinicians' costs.

PRESENTATION: The presentation provided an overview of use and spending under the Medicare Physician Fee Schedule (PFS), which pays 1.4 million clinicians for 1.1 billion services to 27.5 million fee-for-service (FFS) patients at a cost of $93.8 billion. MedPAC's payment adequacy framework focuses on beneficiary access to care, quality of care and clinicians' revenues and costs.

MedPAC's 2025 survey generally reported better access to care for Medicare beneficiaries than privately insured patients (generally characterized as shorter wait times for appointments, including new patient visits). Physicians are accepting new Medicare patients. The total number of clinicians billing the fee schedule is growing, including rapid growth in the number of advanced practice nurses and physician assistants. MedPAC staff rated beneficiary access to care as "positive."

Quality is hard to measure as MedPAC finds MIPS to be fundamentally flawed. Other quality indicators MedPAC tracks remained relatively stable. MedPAC rates quality of care as "indeterminate."

MedPAC found that allowed charges per FFS beneficiary grew 4.1 percent in 2024. Inflation as measured by the Medicare Economic Index (MEI) is moderating and expected to slow to 2.1 percent in 2027. The ratio of private insurance rates to Medicare rates increased slightly in 2023. MedPAC staff rates this metric of access as "somewhat positive."

The Chair's draft recommendation for 2027 is to increase Medicare's 2026 base payment rate for physician and other health professional services by 0.5 percentage points more than current law. The Chair notes that even though the recommendation is 0.5 percentage points more than current law, it would still be a reduction from 2026 to 2027 because of the one-time only payment update for 2026 of 2.5 percent.

DISCUSSION: The discussion included several different topics. One commissioner indicated that access to physicians/practitioners is the same or better for Medicare beneficiaries than private pay patients despite Medicare paying less than private insurers. Another commissioner inquired about wait times for Medicare beneficiaries to access a specialist while acknowledging positive access among Medicare beneficiaries to primary care physicians.

Several commissioners commented on the increase in the number of care management codes as well as the creation of the add-on code G2211 for patient intensity. There were questions as to whether these additional service codes are improving care to the point of decreasing hospitalizations. The Chair noted that utilization of these additional services remains relatively low despite CMS creating many additional coding opportunities for primary care services describing them as "patches."

Another commissioner raised concerns that the Chair's draft recommendation will create an overall update for all physicians but would not narrow the differential in primary care/specialty incomes. The Chair responded that MedPAC's charge in this session is the overall update for all physician services. The issue of narrowing differential incomes between specialists and primary care has been addressed by prior recommendations made by MedPAC in previous years.

The most robust discussion concerned a table in the presentation showing an increase of 104 percent in spending per beneficiary since 2000 despite cumulative MEI growth of 56 percent and a PFS of 14 percent during this same period. The commentary noted that the federal government has been "squeezing" physicians/practitioners by increasing Medicare rates less than inflation yet services per beneficiary continues to grow. One commissioner stated that despite MedPAC's many recommendations over the years intending to control spending growth, spending per beneficiary for physician services continues to grow.

There was discussion on whether this growth is a behavioral response to fee changes or just inherent growth in services per beneficiary due to other factors (*e.g.*, aging of the population). Despite these findings, most commissioners appear likely to support the Chair's draft recommendation, when it is brought up for a vote at the January 2026 MedPAC public meeting, although there may be at least one and perhaps two that support an update to the 2026 rate retaining the temporary 2.5 percent update with an update of MEI plus 0.5 percentage points (it was unclear whether this addition would be net of productivity or not).

2. ASSESSING PAYMENT ADEQUACY AND UPDATING PAYMENTS: HOSPITAL INPATIENT AND OUTPATIENT SERVICES; MANDATED REPORT ON RURAL EMERGENCY HOSPITALS; AND UPDATE ON SITE-NEUTRAL PAYMENTS (Alison Binkowski, Betty Fout, Alexandra Harris, Jeff Stensland, Brian O'Donnell, Ledia Tabor, Dan Zabinski; 1:30 PM - 2:55 PM)

ISSUE: By law, each year the Commission reviews Medicare's fee-for-service payment policies and makes payment update recommendations. For its March 2026 report to the Congress, the Commission considers whether Medicare inpatient and outpatient payments to general acute care hospitals are adequate and how they should be updated in 2027. Beginning in March 2024, the Commission also began reporting annually on payments to rural emergency hospitals (REHs). The staff presentation includes information on beneficiaries' access to hospital care, quality of care, hospitals' access to capital, and the relationship between Medicare's payments and hospitals' costs. It also includes information on REHs and site-neutral payments.

PRESENTATION: The presentation provided an overview of inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS) spending under FFS for 2024. Medicare spent $104.6 (plus $5.9 billion for uncompensated care) on the IPPS for 6.5 million inpatient stays with respect to 4.2 million beneficiaries and 3,095 hospitals. For OPPS, Medicare spent $52.4 billion (plus $22.0 billion for separately payable items) for 64.7 million patient encounters with respect to 15.8 million beneficiaries and 3,060 hospitals.

