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# MedPAC Holds November 2026 Meeting

On November 5 and 6, 2026, the Medicare Payment Advisory Commission (MedPAC) held a public meeting, which included the following sessions:

- Recent changes in the Medicare physician fee schedule (PFS) that affect primary care,
- Charge-based coinsurance at rural health clinics (RHCs),
- Analysis of aberrant patterns of care among hospice and home health providers,
- Findings from MedPAC's focus groups with Medicare beneficiaries and physicians, nurse practitioners, and pharmacists, and
- Medicare eligibility notification and the State Health Insurance Assistance Program (SHIP) operations and funding.

The full agenda for the meeting and presentations for the sessions are available here.

## MEDPAC DISCUSSES RECENT CHANGES IN THE PFS

MedPAC staff presented on how recent changes to the PFS impact primary care. While a robust primary care infrastructure is associated with healthier populations, improved access to care, and lower costs, the number of primary care physicians (PCPs) has been declining, and beneficiaries report greater difficulty finding a PCP than a specialist. MedPAC has previously made recommendations to support primary care, including budget-neutral payment adjustments, add-on payments, and a medical home pilot. Recently, the Centers for Medicare and Medicaid Services (CMS) has also taken complementary steps to support primary care, including adding billing codes for care management and increasing payment rates for commonly performed evaluation and management (E&M) office visit codes.[1]

[1] MedPAC's analysis does not address recently finalized E/M changes in the CY 2027 PFS Final Rule.

To assess changes in E&M policies, staff analyzed spending and utilization of care management codes and examined the impact of increased payment rates for E&M outpatient visit codes.

## Care Management Codes

New billing codes in support of primary care, such as advanced primary care management (APCM) codes, provide a reimbursement pathway for these services. While most of the new codes can be billed by clinicians of any specialty who remain at the center of the patient's care, care management codes comprise a greater share of PFS revenue for primary care practices than for specialty or multispecialty practices. Staff found that clinicians who billed for care management codes had higher revenue than non-billers in 2025, with that revenue accounting for 8 percent of their total PFS revenue. For PCPs in particular, the codes account for 13 percent of their total PFS revenue, with PCPs having the largest share of care management payments. Of all the practices billing care management codes in 2025, nearly three-quarters were primary care and multispecialty practices, and 13 percent were specialty practices.

## E&M Codes

In 2021, CMS increased payment rates for E&M office and outpatient codes, which cover a clinician assessment of patients and the management of their care. Overall, changes drove a 49 percent increase in spending per beneficiary from 2020 to 2025, with aggregate E&M visit code spending growing to $25.5 billion in 2025. Such increases led to an estimated rise in E&M payment rates and a net increase in PFS revenue for clinicians with relatively high E&M usage. Clinicians with relatively low E&M usage, in contrast, saw a net decrease in PFS revenue. Overall, E&M office and outpatient visit codes accounted for 26 percent of total PFS spending in 2025.

## Commissioner Discussion

Commissioners discussed the scope of the analysis and inquired about annual chronic condition codes, APRNs, and PAs.

Regarding future solutions, Commissioners cautioned against repetitive actions, such as paying more or adding more codes. Some asked whether the codes had improved care for chronic conditions and whether there were differences in care between practices that use them and those that do not. Suggested solutions included developing a simplified payment system, modifying payment under existing codes rather than implementing new codes, or implementing population-based payment.

Commissioners also discussed the use of third-party care management and remote physiologic monitoring, noting concerns about rapid spending growth and the use of automation. However, some Commissioners believed that technology could be a valuable means of simplifying the system.

Overall, Commissioners broadly supported continued research on primary care. The most repeated themes were the specifics of the personnel using the new codes, the outcomes of the codes, and the efficacy of spending. In closing, the Chair expressed support for continued research, suggested staff broaden the definition of primary care to include behavioral health, and cautioned against the potential for artificial intelligence (AI) to worsen the rapid growth of third-party care management and RPM. The Commission is not making a recommendation at this time, and staff will consider future follow-up.

