



Justification of appropriation request for the Committees on Appropriations

Fiscal Year 2027



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Justification of appropriation request

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Medicare Payment Advisory Commission’s request for appropriations for fiscal year 2027

The Medicare Payment Advisory Commission (MedPAC) requests appropriations of \$15.048 million for fiscal year (FY) 2027. The request amounts to an increase of \$375,000, or 2.56 percent, from the \$14.673 million that MedPAC received for FY 2026.

Our FY 2027 request is based on considerable interest from the Congress in the expert analysis and advice the Commission provides to support the dual goals of ensuring Medicare beneficiaries’ access to high-quality care and addressing the program’s urgent fiscal challenges. The Commission routinely provides assistance to the Congress with congressional testimony, technical assistance on draft legislation, data analysis, and briefings on a range of Medicare payment issues—particularly for the staff of the committees with jurisdiction over Medicare. In 2025, the Commission fulfilled over 250 requests for technical assistance from congressional staff.

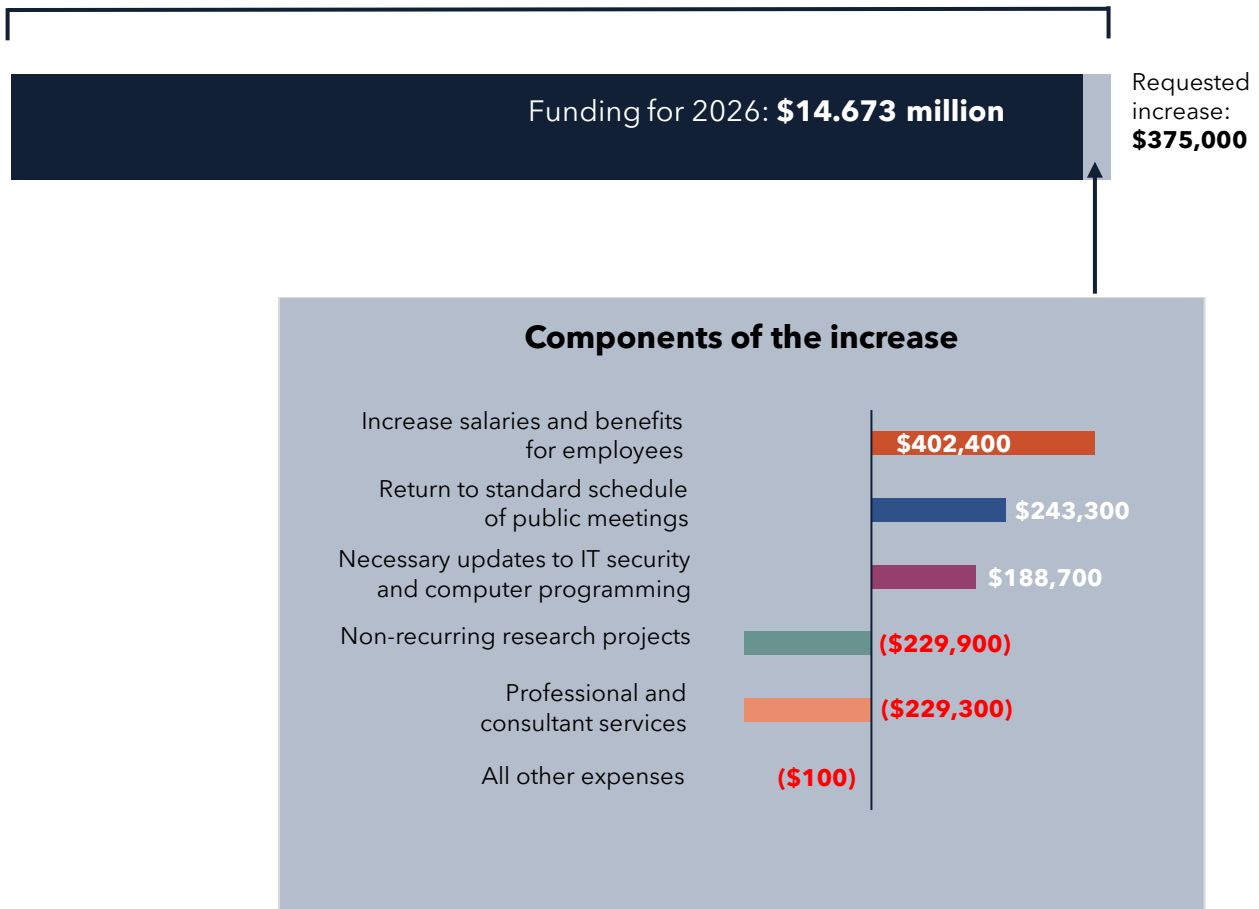
The requested budget would provide MedPAC the resources to support the Congress in its mission to oversee a growing and increasingly complex Medicare program and to help ensure its long-term sustainability. As the Medicare program grows in size and complexity, so too do the challenges it faces, as reflected in the breadth of the Commission’s recent work, which included:

- addressing cost-sharing differences faced by beneficiaries in rural areas;
- tracking the effects of software technologies and machine learning in the Medicare program;
- monitoring and reporting on the effects of changes to Medicare made under the Inflation Reduction Act, including recent increases in Part D plan bids and program spending, and changes in beneficiaries’ cost sharing;
- analyzing the quality of care for Medicare patients residing in nursing homes; and
- continued analysis of options to expand “site-neutral” payments in Medicare.

MedPAC anticipates a high volume of requests for assistance from the 119th Congress as lawmakers confront Medicare’s urgent fiscal challenges. Additional resources would enable us to be even more responsive to these requests.

Components of MedPAC’s requested \$375,000 increase

FY 2027 request: \$15.048 million



The FY 2027 request would allow MedPAC to operate at a full staffing level of 38 full-time employees, to help further develop the Commission’s analytic and policy work and expand our ability to respond to congressional requests across a range of Medicare payment issues. Specifically, the FY 2027 budget request would allow the agency to:

- increase salaries and benefits for employees to continue offering competitive compensation for Medicare experts;
- return to our standard schedule of seven public meetings with commissioners, relative to FY 2026 when two meetings were cancelled due to a lapse in appropriation; and
- maintain the necessary updates to IT security systems, hardware, software, and computer programming.

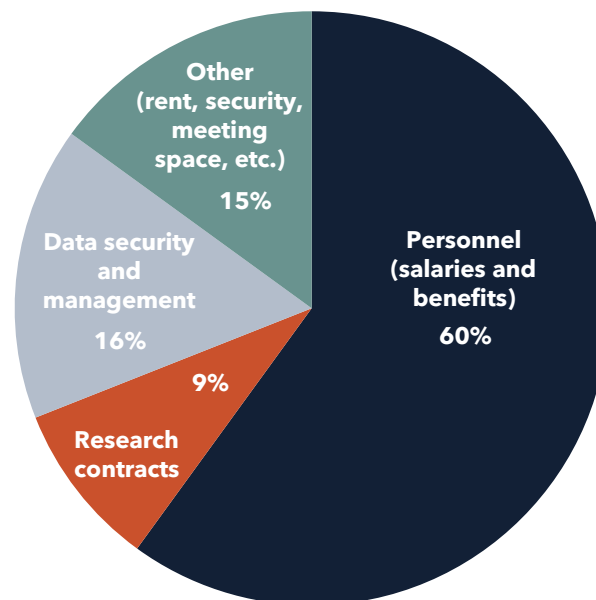
The requested increases are offset by reductions in:

- funding for non-recurring research projects
- professional and consultant services and all other expenses

MedPAC's budget request and its effect on agency operations

MedPAC's budget has relatively few major cost centers: personnel; data management and security; research contracts; and other costs, such as rent and security. Our FY 2027 request is distributed across those four centers, with 60 percent in personnel costs, including salaries and benefits; 16 percent in data security and management; 9 percent in funding for research contracts; and 15 percent in other costs, including rent, security, space at the Ronald Reagan Building and International Trade Center for Commission meetings, travel costs, professional and consultant services, commercial contracts, as well as equipment and furnishings. The concentration of costs in these areas makes it difficult to continuously find additional efficiencies; however, we continue to constrain spending within our control.

FY 2027 request: Allocation of MedPAC's costs, by major cost center



The \$15.048 million requested level of funding reflects the costs of the human capital, policy research, and data management and security needed to ensure MedPAC's efficient operation in support of the Congress's ongoing work to oversee and improve the Medicare program. Demand for MedPAC's analyses and the Commission's workload has grown along with the Medicare program. A detailed analysis of MedPAC's cost centers is in [Appendix C](#).

Funding request for personnel costs

The Commission's greatest strength, as well as our largest cost center, is human capital. The Commission staff consists of a small management staff, an analytic staff, and a small administrative and operational staff. The management and analytic staff are highly trained health policy analysts and economists who are experts in their respective fields, with extensive backgrounds in health policy research and financing, the health care sector, and government. The Commission's capacity to provide expert information to the Congress relies heavily on maintaining its staff of experts and their institutional knowledge of the Medicare program.