MedPAC's payment adequacy framework for hospital services focuses on beneficiaries' access to care, quality of care, hospital access to capital, and FFS Medicare payments and costs. The presentation indicates that hospitals continue to have available inpatient and ED capacity in 2024. The supply of hospitals remained stable between FY 2024 and FY 2025. Inpatient stays and outpatient encounters per beneficiary increased (1.5 per cent per 1,000 Medicare beneficiaries for inpatient and 4.0 percent per beneficiary for OPPS). MedPAC staff rated beneficiary access to care as "positive."

Quality indicators are mixed. FFS mortality rates improved while the FFS readmission rates worsened and measures of patient experience remained stable. MedPAC rates quality of care as "mixed."

All payer operating margins increased in FY 2024 (in part because of 340B remedy payments), while there was slower growth in labor costs and growth in profitable outpatient drugs relative to FY 2023. However, Medicare FFS margins increased but remained low in FY 2024. "Relatively efficient" hospitals that historically perform well on quality and cost metrics showed Medicare margins of -1 percent compared to -12.1 percent for other hospitals. MedPAC rates access to capital as "positive" and FFS Medicare payments and costs as "negative."

The presentation reiterates MedPAC's prior recommendation to replace Medicare's disproportionate share and uncompensated care payments with a Medicare Safety Net Index

(MSNI). MedPAC indicates that MSNI continues to be a better predictor of hospitals' all-payer operating margins and includes direct payments to hospitals for both their FFS and MA patients.

The Chair's draft payment update recommendation: For 2027, update the 2026 hospital base payment rates by the amount specified in current law, and implement the MSNI with an additional $1 billion.

The staff presentation also included a mandated report on REHs—rural, outpatient only hospitals that receive fixed payments to support stand-by costs of maintaining an emergency department and receive 105 percent of the OPPS payment rates. The number of REHs increased from 21 in 2023 to 44 in 2025. REHs received over $100 million in 2024 (more than 99 percent of these payments came from the $276,000 per month payment for standby costs). REHs report that MA plans match the enhanced OPPS payment for services but not the standby cost payment.

The presentation on site neutral payment reiterated MedPAC's 2023 recommendation to align payment rates for select services across ambulatory sites where safe and appropriate. It also notes that site neutral payment sets payment based on efficient delivery of care, not on setting and reduces incentives for providers to consolidate.

DISCUSSION: The discussion began with an announcement that this meeting would be the last one for longtime MedPAC staffer, Jeff Stensland. The Executive Director and the Chair recognized Jeff's service to MedPAC and his exceptional analytical and policy skills and contribution to public policy over the years. Many commissioners joined in praising Jeff's service.

A significant portion of the commissioners' discussion was about the efficient hospital model and how it has been validated. The staff explained how the hospitals are selected. Executive Director Masi noted that the list of efficient hospitals are not made public but only used as a measure of payment adequacy. One commissioner asked for the list of efficient hospitals to be published to create pressure for improvement among other hospitals.

Another significant topic of discussion included REHs. commissioners are interested in recommending that the standby cost payment of $276,000 per month be excluded from the MA benchmark if it is not paid by MA plans.

With respect to the quality findings, there was discussion about whether higher readmissions and lower mortality are complementary trends rather than conflicting ones. The suggestion was that readmissions could be an explanatory factor in reducing mortality.

One commissioner stated that hospitals are overpaid under the OPPS but underpaid under the IPPS and suggested that the margins should be separated by inpatient and outpatient services. The Chair disagreed and supported using the overall hospital margins to assess payment adequacy.

There was discussion about why the Chair's draft recommendation is to add $1 billion to MSNI rather than some other figure. The Chair explained that the $1 billion for MSNI is intended to

supplement hospital margins based on a judgment; margins should increase by ½ of a percentage point for hospitals that are most challenged.

The commissioners were generally supportive of the Chair's support for additional MedPAC work on site-neutral payment but raised concerns about expanding the policy to on-campus departments. One commissioner expressed concern that the discussion be sufficiently nuanced in MedPAC's report to support site neutral payment, but recognize limitations of the policy and counterarguments about the need for hospitals to be financially viable to be available as sources of care for Medicare beneficiaries.

3. POST-ACUTE CARE: TRENDS AND KEY ISSUES (Carol Carter; 3:00 PM - 4:00 PM)

ISSUE: Beneficiaries who require recuperative or rehabilitative care may be treated in skilled nursing facilities (SNFs) or inpatient rehabilitation facilities (IRFs) or by home health agencies (HHAs). While all three settings provide rehabilitation, skilled nursing, and personal care, the level of care varies, and the three settings differ in terms of Medicare benefits and cost sharing requirements under FFS Medicare. Researchers have found some overlap in the types of patients treated in the three settings; however, data limitations undermine comparisons of outcomes and quality within and across settings. Medicare FFS margins for SNFs, HHAs and IRFs are high. Efforts to improve FFS payment for post-acute care have been on-going. Alternative payment models may show promise, while the shift in enrollment away from FFS Medicare to Medicare Advantage has important implications for providers and beneficiaries.

