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MedPAC Releases June 2026 Report to Congress

On June 15, 2026, the Medicare Payment Advisory Commission (MedPAC) released its June 2026 Report to Congress, which included the following chapters:

- Improving payment incentives in Medicare,
- The complexity of Medicare enrollment decisions for beneficiaries,
- Medicare payment operations and their role in identifying improper payments,
- Estimated association between MA enrollment and hospitals' and post-acute care (PAC) providers' finances, and
- Access to hospice and certain complex palliative services for beneficiaries with end-stage renal disease (ESRD) or cancer.

The full report is available here.

MEDPAC EXAMINES IMPROVEMENTS TO PAYMENT INCENTIVES IN MEDICARE

The Commission examined how Medicare's three major payment approaches (fee-for-service (FFS), alternative payment models (APMs), and Medicare Advantage (MA)) create different incentives that affect spending, care delivery, and beneficiary access. Medicare spending is a growing concern, with total spending of $1.1 trillion in 2024, equal to 3.8 percent of GDP, and projected to exceed 5 percent of GDP by 2032. Such growth strains the federal budget, national tax revenues, and beneficiary premiums. Major drivers of this increased spending include expansion in volume and clinical intensity of services, particularly Part B services and physician-administered drugs.

FFS Medicare

MedPAC finds that FFS Medicare gives beneficiaries broader provider access while incentivizing providers to deliver more services, as payment is often tied to each item, service, or stay. This, in turn, increases low-value and fragmented care, as well as spending in higher-cost settings. FFS Medicare also lacks an annual out-of-pocket limit, which can expose beneficiaries without supplemental coverage to high costs.
The Commission recommends lowering the cost-sharing for high-value care while maintaining it for low-value care, adding an annual out-of-pocket limit, improving

payment rate accuracy, applying a charge on supplemental coverage, and expanding site-neutral payment for services that can be safely provided in outpatient settings.

Alternative Payment Models

APMs are intended to improve FFS Medicare by encouraging providers to coordinate care, reduce low-value services, and manage spending while maintaining quality. The success of APMs has been assessed as mixed. Some models have generated modest savings, while others have produced little or no savings once bonus payments are included.

The Commission raises concerns that APM spending targets may be inaccurate, while models may encourage coding intensity or favorable selection, and financial incentives may not always reach individual clinicians. Thus, the Commission recommends operating fewer, more coordinated models, improving benchmarks and spending-target methods, and reducing opportunities for participants to increase payments without improving efficiency or quality.

Medicare Advantage

MA plans were found to have stronger incentives than FFS Medicare to manage care because they receive capitated payments and can use tools such as provider networks, prior authorization, referral requirements, and different cost-sharing designs. While these tools can help reduce unnecessary care and allow plans to offer supplemental benefits, they may also create access barriers if used too aggressively.

One of the Commission's concerns is that MA costs Medicare more than FFS Medicare would have for similar beneficiaries. After accounting for favorable selection and coding intensity, Medicare is estimated to spend 14 percent more (approximately $76 billion) on MA enrollees in 2026 than it would have spent had these enrollees been in FFS. To improve MA payment accuracy, the Commission recommends revising benchmarks, strengthening risk adjustment, improving encounter data and coding intensity accounting, and replacing the current quality bonus program with a value-based incentive program using fewer, population-based measures.

Overall Recommendations and Future Plans

The Commission emphasizes concerns that Medicare's current payment incentives can increase spending without improving quality or access. Moving forward, MedPAC will continue to review Medicare spending trends, FFS payment alignment, APM design, MA payment accuracy, MA plan incentives related to access and efficiency, and ways to reduce low-value care in FFS Medicare.

MEDPAC EXAMINES THE COMPLEXITY OF MEDICARE ENROLLMENT DECISIONS FOR BENEFICIARIES

In this chapter, MedPAC reviewed the complexity of Medicare enrollment decisions for beneficiaries and information sources commonly used for decision-making. When choosing coverage, beneficiary decisions include when to enroll, whether to choose FFS Medicare or MA, and whether to add on Part D coverage or purchase Medigap. Beneficiaries may struggle to compare these options because the choices affect cost, provider access, drug coverage, supplemental benefits, and future flexibility. Missing key deadlines can result in long-term financial penalties, underscoring the importance of clear enrollment information.

Enrollment Timing Complications

Individuals who receive Social Security benefits before age 65 are generally automatically enrolled in Part A and Part B. However, as the Social Security full retirement age has increased, more people become eligible for Medicare before they begin receiving Social Security benefits. These individuals must take action on their own during the correct enrollment window. Beneficiaries who miss key enrollment windows may incur long-term penalties for Part B or Part D coverage unless they qualify for special enrollment periods, such as employer-sponsored coverage.