MedPAC requests \$9.0 million for salaries and benefits to support 38 full-time employees (36 full-time-equivalent (FTE) staff members and 2 FTE commissioners) by the end of FY 2027, an increase of \$520,400 (an increase of \$402,400 for staff members and an increase of \$118,000 for commissioners). Staffing at this level will allow the Commission to continue providing expert information and advice to the Congress in a timely way. The Commission also expects the retirement of long-serving staff members over the next few years. Hiring replacement staff in a timely manner to transfer institutional knowledge will be critical for the agency's long-term effectiveness to assist the Congress. The proposed budget would allow MedPAC to restore and sustain full staffing levels while ensuring smooth transitions as experienced members of the staff retire.

As noted above, our FY 2027 request includes an increase in staff personnel costs of \$402,400. This increase for salaries and benefits is in line with estimates of inflation and the cost-of-living adjustment, allowing MedPAC to continue to offer competitive compensation for Medicare experts. Maintaining our staffing level reflects a human capital strategy that will enable us to support the Congress as effectively as possible.

Our FY 2027 budget request also includes an increase of \$118,000 in commissioner personnel costs to account for seven expected in-person public meetings during FY 2027. The Commission held four in-person public meetings and one virtual public meeting during FY 2026 due to the lapse in funding that occurred from October 1 through November 12. The Commission had scheduled public meetings for October 9–10, 2025, and November 6–7, 2025, that were subsequently cancelled. We held our December 2025 meeting virtually to allow for additional meeting time when commissioners otherwise would have been traveling to and from Washington, DC. Cancelling the October 2025 and November 2025 public meetings and moving the

December 2025 public meeting to be virtual all reduced the Commission's FY 2026 spending for commissioner personnel costs. Historically, the Commission has met seven times per fiscal year, thus our FY 2027 request reflects a return to the Commission's usual meeting schedule, and the associated commissioner personnel costs.

Funding request for research costs

MedPAC also devotes a portion of our budget to contract support for select research projects ([Appendix I](#)). The Commission achieves efficiencies by contracting additional expertise to supplement the work of Commission staff. Because of MedPAC's workload and the complexity of our analyses, access to external researchers has been vital to providing timely and accurate advice to the Congress on key Medicare policy issues. Our FY 2027 funding request includes \$1.376 million for external research contracts. The Commission funds several research contracts each year that are critical to its analysis of the Medicare program. For more than 20 years, the Commission has funded an annual survey of privately insured individuals between the ages of 50 and 64 and Medicare beneficiaries ages 65 and over to assess beneficiaries' access to care. Additionally, the Commission conducts focus groups with Medicare beneficiaries and clinicians participating in Medicare. These activities are important to how the Commission learns about issues facing Medicare beneficiaries and provides an opportunity to hear directly from patients.

Our budget request also reflects reduced spending on research contracts of \$229,900 (14 percent) relative to FY 2026. This reduction is the result of several one-time research projects reflected in our FY 2026 budget that we do not anticipate repeating in FY 2027, including:

- focus groups with pharmacists to better understand how recent changes, including the Inflation Reduction Act of 2022, are affecting pharmacies and Medicare beneficiaries.
- analyses to understand the accuracy of the new case-mix groups implemented in 2020 under the skilled nursing facility prospective payment system and the home health agency prospective payment system.
- research to better understand coverage, payment, and use of Part B drugs and skin substitute products for beneficiaries enrolled in Medicare Advantage.

Funding request for data management and security

Our FY 2027 funding request includes \$2.430 million for maintaining the security of MedPAC's information technology, infrastructure, and data assets, including sensitive Medicare data. This represents a mission-critical cost, and it is a \$188,700 increase from 2026.

The Congress relies on the Commission as a source of data-driven and empirically rigorous information and expertise. MedPAC is tasked with analyzing large datasets that contain sensitive information. The volume of these data continues to grow while MedPAC maintains historical data to conduct longitudinal analyses.

The security of the Medicare data the Commission analyzes for the Congress is a mission-critical responsibility. The Commission contracts with a data management firm to provide a secure environment in which the data are stored and analyzed. This contractor also supplements our data programming capacity. The Commission also contracts with an expert to ensure the security of MedPAC's information technology environment.

MedPAC faces continuous cyber-security threats from both domestic and international origins. The primary targets include email communications, endpoint attacks, and overall domain management. MedPAC regularly evaluates data requirements and security needs to ensure the environment that we maintain remains secure.

The importance of accurate analysis of sensitive data is central to MedPAC's mission. Accordingly, we maintain a strong and ongoing focus on cyber security and operational safeguards designed to protect the mission-critical resources afforded to the Commission.

Funding request for other nonpersonnel costs

The Commission also incurs other costs in the course of fulfilling our mission. The largest of those costs include rent (including security payments to the Department of Homeland Security), spending on specialized labor from professional and consultant services and commercial contracts, and spending on equipment the Commission purchases to safeguard our data assets. MedPAC's FY 2027 request includes a \$104,000 decrease in other costs, primarily driven by two partially offsetting factors: an increase in nonpersonnel costs associated with holding seven public meetings and a reduction in professional and consultant services.¹

The Commission planned to hold seven public meetings in the Ronald Reagan Building and International Trade Center in Washington, DC, during FY 2026, consistent with prior years. Due to the lapse in appropriations from October 1, 2025, through November 12, 2025, the Commission was unable to hold two planned public meetings. As a result, to meet our congressional mandate, we expanded the December meeting agenda beyond its typical focus on payment adequacy, incorporating work that otherwise would have been presented earlier in the fall. The December agenda included two sessions in response to congressional mandates: the impact of recent

¹ The \$104,000 decrease stems from two factors: A \$125,300 increase in nonpersonnel public meeting costs—including the cost of commissioner travel and the cost associated with renting space at the Ronald Reagan Building and International Trade Center in Washington, DC—and a \$229,300 reduction in professional and consultant services.

changes to the home health prospective payment system and an assessment of the Medicare ground ambulance data collection system. Our FY 2027 request includes a \$125,300 increase that reflects the expectation that the Commission will hold all seven of its planned public meetings during FY 2027 in the Ronald Reagan Building and International Trade Center in Washington, DC, during 2027. This expected increase is relative to FY 2026, when two scheduled public meetings were cancelled due to the lapse of funding. This request also includes the increased travel costs for commissioners to attend each of the seven public meetings in person.

Prior to FY 2026, the Commission had been operating at a reduced staffing level with the assistance of part-time consultants. MedPAC consultants maximize the Commission's staffing flexibility and also provide targeted support and specialized labor, as needed. For example, in FY 2026, a consultant provided analytic expertise to complete a mandated report on the ground ambulance cost reporting system.

The Commission's FY 2027 request includes a \$229,300 reduction in professional and consultant services. Upon completion of our mandated report analyzing the ground ambulance cost data system in June 2026, we expect to reduce our spending on consultant services for FY 2027. We are currently training members of our full-time analytic staff to take responsibility for this analytic area to be able to provide future support to the Congress.

Role of MedPAC in supporting the Congress

MedPAC is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program ([Appendix B](#)). MedPAC advises the Congress on payments to providers in Medicare's traditional fee-for-service (FFS) program and to private health plans participating in Medicare Advantage (MA) and provides information on beneficiaries' access to care, quality of care, and other issues affecting Medicare beneficiaries and providers.

Public meetings and publications

The Commission meets publicly to discuss policy issues and formulate recommendations to the Congress. (For a listing of current commissioners, see [Appendix D](#).) In the course of these meetings, commissioners consider the results of staff research and input from interested parties. For a detailed listing of the Commission meeting dates and major agenda items for FY 2025 and FY 2026, see [Appendix E](#). The Commission's work in all instances is guided by three principles:

- Beneficiaries should have access to high-quality care in an appropriate clinical setting.
- Medicare's payments should support efficient care delivery, thereby ensuring that the program's fiscal burden on beneficiaries and taxpayers is not greater than necessary.
- Providers should have incentives to supply appropriate care in an efficient manner.

To fulfill our charge of informing and advising the Congress on the Medicare program, MedPAC publishes a number of products each year: two standing mandated annual reports, comment letters on CMS's proposed regulations, compilations of data and statistics on the Medicare program, and summaries of Medicare payment systems. [Appendix F](#) includes a list of recent congressionally mandated and formally requested reports. [Appendix G](#) includes a list of MedPAC's recent products.

Policy development

The Commission plays an important role in Congress's policy development process. MedPAC develops policy ideas through statutory mandates, congressional interest, commissioner interest, and our analytic staff. To support such policy development, the Commission conducts data analysis through both public and private data sources, primary source data collection, and research through contracts. (See [Appendix H](#) and [Appendix I](#) for details about the Commission's primary source data collection and projects funded through research contracts.)

