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MedPAC Holds September 2026 Meeting

On September 3 and 4, 2026, the Medicare Payment Advisory Commission (MedPAC) held a public meeting, which included the following sessions:

- Context for Medicare payment policy,
- Issues and potential policy directions in Part D,
- Workplan: Ambulatory surgical centers,
- Examining use of post-acute care services by beneficiaries in fee-for-service Medicare and Medicare Advantage, and
- Accuracy of Medicare Advantage risk adjustment at the plan level.

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

MEDPAC DISCUSSES CONTEXT FOR MEDICARE PAYMENT POLICY

In this session, MedPAC staff presented a high-level overview of national healthcare spending trends, beneficiary affordability, and the ongoing rise of provider consolidation. Medicare spending has outpaced national trends in recent years, growing by 8-9% annually, and Medicare Advantage (MA) enrollment reached 55% of the beneficiary population. Staff highlighted a shift in spending from inpatient (Part A) to outpatient (Part B) settings and a recent surge in Part D spending associated with the Inflation Reduction Act's (IRA) benefit redesign.

Medicare financing also faces longer-term pressures as the number of workers per beneficiary continues to decline. The Part A trust fund is projected to become insolvent by 2033, according to the Medicare Trustees, and by 2040, according to the Congressional Budget Office (CBO). Within Part B, spending on clinician-administered drugs in non-facility settings has accelerated the fastest, driven by higher-priced drugs, price increases for existing products, shifts in the mix of drugs furnished, and rapid increases in spending on skin substitutes.

Staff estimated that in 2026, Medicare will spend 14% more on MA beneficiaries than it would if those beneficiaries were enrolled in FFS Medicare, primarily due to inaccuracies in risk adjustment. However, MA enrollees pay lower premiums in general, which lowers cost sharing, while most FFS beneficiaries have private supplemental insurance that covers some or all of their cost sharing. Across many plans, beneficiaries reported affordability challenges, while Part B premiums have increased over time.

MedPAC staff also highlighted continued provider consolidation, including consolidation among similar providers (e.g., hospitals merging with hospitals), integration between providers with referral relationships (e.g., hospitals acquiring physician practices), and acquisitions involving insurers, corporate entities, and private equity (PE) firms. Consolidation may provide benefits such as more efficient care delivery and greater access to capital, but it has also been associated with higher payment rates and increased self-referrals. Provider-provider and PE-provider integration have been associated with higher payments, while payer-provider consolidation may increase coding intensity. For now, the impact of such provider mergers and acquisitions on quality and access remains mixed.

Commissioner Discussion

Commissioners primarily focused their discussion on the long-term sustainability of Medicare financing and the need for greater urgency regarding the growth of Part B spending. One commissioner suggested developing a memorable metric similar to the Part A trust fund insolvency date to illustrate the trajectory of Part B spending. On MA, commissioners raised concerns about coding intensity, favorable selection, benchmarks, and star ratings, and asked whether sensitivity analyses could clarify the range around the estimated 14% overpayment.

Commissioners also discussed the effects of provider consolidation, including research linking PE-driven integration with higher mortality rates and decreased staffing levels. Conversely, some noted that rising costs are often driven by uncontrollable external factors, such as labor shortages, the increasing clinical complexity of an aging population, and expensive technological advancements.

Commissioners requested additional comparative data on Medicare premium growth relative to commercial market inflation and Social Security cost-of-living adjustments, as well as further analysis of whether Medicare payment policies, including the lack of site-neutral payments, may be inadvertently incentivizing further consolidation. Several also emphasized the importance of analyzing whether current affordability protections adequately support the most vulnerable beneficiaries. MedPAC plans to feature these refined findings in its March 2027 Report to Congress.

MEDPAC DISCUSSES ISSUES AND POTENTIAL POLICY DIRECTIONS IN PART D

MedPAC staff examined early experience under the IRA redesign of the Medicare Part D benefit, which restructured liability among beneficiaries, plans, manufacturers, and Medicare, and established an annual out-of-pocket (OOP) cap.

Part D Spending and Benefit Trends

Beneficiary OOP costs have fallen about 25% since 2023 and by 50% among the highest-spending beneficiaries. Staff also highlighted broader strengths, including high enrollment (80% of Medicare beneficiaries are Part D enrollees), high satisfaction rates and improved access to medications, wide-ranging plan availability, and increased generic use. At the same time, total Part D spending increased 22% in 2025 to $351 billion, with two-thirds of that spending occurring after beneficiaries hit their OOP cap.