Difficulty Weighing Trade-Offs Between FFS Medicare and MA

FFS Medicare generally offers broader provider access and fewer utilization-management requirements, but beneficiaries without another source of supplemental coverage may face higher out-of-pocket costs. MA plans may offer lower premiums, an annual out-of-pocket limit, prescription drug coverage, and supplemental benefits. However, MA enrollees also may face provider networks, prior authorization, and plan benefit changes from year to year. These trade-offs become especially important when beneficiaries' health needs change or when they want to switch coverage.

Switching Coverage

Switching coverage can be difficult for beneficiaries whose health needs change after initial enrollment. Moving from MA back to FFS Medicare can be costly if a beneficiary no longer has guaranteed access to Medicare coverage. In most states, Medigap insurers may deny coverage or charge higher premiums based on health status after the initial guaranteed-issue period ends. MedPAC found that beneficiaries in states with stronger Medigap protections were more likely to switch from MA to FFS after a serious diagnosis.

MA Marketing

MA marketing can also complicate decision-making, particularly when beneficiaries receive frequent advertisements, mailings, calls, or other outreach from plans and third-party marketing organizations. The report notes that some marketing may be misleading or fail to provide beneficiaries with enough information to choose the best plan for their needs. Complaints related to Medicare marketing have increased substantially in recent years, and agent compensation arrangements may create incentives that affect which plans are presented.

Sources of Information

Beneficiaries can use CMS tools, SHIP counseling, and insurance agents to aid their decision-making process. Though each resource has its limitations, insurance agents were particularly helpful for beneficiaries navigating the Medicare enrollment process. Many beneficiaries who participated in MedPAC's annual focus groups reported positive experiences when working with them to determine their premiums and out-of-pocket costs for various plans. Among Medicare beneficiaries aged 65 and older, around 30 percent on FFS and 31 percent on MA reported turning to agents for assistance, according to a 2022 Commonwealth survey. Medicare Plan Finder has improved by adding more information on MA provider networks and supplemental benefits, but gaps remain in provider directory accuracy, prior authorization details, supplemental benefit limits, and Medigap premium information. SHIP provides free and unbiased counseling, but funding has not kept pace with Medicare enrollment growth, and counselors are now facing more complex questions from beneficiaries.

Recommendations

The Commission expressed interest in continuing to improve Plan Finder, strengthen SHIP support, and develop technology-based tools, such as chatbots, plain-language plan materials, and personalized plan comparisons, as areas for continued review. Moving forward, the Commission intends to continue to monitor the issue and consider potential policy options.

MEDPAC DETAILS PAYMENT PROCESSES AND MEASURES TO IDENTIFY AND REDUCE IMPROPER PAYMENTS AND FRAUD

Improper payments are payments that should not have been made or were made in the incorrect amount. For fiscal year 2025, the Department of Health and Human Services (HHS) estimated the total improper Medicare payments at $56.7 billion, including $28.8 billion from FFS Medicare, $23.7 billion from MA, and $4.2 billion from Medicare Part D.

Processing FFS Medicare payments

CMS awards contracts to private entities called Medicare administrative contractors (MACs) to process claims for FFS beneficiaries in specific regions. In fiscal year 2023, MACs processed over 1.1 billion claims and paid out approximately $431.5 billion.

Detecting and preventing improper FFS Medicare payments

Prior to issuing payment, MACs verify beneficiary enrollment and perform front-end edits to ensure claims are accurate and complete. Claims are checked for duplicates or prior authorization numbers and evaluated for compliance with Medicare coverage and payment policies. National Correct Coding Initiative (NCCI) edits are applied to ensure claims do not contain items or services that should not be billed together.

CMS has established nationwide prior authorization requirements for certain services, though its use is generally limited to services that have experienced a substantial increase in volume or excess utilization.

To identify and reduce improper payments before they are made, MACs conduct prior authorization and pre-claim reviews.

- CMS recently launched the Wasteful and Inappropriate Service Reduction (WISeR) Model, which leverages artificial intelligence and machine learning to improve the prior-authorization process.
- CMS is testing whether pre-claim reviews for home health services (HHS) and inpatient rehabilitation facilities (IRFs) can decrease appeals and improve provider compliance with Medicare rules. While payments for home health services declined, other concurrent system changes prevented CMS from attributing the decrease to the demonstration. From 2023 to 2024, only a 4 percent change in the amount paid to IRFs in two states was observed.

CMS engages three types of contractors to perform additional claims reviews:

- The unified program-integrity contractors (UPICs) conduct medical-record reviews, data analysis, and investigations to detect improper payments, referring credible allegations of fraud to law enforcement. Investigations can be initiated by referrals from MACs or the Fraud Prevention System (FPS), which uses predictive analytics and data analysis to identify suspicious billing patterns.
- The recovery audit contractors (RACs) identify a wide variety of improper payments through post-payment audits. The RACs receive contingent fees from a portion of their overpayment recoveries. In fiscal year 2024, RAC audits uncovered $227.8 million in improper payments.