Below are three examples of policies that the Commission has developed for consideration by the Congress.

Rural beneficiaries' access to care

The Commission has had longstanding interest in ensuring that rural beneficiaries have good access to health care. Most recently, the Commission recommended that the Congress and CMS create a new type of hospital that focuses on outpatient services to help ensure beneficiary access to emergency services in rural areas. The Congress enacted the Rural Emergency Hospital program in the Consolidated Appropriations Act, 2021, directionally consistent with the Commission's recommendation. The Commission continues to report to the Congress on the implementation of this new facility designation and its effect on rural beneficiaries' access to care.

Further, in our June 2025 report to the Congress, the Commission recommended a reduction in beneficiary cost sharing for outpatient services provided in critical access hospitals to improve fairness in cost-sharing liability across urban and rural outpatient services. Moving toward more equalized payment for similar services has been integral to the Commission's work for well over a decade.

Medicare drug pricing and payment policy

The Commission has also played an integral role in Medicare drug pricing and payment policy. In addition to our annual report on the Medicare Part D drug program, the Commission has developed drug policy ideas to help address the high cost that the Medicare program and its beneficiaries pay for drugs under both Medicare Part B and Part D. For example, the Commission recommended redesigning the Part D benefit to establish a cap on out-of-pocket spending by beneficiaries and improve plan incentives to manage program costs.

Site-neutral payments in Medicare

The Commission has twice recommended that Medicare move toward more site-neutral payments, first in 2014 and again in 2023. Moving to site-neutral payments would improve incentives under the Medicare program and enhance value for beneficiaries and taxpayers. The Bipartisan Budget Act (BBA) of 2015 required CMS to implement site-neutral payment rates for services provided in certain off-campus outpatient departments. In 2019, CMS extended site-neutral payment rates to clinic visits provided in almost all off-campus outpatient departments, and, for 2026, expanded site-neutral payment rates to drug-administration services. However, there remain additional opportunities to expand site-neutral policies across ambulatory settings. The Commission continues to develop options to expand site-neutral payments in Medicare, including to clinic visits provided in on-campus locations and to other outpatient services provided in off-campus locations that are currently exempt from the BBA of 2015 site-neutral policy.

Beyond the examples provided above, the Commission’s recommendations and analyses have informed much of the major Medicare legislation over the last decade, including the Consolidated Appropriations Act, 2026; the Inflation Reduction Act of 2022; the Consolidated Appropriations Act, 2022; the Consolidated Appropriations Act, 2021; and the BBA of 2018, as detailed in [Appendix J](#).

Technical support for congressional staff

The Commission plays a vital role supporting the Congress in its policy deliberations related to the Medicare program. MedPAC strives to inform policymakers’ discussions with reports on emerging issues or trends in Medicare. Commission staff provide technical support to congressional staff, working with the committees that have jurisdiction over Medicare and others to support the policymaking process. This technical support takes many forms, including reviewing draft legislation and providing technical feedback, representing and explaining the views of the Commission on particular topics, briefing congressional staff on Medicare payment systems, and generating original analytic work upon request. Congressional staff frequently submit requests with short turn-around times on a wide variety of Medicare topics that require, at different points, the expertise of nearly all Commission staff members. In 2025, the Commission provided briefings for congressional staff on topics including the Medicare program overall, the MA program, double-bonus counties in MA, comparisons of spending across the MA and FFS programs, advanced alternative payment models, durable medical equipment, laboratory services, ambulance services, and graduate medical education.

The Commission also provides more formal support in the form of testimony during congressional hearings. In September of 2023, the Commission submitted a statement for the record on examining policies to improve seniors’ access to innovative drugs, medical devices, and technology. In October of 2023, the Commission provided testimony on ensuring Medicare beneficiaries’ access to care and reducing burden for providers. Most recently, in April of 2024, the Commission provided testimony on improving payment accuracy in the Medicare program.

Committees also ask for information from the public, stakeholders, and technical experts through formal requests for information. Where appropriate, the Commission provides responses to these requests. Since 2023, the Commission has responded to congressional requests for information on the Medicare Access and CHIP Reauthorization Act (MACRA), dually eligible beneficiaries, improving access to health care in rural and underserved areas, MA data, physician payment policy options, and primary care provider reform.

Transparency

The Commission takes several important steps to promote transparency in our work. We webcast Commission meetings for public viewing and publish meeting

transcripts and presentations on our website. The Commission also solicits public comments at each public meeting, inviting stakeholders to submit written comments to commissioners and/or meet with MedPAC staff. The Commission distributes all stakeholder comment letters submitted in response to public meetings to commissioners and posts them on our website for public viewing. A list of stakeholders the Commission staff met with in 2025 can be found in [Appendix K](#) of this document.

Each fall, the Commission publishes our expected analytic agenda for the upcoming year, allowing the Congress and Medicare's stakeholders advance notice and opportunity to provide timely information and feedback on the Commission's planned work.

The Commission also publishes all reports to the Congress, recommendations, comment letters, data books, Payment Basics, and congressional testimony on our website. In addition, MedPAC staff present analytic work at external conferences and receive feedback from researchers and other attendees. These presentations are posted on our website to broaden access to MedPAC's research and analysis.

For the Commission's March and June reports to the Congress, we identify individuals outside of the organization to read, review, and provide comments on our draft materials. These individuals represent stakeholder groups, researchers, and experts. A list of the individuals who have provided comments is included in the acknowledgments section of each report to the Congress, reinforcing the rigor and openness of MedPAC's review process.

Highlights of MedPAC's work in FY 2025

The Commission is involved in the Medicare policymaking process in several capacities, including fulfilling reports mandated by the Congress on a wide range of topics, identifying and calling attention to emerging issues and trends, supporting the legislative process through recommendations and technical assistance to the Congress, and monitoring the implementation and effect of new policies. The Commission's impact can be gauged through our publications and accomplishments as well as our influence on policy.

Accomplishments

The Commission's accomplishments, detailed in Appendix E through Appendix K, include both congressionally mandated work products and additional requests made to the Commission. For example, in FY 2025, MedPAC:

- submitted our two annually mandated reports to the Congress ([Appendix G](#));
- submitted responses to two congressional requests from the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies ([Appendix F](#));
- produced a data book on health care spending and the Medicare program ([Appendix G](#));
- held five public meetings ([Appendix E](#));
- responded to over 250 requests for technical assistance from the Congress, including reviewing draft legislation, conducting original data analysis, and providing subject-matter briefings;
- submitted written comments on 10 proposed rules and other policy solicitations from CMS ([Appendix G](#));
- published 20 Payment Basics briefs, an annually updated series widely used by congressional staff ([Appendix G](#));
- conducted seven in-person focus groups with Medicare beneficiaries and clinicians in St. Louis, MO, as well as one virtual focus group with beneficiaries residing in rural areas across the U.S., to better understand the experience of Medicare beneficiaries and their health care providers ([Appendix H](#));
- fielded an annual survey through mail and online for approximately 5,000 Medicare beneficiaries ages 65 and over and approximately 5,000 privately insured people ages 50 to 64 in order to better understand beneficiaries' access

to care and experience with the health system, to help inform our work in ways that claims analysis cannot ([Appendix H](#));

- conducted site visits to two states to better understand the experiences of rural hospitals and providers of dialysis and hospice ([Appendix H](#)); and
- held more than 70 meetings with over 100 stakeholder groups and policy analysts in order to gather input for policy consideration ([Appendix K](#)).

Adopted recommendations and policies

The Commission’s impact can be gauged by the degree to which the Commission’s deliberations are relied on by the Congress in shaping Medicare policy. For example, recent Medicare legislation—both introduced and enacted—has been informed by MedPAC’s recommendations (see [Appendix J: Adoption of MedPAC Recommendations for specifics](#)).

Requested authority

In addition to our FY 2027 appropriation request, in coordination with the Medicaid and CHIP Payment and Access Commission (MACPAC), we request a legislative change to our contracting authority that would allow both agencies to operate more efficiently and grant us the same flexibilities afforded to other legislative branch agencies.

Multi-year contracting authority

Both MedPAC and MACPAC use contracts to support analytic and security functions. Currently, our agencies must structure the terms of contracts to align with the federal fiscal year on a 12-month period. Thus, our agencies must renegotiate or renew many of our contracts at the same time each year. Multi-year contracting authority would allow our commissions to obtain more competitive pricing for services that we currently purchase on a fiscal year basis by securing best value to the government for longer periods of time. In addition, multi-year contracting authority would increase agency efficiency by reducing the administrative burden of negotiating contracts on an annual basis. As specified in 41 USC 3904, this authority is currently provided for the Government Accountability Office, the Library of Congress, the Chief Administrative Officer of the House of Representatives, the Congressional Budget Office, the Secretary and Sergeant at Arms and Doorkeeper of the Senate, the Capitol Police, the Architect of the Capitol, and the Secretary of the Smithsonian Institution.