PRESENTATION: The staff presentation began with an overview of three major post-acute care (PAC) settings: SNF, HH, and IRF. Dr. Carter presented basic information on number of providers, Medicare spending, utilization of services, and trends over time. Dr. Carter then recapped the types of services provided among the three sectors, how the services overlap and differ, and differences in Medicare's criteria for coverage and cost sharing. Despite differences in levels of care, MedPAC has long documented that similar beneficiaries may receive treatment across these three settings; Dr. Carter described the reasons for why this happens. Dr. Carter then discussed data limitations that prevent Medicare and policymakers from being able to compare quality and outcomes across these settings, which make it difficult to define the "best" setting for a given patient with a given condition. She then described incentives in the payment systems for each setting that influence the choice of setting, and the settings provided (*e.g.*, use of therapy as a factor in payment in the SNF and HH prospective payment systems), and how undesirable incentives have been corrected over time. Dr. Carter then described attempts (including MedPAC's) to develop a unified payment system across PAC settings. The next module of the staff presentation discussed PAC use in advanced payment models and under Medicare Advantage. Lastly, Dr. Carter described the Commission's PAC workplan for its next analytic cycle.

DISCUSSION: Commissioners asked clarifying and technical questions in the first round of discussion, per MedPAC's customary practice. Commissioner comments in the second round were varied. Some commissioners acknowledged the prior work on a unified PAC PPS, but were not surprised this work had never come to fruition, given the pronounced differences in

regulatory structures across these three PAC settings (Commissioner Miller was particularly acerbic in his comments on this topic). Of note, Commissioner Konetzka commented on "low-value IRF care." Several commissioners (Konetzka, Upchurch, Dusetzina, Sarran, and Damberg) spoke to the importance of patient experience data, and the need to analyze this data for use in refinements of the SNF value-based purchasing program. Several commissioners (Sarran, Rambur, Damberg) spoke to the need to improve the SNF VBP. Multiple commissioners (Konetzka, Upchurch, Sarran, and Metan) expressed a desire for more analytic work going forward on Medicare Advantage plans' use of PAC. Other comments were varied, and unique to specific commissioners.

At the moment, it does not appear that this presentation is queuing up a specific workproduct as its endpoint (*e.g.*, a report chapter focused on PAC), but rather that the commissioner input provided in this session will serve to guide the staff's ongoing work on PAC issues, and could appear in general analytic work over the remainder of the Commission's analytic cycle this year, and into the 2026-2027 analytic cycle.

4. ASSESSING PAYMENT ADEQUACY AND UPDATING PAYMENTS: SKILLED NURSING FACILITY SERVICES (Brian Klein-Qiu, Carol Carter; 4:15 PM - 5:15 PM)

ISSUE: By law, each year the Commission reviews Medicare's fee-for-service payment policies and makes payment update recommendations. For its March 2026 report to the Congress, in this session, the Commission considers whether payments to skilled nursing facilities (SNFs) are adequate and how they should be updated in 2027. The staff presentation includes information on beneficiaries' access to SNF care, quality of care, SNFs' access to capital, and the relationship between Medicare's payments and SNFs' costs.

PRESENTATION: Staff present their analysis of indicators of the adequacy of Medicare fee-for-service (FFS) payments to SNFs, along with the Chair's draft payment update recommendation. Staff report that beneficiary access to care, measured by supply of providers and utilization of services, was stable in 2024-2025. Quality indicators (discharge to the community, preventable hospital readmissions, and staffing measures are described as "stable" between 2023-2024, but gaps in data exist (notably patient experience data, that the commissioners highlighted in their discussion in the preceding session). Staff describe access to capital indicators as "positive," given investor interest and improvements in all-payer margins. The Medicare margin in 2024 was 24.4 percent, up from 2023, and for-profit SNFs had margins approaching 30 percent. MedPAC projects an aggregate SNF margin of 25 percent in 2026. **The Chair's draft payment update recommendation is for the Congress to reduce 2027 base payment rates by 4 percent**. This recommendation would reduce spending relative to current law.

Staff also discussed the SNF star rating system. Specifically, staff discussed ways to increase the prominence of nursing home staffing in the calculation of SNFs' star ratings, highlighting research showing the relationship between staffing and nursing home outcomes. Staff discussed an alternative under which the current three quality domains were equally weighted, and one in which staffing was given a 60 percent weight (with the other two domains – inspections and

quality - weighted 20 percent each). Staff presented the distributional impacts on star ratings of each of the alternative approaches.

DISCUSSION: Commissioners asked clarifying and technical questions in round one of the discussion.

In the round two discussion, **commissioners who spoke to the point were generally supportive of the update recommendation to reduce SNF payment rates by 4 percent**, although Commissioners Poulsen and Konetzka suggested the recommendation could be more "aggressive." Several commissioners addressed the presentation's material on SNF staffing (Konetzka "staffing is everything," Sarran, Poulsen, Damberg, Upchurch), but there was not a consensus on whether or not to recommend increasing the weight of the staffing domain in the star ratings system. The commissioners who spoke in the previous session on the need to improve the SNF VPB tended to reiterate those comments here. Other comments were "one off" on various topics.

Based on the commissioners' discussion, HFMA would anticipate that the Commissioners will vote on the -4 percent update recommendation (unchanged) at the January public meeting, and that the recommendation will pass with strong support.

We note that there is a certain inconsistency in the relationship between PAC providers' Medicare margins and the corresponding draft Chair's update recommendations that was not addressed by the staff, although Commissioner Metan picked up on this point in the Friday home health payment update session. Specifically, MedPAC projects that SNFs will have the highest 2026 Medicare margin, but recommends reducing SNF payments by the smallest amount among the three PAC sectors.

