National Rural Health Association

MedPAC March 2026 Report to Congress: Medicare Payment Policy

The Medicare Payment Advisory Commission (MedPAC) recently sent its annual March 2026 Report to Congress on Medicare Payment Policy. The Report covers several relevant rural issues such as hospital funding, physician payment, and Medicare Advantage.

You can access the Report here. If you have any questions, please contact Alexa McKinley Abel (amckinley@ruralhealth.us).

Medicare FFS Payment Adequacy and Updates

Congress requires MedPAC to annually make payment update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. The goal of this update is to ensure beneficiary access while maintaining fiscal sustainability.

Hospital inpatient and outpatient services

For fiscal year (FY) 2027, MedPAC recommends that Congress **increase base hospital payment rates for all hospitals** and **direct additional resources to hospitals serving a high share of Medicare and low-income Medicare beneficiaries.** Specifically, MedPAC recommends that:

- Congress should update the 2026 Medicare base payment rates for general acute care hospitals **by the amount specified in current law**.
- In addition, Congress should implement the Medicare Safety-Net Index (MSNI), with $1 billion added to the MSNI pool.

The Report shows that while hospitals with higher values on the MSNI generally already have higher FFS Medicare margins, the MSNI adjustment would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing financial challenges. This proposal includes direct payments to hospitals for their FFS and Medicare Advantage (MA) patients.

Additionally, rural hospitals would generally receive more payments under the MSNI than under the current disproportionate share hospital (DSH) and uncompensated care payments. MSNI adjustments are proposed in phased changes to ease the transition for hospitals that would receive lower safety-net payments under the MSNI.

MedPAC also recommends that Medicare should move toward site-neutral payments.

Physician and other health professional services

Medicare beneficiaries generally reported strong access to clinician services, with access measures often equal to or better than those reported by privately insured individuals. Medicare beneficiaries also reported high satisfaction with their ability to find clinicians who accept their insurance and obtain timely appointments.

The supply chain of clinicians billing Medicare continues to grow overall, although the composition of the workforce is shifting. MedPAC notes that:

- Rural and urban Medicare beneficiaries reported similar overall access to clinician services, though rural beneficiaries were more likely to receive primary care from nurse practitioners or physician assistants (28% compared to 16% in urban areas).

- Rural beneficiaries were also less likely to report seeing a specialist annually and more likely to report dissatisfaction with specialist availability, reflecting persistent workforce and geographic access challenges.
- Of those looking for new primary care providers (PCP), 65% of rural Medicare beneficiaries reported ease in finding a new PCP, compared to 48% of their urban counterparts.

Most physician payment adequacy indicators remained stable in 2024, although clinicians' input costs remain elevated relative to historical trends. For calendar year (CY) 2027, MedPAC recommends that Congress:

- **Increase payment rates for physicians' and other health professionals' services by 0.5 percentage points more than current law.**

Under current law, payment rates would otherwise decline in 2027 due to the expiration of a temporary 2.5% update applied in 2026 and the smaller annual updates established under the Medicare Access and CHIP Reauthorization Act (MACRA). MedPAC's recommendation would partially offset these reductions and result in:

- A 1.25% update for clinicians participating in advanced alternative payment models (A-APMs), and
- A 0.75% update for other clinicians, relative to current law.

The Commission concluded that these adjustments would help address ongoing clinician input cost pressures while maintaining incentives for cost control within the Medicare program.

Post-acute care: Trends and key issues

Medicare's post-acute care (PAC) system continues to reflect misaligned payment incentives and variation in utilization across settings. PAC includes skilled nursing facilities (SNFs), home health agencies (HHAs), and inpatient rehabilitation facilities (IRFs), which provide similar services at different levels of intensity but operate under distinct payment systems and benefit structures. In 2024, FFS Medicare spending on PAC totaled $57.7 billion, including $31 billion for SNFs, $15.7 billion for HHAs, and $11 billion for IRFs. While overall PAC spending has declined slightly over time, per-beneficiary spending has increased, and Medicare margins across PAC providers have remained in the double digits for more than two decades, indicating that payments continue to exceed provider costs overall.

