

MedPAC Holds December 2025 Meeting

On December 4 and 5, 2025, the Medicare Payment Advisory Commission (MedPAC) held a public meeting.

By law, the Commission reviews Medicare’s fee-for-service (FFS) payment policies each year and makes payment update recommendations. MedPAC’s recommendations are informed by four indicators: beneficiaries’ access to care, quality of care, access to capital, and provider revenues and costs. Sessions included:

- Assessing payment adequacy and updating payments: Physician and other health professional services;
- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; mandated report on rural emergency hospitals; and update on site-neutral payments;
- Assessing payment adequacy and updating payments: Skilled nursing facility services;
- Assessing payment adequacy and updating payments: Home health care services; and
- Assessing payment adequacy and updating payments: Hospice services.

Other sessions included:

- Post-acute care: Trends and key issues;
- Improving Medicare’s payment approaches; and
- Mandated report: Assessment of recent changes to the home health prospective payment system.

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

MEDPAC WEIGHS A MODEST INCREASE IN PHYSICIAN PAYMENT

In this session, the Commission focused on assessing payment adequacy and updating payments for physician and other health professional services. In 2024, care for 27.5



million FFS Medicare patients resulted in \$93.8 billion in payments under the Physician Fee Schedule (PFS).

Access to Care: Beneficiary access to care was assessed through MedPAC's annual patient survey. Overall, the Commission reported that Medicare enrollees generally have better access than privately insured individuals. Medicare beneficiaries also reported higher rates of satisfaction when searching for new providers, easier access to timely appointments, and shorter wait times compared to those with private insurance. In 2024, 95 percent of non-pediatric physicians accepting new patients also reported accepting "all" or "some" new Medicare patients. While the number of clinicians billing Medicare's fee schedule grew by 2.2 percent per year from 2019 to 2024, the mix of billing providers has shifted. This reflects rapid growth in Advanced Practice Registered Nurses (APRNs), Physician Assistants (PAs), and specialist physicians, accompanied by a decline in primary care providers.

Quality: Despite noted difficulties in measuring quality, the Commission found key indicators remained relatively stable for 2024. The Commission focused on two metrics: (1) ambulatory care-sensitive (ACS) hospitalizations and emergency department (ED) visits, and (2) FFS Consumer Assessment of Health Providers and Systems (CAHPS) patient experience scores. In 2024, ACS hospitalizations and ED visits remained below pre-pandemic levels and were almost unchanged compared with 2023. CAHPS patient experience scores remained stable, with FFS Medicare ratings of 84/100 and health care quality of 86/100.

Access to Capital: MedPAC does not evaluate physician access to capital due to data limitations.

Clinician Revenues and Costs: According to MedPAC's assessment, both clinician revenues and costs exhibited moderately positive trends. In 2024, allowed charges per FFS beneficiary rose by 4.1 percent. The new complexity add-on code, G2211, accounted for one-fifth of this total increase. For 2026, due to the higher Evaluation and Management (E&M) payments, expanded care management, and the 2.5 percent efficiency adjustment, the Commission expects increased payments for primary care providers. Clinician input costs, as measured by the Medicare Economic Index (MEI), moderated to 3.0 percent in 2024. Though this remains slightly elevated in MedPAC's assessment, it is projected to slow to 2.1 percent in 2027. On the other hand, PFS spending per beneficiary has grown significantly faster than payment updates, increasing by 104 percent between 2000 and 2024. This is in stark comparison to a 56 percent increase in the MEI and a 14 percent increase in scheduled payment updates. Provider compensation increased by 6 percent for physicians and 2 percent for Nurse Practitioners (NPs) and Physician Assistants (PAs), with radiologists, surgeons, and non-surgical proceduralists remaining the highest-paid. MedPAC also found that

private Preferred Provider Organization (PPO) payments were, on average, 140 percent of Medicare rates, representing a 4 percent year-over-year increase. Even so, the Commission expects clinicians to continue accepting Medicare due to their commitment to treating patients, Medicare's prompt payment, and the higher administrative burdens in the private market.