Staff pointed to two sources of increased spending: the true out-of-pocket (TrOOP) costs policy and the benefit design. The TrOOP policy contributes to higher program costs by covering 80% of catastrophic spending, and supplemental benefits count toward the OOP limit, so enrollees in enhanced plans may reach the catastrophic phase well before reaching the OOP limit. Such factors, together with an increase in higher basic benefit costs (stemming from basic premiums, Medicare's reinsurance payments, and Medicare's direct subsidies for all plans), combine to drive spending under TrOOP. The policy altogether lowers the effective OOP limit while inflating Part D costs.

Staff also noted that the benefit design, on the other hand, contributes to increased Part D spending by way of the restricted use of cost-sharing differentials to manage utilization (differentials are limited to prescriptions filled in the initial coverage phase (ICP)) and a higher deductible combined with a lower OOP limit, which shortens the ICP. Furthermore, the current nature of the benefit may constrain plans' ability to encourage lower-cost drug use or to negotiate rebates from manufacturers.

Potential Policy Approaches

MedPAC staff floated three solutions, including 1) not counting supplemental coverage toward the OOP cap, 2) redesigning the benefit to extend the initial coverage phase, and 3) providing plans with more tools to encourage use of lower-cost drugs once beneficiaries reach the OOP cap. Staff maintained that excluding supplemental benefits from the TrOOP could delay progression to the catastrophic phase, accruing enrollee cost-sharing to the OOP limit while lowering basic benefit costs and premiums, although it could increase supplemental costs and premiums. Extending the ICP could similarly increase the share of spending subject to plan utilization management and reduce spending in the catastrophic phase, potentially helping moderate overall spending growth.

Commissioner Discussion

Commissioners had concerns about the proposed fixes to increased Part D spending, noting that they were not a solution. Several commissioners argued that the real driver of increased spending is the price of a small number of very expensive drugs (i.e., cancer treatments and GLP-1s) used by the 6% of beneficiaries who account for 60% of all Part D spending. Several commissioners asked staff to dig deeper into the demographics of the 6%, specifically their diagnoses, ages, and whether they are near the end of life.

There was broad support for stopping supplemental coverage from counting toward the OOP cap and for redesigning the benefit to shrink the deductible and/or coinsurance, although commissioners were split on whether to also raise the OOP cap itself. Other ideas included imposing cost-sharing after the cap (with protections for low-income beneficiaries), expanding Medicare drug price negotiation, and addressing pharmacy benefit manager practices.

The Chair closed by naming three areas for continued work: examining the 6% of beneficiaries driving the highest spending, further refining the OOP cap calculation, and continuing to explore potential changes to the coverage phases. He also flagged that today's low premiums are supported by temporary policies set to expire, and that a related chapter on the standalone drug plan market is coming at the January meeting. MedPAC is not making a formal recommendation at this time. The staff plans on refining the analysis, including examining the characteristics and spending patterns of the highest-spending beneficiaries, before bringing it back to the Commission.

MEDPAC PROVIDES AN OVERVIEW OF ASCS

MedPAC staff presented an overview of ambulatory surgical centers (ASCs)—facilities that provide outpatient surgical procedures without requiring an overnight stay.

ASC Growth and Utilization Trends

Medicare makes two payments when a beneficiary receives a procedure in an ASC: 1) a facility payment through the ASC payment system and 2) a clinician services payment through the physician fee schedule (PFS). For the facility payment, CMS uses the hospital market basket to update the ASC conversion factor. For several years, the Commission has recommended that ASCs submit cost data to inform decisions about the appropriate level of payment for ASC services and evaluate whether an alternative input price index would more appropriately reflect ASC costs.

The number of ASCs grew 12% between 2019 and 2024, reaching 6,400 Medicare-certified facilities serving 3.4 million beneficiaries in 2024. ASCs remain concentrated in urban areas (94%), and about 68% are single-specialty facilities, most commonly

focused on gastroenterology and ophthalmology, with recent growth in pain management, cardiology, and orthopedics. Growth has been driven in part by shifts in clinical practice and the expansion of procedures performed in ambulatory settings. Compared with hospital outpatient departments (HOPDs), ASCs may also offer patients greater convenience and lower cost-sharing and provide physicians with specialized staff and greater control over their work environment.

ASC surgical procedures per FFS beneficiary grew by 1% annually from 2019 to 2023 before increasing 3.4% in 2024. Volume remains concentrated in a relatively small set of services, with seven procedures accounting for half of ASC surgical volume in 2024. Hip, knee, and shoulder replacements continue to increase, although the overall service mix has remained relatively stable, with 18 of the 20 most common services in 2019 remaining among the top 20 in 2024.