MedPAC highlights several key trends and challenges across PAC settings:

- Beneficiary access to PAC is influenced by workforce constraints, with staffing shortages limiting the availability of SNF beds and home health services and contributing to delays in care transitions from hospitals.
- Utilization patterns have shifted over time, with SNF volume declining significantly, home health use decreasing modestly, and IRF use increasing. HHAs are now the most common PAC setting following hospital discharge, while SNF use remains below pre-pandemic levels.
- There is substantial overlap in the types of patients treated across PAC settings, but no clear, evidence-based framework exists to guide placement decisions. Instead, referrals are often shaped by provider availability, patient support systems, and payment incentives.
- Quality measurement remains limited by inconsistent reporting, gaps in patient-experience data, and challenges in comparing outcomes across settings, resulting in mixed evidence on which PAC setting produces the best outcomes for similar patients.

Overall, MedPAC finds that current FFS payment incentives may encourage inefficient care, while existing value-based purchasing programs have had limited impact on improving quality. APMs and MA plans are reducing PAC use, but may also influence access and care patterns in ways that warrant continued monitoring.

Skilled nursing facility (SNF) services

Medicare payments to SNFs remain strong overall, although financial performance varies widely across facilities and regions. In 2024, the FFS Medicare margin for freestanding SNFs was 24.4%, indicating that Medicare payments substantially exceeded provider costs. Rural SNFs reported somewhat lower margins, approximately 21% compared to 24.8% for urban facilities. Lower margins were observed among smaller, rural, and low-volume facilities as these often face higher per-patient costs and reduced ability to achieve operational efficiencies.

MedPAC's payment adequacy indicators for SNF services were generally positive:

- Beneficiary access to SNF care remains stable, with 88% of Medicare beneficiaries living in a county with three or more SNFs or swing-bed facilities.
- SNF admissions per 1,000 FFS beneficiaries declined by 4% in 2024, continuing a long-term trend toward fewer SNF admissions due to workforce constraints.
- Staffing shortages and workforce turnover remain a concern, with the median nursing staff turnover rate at 46% in 2024.

For FY 2027, **MedPAC recommends that Congress reduce the 2026 Medicare base payment rates for SNFs by 4%.** The Commission concluded that current payment levels are more than adequate to maintain beneficiary access to SNF care. MedPAC projects that the FFS Medicare margin for freestanding SNFs will increase to approximately 25% by 2026, indicating that payments will remain well above provider costs even if rates are reduced.

MedPAC emphasizes that the purpose of the recommended reduction is to better align Medicare payments with provider costs while maintaining incentives for cost control within the SNF prospective payment system.

Home health care services

Home health care utilization among Medicare beneficiaries remains substantial but varies across geographic areas. In 2023, home health utilization was lower on a per capita basis in rural areas, averaging 21.7 thirty-day periods per 100 FFS Medicare beneficiaries in rural counties compared with 24.8 thirty-day periods per 100 beneficiaries in urban counties.

Although rural use is lower overall, MedPAC notes that rural counties include both low- and high-utilization areas, indicating substantial variation in service use across rural communities. Additionally, home health visits have declined over time, with the number of in-person visits per full 30-day period falling by 18% between 2019 and 2024. Following the COVID-19 pandemic, home health care remains the most common formal post-acute care setting following hospital discharge, even as utilization patterns have shifted. The Report discussed telehealth and remote patient monitoring (RPM) remain underutilized in the home health benefit. Only about 12 percent of home health agencies reported furnishing at least one telehealth visit, and telehealth or RPM services were included in only 2.2 percent of 30-day care periods in 2024. MedPAC also found that Medicare payments to home health agencies remain well above provider costs, with the FFS Medicare margin estimated at 21.2% in 2024.