## MEDPAC DISCUSSES COINSURANCE AT RHCS

In this session, MedPAC staff provided an overview of Medicare's payment system for RHCs and discussed the implications of charge-based coinsurance, proposing an alternative to it .

### Overview of RHCs

RHCs were established under the Rural Health Clinic Services Act of 1977 to expand access to primary care in specified underserved rural areas. There are two broad types of RHCs: 1) provider-based RHCs, which are operated as part of another Medicare-certified facility, and 2) independent RHCs, which are freestanding outpatient clinics.

Recent regulatory changes have granted RHCs greater flexibility to expand specialty service offerings. A MedPAC analysis of 2025 RHC Fee-for-Service (FFS) Medicare claims found that approximately 5,200 RHCs furnished more than 10 million visits to 2.3 million beneficiaries, generating more than $2.3 billion in Medicare program spending and beneficiary cost-sharing.

### FFS Medicare RHC Payment System

FFS Medicare's RHC payment system generally bundles all professional services furnished in a single day into a single payment: a facility-specific, cost-based, all-inclusive rate (AIR). Medicare pays 80 percent of the AIR, subject to applicable payment limits. Beneficiaries' coinsurance is 20 percent of the total billed charges, rather than 20 percent of the AIR. As a result, combined Medicare payments and beneficiary cost-sharing can exceed the AIR. RHCs may also receive multiple AIR payments for services furnished on the same day.

Payment for independent and non-specified RHCs also changed after April 1, 2021, following changes passed in the Consolidated Appropriations Act of 2021 (CAA, 2021) that established a phased increase in the national statutory payment limit. By 2028, the payment limit will increase to $190, representing a cumulative increase of approximately 120 percent since 2021.

Growth in the number of RHCs billing FFS Medicare accelerated between 2020 and 2022. Independent RHCs accounted for a particularly substantial increase in 2022, suggesting that the 2021 payment limit increase may have made RHC participation more financially attractive. The entry of private equity-backed operators and the conversion of existing clinical practices into RHCs may have contributed to this growth.

## Implications of Charge-Based Coinsurance for Beneficiaries

Under FFS Medicare, Medicare program payments remain unchanged as beneficiary coinsurance increases, assuming the AIR and applicable payment limit remain constant. As a result, RHCs with higher charges receive greater total payments from Medicare and beneficiaries combined, creating a financial incentive to increase charges while exposing beneficiaries to higher and more variable cost-sharing liabilities.

Historically, AIRs for specified provider-based RHCs have been substantially higher than the national statutory per-visit payment limit. Variations in AIRs reflect differences in allowable costs per visit and may be driven by factors such as the types of services furnished, the mix of clinicians employed, and geographic isolation.

Beneficiaries often face coinsurance exceeding 20 percent of the AIR. At independent RHCs, average beneficiary coinsurance was approximately 36 percent of the estimated AIR per visit. Even within the same RHC classification, beneficiaries face substantially different coinsurance amounts depending on how individual clinics set their charges. As RHC charges continue to rise, beneficiaries' dollar coinsurance liability is likely to increase, potentially outpacing growth in Medicare payments.

In the future, statutory per-visit payment limits will be adjusted annually based on MEI growth. From 2018 to 2025, average annual MEI growth was 2.8 percent, compared with the average annual growth in RHC charges per visit of 6.6 percent at independent RHCs, 4.4 percent at non-specified provider-based RHCs, and 6.3 percent at specified provider-based RHCs.

## Telehealth Services and Charge-Based Coinsurance

In 2020, Congress temporarily authorized RHCs to furnish distant-site telehealth services, with payment based on rates comparable to those under the Physician Fee Schedule (PFS). In 2022, coverage for mental health telehealth services was made permanent, with visits reimbursed under the standard RHC AIR methodology and beneficiary coinsurance generally set at 20 percent of RHC charges. Non-mental health telehealth flexibilities have been temporarily extended through December 31, 2027, with payment based on a PFS-equivalent rate. Beneficiary coinsurance for these services is 20 percent of the lesser of the applicable payment rate or submitted charges.