Sector	Chair's 2027 draft update recommendation	Projected 2026 Medicare margin
Skilled nursing facility	-4%	25%
Inpatient rehabilitation facility	-7%	18%
Home health agency	-7%	19%

5. ASSESSING PAYMENT ADEQUACY AND UPDATING PAYMENTS: INPATIENT REHABILITATION FACILITY SERVICES (Laurie Feinberg, Betty Fout, Alison Binkowski; 5:20 PM - 6:20 PM)

ISSUE: By law, each year the Commission reviews Medicare's fee-for-service payment policies and makes payment update recommendations. For its March 2026 report to the Congress, in this session, the Commission considers whether payments to inpatient rehabilitation facilities (IRFs) are adequate and how they should be updated in 2027. The staff presentation includes information on beneficiaries' access to IRF care, quality of care, IRFs' access to capital, and the relationship between Medicare's payments and IRFs' costs.

PRESENTATION: Staff present their analysis of indicators of the adequacy of Medicare fee-for-service (FFS) payments to SNFs, along with the Chair's draft payment update

recommendation. According to MedPAC staff, beneficiaries' access to IRF care (measured by supply of providers and utilization of services) was positive in 2024. Medicare stays increased 8 percent in the aggregate, and increased by 10 percent on a per capita basis. Quality (discharge to community and potentially preventable hospital readmissions) was stable from 2023 to 2024. Staff raise concerns about the validity of provider-reported patient outcomes data. IRFs' access to capital was described as "strong" in 2024, with an all-payer margin of 12 percent in 2024. IRFs' Medicare margins were 17.1 percent in 2024, up from 14.8 percent in 2023. Freestanding IRFs' had an aggregate Medicare margin of 25 percent in 2024. MedPAC projects an aggregate margin of 18 percent in 2026. These indicators inform the Chair's draft payment update recommendation: **For FY 2027, the Congress should reduce the 2026 Medicare base payment rate for IRFs by 7 percent.** This recommendation would reduce spending relative to current law.

DISCUSSION: Commissioners asked clarifying and technical questions in round one of the discussion. There was a notable amount of interest in the composition of the smallest IRFs in the sector, given their persistently negative Medicare margins. One commissioner asked about the reason for the difference in margins between for-profit and non-profit IRFs, and whether there is an associated difference in quality and outcomes. Commissioner Damberg asked about the reason for the growth in IRF utilization between 2023 and 2024; staff did not have an explanation on hand. Commissioner Miller spoke at great length, asking whether health services research has examined longer-term Medicare cost savings stemming from shorter-term improvements in patient functional status, and asking about the IRF staffing model relative to other PAC sectors.

For the most part, commissioners who spoke to the topic directly seemed to support the -7 percent update recommendation. Commissioner Damberg, however, was concerned about the heterogeneity of margins across different types of IRFs. Commissioner Barr, however, indicated that she "can't support this recommendation" because she didn't have enough information about rural IRFs and the potential effect of a -7% update on this subgroup.

Looking ahead, HFMA belives **it is likely that the Commission will vote on the -7% update recommendation at its January 2026 public meeting**. Commissioner support for this recommendation will likely be strong, but it would not be surprising if Commissioner Barr voted against this recommendation.

Friday, December 5, 2025

6. ASSESSING PAYMENT ADEQUACY AND UPDATING PAYMENTS: HOME HEALTH CARE SERVICES (Evan Christman; 10:00 AM - 11:00 AM)

ISSUE: By law, each year the Commission reviews Medicare's fee-for-service payment policies and makes payment update recommendations. For its March 2026 report to the Congress, in this session, the Commission considers whether payments for home health care services are adequate and how they should be updated in 2027. The staff presentation includes information on beneficiaries' access to home health care, quality of care, home health agencies' (HHA) access to capital, and the relationship between Medicare's payments and HHAs' costs.

PRESENTATION: Staff presented their analysis of indicators of the adequacy of Medicare fee-for-service (FFS) payments to HHAs, along with the Chair's draft payment update recommendation. Staff describe beneficiaries' access to home health care as "mostly positive," noting a small decline in the number of Medicare-participating HHAs (focusing on potential program integrity issues in California, especially Los Angeles), but concurrently an increase in volume per capita. HH quality of care is described as "stable," with no noteworthy change in rates of discharge to the community, or patient experience measures between 2023 and 2024. Access to capital (a less-important payment adequacy indicator for this sector) was described as positive (5 percent all-payer margin in 2024). Lastly, the relationship between Medicare payments and providers' costs was positive, with HHAs showing a 2024 Medicare margin of 21.2 percent. MedPAC staff project a 2026 Medicare margin of 19 percent. The Chair's draft payment update recommendation is that **for 2027, the Congress should reduce the 2026 Medicare base payment rate for home health care services by 7 percent**. The recommendation would reduce spending relative to current law.