MedPAC key recommendations to Congress include:

- **Reduce the 2026 base payment rate by 7% for CY 2027.** This recommendation would decrease federal program spending by $750 million to $2 billion in one year and by $10 billion to $25 billion over five years. The report emphasized that home health services can be a high-value benefit when delivered efficiently, particularly because care delivered in the home is often less costly than institutional post-acute care settings.

The Medicare Advantage program: Status report

To monitor program performance, MedPAC examines MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for beneficiaries enrolled in traditional FFS Medicare. MA enrollment continues to grow steadily. In 2025, **55% of eligible Medicare beneficiaries were enrolled in MA plans**, representing approximately 34.9 million beneficiaries, up from 54% in 2024.

Key findings:

- MA enrollment increased by approximately 4% from 2024 to 2025, while the population eligible for MA grew by about 2%. Enrollment growth was similar (4%) in both rural and urban areas over that time period.
- Enrollment patterns differ in urban and rural areas. In 2025, 57% of eligible beneficiaries in urban areas were enrolled in MA compared to 49% in rural areas.
- In 2025, 41% of rural MA enrollees were in HMOs compared to 59% of urban enrollees, while 57% of rural enrollees were in local PPOs compared to 40% of urban enrollees, reflecting differences in provider network structure across markets.
- In 2026, 99% of Medicare beneficiaries have access to at least one MA plan, and the average beneficiary can choose from 39 plans offered by eight organizations.
- Special needs plans (SNPs) are a major driver of growth, increasing by 10% in 2025 and accounting for more than half of total MA enrollment growth.
- Medicare payments to MA plans remain substantial, totaling an estimated $537 billion in 2025, including rebate payments used to finance supplemental benefits.

The Report notes that higher payments to MA plans contribute to supplemental benefits and lower cost sharing for MA enrollees. However, these additional payments also increase overall Medicare spending and raise Part B premiums for all beneficiaries, including those enrolled in traditional FFS Medicare.

Mandated Report: Rural Emergency Hospitals

The legislation that created Rural Emergency Hospitals (REHs) mandates MedPAC to annually report on the status of this designation. Findings include:

- In 2025, the number of REHs grew to 44.
- REHs are located in 18 states with at least 4 REHs in Arkansas, Mississippi, Oklahoma, and Texas.
- In CY 2024, REHs received over $100 million in enhanced Medicare payments, almost all of which were from fixed monthly payments.
- In CY 2024, REHs received about $24 million for OPPS-equivalent services, which was $1.2 million higher than the amount would have been using standard OPPS rates. The OPPS-equivalent services that accounted for the highest share of spending at REHs were ED visits, observation visits, and partial-hospitalization mental health services.

MedPAC continues to monitor rural hospital uptake of the REH designation and any policy issues. For example, in interviews with REHs, they reported that MA plans tend to match FFS's claimsbased payment rates for REHs but (as expected) do not pay REHs fixed monthly payments. However, Medicare's fixed monthly payments to REHs are included in MA benchmarks.

Mandated Report: The Impact of recent changes to the home health prospective payment system

MedPAC's evaluated Patient-Driven Groupings Model (PDGM), which was implemented in 2020 and replaced the prior 60-day episode-based payment system with a 30-day unit of payment and removed therapy visits as a payment driver. To assess program performance MedPAC examined changes in utilization, quality of care, and financial performance for FFS Medicare beneficiaries.

Key findings include:

- Changes in visit intensity were somewhat smaller in rural areas. The PDGM was associated with a reduction in therapy visits across all settings, but the decline was less pronounced in frontier rural areas, approximately 17.2%, compared to other areas, about 21%.
- The PDGM was not associated with significant changes in access to care, length of stay, or likelihood of receiving home health services, including rural areas.

The FFS Medicare margin for home health stays remained high at approximately 24.1% overall in 2023, indicating that Medicare payments continue to exceed provider costs following implementation of the PDGM.