To allow for multi-year contracting authority, the Commission respectfully asks for consistent authority with other legislative branch agencies, as detailed in [Appendix A](#).



Appendixes

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APPENDIX A: Appropriations language on multi-year contracting

For expenses necessary to carry out section 4022 of the Balanced Budget Act of 1997, Public Law 105-33 (42 U.S.C. §1395b-6), \$15,048,000 to be transferred to this appropriation from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds.

MULTI-YEAR CONTRACTING AUTHORITY FOR MEDPAC AND MACPAC.

Section 3904 of title 41, United States Code, is amended by adding at the end the following new subsection:

“(i) THE MEDICARE PAYMENT ADVISORY COMMISSION.—The Medicare Payment Advisory Commission may use available funds to enter into contracts for the procurement of severable services for a period that begins in one fiscal year and ends in the next fiscal year and may enter into multi-year contracts for the acquisition of property and services to the same extent as executive agencies under the authority of sections 3902 and 3903 of this title.”

“(j) THE MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION.—The Medicaid and CHIP Payment and Access Commission may use available funds to enter into contracts for the procurement of severable services for a period that begins in one fiscal year and ends in the next fiscal year and may enter into multi-year contracts for the acquisition of property and services to the same extent as executive agencies under the authority of sections 3902 and 3903 of this title.”

APPENDIX B: Authorizing legislation

The Commission’s authorization is contained in Section 4022 of the Balanced Budget Act of 1997, Public Law 105-33 (42 U.S.C. §1395b-6). This legislation authorizes “such sums as may be necessary.”

<i>(In thousands of dollars)</i>			
FY 2026 authorized	FY 2026 appropriated	FY 2027 authorized	FY 2027 request
\$14,673	\$14,673	N/A	\$15,048

Note: FY (fiscal year), N/A (not applicable).

APPENDIX C: Funding and staffing tables

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TABLE C-1. Summary of changes in requested appropriation for FY 2027

	FY 2026 appropriation base		FY 2027 request change from base	
	FTE	Budget authority	FTE	Budget authority
Increases:				
Personnel compensation	36	\$6,055,000	38	+\$430,000
Personnel benefits		2,426,600		+90,400
Computer programming		1,667,480		+82,520
Equipment/Furnishings		126,620		+82,000
Misc. other services: Commercial contracts		461,900		+60,000
Travel		172,350		+57,300
Software		189,260		+24,140
Other government services		18,790		+6,630
Rent (lease)		810,000		+5,000
GSA/USDA to LOC/NFC support services		56,340		+3,660
Trainings and conferences		26,600		+2,500
Cell/telephone/courier/internet		37,220		+1,200
Supplies/Materials		9,550		+750
Publications		108,820		+140
Decreases:				
Research contracts		1,606,020		-229,900
Professional and consultant services		742,650		-229,340
Security payments to DHS		144,000		-12,000
No change:				
Printing and reproduction		12,000		0
Postage		1,000		0
Leased equipment		800		0
Net change:				+\$375,000

Note: FY (fiscal year), FTE (full-time equivalent), GSA (Government Services Administration), USDA (United States Department of Agriculture), LOC (Library of Congress), NFC (National Finance Center), DHS (Department of Homeland Security), OPM (Office of Personnel Management). Components may not sum to totals because of rounding.

TABLE C-2. Actual and requested budget authority by object class, FY 2025-2027

Object classification	<i>(In thousands of dollars)</i>			
	FY 2025 actual	FY 2026 enacted	Change	FY 2027 request
Personnel compensation				
Full-time staff	\$5,537	\$5,800	+\$320	\$6,120
Commissioners	<u>322</u>	<u>255</u>	<u>+110</u>	<u>365</u>
	5,859	6,055	+430	6,485
Personnel benefits				
Full-time staff	2,216	2,407	+82	2,489
Commissioners	<u>25</u>	<u>20</u>	<u>+8</u>	<u>28</u>
	2,240	2,427	+90	2,517
Travel				
Staff	30	54	—	54
Commissioners	141	110	+65	176
Consultants	<u>8</u>	<u>8</u>	<u>-8</u>	<u>—</u>
	178	172	+57	230
Rent (lease)	796	810	+5	815
Cell/telephone/courier/internet	35	37	+1	38
Leased equipment	1	1	—	1
Postage	<u>—</u>	<u>1</u>	<u>—</u>	<u>1</u>
	832	849	+6	855
Printing and reproduction	10	12	—	12
Misc. other services: Commercial contracts	497	462	+60	522
Computer programing	1,515	1,667	+83	1,750
Research contracts	1,180	1,606	-230	1,376
Other government services (GSA, NFC, OPM)	33	19	+7	25
LOC support services	57	56	+4	60
Training and conferences	17	27	+3	29
Security payments to DHS	124	144	-12	132
Professional and consultant services	<u>796</u>	<u>743</u>	<u>-229</u>	<u>513</u>
	4,219	4,724	-316	4,408
Office supplies/services	6	10	+1	10
Publications	<u>100</u>	<u>109</u>	<u>—</u>	<u>109</u>
	105	118	+1	119
Software	189	189	+24	213
Equipment	91	127	+82	209
Furnishings	<u>11</u>	<u>—</u>	<u>—</u>	<u>—</u>
	291	316	+106	422
Subtotal	\$13,735	\$14,673	+375	\$15,048
Lapsing	\$89	—	—	—
Total	\$13,824	\$14,673	+375	\$15,048

Note: FY (fiscal year), GSA (General Services Administration), NFC (National Finance Center), OPM (Office of Personnel Management), LOC (Library of Congress), DHS (Department of Homeland Security). Components may not sum to totals because of rounding.

TABLE C-3. Actual and requested funding, FY 2025-2027

	<i>(In thousands of dollars)</i>			
	FY 2025 actual	FY 2026 enacted	Change	FY 2027 request
Administration and management (primarily staff and commissioner salaries and benefits)	\$10,243	\$10,657	+\$752	\$11,409
Data development, analysis, and research (primarily data management and security and outside consultant costs)	\$3,492	\$4,016	-\$377	\$3,639
Lapsing	\$89	—	—	—
Total	\$13,824	\$14,673	\$375	\$15,048

Note: FY (fiscal year). Components may not sum to totals because of rounding.

TABLE C-4. Actual and requested personnel, FY 2025-2027

	FY 2025 actual	FY 2026 enacted	Change	FY 2027 request
Executive level: Commissioners ^{a,b}	2	1	+1	2
Executive level: Executive director	1	1	0	1
GS/GM-13 to GS/GM-15	26	27	+1	28
GS-6 to GS-12	6	7	0	7
Staffing level (FTEs)	35	36	+2	38

Note: FY (fiscal year), GS/GM (General Schedule), FTE (full-time equivalent). Components may not sum to totals due to rounding. This schedule is for comparison purposes only. MedPAC does not use the General Schedule of grading and salaries. Each salary is determined individually following U.S. Senate personnel rules and MedPAC's personnel policies and procedures. Reflects full-year FTE averages.

^a*The number of executive level staff includes 2 FTEs allocated among MedPAC's 17 part-time commissioners. MedPAC's authorizing legislation requires that commissioners be paid the per diem equivalent of the rate provided for Level IV of the Executive Schedule for the time they devote to Commission business. The other position is the executive director.*

^b*The increase in executive level FTEs for commissioners is due to an expected return to the usual number of public meetings for FY 2027.*

TABLE C-5. Actual and projected staffing levels, FY 2006-2027

Fiscal year	Number of full-time equivalent positions^a
2006	35
2007	34
2008	32
2009	34
2010	35
2011	37
2012	37
2013	36
2014	35
2015	34
2016	36
2017	35
2018	33
2019	35
2020	33
2021	32
2022	33
2023	34
2024	33
2025	35
2026	36
2027	38 ^b

Note: Reflects full-year full-time equivalent (FTE) average number of positions.

^aThe total FTE level includes 2 FTEs representing the part-time work of the 17 commissioners, with the exception of 2026, where the part-time work of the 17 commissioners equaled 1 FTE due to a lapse in appropriations that resulted in two fewer public meetings during the fiscal year.

^bThe number of FTEs for fiscal year 2027 is projected.

TABLE C-6. Budget estimates and appropriations, FY 2008–2027

Fiscal year	Budget estimate to the Congress	Appropriation
2008 ^a	\$10,748,000	\$10,560,000
2009	\$11,403,000	\$11,403,000
2010	\$11,800,000	\$11,800,000
2011 ^b	\$12,749,000	\$12,425,000
2012 ^c	\$13,100,000	\$11,778,000
2013 ^d	\$12,210,000	\$11,162,000
2014	\$12,087,000	\$11,519,000
2015	\$12,300,000	\$11,749,000
2016	\$12,100,000	\$11,925,000
2017	\$12,234,000	\$11,925,000
2018	\$12,295,000	\$12,545,000
2019	\$12,471,000	\$12,545,000
2020	\$12,645,000	\$12,545,000
2021	\$13,142,000	\$12,905,000
2022	\$13,310,000	\$13,292,000
2023	\$13,440,000	\$13,824,000
2024	\$13,824,000	\$13,824,000
2025	\$14,477,000	\$13,824,000
2026	\$14,673,000	\$14,673,000
2027	\$15,048,000	

^a For fiscal year (FY) 2008, the Commission received an appropriation of \$10,748,000 that was reduced to \$10,560,000 by an across-the-board rescission.