DISCUSSION: As usual, commissioners asked clarifying and technical questions in round one of the discussion. Commissioner Sarran asked if staff have the capacity to distinguish HH utilization by beneficiaries in California, parsing between ACO-aligned beneficiaries compared to other FFS beneficiaries. Commissioner Poulsen asked if the program integrity issues in California are unique, or a leading indicator of a broader trend. Commissioner Barr asked whether HH utilization varies by urban versus rural areas (something that MedPAC includes as part of its regular order assessment of payment adequacy). Staff committed to pursuing a more granular analysis of this use.

In round two of the discussion, commissioners appeared generally in favor of the recommendation (but note Commissioner Metan's comments about consistency across the PAC sectors, discussed above – he was the only commissioner to have noted this). Several commissioners (Damberg, Cherry, Sarran) expressed an interest in having a better understanding of the HH program integrity issues in California. Some commissioners asked for additional stratifications of the data presented by the staff (*e.g.*, post-hospital discharge HH users compared with those admitted from the community (Konetzka, Upchurch)). Other comments were one-off, and touched on various topics specific to individual commissioner interests.

HFMA anticipates that the Commission will vote on the -7 percent update recommendation at its January 2026 public meeting, and that the recommendation will pass with strong support.

7. ASSESSING PAYMENT ADEQUACY AND UPDATING PAYMENTS: HOSPICE SERVICES (Kim Neuman; 11:05 AM - 12:05 PM)

ISSUE: By law, each year the Commission reviews Medicare's fee-for-service payment policies and makes payment update recommendations. For its March 2026 report to the Congress, in this session, the Commission considers whether payments for hospice services are adequate and how they should be updated in 2027. The staff presentation includes information on beneficiaries' access to hospice services, quality of care, hospices' access to capital, and the relationship between Medicare's payments and hospices' costs.

PRESENTATION: Staff present their analysis of indicators of the adequacy of Medicare fee-for-service (FFS) payments to hospices, along with the Chair's draft payment update recommendation. The staff analysis suggests payment adequacy indicators for the hospice sector are generally positive. The supply of providers increased by 2.6 percent in 2024, the share of Medicare decedents using hospice increased, and length of stay increased; the average number of visits per week in a hospice episode was stable, increasing by 1 percent between 2023 and 2024. Staff described hospice quality of care as "stable or improved," with CAHPS[1] survey scores stable in 2024, while admission processes of care and the number of end-of-life visits increased slightly. Like home health, access to capital is a less important indicator for the hospice sector, but staff described this as positive when viewing the growth in the number of hospices, and their financial performance. Medicare margins were described as "strong," at 8 percent in 2023, a slight decline from 2022, but with wide variation by hospice type.[2] Staff project that the Medicare margin will increase to 9 percent in 2026. **The Chair's draft recommendation is that for FY 2027, the Congress should eliminate the update to the 2026 Medicare base payment rate for hospice**. The recommendation would reduce spending relative to current law.

DISCUSSION: Commissioners asked clarifying and technical questions in round one of the discussion. Commissioner Barr asked about hospices' effect on aggregate Medicare spending. Staff responded that the health services research literature is mixed, and that methodological issues make such assessments complicated, but the staff have additional work on this topic underway. Commissioner Upchurch asked about pastoral care, volunteer costs, and bereavement services. Commissioner Damberg asked if MedPAC has ever tried to infer hospices' service areas by examining utilization (staff have not done this).

Round two comments were varied, but supportive of the Chair's draft payment update recommendation, but with several commissioners (Damberg, Barr, Poulsen, Cherry) expressing some hesitation about recommending eliminating the payment update for 2027. Some

[1] CAHPS: Consumer Assessment of Healthcare Providers and Systems.
[2] MedPAC's calculation of margins for hospices lags a year behind that for other sectors, due to the availability of data necessary to calculate the return of overpayments for hospices that exceed Medicare's cap on aggregate payments to any individual hospice in a given year.

commissioners commented on the material related to hospices' quality of care (Commissioner Sarran described the hospice equivalent of "never events"), and others commenting about access to hospice care in rural areas.

While most commissioners who spoke to the topic specifically **supported the recommendation**, given some of the concerns expressed by several commissioners, HFMA believes it is possible that the Chair may revise the update recommendation, and that a recommendation for a positive update (*e.g.*, market basket minus 1 percentage point, half of market basket, positive 1 percent, *et cetera*) could be presented to the Commission for a vote at the January 2026 public meeting.

8. ASSESSING PAYMENT ADEQUACY AND UPDATING PAYMENTS: OUTPATIENT DIALYSIS SERVICES (Nancy Ray, Grace Oh; 12:45 PM - 1:45 PM)

ISSUE: By law, each year the Commission reviews Medicare's fee-for-service payment policies and makes payment update recommendations. For its March 2026 report to the Congress, in this session, the Commission considers whether payments for outpatient dialysis services are adequate and how they should be updated in 2027. The staff presentation includes information on beneficiaries' access to outpatient dialysis services, quality of care, dialysis facilities' access to capital, and the relationship between Medicare's payments and dialysis facilities' costs.

