CHAMBER HILL

INSIGHTS

Select Sessions from MedPAC April Meeting: Payment Incentives, Impact of MA on Certain Providers' Finances, and I-SNPs

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On April 9 and 10, the Medicare Payment Advisory Commission (MedPAC) met for their April meeting, the last meeting in the 2026 Cycle. Commissioners discussed several topics including, how to improve payment incentives, the impact of Medicare Advantage (MA) on hospitals' and post-acute care (PAC) providers' finances, and institutional special needs plans (I-SNPs). Commissioners all expressed concerns with the current system and voiced numerous solutions.

IMPROVING PAYMENT INCENTIVES IN MEDICARE

MedPAC staff began this session discussing the drivers of Medicare's spending growth, payment incentives within fee-for-service (FFS), alternative payment models (APMs) and MA, as well as recommendations to improve Medicare's incentives. These recommendations can be viewed on slides 29-38 in the Improving Payment Incentives" slideshow found here. MedPAC staff shared that its presentation, along with the Commissioners' discussion, will be included in the MedPAC June 2026 report to Congress.

Overall, Commissioners agreed on the shortcomings of FFS, APMs, and MA, saying that they each have their strengths and weaknesses when it comes to payment incentives. Commissioners expressed that FFS is foundational, in that it serves as a guardrail to ensure MA provides a variety of services, yet it leads to high inflation. Commissioners shared that APMs are an incentive layered on top of FFS and have tools to avoid unnecessary plan expenses but do not have sufficient funding to support the infrastructure needed. In terms of MA, a few Commissioners said that it is effective at controlling costs, but the incentive is currently centered around coding care rather than quality of care. Commissioners concluded that each of these services play a core role and are vital but agreed that there needs to be stronger tools to provide better incentives to providers.

Additionally, Commissioners emphasized the need to ensure beneficiaries know they are being enrolled in Medicare, MA, or APMs so they can best understand the benefits available to them. There was also concern regarding the rise of costs as people age and are diagnosed with additional chronic illnesses. Commissioners recommended payment mechanisms that encourage specialist-led services with more focus on patients and increased specialist engagement with APMs to combat the rising costs. A few Commissioners mentioned rising drug costs and expressed concern over the focus on price and quantity impacts, rather than innovation impacts. A few Commissioners noted that there are tools in place to manage every cost except for drug costs and recommended the utilization component as an incentive to control when drugs are used in a managed environment.

MA ENROLLMENT AND HOSPITALS' AND POST-ACUTE CARE (PAC) PROVIDERS' FINANCES

MedPAC staff began this session giving a brief background on MA enrollment and plan incentives, then discussed how MA enrollment affects hospital finances and PAC providers' finances. The staff explained the elements of the study they conducted as there was no pre-existing literature that included all of the information they needed. Their research showed that there is no significant association between MA penetration and hospitals' and PAC providers' finances, despite complaints that providers are experiencing difficulties navigating the space. This chapter will be included in the June 2026 Report to Congress.

A number of Commissioners voiced concerns on the subjectivity of what is medically necessary, specifically in terms of referrals and denials. One Commissioner detailed that providers have different resources they use to evaluate medical necessity than health plans do, which contributes to different decisions. One Commissioner explained that an MA plan can decide a procedure is not necessary if it's nonemergent, which leads to increased time-to-placement, which increases costs. While the overturn rate of these denials is very high, providers then lose money and time appealing the decision. Other Commissioners echoed concerns about this. One Commissioner questioned if the reason data is not reflecting the issue is due to the way providers and hospitals have adjusted to MA market penetration in order to combat the rising costs.

Commissioners also spent time discussing heterogeneity between MA plans, and between home health agencies (HHAs), skilled nursing facilities (SNFs), and inpatient rehabilitation facilities (IRFs). Commissioners explored how MA plans vary in how they approach situations depending on the geography and relationships with providers in the areas they are operating in. Commissioners noted that each facility varies in size, coverage, and care level and that these differences impact the solutions they need. For example, one commissioner detailed that smaller SNFs operate better than larger SNFs, while smaller HHAs are not as effective as larger HHAs. Commissioners continuously raised this concern and there was agreement about the need to look into the structural failures currently in place that are either positively or negatively impacting each player.

INSTITUTIONAL SPECIAL NEEDS PLANS (I-SNPS): PROVISION OF SERVICES, NETWORK-ADEQUACY REQUIREMENTS, AND STAR RATINGS

MedPAC staff began this session reviewing their work last year on I-SNPs. Staff also emphasized that this work will not be included in the June 2026 Report to Congress, but if there were commissioner interest, they would conduct additional work in the next cycle and include this as a chapter in the June 2027 Report.

A number of Commissioners voiced concerns about the interaction between Medicare and Medicaid plans within I-SNPs as it is the only model that can apply to long-stay older adults on Medicaid that are getting care in nursing homes from Medicare. One Commissioner specifically raised the issue of conflicting incentives in terms of nursing homes electing to send patients to the hospital due to higher reimbursement rates from Medicare versus I-SNPs focus on keeping care within the nursing home. Additionally, Commissioners expressed the need to better understand what nurse practitioners are doing and how they interact with the rest of the nursing home staff.

Other Commissioners also asked questions regarding the functionality of I-SNPs and the data collected on them. One Commissioner asked if there was a way to identify incident to billing in nurse practitioner visits, to which the staff explained that they are salaried employees, so it is unclear if they are cataloging every visit. Another Commissioner asked why insurer sponsored I-SNPs are getting higher star ratings over those that are provider sponsored. Staff explained that insurer sponsored I-SNPs are simply larger, so they have more enrollees and therefore get more data. Additionally, one Commissioner proposed having CMS require SNP beneficiaries, or their proxy, be educated about the choice of FFS, MA, or I-SNP coverage within the nursing home.

Today's sessions concluded with a public comment period. Shannan Wu, the Director of Payment Policy at the American Hospital Association urged MedPAC to continue carefully examining the role MA plays in access to care and spending. Wu explained that the major high-cost drivers in Medicare can be found in MA, despite the greater administrative burdens, and believes the Commission should look towards combatting that.

We trust you found this summary useful. Please reach out to us with any questions.