^b For FY 2011, the Commission received an appropriation of \$12,450,000 that was reduced to \$12,425,000 by an across-the-board rescission.

^c For FY 2012, the Commission received an appropriation of \$11,800,000 that was reduced to \$11,778,000 by a rescission.

^d FY 2013 reflects the appropriated amount after the sequester.

APPENDIX D: Commission members, 2025-2026

The Commission’s 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the U.S. Comptroller General. Appointments are staggered; the terms of five or six commissioners expire each year.

Member and affiliation	Appointed	Term expiration
Michael Chernew, Ph.D.^a Chair Harvard Medical School Boston, MA	5/21/2020	4/30/2026
Betty Rambur, Ph.D., R.N., F.A.A.N.^a Vice Chair University of Rhode Island Kingston, RI	5/21/2020	4/30/2026
Brian Miller, M.D., M.B.A., M.P.H. Johns Hopkins University Baltimore, MD	5/31/2023	4/30/2026
Cheryl Damberg, Ph.D.^a RAND Corporation Santa Monica, CA	5/26/2022	4/30/2027
Gina Upchurch, R.Ph., M.P.H.^a Senior PharmAssist Durham, NC	5/31/2023	4/30/2027
Gokhan Metan, M.Sc., Ph.D., NACD.DC WiseCare AI Inc.; Catalight St. Louis, MO	5/29/2025	4/30/2028
Gregory Poulsen, M.B.A.^a Intermountain Healthcare Salt Lake City, UT	5/26/2022	4/30/2028

Joshua Liao, M.D., M.Sc. University of Texas Southwestern Medical Center Dallas, TX	5/29/2024	4/30/2027
Kenny Kan, F.S.A., C.P.A., C.F.A., M.A.A.A.^a Horizon Blue Cross Blue Shield Newark, NJ	5/26/2022	4/30/2028
Lynn Barr, M.P.H.^a Barr-Campbell Family Foundation Lahaina, HI	6/2/2021	4/30/2027
Paul Casale, M.D., M.P.H. Weill Cornell Medical College New York, NY	5/30/2024	4/30/2027
Robert Cherry, M.D., M.S.^a University of California Health; UCLA Health Los Angeles, CA	5/26/2022	4/30/2028
R. Tamara Konetzka University of Chicago Chicago, IL	5/31/2023	4/30/2026
Scott Sarran, M.D., M.B.A.^a Harmonic Health; Triple Aim Geriatrics Cook County, IL	5/26/2022	4/30/2028
Stacie B. Dusetzina, Ph.D.^a Vanderbilt University School of Medicine Nashville, TN	6/2/2021	4/30/2027
Thomas Diller, M.D., M.M.M. AdventHealth Provider Network Maitland, FL	5/29/2025	4/30/2028
Wayne J. Riley, M.D.^a State University of New York Downstate Brooklyn, NY	5/21/2020	4/30/2026

^a Member was reappointed to a second term.

APPENDIX E: Recent Commission meetings and major agenda items

From October through September of each fiscal year, the Commission holds seven public meetings to develop and approve reports and make recommendations to the Congress. The Commission staff briefs the committees that have jurisdiction over Medicare, as well as CMS and MACPAC, before each meeting to ensure that those staff are informed of the items that compose each meeting's agenda.

The Commission contracts with the Ronald Reagan Building and International Trade Center in Washington, DC, as the venue for our live-streamed public meetings, given our statutory mandate to hold deliberations in public. Throughout FY 2025, each live-streamed session was viewed by approximately 150 to 300 attendees. There is broad interest from staff on the committees with jurisdiction over Medicare, stakeholders across the country, other government personnel, and members of the public to continue to view the Commission's deliberations virtually.

October 10-11, 2024

- Medicare beneficiaries in nursing homes
- Findings from MedPAC's annual beneficiary and provider focus groups
- Supplemental benefits in Medicare Advantage
- Work plan for a mandated final report on the impact of recent changes to the home health prospective payment system
- Initial estimates of home health care use among Medicare Advantage enrollees

November 7-8, 2024

- Reforming physician fee schedule updates and improving the accuracy of payments
- Considering the participation bonus for clinicians in advanced alternative payment models
- Structural differences between the PDP and MA-PD markets
- Workplan: Assessing Medicare Advantage provider networks
- Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities

December 12-13, 2024

- Assessing payment adequacy and updating payments: Physician and other health professional services
- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; and mandated report on rural emergency hospitals

- Assessing payment adequacy and updating payments: Skilled nursing facility services
- Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services
- Assessing payment adequacy and updating payments: Home health care services
- Assessing payment adequacy and updating payments: Hospice services
- Assessing payment adequacy and updating payments: Outpatient dialysis services

January 16-17, 2025

- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services
- Assessing payment adequacy and updating payments: Physician and other health professional services
- Assessing payment adequacy and updating payments: Hospice services
- Assessing payment adequacy and updating payments: Outpatient dialysis services
- Assessing payment adequacy and updating payments: Skilled nursing facility services
- Assessing payment adequacy and updating payments: Home health agency services
- Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services
- The Medicare Advantage program: Status report
- Medicare prescription drug program (Part D): Status report
- Reducing beneficiary cost-sharing for outpatient services at critical access hospitals
- Ambulatory surgical center services: Status report
- Eliminating Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities

March 6-7, 2025

- Reforming physician fee schedule updates and improving the accuracy of relative payment rates
- Reducing beneficiary cost sharing for outpatient services at critical access hospitals
- Background: Medicare insurance agents
- Preliminary work on Medigap
- Mandated report: Payment for ground ambulance services
- Examining home health care use among Medicare Advantage enrollees
- Institutional special needs plans

April 10-11, 2025

- Reforming physician fee schedule updates and improving the accuracy of relative payment rates
- Structural differences between the PDP and MA-PD markets
- Assessing the utilization and delivery of Medicare Advantage supplemental benefits
- Exploring the effect of Medicare Advantage on rural hospitals
- Paying for software technologies in Medicare
- Access to hospice and certain services under the hospice benefit for beneficiaries with end-stage renal disease and beneficiaries with cancer
- Regulations, star ratings, and FFS Medicare policies aimed at improving nursing home quality

September 4-5, 2025

- Medicare payment operations and improving payment accuracy
- Oversight needed to ensure Medicare's sustainability: A report from the Government Accountability Office
- Context for Medicare payment policy
- Access to hospice and certain services under the hospice benefit for beneficiaries with end-stage renal disease or cancer
- The association between changes in Medicare Advantage enrollment and hospital finances

The October and November 2025 meetings were cancelled due to a lapse in appropriations.

December 4-5, 2025

- 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
- Post-acute care: Trends and key issues
- Assessing payment adequacy and updating payments: Skilled nursing facility services
- Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services
- Assessing payment adequacy and updating payments: Home health care services
- Assessing payment adequacy and updating payments: Hospice services
- Assessing payment adequacy and updating payments: Outpatient dialysis services

- Improving Medicare’s payment approaches
- Mandated report: The impact of recent changes to the home health prospective payment system
- Mandated report: Assessment of the Medicare ground ambulance data collection system

January 15-16, 2026

- Assessing payment adequacy and updating payments: Physician and other health professional services
- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services
- Assessing payment adequacy and updating payments: Skilled nursing facility services
- Assessing payment adequacy and updating payments: Home health agency services
- Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services
- Assessing payment adequacy and updating payments: Outpatient dialysis services
- Assessing payment adequacy and updating payments: Hospice services
- Mandated report: The impact of recent changes to the home health prospective payment system
- Analyzing recent increases in Part D bids
- Medicare prescription drug program (Part D): Status report
- Ambulatory surgical centers: Status report
- The Medicare Advantage program: Status report
- Mandated report: Dual-eligible special-needs plans

March 2-3, 2026

- Mandated report: Assessment of the Medicare ground ambulance data collection system
- Access to hospice and certain complex palliative services for beneficiaries with end-stage renal disease and beneficiaries with cancer
- Provider participation in Medicare Advantage networks
- Considerations for implementing Medicare Advantage encounter data in risk adjustment
- The complexity of Medicare enrollment decisions for beneficiaries
- Medicare Part B premium Payment Basics

The Commission plans to meet in April of 2026 to complete its 2025–2026 public meeting cycle.