PRESENTATION: Staff presented their analysis of indicators of the adequacy of Medicare fee-for-service (FFS) payments to outpatient dialysis facilities, along with the Chair's draft payment update recommendation. With respect to access to care, the staff presentation described dialysis facility capacity as "aligned with demand," with a slight decline in the number of treatment stations, but also a decline in the number of Medicare beneficiaries using dialysis (attributable to pandemic mortality, and an increase in the use of home dialysis). Staff presented a mixed picture of dialysis facilities' quality of care, with measures like hospitalizations and patient experience steady between 2023 and 2024, but an increase in the use of hospital emergency departments (ED) by beneficiaries on dialysis. Staff described dialysis facilities' access to capital as "strong," with an all-payer margin of 16 percent being attractive to investors. Lastly, dialysis facilities exhibited a 4.5 percent Medicare margin in 2024, with a projected 2026 margin of 4 percent (historically, dialysis facilities' Medicare margin has ranged between 0 and 2 percent). The Chair's draft payment update recommendation is that **for 2027, the Congress should eliminate the update to the 2026 Medicare base payment rate for outpatient dialysis services**. This recommendation would reduce spending relative to current law, which calls for a 1.6 percent update.

DISCUSSION: Again, Commissioners asked clarifying and technical questions in round one of the discussion. Commissioner Damberg asked about why some beneficiaries are using the hospital ED for dialysis services. She also asked whether home dialysis is less expensive to deliver than in-facility dialysis. Staff did not have answers to either question. Commissioner Poulsen asked whether the market concentration of the two large dialysis organizations (LDOs) improves, or hinders, access to care. Commissioner Cherry also commented on the increase in ED use among beneficiaries on dialysis, asking if there was a correlation between this

phenomenon and dialysis facility staffing. Commissioner Konetzka asked about payment incentives that favor in-center vs. home dialysis.

Most commissioners who spoke in round two voiced support for the Chair's draft recommendation, although Commissioner Barr expressed concerns about the relatively low margin for this sector, and the effect of a payment reduction on quality of care. Several commissioners voiced concern about the quality of care for beneficiaries with ESRD, noting that the highest patient experience ratings for the sector were relatively low compared to other sectors. Several commissioners (Sarran, Dusetzina, Upchurch, Damberg), wanted additional information on the relationship between Medicare Advantage and ESRD, and the implications of lack of guaranteed issue Medigap in many states for locking in beneficiaries with ESRD in MA plans. Commissioner Miller was vocal in his support for private equity in this sector.

In general, **commissioner support for the recommendation to eliminate the payment update for dialysis facilities for 2027 was strong, and HFMA believes it is very likely that this recommendation will be voted on and pass at MedPAC's January 2026 public meeting**.

9. IMPROVING MEDICARE'S PAYMENT APPROACHES (Rachel Burton, Stuart Hammond, Luis Serna; 1:50 PM - 3:15 PM)

ISSUE: Medicare spending is projected to nearly double over the next decade, driven by expected growth in the number of beneficiaries and in the volume and intensity of services delivered per beneficiary. Since payment policy can have an impact on volume and intensity growth, it is important to consider the advantages and disadvantages of Medicare's different payment methods—fee-for-service, alternative payment models (APMs) such as accountable care organizations, and Medicare Advantage (MA) - and improvements that should be made to each.

PRESENTATION: Note that the Chair, Mike Chernew, appears to be personally invested in the work (the presentation began with the phrase "at the Chair's request.") The staff presentation began with a discussion of the three main payment models in Medicare: FFS, APMs, and MA. Staff then presented an overview of some of the macro-level spending trends related to the Medicare program (*e.g.*, Medicare represents about 20 percent of national health care spending ($1 trillion in 2024), Medicare will consume about 25 percent of Federal Income tax revenue in 2035, *et cetera*. Staff discussed the slowdown in Medicare spending between 2010 and 2017, and the subsequent uptick in spending since that time. Staff assert that much of the growth in Part B spending is driven not by price or demographics, but rather volume and intensity of services (physicians prescribing more, and more costly, items and services over time).

Staff then shifted to a discussion of the incentives intrinsic to each of Medicare's payment mechanisms (FFS, APMs, and MA). Staff discussed volume incentives under FFS, and coding incentives in APMs and MA. Staff then inventoried past MedPAC recommendations to improve each of these payment approaches. With respect to future work, staff mentioned controlling volume and intensity in FFS and exploring greater use of site-neutral payment policies, improving the design of APMs, and exploring different ways of paying MA plans.

DISCUSSION: Chair Chernew indicated that this material will compose a short chapter in the Commission's June 2026 Report to the Congress. Unlike other sessions, there was only one round of commissioner commentary, and the Chair personally managed the discussion. He indicated that the forthcoming chapter will be relatively contained, "focusing on conceptual issues behind payment issues discussed" in the presentation. (He used the phrase "conceptual issues" several times in kicking off the discussion.) The material did not appear detailed enough to compose an actual workplan, although several commissioners expressed support for the "direction" of the chapter. Given the Chair's personal involvement in this work, it was easy to come away from the discussion with a sense of this chapter being a capstone product documenting the major issues the Commission had dealt with during his six-year tenure.