Draft Recommendation and Commission Discussion

Based on these findings, the Chair's draft recommendation is: **"For calendar year 2027, the Congress should increase payment rates for physician and other health professional services by 0.5 percentage points more than current law."** This would result in participating Advanced Alternative Payment Model (A-APM) clinicians receiving a 1.25 percent update (0.75 percent statutory update + 0.5 percent additional update) and non-qualifying clinicians receiving a 0.75 percent update (0.25 percent statutory update + 0.5 percent additional update). The Commission expects this to preserve clinicians' willingness to treat FFS Medicare beneficiaries and maintain access to care, while resulting in increased spending.

During their discussion, the Commission highlighted concerns around beneficiary access, spending, payment disparities, safety-net funding, and consolidation. Several Commissioners noted the counterintuitive finding that Medicare beneficiaries report better access than the privately insured, despite lower Medicare payment rates—pointing to increased use of APRNs and PAs. Overall, the group was concerned about the ongoing decline in primary care availability. Regarding payment issues, the Commission emphasized that rising physician compensation is a poor proxy for Medicare profitability amid consolidation, while expressing a strong interest in whether new codes, such as G2211, meaningfully improve patient outcomes. A central theme was that Medicare FFS spending per beneficiary continues to outpace fee schedule updates. Although the recommended 0.5-point increase above current law is viewed as a pragmatic step, some argued it still amounts to a net pay cut. Commissioners also reiterated that the current quality measurement system is fundamentally flawed, particularly the Merit-based Incentive Payment System (MIPS). On the Medicare Safety-Net Index (MSNI), there was broad support for implementing this framework to redistribute Disproportionate Share Hospital (DSH) and uncompensated care payments, with mixed views on adding \$1 billion to the pool. Finally, Commissioners continued to support advancing site-neutral payments to address consolidation.

MEDPAC ASSESSES PAYMENT ADEQUACY FOR INPATIENT AND OUTPATIENT HOSPITAL SERVICES, REVIEWS MANDATED REPORT ON RURAL EMERGENCY HOSPITALS AND DISCUSSES SITE-NEUTRAL PAYMENTS

In this session, the Commission reviewed its assessment of hospital inpatient and outpatient services under Medicare, as well as a mandated report on Rural Emergency Hospitals (REHs), and an update on site-neutral payments. In 2024, the Inpatient Prospective Payment System (IPPS) covered 3,095 hospitals serving 4.2 million users, with payments totaling \$104.6 billion plus an additional \$5.9 billion for uncompensated care. Conversely, the Outpatient Prospective Payment System (OPPS) reimbursed 3,060 hospitals with a user base of 15.8 million, and payments of \$52.4 billion supplemented by \$22.0 billion for separately payable items.

Access to Care: The overall supply of hospitals remained relatively stable, with a -0.6 percent decrease in the number of hospitals from 2023 to 2024. The volume of FFS Medicare services per beneficiary increased slightly, with inpatient stays rising by 1.5 percent and outpatient encounters increasing by 4.0 percent.

Quality of Care: In 2024, FFS Medicare quality indicators showed mixed results. On one hand, the FFS mortality rate improved from 7.6 to 7.4 percent, though the FFS readmission rate worsened from 15.1 to 15.4 percent. Patient experience measures were stable compared to 2023 but generally remained below 2019 levels.

Access to Capital: Hospital finances improved in 2024 with all-payer operating margin reaching 6.5 percent, and further improvement is expected in 2025. MedPAC staff identified this growth was driven by 340B remedy payments and slower growth in labor costs.

Medicare Costs and Payments: The FFS Medicare hospital margin remained low but improved slightly in 2024 to -12.1 percent (excluding relief funds), driven by growth in profitable outpatient drugs and slower labor cost growth. For relatively efficient hospitals (about 13 percent of hospitals), the median FFS Medicare margin rose to -1 percent. By 2026, overall margins are projected to improve to -10 percent, with efficient hospitals reaching a median margin of 1 percent, although there is significant variation by hospitals. Given the variation, and since 2023, MedPAC continues to recommend that Congress redistribute DSH and uncompensated care payments using the Medicare Safety-Net Index (MSNI). This score is calculated by adding the hospital's low-income share of Medicare volume, uncompensated costs as a share of all-payer revenue, and half the Medicare share of volume. MedPAC argues this is a superior metric to the current DSH metric as it is a better predictor of hospital all-payer operating margin.