APPENDIX F: Congressionally mandated and formally requested reports

In addition to our standing annual reports to the Congress, the Commission publishes specific reports that directly respond to congressional mandates in legislation or formal requests as listed below.

Published reports

Mandate	Consolidated Appropriations Act, 2021: Review payments to rural emergency hospitals (recurring annually)
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Publish date: March 15, 2025

Description: In our March 2024 report to the Congress, the Commission described the historical context that led to the creation of rural emergency hospitals (REHs) and the characteristics of the first cohort of REHs. In the March 2025 report, MedPAC provided updated information on the number of REHs and payments made from fee-for-service Medicare to REHs in the first full year that the designation was available.

Mandate	Affordable Care Act of 2010: Review Medicaid use and spending and non-Medicare margins in nursing homes (recurring annually)
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Publish date: March 15, 2025

Description: Almost all skilled nursing facilities (SNFs) are also long-term care nursing facilities, and Medicaid finances most long-term care services provided in SNFs. Some state programs also cover the SNF copayments for beneficiaries who are dually eligible for Medicare and Medicaid and who stay more than 20 days in a SNF. MedPAC reports on nursing facility spending trends for Medicaid and financial performance for non-Medicare payers. Beginning in 2012, as part of our March report, we include a review of aggregate trends in spending, utilization, and financial performance under the Medicaid program under title XIX and the private market for health care services.

Congressional request

House Appropriations Committee Report, FY 2025: Differential coding in Medicare fee-for-service (FFS)

Publish date:

March 15, 2025

Description:

A report requested by the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies on estimating the extent to which different incentives result in different relative rates of diagnostic coding for Medicare Advantage (MA) and FFS beneficiaries and the extent to which such coding differences may result in payment differentials between MA and FFS.

Congressional request

House Appropriations Committee Report, FY 2025: Medicare beneficiaries' access to care

Publish date:

March 15, 2025

Description:

A report requested by the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies on Medicare beneficiaries' access to care, including the share of primary care providers that refuse to accept or limit the acceptance of new Medicare patients and data on Medicare patients' wait times for visits with new primary care providers.

Mandate

Consolidated Appropriations Act, 2021: Review payments to rural emergency hospitals (recurring annually)

Publish date:

March 15, 2026

Description:

MedPAC's required annual report on payments to rural emergency hospitals (see above).

Mandate

Affordable Care Act of 2010: Review Medicaid use and spending and non-FFS Medicare margins in nursing homes (recurring annually)

Publish date:

March 15, 2026

Description:

MedPAC's required annual review of aggregate trends in spending, utilization, and financial performance under the

Medicaid program under title XIX and the private market for health care services (see above).

Mandate **BBA of 2018: Effects of home health payment reform**

Publish date: March 15, 2026 (Final report)

Description: Final report on the application of a 30-day unit of service for home health payment.

Mandate **BBA of 2018: Performance of special needs plans (SNPs) (recurring biennially)**

Publish date: March 15, 2026

Description: A study on the performance of MA special needs plans (SNPs). Initial report due March 15, 2022, and mandated biennially thereafter through 2032 and every five years beginning in 2033.

Pending reports

Mandate **BBA of 2018, as updated by the Consolidated Appropriations Act, 2022: Costs of providing ambulance services**

Due date: June 15, 2026

Description: A report on information submitted by providers and suppliers of ground ambulance services through the data collection system, the adequacy of payments for ground ambulance services, and geographic variations in the cost of furnishing such services.

Mandate **BBA of 2026: Agreements with pharmacy benefit managers**

Due date: Two years after the data become available (Initial report)

Description: A report on the agreements with pharmacy benefit managers with respect to prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs).

Mandate **BBA of 2026: Agreements with pharmacy benefit managers**

Due date: Two years following publication of the initial report (Final report)

Description: A report updating information on the agreements with pharmacy benefit managers with respect to PDPs and MA-PDs and changes over time.

APPENDIX G: MedPAC's products in fiscal year 2025

In fiscal year 2025, the Commission completed all requested/mandated reports and presented them to the Congress in accordance with statutory deadlines.

March 2025 report to the Congress

On March 13, 2025, the Commission submitted our annual mandated report to the Congress on Medicare payment policy, complying with a statutory requirement each year to provide the Congress with recommendations on whether and how to update Medicare's payments to different providers and the rationale for our recommendations. The report addressed the following areas:

- Assessing payment adequacy and updating payments for hospital inpatient and outpatient services, physician and other health professional services, outpatient dialysis services, skilled nursing facility services, home health services, inpatient rehabilitation facility services, and hospice services;
- The status of ambulatory surgical center services;
- The status of Medicare's Part D prescription drug benefit;
- The status of the Medicare Advantage (MA) program;
- Technical appendixes on estimating MA coding intensity and favorable selection; and
- Eliminating Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities.

To fulfill a statutory requirement, this report also included our annual chapter on the budgetary context for Medicare payment policy. It also included:

- A report mandated by the Consolidated Appropriations Act, 2021, to review data on payments to rural emergency hospitals.
- A report mandated by the Affordable Care Act of 2010 to review Medicaid use and spending and non-FFS Medicare margins in nursing homes.
- A report requested by the House Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies' FY 2025 committee report to analyze differences in diagnostic coding between the Medicare fee-for-service and Medicare Advantage programs.
- A report requested by the House Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies' FY 2025 committee report to analyze Medicare beneficiaries' access to care—including data on Medicare patients' wait times for visits with new primary care providers.

June 2025 report to the Congress

On June 12, 2025, the Commission submitted our annual mandated report to the Congress on Medicare and the health care delivery system. This report focused on broad questions confronting the Medicare program, as well as more sector-specific issues, and fulfilled a statutory requirement to each year provide the Congress with a report examining the issues facing the Medicare program. Topics included:

- Reforming physician fee schedule updates and improving the accuracy of relative payment rates;
- Supplemental benefits in MA;
- Examining home health care use among MA enrollees;
- Part D prescription drug plans for beneficiaries in fee-for-service Medicare and MA;
- Medicare beneficiaries in nursing homes;
- Medicare’s measurement of rural provider quality; and
- Reducing beneficiary cost sharing for outpatient services at critical access hospitals.

A Data Book: Health Care Spending and the Medicare Program

MedPAC’s Data Book, published in July 2025, provides tables and graphs describing the Medicare program, Medicare beneficiaries and their utilization of health care services, and Medicare’s payment systems. The first edition of MedPAC’s Data Book was published over 20 years ago in response to discussions with congressional staff members regarding ways that MedPAC can better support them.

Payment Basics

Payment Basics, published in October 2024, is a series of brief overviews of how 20 of Medicare’s payment systems function.

MedPAC comments on CMS regulations

In addition to our mandated reports, during the past year, the Commission has submitted written comments on 10 proposed rules. Our comment letters serve as a resource for both committee staff and CMS, providing a stronger understanding of the proposed regulations and their larger potential policy implications, and are all posted on our website. The proposed rules on which the Commission submitted comments are listed below:

- Proposed rule on policy and technical changes to the MA Program and Medicare Prescription Drug Benefit Program for 2026 (01/27/2025)
- Advance notice of methodological changes for CY 2026 for MA capitation rates and Part C and D payment policies (02/10/2025)

- Proposed rule on hospice for FY 2026 (06/09/2025)
- Proposed rule on skilled nursing facilities for FY 2026 (06/09/2025)
- Proposed rule on inpatient rehabilitation facilities for FY 2026 (06/09/2025)
- Proposed rule on inpatient prospective payment systems for FY 2026 (06/09/2025)
- Proposed rule on the home health prospective payment system for CY 2026 (08/26/2025)
- Proposed rule on the payment system for end-stage renal disease for CY 2026 (08/29/2025)
- Proposed rule on CY 2026 revisions to payment policies under the physician fee schedule and other changes to Part B payment policies (09/11/2025)
- Proposed rule on the payment systems for hospital outpatient departments and ambulatory surgical centers for CY 2026 (09/12/2025)

In 2026, the Commission expects to comment on between 10 to 15 proposed rules, regulations, and other requests for information from CMS; it expects to comment on a similar number for 2027.

Professional conference participation

In 2025, Commission staff extended public outreach by presenting MedPAC’s work at two professional conferences and one professional webinar.

MedPAC staff presented work at AcademyHealth’s Annual Research Meeting in Minneapolis, MN. Five analysts presented work that the Commission has discussed and published. The following analyses were presented and are posted on MedPAC’s website:

- “Examining Medicare Advantage Enrollees’ Home Health Utilization”
- “Assessing the Utility of Medicare Advantage (MA) Encounter Data for Analyzing the Use of Supplemental Benefits”
- “How Do Differences in Diagnostic Coding Intensity Affect Payments to Medicare Advantage Plans and Stand-Alone Prescription Drug Plans for Part D Benefits?”
- “The Use of Prior Authorization in Medicare Advantage, 2021-2023”
- “The Effect of Medicare Advantage on Hospital Profitability”

MedPAC staff presented work at the annual National Rural Health Association and Federal Office of Rural Health Policy conference. Two analysts presented work on rural health payment policy.