Commissioner comments, as might be expected with respect to such a topic, were extremely varied, and it was difficult to identify general themes around which more than one or two commissioners gravitated. Some commissioners (Poulsen, Dusetzina, Upchurch) noted the role of pharmaceuticals in Medicare spending growth, and stated that none of the payment platforms were really able to address pharmaceutical prices (Chair Chernew rebutted this assertion, saying that MA plans and APMs would likely have more success addressing pharmaceutical prices than FFS Medicare). Several commissioners (Damberg, Dusetzina, Metan, Rambur, Sarran, Miller, Konetzka, Cherry) commented on various aspects of MA, ranging from the need for reform on how Medicare pays MA plans, to the need for greater transparency in supplemental benefits, to concerns about integrating hospice into the MA benefit package. At least two commissioners (Dusetzina, Metan, Konetzka) asserted the need for a cap on beneficiary out-of-pocket cost sharing liability in the traditional FFS program.

This work appears to be on track for inclusion as a chapter in the Commission's forthcoming June 2026 report to the Congress. It is possible that this work will be bookended in one of the Commission's spring meetings, but it is not necessary to do so for inclusion in the June publication. No recommendations will be included in this chapter.

10. MANDATED REPORT: THE IMPACT OF RECENT CHANGES TO THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (Evan Christman, Betty Fout, *et al*.; 3:30 PM - 4:55 PM)

ISSUE: In 2020, CMS implemented major changes to FFS Medicare's home health prospective payment system (PPS), as required by the Bipartisan Budget Act (BBA) of 2018. These included a new 30-day period as the unit of payment (replacing the 60-day unit) and a new patient classification system (the Patient-Driven Groupings Model (PDGM)), which eliminated the number of therapy visits as a factor in the payment system. The BBA of 2018 requires MedPAC to assess the impact of the changes to the home health PPS on agency payments and costs and the delivery and quality of care, and to provide an interim and a final report to the Congress. In March 2022, the Commission submitted its interim report assessing the initial impact of the PDGM on home health care in 2020. While disruptions related to COVID-19 complicated the analysis, MedPAC found that the PDGM itself did not substantially disrupt access to home health care. The Commission's final report is due on March 15, 2026.

PRESENTATION: The staff presentation provided background material on the Medicare home health benefit, and the home health PPS. The BBA of 2018 made substantial changes to the HH PPS, discussed above, and mandated that MedPAC evaluate the impacts of these changes. MedPAC submitted an interim report on these impacts in 2022, and in this session presented the findings that will be included in its final report.

MedPAC's evaluation uses an interrupted time series regression model, focusing on 2023 data (the most recent year of PDGM data, least likely to have reflected the effects of the COVID-19 pandemic). MedPAC concedes limitations in its analyses, noting that constructing the counterfactuals against which actual utilization data are compared, is complicated by factors for which their regression analysis could not control.

MedPAC reports that between 2016 and 2023, the share of beneficiaries using HH, and the number of HH visits per HH stay, declined. Staff indicate that PDGM "was associated" with a slight decline in the use of HH. Additionally, staff noted a considerable decline in the number of visits per home health stay, especially therapy visits per stay, of over 21 percent during this time (as would have been anticipated, given the changes in the HH PPS). Staff report that PDGM was associated with little change in patient functional status, but there were improvements in the rate of avoidable hospitalizations. Lastly, staff indicate that PDGM was associated with a 3.6 percent higher payment-to-cost ratio relative to the non-PDGM counterfactual. MedPAC will present additional analytic work related to this mandate in January 2026.

DISCUSSION: Commissioners were given the opportunity to ask clarifying questions in the first round of commissioner discussion. Commissioner Konetzka asked about differences in the rate of change in hospital- vs community-admitted home health patients. She also asked about the reduction in RN visits per stay. Commissioner Dusetzina asked if MedPAC had considered censoring 2020 data due to the effects of the COVID pandemic. Commissioner Diller asked about the savings attributable to Medicare stemming from the reduction in avoidable hospitalizations. Commissioner Upchurch asked whether HHAs have a preference for Part A or Part B covered stays. Commissioner Damberg asked about the finding of fewer nursing visits and fewer therapy visits per stay (Table 9 – payment-to-cost ratios (PTC) in the commissioners' meeting materials); were there other changes to the labor mix that might have affected PTC ratios?

Interestingly, there were very few commissioner comments in Round two of the discussion, suggesting that generally commissioners understood, and were satisfied with the analytic work presented. Commissioner Konetzka commented that the methodology underlying the work presumed that there was no "re-setting" in the provision of HH care post-COVID-19 pandemic. Commissioner Rambur asked about changes to the nursing workforce labor market post-pandemic.

Staff will present additional analytic work at the January 2026 MedPAC public meeting, and this material will compose a chapter in the Commission's forthcoming June 2026 Report to the Congress. The report will not include bold-faced voted-on recommendations related to the PDGM, but that in itself is noteworthy, as the Commission has not identified any major flaws or

adverse consequences of the PDGM that warrant immediate change to protect beneficiaries or the Medicare program.

11. MANDATED REPORT: ASSESSMENT OF THE MEDICARE GROUND AMBULANCE DATA COLLECTION SYSTEM (Dan Zabinski, Jeff Stensland, *et al*.; 5:00 PM - 6:30 PM)

ISSUE: CMS did not have cost data when the Medicare ambulance fee schedule (AFS) was developed. Without cost data, it is not possible to know if Medicare's payments to ambulance organizations are adequate to ensure beneficiary access to care. Further, it cannot be determined if payments under the AFS appropriately vary with the costs of transporting beneficiaries with different needs in different locations. To support analysis of whether the AFS payments are appropriate, the Congress directed CMS—via the Balanced Budget Act (BBA) of 2018—to implement the Ground Ambulance Data Collection System (GADCS). CMS collected data for 2022 and 2023 from a sample of ambulance organizations, including information on organization characteristics, service area, service volume, response times, staffing and service mix, and certain categories of costs and revenues. The BBA of 2018 requires MedPAC to report on the information submitted under the GADCS, including the burden on ambulance organizations of collecting the data and the utility of the data for ambulance payment. The report is due on June 15, 2026.