Draft Recommendation and Commission Discussion

The Chair's draft recommendation states that for 2027: **“Congress should update the 2026 Medicare base payment rates for general acute care hospitals by the amount specified in current law. Additionally, the Chair recommends that Congress implement the Medicare Safety-Net Index (MSNI) described in the March 2023 report, with an additional \$1 billion added to the MSNI pool.”**

Turning to the mandated report on Rural Emergency Hospitals (REHs), this designation establishes rural, outpatient-only hospitals with 24/7 emergency departments that receive fixed Medicare payments plus 105 percent of the OPPS rates for emergency and outpatient FFS services. In 2024, the number of REHs increased from 38 to 44, receiving over \$100 million in enhanced payments. The Commission will continue to monitor REHs and Medicare Advantage’s (MA’s) matching payments.

MedPAC has also supported site-neutral payments, where appropriate, to better align payment rates, incentives, and the efficiency of care. Medicare has incrementally adopted site-neutral payments since 2017, with continued expansion expected in 2026 and beyond, particularly in Provider-Based Departments (PBDs).

In the Commissioner discussion, the majority of members were strongly supportive of the Chair's overall payment update and the targeted \$1 billion addition to the MSNI pool. Nearly all commissioners raised significant reservations regarding the financial sustainability of hospitals and the models used for payment. One major concern is that the projected 1 percent net operating margin for efficient hospitals under the recommendation would be insufficient to support essential capital investments (e.g., updating equipment, new technology, and AI), arguing that hospitals likely need margins closer to 3 percent—especially given that many hospitals are not operating at this level of efficiency. There were also repeated calls for more validation and transparency around MedPAC’s definition of “efficient hospital”.

Discussion on site-neutral payments was nuanced. Many commissioners supported greater transparency and revisions to the payment methodology, but urged caution to avoid unintended harm, noting that hospitals absorb uncompensated care and that communities could be adversely affected by these payments. Commissioners also requested clarification on how the \$1 billion MSNI pool was calculated. MedPAC staff responded that this figure reflects a “balancing” of margins, corresponding to approximately 0.5 percent. Critiques of quality measures, squeezing providers to control costs, and separating IPPS/OPPS updates were also discussed.

MEDPAC EXAMINES DRAFT RECOMMENDATION FOR A FOUR PERCENT REDUCTION IN PAYMENTS FOR SKILLED NURSING FACILITIES FOR 2027

In this session, MedPAC reviewed Skilled Nursing Facility (SNF) payment rates. MedPAC staff presented the Commission's assessment of payment adequacy for SNF services under FFS Medicare and discussed a draft recommendation for updating SNF payment rates. The session also included a discussion of potential implications for previously announced federal staffing requirements, which have since been withdrawn.

Access to Care: Staff reported that beneficiary access to SNF care remains adequate. Occupancy rates are high, at a median of 83 percent. Both occupancy rates and SNF utilization have also rebounded to pre-pandemic rates. Though the number of SNFs declined by 1 percent in both 2024 and 2025, in 2024, 88 percent of Medicare beneficiaries lived in a county with 3 or more SNFs or swing-beds.

Quality: Indicators of quality in SNFs were reported to be largely stable. Key measures, including Discharge to Community and Potentially Preventable Readmissions, showed minimal changes. Staff highlighted ongoing workforce challenges, with nursing staff turnover remaining high at approximately 53 percent. Commission staff assessed these staffing issues are a potential concern for future facility operations.

