MedPAC Recommends Increasing Physician Payment Rates, Cutting Rates For SNF, Home Health, Inpatient Rehab

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Congress should increase Medicare payment rates for physicians but reduce payment rates for skilled nursing facilities, home health agencies and inpatient rehabilitation facilities, while eliminating payment updates for outpatient dialysis services and hospice, the Medicare Payment Advisory Commission (MedPAC) recommends in its March 2026 report to Congress released Thursday (March 12).

The American Medical Association welcomed the payment update, which the lobby noted would be on top of .25% and .75% increases slated under current law. However, AMA was disappointed that MedPAC's recommendation did not call for linking physician fee updates to the Medical Economic Index, which the panel did last year.

"MedPAC should continue urging Congress to link physician payment updates to MEI to provide stability for physician practices and certainty for patients. Other health care providers have payments linked to inflation, which spares them the annual year-end scramble in Congress to fend off payment cuts," AMA President Bobby Mukkamala said. "The AMA will carry this message to Congress and hopes it resonates in the marble halls as it does in the exam room."

The National Alliance for Care at Home condemned MedPAC's recommendations to reduce home health pay and eliminate payment updates for hospice care.

"If implemented, these actions would further reduce access to care for vulnerable populations, at a time where demand for care at home is increasing," the group said.

In January, the organization argued the proposed recommendations to reduce home health pay and not change payments rates for hospice does not reflect the industry's operating realities or the cumulative impact of recent policy changes.

The MedPAC report also includes the commission's annual Medicare Advantage cost analysis, which, as previewed in January, finds that MA overpayments will reach $76 billion in 2026 due to coding intensity and favorable selection. However, insurance lobbies say that analysis is based on incomplete and inaccurate data and should not be relied on for policymaking.

The report also includes a status update on Part D, which examines the rapid increase in spending and plan bids as the Inflation Reduction Act redesign of the program take effect.

FFS recommendations

Similar to what the commissioners discussed in January, MedPAC recommends Congress increase payment rates for physician and other health professional services by 0.5 percentage points in calendar year 2027 but

reduce base payment rates by 4% for skilled nursing facilities, 7% for home health agencies and 7% for inpatient rehabilitation facilities.

MedPAC also says Congress should eliminate the update to the 2026 base payment rates for outpatient dialysis services and hospice.

Commissioners Brian Miller and Kenny Kan voted against recommending increasing physician payments.

During a press conference Thursday, MedPAC Executive Director Paul Masi said the commission is recommending an increase in physician payments and targeted support toward hospitals that treat large shares of low-income Medicare patients based on mixed findings from the commission.

“In the hospital sector, the Commission's analysis of payment adequacy was similar to prior years, in that it was mixed,” Masi said. “Certain access measures remained fairly positive. Medicare beneficiaries’ utilization of hospital services increased. However, hospital margins for fee-for-service discharges remained substantially negative. We estimate that in 2024 Medicare margins for hospitals were roughly negative 12% and so that was one important contributor to why the commission wanted to target some additional support for hospitals.”

MedPAC recommends updating the 2026 Medicare base payment rates for general acute care hospitals by the amount specified in current law. The panel also recommends implementing the Medicare Safety-Net Index (MSNI) the commission outlined in its March 2023 report and increasing the MSNI pool to $1 billion. Kan and Miller abstained from this vote.

MA findings

MedPAC found that Medicare spends about 14% more for MA enrollees than it would if those beneficiaries were enrolled in regular Medicare, translating to a projected $76 billion in 2026. According to MedPAC, the spending difference varies by MA organization and results from favorable selection of beneficiaries into MA and coding intensity.

MedPAC says favorable selection, where beneficiaries with lower spending than predicted by their risk score tend to enroll in MA, will increase MA payments by about 11% compared to what Medicare would have paid for. And MA plans having higher coding intensity of diagnostic patterns will result in MA risk scores about 4% higher than risk scores for similar FFS beneficiaries, MedPAC says. However, coding intensity has declined over the past few years due to changes to the V28 risk adjustment model, MedPAC found.

The commission’s MA report, initially presented at MedPAC’s January meeting, also projects MA will continue to grow in 2026 and cover about 55% of the Medicare population, about 34.7 million, up slightly from the 54% of enrollees projected for 2025.

MedPAC also found average MA rebates are projected to reach a record high, despite the phase-in of the V28 model, which Masi attributed to plans being able to generally reduce medical expenses.

Regarding enrollees with ESRD, MedPAC found that finances have improved overall “for both MA plans and dialysis facilities with increasing MA enrollment,” as plans went from roughly breaking even on medical costs for enrollees with ESRD in 2018 to having payments plans exceeded their medical costs by an average of 12 percent by 2023.

The Better Medicare Alliance (BMA) on Thursday reiterated its argument that MedPAC's assumptions are flawed, pointing to a January article by CMS officials that found overpayments in the 1.5%-2% range when using updated methodologies and other recent studies and op-eds to back up their view.