ISSUE: CMS did not have cost data when the Medicare ambulance fee schedule (AFS) was developed. Without cost data, it is not possible to know if Medicare's payments to ambulance organizations are adequate to ensure beneficiary access to care. Further, it cannot be determined if payments under the AFS appropriately vary with the costs of transporting beneficiaries with different needs in different locations. To support analysis of whether the AFS payments are appropriate, the Congress directed CMS—via the Bipartisan Budget Act (BBA) of 2018—to implement the Ground Ambulance Data Collection System (GADCS). CMS collected data for 2022 and 2023 from a sample of ambulance organizations, including information on organization characteristics, service area, service volume, response times, staffing and service mix, and certain categories of costs and revenues. The BBA of 2018 requires MedPAC to report on the information submitted under the GADCS, including the burden on ambulance organizations of collecting the data and the utility of the data for ambulance payment. The report is due on June 15, 2026.

PRESENTATION: The staff presentation began with an overview of what is covered under the AFS and the payment methodology. Payment under the AFS has two parts: mileage, and services provided during transport. Mileage is a function of a conversion factor ($8.97), the location of the ambulance pickup (urban, rural, and super rural), and an add-on payment for the 1st 17 miles of rural/super-rural pickups. For payment of the services provided during transport, payment is a function of a conversion factor ($278.98), the applicable RVU (service complexity), the location of the pickup (urban, rural, super rural) and the practice expense geographic practice cost index (PE GPCI), which measures the geographic differences in costs. Adjustments for location of the pickup (2% for urban and 3% for all rural, and an additional 22.6% for super rural) are temporary.

In the staff presentation, staff provided an overview of the GADCS, which includes data on ambulance organizations' characteristics, service area, service volume, service mix, staffing, costs, and revenues. CMS surveyed 10,600 ambulance organizations that provided services in 2017, 2018, or 2020. For survey years 2022 and 2023, about 7,500 organizations submitted GADCS data – the other 2,500 organizations were excluded because the organizations were no longer active or chose not to participate in survey. Overall, CMS collected data from 71% of the organizations that provided ambulance services. Based on this response rate and the design of the GADCS, MedPAC staff stated that the cost data collected can be used to assess the accuracy of AFS payments and obtain nationally representative results. Staff also noted that the GADCS includes over 600 variables and many may not be needed for evaluating ambulance costs. MedPAC staff noted that GADCS does not include data on providing care specifically to Medicare beneficiaries, so transport costs can be calculated for all patients but not specially for all Medicare beneficiaries. Industry stakeholders also expressed an overall desire for continued data collection, but small rural, organizations reported difficulty collecting and submitting data and wondered about the usefulness of so many questions.

In the discussion of MedPAC's analysis, staff presented an analysis that showed the volume of transports has a strong effect on per-unit costs. The cost per transport is $2,852 in the lowest quartile (average of 166 transports per organization) compared with $914 in the highest quartile (average of 15,721 ambulance transports per organization). The staff also provided an overview of the regression analysis that examined the effect of certain cost drivers on ground ambulance costs (the dependent variable in the analysis). The explanatory variables in the model were categorized as operational (*e.g.*, number of transports, average response time, complexity of transports, type of staffing model and mix of ground ambulance services), geographic (*e.g.*, urban, rural, and super rural), type of ownership (for-profit, nonprofit, and government), and share of revenue that is from local tax revenue. The regression results showed that costs rise at a slower rate than transports, indicating economies of scale. Specifically, a 10 percent increase in transports increases costs by about 7 percent. In general, volume is a strong driver of costs, and current AFS adjustments are not well targeted. Staff concluded that GADCS is a good first step but that it has a lot of variables, of which many may not be needed for purposes of cost analysis, and the survey could be improved through streamlining.

DISCUSSION: Commissioners were in general agreement that GADCS was an important step towards developing more accurate Medicare payment rates for ground ambulance services. There was discussion about what accounted for the economies of scale in the provision of ground ambulance services. Staff responded that this was largely related to the high fixed costs associated with providing ambulance services and that cost per unit goes down with more volume. There was also general agreement that the cost of ground ambulance services should not vary for Medicare patients, given the level of fixed costs. Commissioners generally agreed that data on this issue should continue to be collected but that the level of granular data collected could be reduced to lessen the survey burden. Several commissioners also suggested that these data could be collected less frequently than annually and survey sampling could be used instead of collecting data on all ground ambulance organizations.

Chair Chernew states that this work will be included in a June 2026 report and that it will likely include a recommendation to continue collecting ground ambulance cost data (using a streamlined version of the GADCS) on a periodic basis. Commissioners will need to continue discussion on how often such data collection should occur - every two, three, or five years, for example.