Access to Capital: In 2024, key indicators of access to capital remained positive. Investment interest in the setting remained strong, with the all-payer margin for SNFs increasing to 2.1 percent in 2024 (up from 0.4 percent in 2023). MedPAC staff noted that overall financial performance in the sector is heavily tied to state Medicaid nursing home reimbursement rates.

Medicare Payments and Costs: Medicare FFS margins remained high for 2024 at 24.4 percent. Despite a strong overall performance, margins within the sector varied significantly between for-profit and nonprofit SNFs (27.2 percent and 10.8 percent, respectively) and between high- and low-volume SNFs (28.5 percent and 11.1 percent, respectively). MedPAC also projects the SNF FFS margin will grow to 25 percent in 2026.

The presentation also examined the federal staffing requirements scheduled to be implemented beginning in 2026. As of December 2nd, HHS has [repealed](#) these requirements in alignment with statutory direction from the One Big Beautiful Bill Act of 2025.

Draft Recommendation and Commission Discussion

Based on these findings, the Chair's draft recommendation is: **"For fiscal year 2027, the Congress should reduce the 2026 Medicare base payment rates for Skilled**

Nursing Facilities by 4 percent.” Staff asserted this reduction would lower Medicare spending relative to current law while maintaining beneficiary access to care.

In discussion, commissioners expressed broad support for the payment reduction recommendation, citing persistently high Medicare margins. Commissioners raised concerns about the interaction between Medicare payments, staffing challenges, MA dynamics, and ownership patterns in the SNF sector, including the role of for-profit operators.

MEDPAC DEBATES SEVEN PERCENT CUT TO HOME HEALTH CARE SERVICES

In this session, MedPAC reviewed home health payment. In 2024, Medicare FFS payments for home health totaled \$16 billion across 12,000 agencies. This provided 8.3 million 30-day periods of care and served 2.7 million FFS beneficiaries.

Access to Care: Overall, MedPAC found that access to care remained strong. In 2024, over 97 percent of FFS beneficiaries lived in an area served by at least two Home Health Agencies (HHAs), and 86 percent lived in an area served by five or more HHAs. The number of agencies declined by 1 percent nationwide in 2024. Home Health utilization remained relatively steady at 7.9 percent of FFS beneficiaries. The number of 30-day periods per enrollee increased slightly in 2024, with the number of beneficiaries discharged to home health still higher than pre-pandemic levels.

This nationwide decline in home health agencies excluded Los Angeles (LA) County, California, which is experiencing especially high growth. Despite only 2.2 percent of Medicare beneficiaries residing in LA county, in 2024 it accounted for 8.7 percent of total home health spending, raising program integrity concerns.

Quality: In 2024, HH quality remained stable. Key quality measures examined by MedPAC included the median facility discharge to community rate (which grew from 79.3 percent in 2021/22 to 80.6 percent 2022/23) and potentially preventable readmissions (which remained low and steady at 3.8 percent). Patients also reported generally favorable views of their agencies through Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS).

Access to Capital: Industry access to capital remained healthy for 2024. The industry had an average all-payer margin of 5 percent in 2024. Though mergers and acquisitions have declined from highs in 2021 and 2022, some local and regional operators continue to expand, signaling a robust market.

Medicare Payments and Costs: Overall Medicare margins for FFS HHAs remained strong for 2024, with an average FFS HHA margin of 21.2 percent. Margins for urban and rural agencies were similar (21.3 percent and 20.4 percent, respectively), though

for-profit and non-profit margins varied significantly (23.1 percent versus 12.2 percent, respectively). MedPAC staff also projected Medicare FFS margins for HHAs of 19 percent in 2026. This margin considers existing policy changes already in place for 2026, including an annual payment update of 2.4 percent, and a -3.9 percent reduction as required by the Balanced Budget Act of 2018 (including both temporary and permanent reductions).

Draft Recommendation and Commission Discussion

Based on these findings, the Chair's draft recommendation is: **"For fiscal year 2027, the Congress should reduce the 2026 Medicare base payment rate for home health care services by 7 percent."**

Commissioners broadly supported the recommendation, with some pointing to existing high margins for HHAs. One commissioner questioned the difference between HHA FFS Medicare margins of 21.2 percent versus all-payer margins of approximately 5 percent. MedPAC staff responded that the Commission lacked sufficient data to provide a detailed response, but that anecdotal evidence suggested reimbursement through MA and other payers is lower than FFS.