"While [MedPAC's] estimates can drive the policymaking discussion, it's important to remember that they are just that: estimates," BMA Senior Vice President of Public Affairs Rebecca Buck said. "And they don't tell the whole story."

BMA and other insurance lobby organizations are pushing Congress to pass the Apples-to-Apples Comparison Act to ensure MedPAC makes adequate comparisons between fee-for-service and MA in its reporting.

Medicare Part D findings

MedPAC also analyzed Medicare Part D data in its annual report, noting that spending on Medicare Part D plans continues to increase at a rapid rate as the Inflation Reduction Act redesign begins to take effect. However, the increase in drug prices, including GLP-1s, factored in as well.

According to the analysis, plans' bids increased by about 180% in 2025 and by 33% in 2026.

Masi said during a press briefing it remains unclear whether the sharp increase in bids represents a one-time adjustment as plans adapt to the redesigned benefit or the beginning of a sustained increase in bid levels. Masi added that plans are still adjusting to the new incentives created by the redesign and that several factors -- including the removal of beneficiary cost sharing above the out-of-pocket cap and the growing use of high-cost specialty drugs -- could affect future spending patterns.

"We talked with actuaries who have expertise in Part D to try to gain some additional information from the environment. And one takeaway from those conversations this past summer was, broadly, that steady state may still be a few years away, and so we're continuing to monitor this closely, given what we've seen the last couple of years and the potential for some additional uncertainty," Masi said.

The commission did not include new policy recommendations for Part D in this year's report. Instead, it designated the chapter as a status update as the redesign of the benefit is still being rolled out, and its full impact on plans, spending and beneficiary behavior continues to be studied.

MedPAC estimates that, between 2023 and 2024, total Part D spending increased roughly 18% -- a notable jump from growth of 10% the previous year. In 2024, payments to stand-alone prescription drug plans and Medicare Advantage drug plans -- including premiums paid by beneficiaries -- totaled about $148.3 billion.

Of that total, Medicare paid roughly $90.3 billion in subsidies to support the basic drug benefit and another $41.3 billion in additional financial assistance for beneficiaries who receive the program's low-income subsidy (LIS). Part D enrollees paid $16.7 billion in premiums for basic benefits.

Those figures do not include roughly $17.7 billion in cost sharing paid directly by beneficiaries at the pharmacy counter or about $500 million in retiree drug subsidies Medicare pays to employers that provide prescription drug coverage to retirees.

As of 2024, overall Medicare spending was about $1.1 trillion, or 3.8% of the total GDP -- a number that is expected to double within the next decade as the baby-boomer generation continues to reach eligibility.

MedPAC tied much of the increase to structural changes in how the Part D benefit is financed under the IRA, as well as higher pharmacy spending among beneficiaries who do not receive the program's low-income subsidy (non-LIS).

The 2022 redesign, commission analysts argue, altered how the Part D benefit is financed by reducing Medicare's reliance on reinsurance payments in the catastrophic phase and shifting more of those costs to private plans and drug manufacturers. Under the previous structure, Medicare paid the majority of costs once beneficiaries reached the catastrophic spending threshold. The redesign moved more of that financial responsibility onto plans, which now receive larger upfront subsidy payments from Medicare to help offset the added risk.

Simultaneously, the law capped beneficiaries' out-of-pocket costs at about $2,000 per year starting in 2025, a policy aimed at protecting seniors from unlimited cost sharing for expensive medications. MedPAC analysts say this change significantly reduced what many beneficiaries pay out of pocket, particularly among those who do not qualify for the program's low-income subsidy and historically faced the highest drug costs.

As a result, under the new structure, Part D bids have risen sharply. MedPAC estimates that the national average bid increased about 180% in 2025 and another 33% in 2026.

Commission analysts said most of the increase in 2025 reflects the mechanical shift in how the benefit is financed rather than a sudden jump in drug prices. MedPAC estimates 82% of the bid increase in 2025 stemmed from changes in financing and plan liability under the redesign, while the remaining increase reflected higher projected drug spending.

By contrast, the projected increase in bids for 2026 appears to be driven primarily by underlying growth in drug spending and utilization, particularly for high-cost medicines.

A report published earlier this month by Avalere Health suggests demand for certain high-cost therapies, specifically GLP-1 drugs, may be contributing to those trends, which MedPAC reinforced in its report. Avalere found that claims for GLP-1 drugs among Medicare beneficiaries enrolled in standalone Part D increased 71% between 2021 and 2023, with the number of beneficiaries rising from about 714,000 to 1.2 million.

While Medicare is statutorily prohibited from covering GLP-1 drugs when they are prescribed solely for weight loss, the medications are covered under Part D when used to treat Type 2 diabetes, which has driven much of the growth in utilization in recent years.

But CMS is starting some Innovation Center demonstrations that will test covering GLP-1s for weight loss. -- *Sigi Ris* (sris@iwpnews.com), *James Jarvis* (jjarvis@iwpnews.com)