CMS maintains the ASC Covered Procedures List (CPL), which includes codes for more than 4,300 procedures covered under the ASC payment system. As part of its effort to eliminate the Medicare Inpatient-Only (IPO) list, CMS has continued expanding the CPL. In 2026, CMS removed 271 procedures from the IPO list and added them to the CPL, along with 276 codes that were previously covered under the Outpatient Prospective Payment System (OPPS). For 2027, CMS has proposed removing an additional 618 codes from the IPO list and adding them to the CPL.

MedPAC's ASC Workplan

While most ASCs are for-profit and at least partially owned by physicians, corporate ownership of ASCs is becoming more common, which may have implications for Medicare spending, quality, and access to care. MedPAC staff presented a workplan for analyses to 1) identify factors associated with geographic differences in ASC supply and 2) assess the impact of ASC growth on outpatient FFS surgical volume:

- **Geographic Differences in ASC Supply:** MedPAC will examine factors that may contribute to geographic variation in ASC availability, as limited supply may restrict beneficiary access to lower-cost outpatient care. Staff will conduct interviews during site visits to ASCs across specialties, states, and levels of market concentration to better understand operational challenges and the effects of ownership on operations and patient care. A multi-year, cross-sectional regression analysis will examine factors associated with the number of ASCs per capita in a market, including population characteristics, surgical capacity and utilization, Certificate of Need (CON) laws, and medical liability levels.

- **Impact of ASC Growth on Surgical Volume:** MedPAC will assess whether growth in ASC supply shifts procedures from HOPDs to ASCs or contributes to

increased overall utilization, potentially due to greater convenience, shorter wait times, and lower cost-sharing. Using a differences-in-differences (DiD) analysis, staff will examine changes in surgical volume following the entry of a new ASC into the market. The analysis will focus on procedures furnished across multiple settings, including joint replacements, cataract removal, colonoscopies, and certain procedures also performed in physician offices, allowing MedPAC to assess both changes in overall utilization and shifts in site of care.

Commissioner Discussion

Commissioners generally supported the workplan, while recommending refinements to the analytical approach, including the use of longitudinal models and modern event-study approaches rather than relying solely on cross-sectional or staggered DiD designs. When examining factors affecting the ASC supply, for example, analysis should explore how geographic differences in provider mix shape which ASCs are available in a market.

As the ASC CPL continues to evolve, commissioners recommended investigating how changes in covered procedures affect facility service offerings, including whether technological advances are enabling more procedures to shift from inpatient settings to ASCs and the associated risks. Several commissioners also highlighted the importance of accounting for patient case mix across sites of care, including how patient complexity may affect procedure volume and risk, particularly as the Medicare population becomes increasingly complex.

Commissioners also requested additional analysis to determine whether rising FFS ASC payments reflect a shift toward lower-cost care or increased overall spending. Suggested analyses included decomposing payment growth into changes in the conversion factor, per-capita volume, and separately payable drugs, as well as examining factors associated with PE acquisitions and continued consolidation.

MedPAC staff plan to incorporate the commissioners' suggestions where feasible, including methodological refinements and facility characteristics, such as the impact of CON laws. If sufficient analysis is completed, staff plan to present results in January 2027 for inclusion in MedPAC's status report on ASCs.

MEDPAC EXAMINES POST-ACUTE CARE USE IN FFS MEDICARE AND MA

MedPAC presented preliminary findings from its analysis of differences in acute and post-acute care (PAC) use among beneficiaries in FFS Medicare and MA. The analysis included 25.6 million FFS beneficiaries and 27.8 million MA enrollees in 2023 and examined services provided by acute care hospitals (ACH), home health agencies

(HHA), skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF), and long-term care hospitals (LTCH).

Staff emphasized that differences in PAC use between FFS and MA should be interpreted cautiously. Higher use in FFS could reflect unnecessary care, while lower use in MA could reflect either more efficient care delivery or barriers to needed care. The findings were also unadjusted for differences in beneficiary characteristics, including age, disability status, dual eligibility, and geography. MedPAC plans to account for these differences in future analyses.

Acute and Post-Acute Care Use

MedPAC found that MA enrollees used slightly less acute and post-acute care overall than FFS beneficiaries in 2023. Approximately 14.2% of FFS beneficiaries used an acute care hospital compared with 13.2% of MA enrollees, while 11.1% of FFS beneficiaries used any PAC service compared with 9.7% of MA enrollees. Differences varied across PAC settings: HHA use was relatively similar, while larger differences were seen for institutional PAC services, particularly IRFs, which were used by 1.2% of FFS beneficiaries compared with 0.4% of MA enrollees. Among beneficiaries who used PAC, median SNF stays were also longer in FFS, at 33 days compared with 20 days in MA.