Many commissioners expressed concerns regarding program integrity within the program, particularly in California. Discussion centered on whether these potential integrity issues represent a broader pattern, with staff noting the data suggests utilization concerns. Commissioners recommended further analysis of Los Angeles County.

Commissioners also discussed and requested additional analyses into disparities in HH access and utilization, and post-hospital versus community-initiated care. On the latter request, one commissioner expressed concern that the in-office visit requirement may restrict access for homebound beneficiaries.

MEDPAC CONSIDERS NO CHANGE TO HOSPICE PAYMENT RATES

By law, the Commission reviews Medicare's hospice payment rates each year and makes payment update recommendations. In 2024, over 6,700 hospice agencies served 1.8 million beneficiaries across 148 million hospice days. Beneficiaries received an average of 3.9 hospice visits per week, with Medicare's total payments in 2024 exceeding \$28 billion. Commission staff assessed payment adequacy across four metrics: beneficiary access to care, quality of care, access to capital, and FFS Medicare payments and costs.

Access to Care: Provider access remained strong in 2024, driven by an increased supply of hospice providers. Between 2023 and 2024, the total number of hospice providers

increased by 2.6 percent, with for-profit agencies accounting for all net growth. This also follows several years of rapid growth, concentrated in several states.

Across the United States, the percentage of decedents (individuals who died in the previous year) that utilized the hospice benefit in 2024 was 52.9 percent. This represents a 1.2 percent increase from the prior year and an all-time high. The total number of hospice users also grew by 4.6 percent, with the total number of hospice agencies increasing by 7.7 percent.

Quality: Measures of hospice quality data remained stable or improved in the most recent data collected. Hospice patient experience, measured through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) remained largely unchanged. End-of-life visits (the share of beneficiaries receiving a nurse or social worker visit on at least two of the last three days of life) increased by 2 percent.

Access to Capital: Staff assessed access to capital remains positive, noting a 5 percent growth in for-profit providers in 2024, and that hospice is less capital-intensive than most other Medicare sectors. Reports from publicly traded hospice companies also indicated generally strong performance in 2025, despite an overall slowdown in mergers and acquisitions over the last few years.

Medicare Payments and Costs: For 2023, the hospice industry reported strong financial performance. FFS Medicare margins remained strong at 8 percent. However, there was significant variability in Medicare FFS margins by provider type, with freestanding and for-profit hospices reporting the highest margins (10.2 percent and 13.7 percent, respectively) versus hospital-based and non-profit agencies (-25.6 percent and -1.3 percent, respectively.) MedPAC staff also projects that overall hospice margins for 2026 will be 9 percent.

Draft Recommendation and Commission Discussion

Based on these findings, the Chair's draft recommendation is: **"For fiscal year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rates for hospice."**

Commissioners were generally supportive of the draft recommendation, with one commissioner advocating for a reduction in payment.

Discussion touched on several disparate topics. First, one commissioner asked whether, with 50% of decedents utilizing hospice this year, the program had demonstrated any savings. MedPAC staff responded that previous research in 2015 had shown no effect, but that newer literature had shown some effects. Two commissioners also highlighted how Medicare still pays Part C rebates even when an enrollee enters hospice, questioning the rationale behind this policy. Staff responded that MA benefits could be

used to pay for treatment outside of the terminal condition covered under hospice. One commissioner also raised concern that approximately 10 percent of CAHPS respondents gave the lowest rating on the question assessing appropriate pain management. This commissioner recommended a potential reduction in payment for these hospices, emphasizing the importance of alleviating pain as part of the hospice mission. Commissioners also briefly discussed pastoral care, the hospice bereavement benefit, and requested more information on rural access and telehealth.