In 2025, more than 75 percent of telehealth visits at RHCs were for non-mental health services paid at the PFS-equivalent rate. Shifting telehealth services to the standard AIR methodology could increase beneficiary cost-sharing by an estimated 85 to 146 percent per visit, discourage in-person care, and create incentives for RHCs to furnish and bill beneficiaries for telehealth services outside the communities they traditionally serve.

## Proposed Alternative to Charge-Based Coinsurance

An alternative to charge-based coinsurance is to set RHC beneficiary coinsurance at 20 percent of the lesser of the applicable AIR (subject to payment limits) or the RHC charges, aligned with a prior Commission recommendation on beneficiary coinsurance for outpatient services at critical access hospitals.

MedPAC staff estimated that this approach would reduce FFS beneficiary coinsurance by 24 percent overall, with reductions varying by RHC classification: 44 percent at independent RHCs, 43 percent at non-specified provider-based RHCs, and 13 percent at specified provider-based RHCs. Staff also estimated that total FFS Medicare payments to RHCs would decrease by approximately 5 percent. This approach would substantially reduce variation in coinsurance by lowering it at RHCs with higher charges.

## Commissioner Discussion

Commissioners identified areas for additional research to inform consideration of RHC payment and cost-sharing alternatives, including beneficiary impacts, Medicare Advantage (MA) payment practices, payment adequacy, and the growth and ownership of RHCs. Feedback will inform future analyses.

Some asked whether beneficiary coinsurance was considered when the 2021 payment limits were increased, how those increases relate to current charges and coinsurance, and impacts on beneficiaries with supplemental coverage. Commissioners broadly supported moving away from charge-based cost sharing, citing its inequities, and asked staff to compare cost-sharing options, including 20 percent of the AIR and copays, and their effects on beneficiaries, RHC revenue, and Medicare spending. Commissioners differed on whether clinics should be held harmless for reductions in beneficiary coinsurance. Several opposed automatically increasing Medicare spending, while others said clinics supported considering temporary or targeted protections where access risks are demonstrated. Commissioners also requested more information on how MA plans reimburse RHCs and determine beneficiary cost sharing.

Commissioners asked about the different payment limits for specified and non-specified provider-based RHCs, including whether the distinction is permanent. They also suggested examining where new clinics are opening in relation to population changes and rurality. Other recommendations for further analysis included the



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assessment of charge trends by clinic type and ownership, factors driving charge growth, and the role of private equity in RHC growth and payment incentives; they also included the examination of the services underlying RHC payment rates and how changes in revenue might affect service delivery and access.

## MEDPAC EXAMINES ABERRANT PATTERNS OF CARE AMONG HOSPICE AND HOME HEALTH PROVIDERS

In this session, MedPAC staff presented an exploratory analysis of aberrant care patterns among hospice and home health providers. Central to the presentation was the relationship between hospice and Medicare spending, and between program integrity initiatives and recommendations, including the May 2026 nationwide 6-month moratorium instituted by CMS. In their exploratory analysis, staffers also addressed the annual aggregate hospice payment cap.

### Home Health Care

Within the home health care space, staffers underscored unusually high volumes of home health care orders, which they noted were one antecedent indicator of fraud, waste, and abuse and therefore a potential point for additional review.

When Medicare beneficiaries require home health care, an eligible practitioner must certify their need. Eligible practitioners can include physicians, nurse practitioners (NPs), PAs, or clinical nurse specialists. Staff found practitioners in the top 1 percent ordered care for substantially more FFS Medicare beneficiaries in 2024 on average, accounting for 19.5 percent of the 30-day home health periods ordered that year. In contrast to the average practitioner, which ordered home health care for 8.8 FFS Medicare beneficiaries, top 1 percent practitioners ordered care for 149.4 FFS beneficiaries.