Post-Acute Care Use Following Hospitalization

MA enrollees were less likely than FFS beneficiaries to receive PAC following an acute care hospitalization. Approximately 65% of MA hospital discharges did not transition to PAC compared with 59% of FFS discharges. MA enrollees were also less likely to transition to SNFs and IRFs, while HHA use was similar. Community-admitted SNF stays were more common in MA, which MedPAC noted likely reflects FFS Medicare's three-day hospital stay requirement.

To better understand how beneficiaries move between care settings, MedPAC examined "PAC pathways," defined as sequences of ACH or PAC stays occurring within 30 days of one another. The most common pathways following a hospital stay were hospital to HHA, hospital to SNF, and hospital to SNF followed by HHA. MA enrollees were more likely to transition directly from a hospital to HHA, while pathways involving IRFs were less common. FFS pathways were somewhat more likely to involve multiple care settings, with 14% involving three or more transitions compared with 12% in MA.

Staff cautioned that the number of transitions does not indicate the intensity, quality, or appropriateness of care. Accordingly, the preliminary findings cannot determine whether the differences reflect better care management in MA, unnecessary utilization in FFS, restricted access in MA, or other factors.

Commission Discussion

Commissioners emphasized that lower PAC use in MA should not automatically be viewed as better performance and called for further analysis of the factors driving differences between FFS and MA. Discussion focused on MA payment arrangements, prior authorization and coverage rules, provider incentives, beneficiary access, and whether beneficiaries in FFS and MA ultimately have different care experiences.

Commissioners also recommended examining variation by clinical condition and beneficiary characteristics, including dual eligibility. They expressed particular interest in the experiences of beneficiaries and families when PAC is denied or delayed, as well as how plan and provider incentives may affect where beneficiaries receive care. MedPAC plans to adjust the findings for differences in beneficiary characteristics and continue comparing PAC use and outcomes in FFS and MA. Future work will also examine specific beneficiary groups, provider quality, and interview findings with PAC providers and MA plan representatives.

MEDPAC EXAMINES MEDICARE ADJUSTMENT RISK-ADJUSTMENT ACCURACY AT THE PLAN LEVEL

MedPAC examined the accuracy of MA risk adjustment at the plan level. Staff emphasized that risk adjustment should account for differences in expected spending across enrollee populations so that plans are appropriately compensated for the health needs of their enrollees.

Plan-Level Payment Accuracy

MedPAC presented a preliminary analysis of MA plan bids to assess how well risk adjustment accounts for differences in expected costs across plans. Risk adjustment reduced variation in plan bids, suggesting that risk scores account for some differences in enrollee populations. However, after adjusting for risk and geography, the 90th percentile plan bid remained 40% higher than the 10th percentile bid, with similar variation across Special Needs Plans (SNPs) and non-SNPs.

Staff noted that this remaining variation does not necessarily indicate problems with risk adjustment, as plan costs can differ for reasons unrelated to enrollee health. However, risk adjustment may not fully account for certain differences across plans. For example, variation in diagnosis coding can affect risk scores, and some plans may enroll beneficiaries who are more costly than their risk scores would predict.

Challenges with the Current Risk-Adjustment Model

MedPAC identified three potential sources of risk-adjustment inaccuracy: the population used to develop the model, the information included in the model, and the model's ability to predict spending. The current model is calibrated using FFS Medicare

data, which may not fully reflect the relationship between health conditions and spending in MA.

MedPAC also examined differences in diagnosis coding across MA plans. Greater coding intensity can increase risk scores and payments, while documenting additional diagnoses can increase administrative burden for providers. Accurately predicting healthcare spending is also difficult because a large share of spending is concentrated among a relatively small number of beneficiaries.

Potential Approaches to Improve Risk Adjustment

MedPAC discussed several potential approaches to improving risk adjustment, including reducing reliance on diagnoses subject to coding discretion, incorporating additional clinical or utilization information, and developing an encounter-based model using MA data. An encounter-based model could better reflect MA enrollee characteristics, coding patterns, and treatment costs, but could also reflect existing MA coding practices and would not eliminate incentives to document additional diagnoses.

Commission Discussion

Commissioners expressed interest in better understanding what drives the remaining variation in plan bids and how potential changes to risk adjustment could affect plan competition. Discussion focused on reducing discretionary diagnosis inputs, using more objective measures of beneficiary health, accounting for unpredictable high-cost beneficiaries, and exploring concurrent risk adjustment. Commissioners also emphasized coding incentives and the importance of limiting administrative burden when considering potential changes to the model.

MedPAC staff plan to continue assessing how accurately risk adjustment accounts for differences across plans. Future analysis will use actual Medicare spending rather than plan estimates to better understand how much variation is attributable to enrollee health. Staff will also examine an approach based on MA encounter data, ways to reduce reliance on diagnoses that plans have more discretion to document, and other possible changes to the risk-adjustment model.

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