COMMISSION EXPLORES KEY TRENDS AND ISSUES IN POST-ACUTE CARE

In this session, MedPAC staff presented an overview of Post-Acute Care (PAC) under FFS Medicare with a focus on Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), and Inpatient Rehabilitation Facilities (IRFs). Staff emphasized that, though these settings differ in eligibility requirements, benefit structures, and intensity of care, similar types of patients are treated across settings. This raises important questions about efficiency and quality.

Staff first reviewed recent utilization and spending trends, noting that Medicare FFS spending on PAC remained significant. In 2024, Medicare spent approximately \$30 billion on SNFs, \$15.7 billion on HHAs, and \$11 billion on IRFs. Average payments and lengths of stay varied significantly, with SNFs accounting for the longest stays at an average of 75 days, while IRFs received the highest payments per stay, averaging \$25,300.

MedPAC analysis also emphasized the variations in care pathways for each of these settings and how they can complicate efforts to determine the most appropriate and cost-effective setting for care. Similar patients often receive care in different settings due to variation in provider supply across markets, the lack of evidence-based placement guidelines for most conditions, differences in clinical judgment, referral practices, and patient preferences.

In addition to these concerns, comparing quality and outcomes across PAC settings is challenging due to data limitations. Case-mix adjustment and quality measures may not accurately capture patient severity, and patient experience measures are unavailable for beneficiaries treated in SNFs and IRFs. MedPAC has previously recommended that CMS develop patient experience measures for all post-acute care settings, noting the need for standardized comparisons.

The presentation also addressed how Medicare FFS payment rates and benefit designs may encourage inefficient care. Staff noted that Medicare margins for SNFs, HHAs, and IRFs have generally exceeded 10 percent over the last two decades. FFS incentives may also promote higher volumes and intensity of PAC services due to a lack of duration

limits, limited cost sharing, and the use of higher-cost settings when lower-cost options may be clinically appropriate. The three-day hospital stay requirement for SNF coverage (or 3-day SNF rule) may also incentivize IRF use for beneficiaries without a preceding hospitalization.

Staff reviewed CMS efforts to improve FFS purchasing, including redesigns of the SNF (2019) and HHA (2020) prospective payment systems to remove therapy volume as a payment driver and instead rely more on patient characteristics and medical complexity. They also discussed programs targeting improper payments and noted that value-based purchasing programs for SNFs and HHAs have thus far shown little impact on quality due to small incentive payments.

Finally, MedPAC staff discussed how alternative payment models (APMs) and MA counter FFS volume incentives. With providers at risk for beneficiary cost of care, APMs have reduced use of higher-cost PAC settings while maintaining or improving quality. MA plans also counter FFS incentives by utilizing prior authorization, provider networks, and other tools to manage PAC use. However, these approaches may impact beneficiary access and provider burden.

In discussion, commissioners focused on the persistent challenges of determining appropriate PAC use given overlapping patient populations, limited quality data, and misaligned incentives across settings. Commissioners expressed interest in continued evaluation of PAC use under MA and FFS Medicare and greater examination of the effects of emerging payment models on PAC providers and beneficiaries.

MEDPAC DISCUSSES BROAD RECOMMENDATIONS FOR FFS MEDICARE, MA, AND ALTERNATIVE PAYMENT MODELS

In this session, the Commission focused on ways to improve Medicare's different payment approaches: FFS Medicare, Alternative Payment Models (APMs), and MA. Since 2000, Medicare spending per beneficiary has nearly tripled from \$5,801 to \$15,808 in 2023. Part B spending has seen the most significant growth, with the CMS Office of the Actuary (OACT) estimating that from 2025 to 2034, the overwhelming majority of Part B spending growth will result from increases in the volume and intensity of services/items used.

MedPAC's analysis broadly focused on assessing overall access to care, incentives, beneficiary cost-sharing, coding, and other metrics to evaluate each payment methodology. For FFS, staff highlighted varying beneficiary access based on supplemental coverage and site-of-service differentials as significant influences on payment rates. The APM discussion focused on dual-sided risk, mandatory versus voluntary participation, and payment rate methodologies, including consideration of

geography and clinical severity. For MA, staff focused on risk adjustment methodologies, coding intensity, and utilization as major drivers of cost and quality.