MedPAC staff also presented work at the National Cancer Institute’s webinar titled: Using Data from CMS to Measure Cancer-Related Care and Outcomes in Medicare

Advantage. One analyst presented work on Medicare Advantage encounter data completeness, diagnostic coding intensity, and favorable selection.

Members of staff will continue to reach out to external groups through professional and academic meetings. Such efforts increase staff knowledge of Medicare policy and research and promote transparency of the Commission's work.

APPENDIX H: Primary source data collection

Gathering primary source data and information is an essential activity for the Commission to fulfill our statutory mission. To that end, the Commission engages in a wide range of primary source data collection efforts, including meeting with key stakeholders, such as individual health care providers, associations of health care providers, beneficiaries, and experts in health care policy and medicine; purchasing non-Medicare proprietary data; conducting a national survey of Medicare beneficiaries; convening focus groups with beneficiaries and providers; and conducting site visits to various health care providers to better understand their experience with the Medicare program.

National survey of beneficiaries

Every year, MedPAC fields a survey to assess beneficiaries' reported access to clinician care. The Commission surveys about 5,000 Medicare beneficiaries ages 65 and over and more than 5,000 privately insured people ages 50 to 64. Survey data are weighted to produce nationally representative results, which are available to us within two months of fielding. The survey provides insight into beneficiary access to care and use of health care services relative to privately insured patients. Findings from this survey are key to our annual assessment of the adequacy of Medicare payments to clinicians.

Focus groups with beneficiaries

Each year, the Commission holds focus groups with Medicare beneficiaries and clinicians. These focus groups provide context to help us better understand the experiences and perspectives of Medicare beneficiaries and providers. Focus groups create opportunities to ask questions that help explain the “how” and “why” of experiences not easily answered through quantitative analysis. In fiscal year 2025, the Commission conducted eight focus groups with Medicare beneficiaries and clinicians. Seven of the focus groups took place in St. Louis, MO. The eighth focus group was virtual and included Medicare beneficiaries residing in rural areas across the United States.

Dialogue with stakeholder groups

In fiscal year 2025, the Commission met with over 100 stakeholder groups. A partial list of the groups the Commission met with in 2025 is included in [Appendix K](#). In 2026, members of the Commission staff will continue to meet with outside groups in order to gather insights to inform MedPAC's findings and recommendations. These interactions are supplemented by written statements submitted by stakeholders to Commission members and staff following our public meetings. Written comments are

distributed to MedPAC commissioners and staff and posted on our website for the public.

Site visits

To increase our understanding of the health care market and the impact of Medicare payment policy on providers, Commission staff make annual site visits to a range of providers across the country, visiting different locations and types of facilities each year. In 2025, staff conducted site visits in West Virginia to interview administrators and staff at rural hospitals. Staff also conducted site visits to interview hospices about their care for beneficiaries with end-stage renal disease and cancer.

APPENDIX I: Recently completed and ongoing research contracts

Research projects funded through contracts cover a variety of issues, including updating quality indicators, cost predictors in several settings, access to care, and more. Specific contracts in fiscal year 2025 include:

Completed

- Analysis of skilled nursing facility case-mix indexes by payer

Ongoing

- Updating Part D price indexes and exploring a new index to measure the effects of launch prices
- Analysis of coverage and generosity of Part D plan formularies
- Analysis of national pharmacy trends
- Evaluation of Patient-Driven Groupings Model
- Updating Part B drug price indexes and analyzing Part B drug spending growth decomposition
- Study of hospices' effect on Medicare spending
- Examining the effects of multiple policy changes on the physician fee schedule relative value units and spending
- Analysis of Medicare Advantage encounter data pricing

Recurring

- Focus groups on beneficiary and clinician perspectives on Medicare and other issues (annual)

APPENDIX J: Adoption of MedPAC recommendations

MedPAC recommendations have informed Medicare policy set by the Congress and CMS on a range of issues. It is difficult to quantify the degree to which our recommendations are adopted because many are adopted with modifications. However, recent legislation has included key provisions that reflect the Commission's recommendations and advice. In addition, CMS has adopted several of the Commission's recommendations through its rulemaking process. Selected policies adopted into law and made through rulemaking since 2018 are listed below.

MedPAC recommendations adopted into law

Consolidated Appropriations Act, 2026

The Consolidated Appropriations Act, 2026 (CAA, 2026), included two provisions consistent with policy ideas that the Commission discussed and recommended.

Extension of certain telehealth flexibilities

The Commission's March 2021 report included a policy option to extend Medicare's telehealth flexibilities for a limited duration following the end of the public health emergency (PHE). CAA, 2026, extended Medicare telehealth flexibilities through the end of December 2027, about four and a half years after the end of the PHE, directionally consistent with the Commission's March 2021 policy option.

Adjustments to Medicare Part D cost-sharing reductions for low-income individuals

In our June 2016 report to the Congress, MedPAC recommended changes to Part D's low-income subsidy (LIS) to modify cost sharing to encourage the use of generic drugs, preferred multisource drugs, or biosimilars, when available. CAA, 2026, modified cost sharing for beneficiaries who receive the LIS, directionally consistent with the Commission's recommendation.

Inflation Reduction Act of 2022

The Inflation Reduction Act of 2022 (IRA) included two provisions consistent with policy ideas that the Commission discussed and recommended.

Restructuring the Medicare Part D benefit above the out-of-pocket threshold

In our June 2020 report, the Commission made recommendations on restructuring the Part D benefit to cap enrollees' out-of-pocket spending so that plans appropriately take on greater insurance risk. This recommendation intended to bring the benefit back to its original approach of using more risk-based payments with stronger incentives for plans to manage benefit spending. The IRA lowered enrollee cost sharing to 0 percent, raised plan liability for both brands and generics to 60

percent, and lowered Medicare reinsurance for brands to 20 percent and to 40 percent for generics. These provisions are directionally consistent with the Commission's June 2020 recommendations.

Modifying the average sales price system

In our June 2017 report, the Commission made recommendations on modifying the Part B drug average sales price (ASP) system. The IRA requires manufacturers to pay Medicare a rebate when the ASP for their product exceeds an inflation benchmark and ties beneficiary cost sharing to the inflation-adjusted ASP, starting in 2023. This policy is consistent with the Commission's June 2017 recommendation.

Consolidated Appropriations Act, 2022

The Consolidated Appropriations Act, 2022, extended Medicare telehealth flexibilities for five months following the end of the PHE, directionally consistent with the Commission's March 2021 policy option to extend Medicare's telehealth flexibilities for a limited duration following the end of the PHE.

Consolidated Appropriations Act, 2021

The Consolidated Appropriations Act, 2021, created a new hospital designation, the rural emergency hospital, consistent with the Commission's June 2018 recommendation.

Bipartisan Budget Act of 2018

The Bipartisan Budget Act (BBA) of 2018 contained several provisions consistent with policy ideas that the Commission has discussed and recommended, including:

Sunsetting the exclusion of biosimilars from the Medicare Part D coverage-gap discount program

In our March 2018 report, the Commission made recommendations to remove the financial incentives that favor originator products and to promote price competition between originator products and biosimilars, which could reduce Part D prices over time. The BBA provision is consistent with the Commission's March 2018 recommendations.

Establishing an enrollment-weighted method of determining star ratings when Medicare Advantage (MA) contract consolidations occur

In our March 2018 report, the Commission made recommendations to prevent certain MA contract consolidations from affecting plan quality ratings and bonus payments. The BBA provision is consistent with the Commission's March 2018 recommendations.

Eliminating the number of therapy visits as a payment factor in the home health prospective payment system (PPS) beginning in 2020

The Commission had long recommended that the number of therapy visits be eliminated as a factor in payment determinations (most recently in our March 2018 report).

Basing a modified Medicare low-volume hospital payment adjustment on total discharges, rather than Medicare discharges only

In our June 2012 report to the Congress on serving rural Medicare beneficiaries (mandated by the Patient Protection and Affordable Care Act of 2010), the Commission discussed the importance of targeting payments to providers in order to improve access while using Medicare spending efficiently. The BBA provision mandating the use of total discharges to measure patient volume is consistent with these goals.

Updating special needs plan (SNP) policy

Consistent with a set of recommendations the Commission made in our March 2013 report, CMS permanently reauthorized institutional SNPs (I-SNPs), narrowed the conditions eligible for chronic condition SNPs (C-SNPs), expanded the existing Center for Medicare & Medicaid Innovation (CMMI) Value-Based Insurance Design Model (allowing for MA benefit design flexibility), required the Secretary to develop a unified grievances and appeals process for dually eligible beneficiaries, and imposed more stringent standards to demonstrate dual-eligible SNP integration.