Apart from the unusually high ordering activity observed at the practitioner level, staff found activity at the home health agency (HHA) level also warrants further review. HHAs with unusually high numbers of 30-day periods per beneficiary were a particular cause for concern. Like practitioners in the home health care space, HHAs in the top 1 percent provided significantly more 30-day periods per FFS user in 2024 compared to the average HHA.

### Hospice

For hospice, staff analyzed aberrant patterns using measures spanning 3 broad areas: admissions and certification patterns, discharge patterns, and the provision of hospice visits. They found that measures varied substantially across hospices, with some providing significantly fewer visits than a typical hospice. Outlier patterns were

observed among both large and small providers, and a few states were overrepresented among outliers on multiple measures. Regarding hospice aggregate cap trends, California, Nevada, Texas, and Arizona were found to drive growth in the share of hospices exceeding the cap. A previous MedPAC analysis of the hospice aggregate cap found that the share of hospices exceeding the cap was increasing. Upon follow-up analysis examining trends in greater detail, MedPAC recommended a wage adjustment and a 20 percent reduction in the hospice aggregate cap. Based on 2023 data, hospices that exceed the cap are for the most part freestanding, located in metropolitan areas, and for-profit. They characteristically have longer stays, higher live discharge survival rates, and higher post-admission survival rates than below-cap hospices. Staff suggested that a cap provided a safeguard for providers intending to enroll patients for long stays who do not meet eligibility requirements while recovering some payments from providers that exceed the cap. Without it, long stays would likely increase.

Overall, staff suggested findings may necessitate further investigation. Future approaches may feature outlier geographic areas and providers.

## Commissioner Discussion

During the discussion, commissioners requested further examination of why high concentrations of hospice outliers are present in certain geographic areas, noting that state-level policies and patient mixes may play a significant role. Several commissioners highlighted the negative effects aberrant providers can have on nearby non-profit hospices. Commissioners also requested follow-up on how provider ownership structures impact care delivery and Medicare spending.

Commissioners discussed several approaches to mitigate aberrant patterns. Some suggested establishing more guardrails for provider entry, including strengthening the oversight of home health and hospice facility accreditation. One commissioner suggested improving methods for detecting waste, fraud, and abuse within facilities, such as analyzing real-time discharge trends. Many commissioners supported conducting qualitative interviews with hospice providers and patients to better inform structural improvements to hospice care. Other suggestions included MedPAC's previous recommendation to make the hospice aggregate cap wage-adjusted, or, if further analysis finds that overutilization is the main driver of these aberrant patterns, integration with MA plans.

Overall, commissioners made analytical suggestions to further examine whether sample size and beneficiary concentration are associated with regional variations in aberrant patterns. MedPAC will include a discussion of aberrant patterns of home health and hospice in the March 2027 update chapters.



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## MEDPAC PRESENTS FINDINGS FROM FOCUS GROUPS WITH MEDICARE BENEFICIARIES AND PHYSICIANS, NURSE PRACTITIONERS, AND PHARMACISTS

In this session, MedPAC staff presented findings from 25 focus groups conducted with Medicare beneficiaries, physicians, nurse practitioners, and, for the first time, outpatient pharmacists. Beneficiaries generally reported satisfaction with their coverage, although some experienced difficulty finding providers, navigating MA networks, and affording prescription drugs. Clinicians described traditional Medicare as administratively simpler than MA and raised concerns about prior authorization, payment denials, and disruptions when providers leave plan networks. Pharmacists highlighted reimbursement pressures, increasing administrative responsibilities, and reduced capacity for medication therapy management, while clinicians reported that the Part D out-of-pocket cap had improved access to some costly medications. Staff emphasized that the qualitative findings illustrate participants' experiences but cannot be generalized to the broader Medicare population.

### Commissioner Discussion

Commissioners expressed concern about barriers to primary and specialty care, particularly for dual-eligible beneficiaries and individuals whose providers leave their insurance networks. Several requested further examinations of how long beneficiaries take to new primary care providers, where they obtain care in the interim, and how contract terminations affect continuity of care. Commissioners also sought more detailed information about prior authorization delays and denials. Commissioners also requested further examination of whether clinician dissatisfaction is specific to MA or, more broad, including utilization management. Several cautioned that satisfaction with coverage can coexist with unmet needs and suggested examining how prior insurance experiences shape beneficiaries' expectations.