Potential Policy Ideas for Improving Payment Methodologies and Commissioner Discussion

FFS Medicare: MedPAC staff suggested that the benefit design be overhauled. Major changes include allowing CMS to vary cost-sharing based on value of care, creation of an out-of-pocket maximum, increases to hospital and physician payment, decreases to post-acute care payment, and reductions in payment for physician-administered drugs under Part B. Staff also advocated for major revisions to the rate setting process, including using empirical data and establishment of a new advisory committee, as well as enacting further site-neutral policies.

APMs: MedPAC staff offered a variety of potential changes. Overarching priorities included a reduction in the number of APMs, increased coordination between this new, smaller pool of APMs, and consolidation of Accountable Care Organizations (ACOs) into a unified model with tracks based on provider size and mandatory episode-based payment for proven episodes. Other draft proposals include a gradual decrease in ACO spending targets and modifications to the ACO methodology to better account for coding intensity and favorable selection of beneficiaries.

MA: Draft concepts focused on adding hospice to MA and updates to the payment methodology. MedPAC staff suggested utilizing larger geographic markets for MA plan payment areas, changes to benchmark calculations, overhauling the MA quality bonus payment program, and improving risk adjustment to account for differences in coding intensity.

Overall, the Commission voiced approval for staff policy ideas. The discussion covered a wide variety of topics, with many commissioners expressing a lack of confidence in existing reimbursement structures. One commissioner highlighted the rise in costs associated with new drugs, while another requested greater transparency across the board. Commissioners also mentioned bundled payments, support for reforming MA bids, and general disappointment with the lack of savings from the MA program, and a request for more transparency. FFS criticism centered on issues with incentives and volume, as well as care coordination. One commissioner was particularly excited about the future of Institutional Special Needs Plans (I-SNPs) and Chronic Special Needs Plans (C-SNPs). Chairman Chernew emphasized the importance of evaluating sweeping changes to these programs.

MEDPAC EXAMINES MANDATED REPORT ON THE NEW HOME HEALTH PROSPECTIVE PAYMENT SYSTEM – THE PATIENT DRIVEN GROUPINGS MODEL (PDGM)

MedPAC staff presented a mandated report examining the impact of recent changes to the home health prospective payment system (PPS). The Balanced Budget Act (BBA) of 2018 revised the home health payment methodology in response to concerns raised by MedPAC and other stakeholders about financial incentives for the provision of therapy. Major changes in the new Patient Driven Groupings Model (PDGM) include reducing clinical episodes from 60 to 30 days, excluding therapy services as a factor in the payment methodology, and updated criteria for determining patient severity. This new system – active beginning in 2020 – measures patient severity on five dimensions: timing, source of referral, clinical diagnosis, functional status, and comorbidities. MedPAC staff's presentation focused on how this redesign of the payment system has altered payment incentives, provider behavior, spending patterns, and access to home health services under FFS Medicare.

MedPAC staff examined how these changes have affected home health utilization and spending. After instituting the new methodology, the average number of visits per home health stay fell from 19.4 in 2019 to 15.9 in 2023 (with the decrease primarily concentrated in therapy visits). The rate of improvement in functional status (mobility and self-care) remained largely unchanged, though the rate of potentially preventable hospitalization during home health care fell from 10.3 percent without PDGM to 8.2 percent with PDGM. MedPAC staff also observed minimal effects on the use of home health care by FFS beneficiaries, and a 3.6 percent higher payment-to-cost ratio.

The Commission also reviewed additional analyses, though staff emphasized isolating changes due to PDGM is particularly challenging given the lack of a control group, and the COVID-19 pandemic. One key statistic that MedPAC staff associated with PDGM is a 6.9 percent increase in the probability of home health use after a hospital stay, and a 7.1 percent in community-initiated episodes.

Commissioners expressed broad support for continued research in this area.

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