Reforming the home health rural add-on payment to better target extra Medicare payments

In our March 2017 report, the Commission concluded that the home health rural add-on payment was poorly targeted. The BBA of 2018 provision aims to better target the add-on payments, which helps to address the Commission's concerns.

Establishing an Accountable Care Organization (ACO) Beneficiary Incentive Program to allow certain two-sided-risk ACOs to make incentive payments to assigned beneficiaries

The Commission has supported giving ACOs more options for incentivizing beneficiaries to use providers within their ACO.

Expanding access to telehealth services in MA and ACOs for end-stage renal disease (ESRD) beneficiaries and for stroke patients

In our March 2018 report on telehealth (mandated by the 21st Century Cures Act), the Commission articulated a set of principles (cost, access, and quality) to evaluate individual telehealth services before adoption into Medicare coverage, and discussed telestroke, MA plans, and ACOs as examples where greater flexibility may be desirable.

Requiring ground ambulance providers to submit cost reports

In our June 2013 report on the ambulance fee schedule (mandated by the Middle Class Tax Relief and Job Creation Act of 2012), the Commission supported requiring ground ambulance providers to submit cost reports.

MedPAC recommendations adopted through CMS's rulemaking process

- The MA/Part D proposed rule for calendar year 2027 requested comment on simplifying and refocusing the star ratings measure set on clinical care, outcomes, and patient experience, citing the Commission's 2020 recommendation.
- The hospital outpatient prospective payment system (OPPS) final rule for fiscal year (FY) 2026 expanded its site-neutral payment policy to drug administration services provided in most excepted off-campus provider-based departments, directionally consistent with the Commission's June 2023 recommendation.
- The physician fee schedule (PFS) final rule for calendar year (CY) 2026 reduced work relative value units (RVUs) for most non-time-based codes using an efficiency adjustment of -2.5 percent, consistent with discussions in the Commission's June 2018 chapter.
- The PFS final rule for CY 2026 reduced practice expense RVUs for facility-based services and redistributed them to all other services, consistent with the Commission's June 2025 report stating that many facility-based services are overvalued.
- Beginning on January 1, 2026, CMS expanded the Durable Medical Equipment, Prosthetic/Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) to include ostomy, tracheostomy, and urologic supplies, consistent with the Commission's June 2018 report to the Congress that supported the expansion of the DMEPOS CBP.
- The MA/Part D final rule for CY 2024 further limited insurers' ability to offer dual-eligible SNP (D-SNP) "look-alike" plans (traditional MA plans targeted at dually eligible beneficiaries), consistent with the Commission's June 2019 chapter on promoting integration in D-SNPs.
- The hospital inpatient prospective payment systems (IPPS) final rule for FY 2023 changed the calculation of the IPPS outlier fixed loss amount, consistent with the Commission's comment to modify the approach to account for the number of costly COVID-19 cases in FY 2021.

- The PFS final rule for CY 2023 required clinicians to use a claims modifier to identify all audio-only telehealth services, consistent with the Commission’s March 2022 recommendation.
- The PFS proposed rule for CY 2023 requested comment on incorporating an administrative benchmark approach to the Medicare Shared Savings Program (MSSP), consistent with discussions in MedPAC’s June 2022 report to the Congress.
- Beginning on January 1, 2021, CMS expanded the DMEPOS CBP to include off-the-shelf knee and back braces. The Commission supported shifting such DMEPOS products from the DME fee schedule to the CBP in our June 2018 report to the Congress.
- The MA and Part D final rule for CY 2021 implemented restrictions for D-SNP “look-alike” plans. In our June 2019 report to the Congress, the Commission raised concerns over the growing use of look-alike plans to circumvent D-SNP requirements.
- In the final rule updating the Medicare payment rates and the value-based purchasing program for skilled nursing facilities (SNFs) for FY 2020, CMS implemented a new case-mix system. The Commission began discussing needed reforms to the SNF PPS in our June 2007 report, and the following year recommended a design to base payments on patient characteristics and to better target payments for nontherapy ancillary services.
- The hospital OPPS final rule for CY 2019 implemented site-neutral payment for evaluation and management clinic visits provided in off-campus hospital outpatient departments and freestanding physician offices. In 2012 and 2014, the Commission recommended that the Congress reduce or eliminate differences in payment rates between hospital outpatient departments and physician offices.
- In the 2019 MA and Part D rate announcement and call letter, CMS adjusted the payment rate for MA employer group waiver plans so that the payments are more consistent with how comparable non-employer plans are paid. The Commission recommended this adjustment in our March 2014 report to the Congress.
- The physician fee schedule final rule for CY 2019 reduced the add-on percentage for certain Part B drugs paid based on wholesale acquisition cost (WAC) from 6 percent to 3 percent. The Commission recommended this policy in our June 2017 report to the Congress.

APPENDIX K: Meetings with external groups

In 2025, as in previous years, MedPAC worked collaboratively with other government entities involved in assessing and implementing the Medicare program. These interactions include exchanging information about health service delivery, quality measurement, and other topics. These collaborations are mutually valuable and contribute to greater coordination and minimized redundancy among government initiatives. MedPAC also spends a substantial amount of staff time meeting with stakeholder organizations to gather data and information and to be accessible to these groups. These meetings may be initiated by MedPAC, interested stakeholder organizations, or through referrals to MedPAC by congressional staff. Below is a list of some of the government entities and stakeholder groups with whom Commission staff met in 2025.

Collaboration with other government entities

Congressional support agencies

Coordination and consultation with the Medicaid and CHIP Payment and Access Commission (MACPAC), the Congressional Budget Office, the Congressional Research Service, and the Government Accountability Office.

Centers for Medicare & Medicaid Services (CMS)

Monthly briefings on a range of issues, as well as ad hoc meetings to discuss specific topics such as coding intensity calculations, actuarial estimates, and other Medicare policy issues; consultations with the Center for Medicare and Medicaid Innovation and the Office of the Actuary.

Agencies within the Department of Health and Human Services

Discussions with the Office of Inspector General, the Health Resources and Services Administration, the Federal Office of Rural Health Policy, and state health departments.

MedPAC meetings with stakeholder organizations

- AccentCare
- Alliance for Health Policy
- Alliance for Home Dialysis
- Alliance for Physical Therapy Quality and Innovation
- Alliance for Value Based Care
- American Ambulance Association
- American Association of Actuaries
- American Association of Colleges of Osteopathic Medicine
- American Association of Nursing Anesthesiology

- American Association of Provider Compensation Professionals
- American College of Mohs Surgery
- American Health Care Association
- American Hospital Association
- American Medical Association
- American Medical Rehabilitation Providers Association
- American Psychological Association
- AmeriLife
- Association for Accessible Medicines
- Association for Air Medical Services
- Association of American Medical Colleges
- ATI Advisory
- The Baldwin Group
- BAYADA Home Health Care
- Berkeley Rural Health Policy Fellowship
- Blue Cross Blue Shield Association
- Boomer Benefits
- The Brookings Institution
- Brown University
- California Hospital Association
- Chapter Medicare Broker
- City of Woodland
- Click Therapeutics
- Common Spirit Health
- CommuniCare
- Curana Health
- DaVita
- Digital Diagnostics
- Dignity Health
- Elevance Health
- Excellus
- Eyenuk
- Forvis Mazars Group
- Global Medical Response
- Graham Spaulding
- GU/32BJ Health Fund
- Hawaii Medical Service Association
- Hawaii State Health Planning and Development Agency
- Health Net
- HeartFlow
- Horizon Government Affairs
- Humana
- Indiana University
- International Association of Fire Fighters
- Interwell
- Johns Hopkins University
- Jukebox Health
- Kaiser Permanente
- Leading Age
- Longevity Health
- Maryland Department of Health
- McDermott
- Medicare Answers Now
- Medicare Solutions
- Mercy Medical Group
- Milliman
- MJ Simson & Company
- National Alliance for Care at Home
- National Alliance for Chronic Disease Directors
- National Association of Benefit and Insurance Professionals
- National Association of Long-term Care Hospitals
- National Comprehensive Cancer Network
- National Home Infusion Association
- National Partnership for Healthcare and Hospice Innovation
- National Rural Health Association
- NBC Universal
- Perspectum
- Phillips
- Project PAUSE
- RAND
- Roseville Sutter Medical Center
- Sacramento Metropolitan Chamber of Commerce
- Sacramento Valley Medical Society
- SCAN Health Plans

- Senior Marketing Specialists
- Sirona Strategies
- SNP Alliance
- Social and Scientific Systems
- Sound LTC Management
- Spurgeon Manor Nursing Home
- Strive
- Sutter Health
- Touchstone Communities
- UC Davis Health
- University of Minnesota
- University of Southern California
- Urban Institute
- US Renal
- Vanderbilt University
- The Vascular Care Group
- Volunteers of America
- Wellspace Health FQHC
- West Virginia Hospital Association
- 1-800-Medicare