Commissioners broadly supported the inclusion of pharmacists in the focus groups and expressed interest in strengthening their role in medication optimization, deprescribing, and polypharmacy management. Several commissioners expressed concern that pharmacists spend more time informing patients about insurance participation, out-of-pocket costs, and patient transfers, thereby increasing the administrative burden and leaving them with less time for patient care. They suggested exploring separate payments for medication management services and improving pharmacist access to electronic health records and insurance claims data. Commissioners also requested further exploration of drug-price transparency, beneficiaries' use of discount programs outside Part D, and challenges understanding the Medicare Prescription Payment Plan.

Additional proposed research areas included beneficiary and clinician awareness of accountable care organizations, health-system referral incentives, and distinct administrative and clinical applications of AI.

Overall, commissioners supported using the focus groups to identify issues for further investigation, while cautioning against drawing population-level conclusions or directly developing policy from these qualitative findings. The Chair highlighted support for the pharmacist groups and interest in deeper examination of dual-eligible beneficiaries, access to care, and artificial intelligence, while acknowledging resource constraints on expanding the research. The findings presented will inform ongoing analytic work and future reports, with additional discussion of access to care in December.

## MEDPAC DISCUSSES MEDICARE ELIGIBILITY NOTIFICATION AND SHIP OPERATIONS AND FUNDING

In this session, MedPAC staff continued work from earlier this year on the enrollment decisions beneficiaries face, including late-enrollment penalties. The full retirement age for Social Security is 67, while the age for Medicare eligibility is 65. Because of this difference, Medicare-eligible individuals who are not eligible for Social Security are neither auto-enrolled nor notified by mail. Staff estimated that up to 2.6 million people aged 64 and 9 months fall into this notification gap. Although a Social Security Administration (SSA)- and CMS-led email campaign intended to remedy this issue has helped, up to 2 million people have yet to be reached by mail or email. Staff suggested Commissioners consider mail notification requirements for the SSA or CMS targeting eligible beneficiaries aged 64 years and 9 months, at an estimated cost of $1.10 per mailing.

Staff also presented on SHIP, which provides grants to deliver free, objective Medicare enrollment assistance. Just over 10,000 counselors served nearly 1.2 million beneficiaries in the second half of 2025, despite not being paid by insurers. Interviews with ACL and grantee staff described counselors as "overburdened," with one grantee halting appointments only three weeks into the 2025 annual enrollment period. When adjusted for inflation, SHIP funding per beneficiary declined over time, failing to keep pace with enrollment growth. Staff also found that states with higher per-beneficiary funding tended to score higher on performance measures. Illustrative funding options included indexing funding to enrollment or spending growth and establishing a dedicated source, such as MA plan fees.

### Commissioner Discussion

Commissioners expressed broad support for mailing notifications and for increasing SHIP funding. Some inquired about the level of funding needed to meet current

demand. For an accurate answer, staffers explained that more data was required because greater access could alter demand. Other commissioners questioned why states with more beneficiaries do not receive more funding and sought to examine the foundations of high-scoring states like Ohio, noting that Ohio benefits from strong state support. Several supported funding per enrollee, with additional support for low-income beneficiaries, and updating performance metrics so that future funding could depend on results.

Commissioners also stressed that messaging needs to be refined and made more detailed, and that SHIP should be better supported, given that both SHIP counselors and insurer-paid brokers have different incentives. Several called for evaluating the role of SHIP counselors and investing in tools to support both counselors and beneficiaries, while others emphasized that the overall complexity of Medicare is a core problem, citing issues with benefit design and beneficiary access. The Commission will revisit the topic in the spring.

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*This Applied Policy® Summary was prepared by Crystal Uba with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact her at cuba@appliedpolicy.com or 202-558-5272.*