- The **supplemental medical review contractor (SMRC)** conducts nationwide medical reviews to determine whether claims follow coverage, coding, payment, and billing requirements.

Measuring improper payments in FFS Medicare

CMS uses Comprehensive Error Rate Testing (CERT) to measure improper payments in FFS Medicare. Between fiscal year 2012 and 2025, the improper payment rate declined from 12.7 percent to 6.6 percent; however, expenditures increased due to a rise in overall Medicare spending during this period. 68 percent of improper payments were attributed to insufficient or missing documentation. Error rates for DMEPOS suppliers (24.2 percent) were substantially higher than error rates for Part B and inpatient prospective payment systems hospital providers.

Assessing improper payments in MA

The MA program allows Medicare beneficiaries to receive benefits from private plans. Medicare pays insurers offering MA plans monthly capitated payments that are risk-adjusted using demographic and diagnostic information to account for differences in enrollees' expected costliness.

Improper payments are measured using the Medicare Part C improper-payment measurement (IPM), which assesses whether diagnosis codes for a random sample of a plan's enrollees are supported by medical documentation. In Fiscal Year 2025, CMS estimated a 6.1 percent error rate in payments to MA plans, representing $23.7 billion in improper payments.

CMS conducts risk-adjustment data-validation (RADV) audits, reviewing medical records to validate diagnosis codes used for risk-adjustment purposes. While the reporting of audit results from previous years has been delayed, recent results indicate that medical record discrepancies accounted for 85 percent of improper payments. CMS recently announced plans to expand RADV audits and published a schedule that would eliminate the backlog of RADV audits.

Assessing and reducing improper payments in Medicare Part D

Under Part D, private plans provide outpatient prescription drug coverage to Medicare beneficiaries. Part D plans receive cost-based reimbursements and monthly capitated amounts that are calculated based on bids that reflect plans' expected costs and are risk-adjusted using demographic and diagnostic information.

Medicare shares spending risk with Part D plans through (1) reinsurance, which covers a portion of costs for individuals with very high spending, and (2) risk corridors, which limit plans' losses and profits when spending differs from expected costs. In both arrangements, Medicare uses a reconciliation process to ensure final payment reflects

its actual financial responsibility. Reconciliation payments are calculated using spending data derived from prescription drug event (PDE) records.

To estimate improper Part D payments, HHS reviews a sample of PDE records for accuracy by comparing reported costs against supporting documentation. These error rates are extrapolated to the total Part D population to estimate the overall payment error rate. In payment year 2023, the Part D payment error rate was estimated to be 4.0 percent of program outlays, for a total of $4.2 billion in improper payments. Insufficient or missing documentation accounted for 75 percent of improper payments.

Fraud prevention, detection, and prosecution

Improper payments that are the result of intentional deception or misrepresentation of information submitted on claims are classified as fraud. Several entities are responsible for the prevention and detection of fraud, including the Center for Program Integrity (CPI), the Department of Health and Human Services Office of Inspector General (HHS OIG), the Department of Justice, the Health Care Fraud and Abuse Control (HCFAC) Program, the Health Care Fraud Partnership, and the Senior Medicare Patrol. OIG reported that its activities during fiscal year 2025 resulted in more than $19 billion in expected recoveries and receivables, $5.7 billion in investigative receivables, and $533 million in audit receivables, and the DOJ reported that it recovered more than $6.7 billion from the health care industry in fiscal year 2025.

Beyond the financial impact, fraudulent activities can expose patients to harmful or unnecessary medical interventions. Recent convictions illustrate the range of consequences that result from health care fraud, including physical injury and avoidable patient deaths. MedPAC cited a 2020 research paper showing that Medicare beneficiaries who received care from providers who were later excluded from Medicare for fraud, patient harm, or a revoked license experienced higher mortality and emergency-hospitalization rates.

ESTIMATED ASSOCIATION BETWEEN MA ENROLLMENT AND PROVIDERS' FINANCES

This chapter detailed the relationship between market-level MA penetration and the financial performance of hospitals and PAC providers. On average, no statistically relevant relation was found between MA enrollment and the all-payer operating margins of hospitals, skilled nursing facilities (SNFs), or home health agencies (HHAs). However, MA enrollees had an average hospital length of stay that was 11.2 percent longer than that of FFS beneficiaries, primarily due to delays in discharging patients to PAC settings. Staff also discussed a policy option to reform uncompensated care (UC)

payments, which the Commission asserts are currently mistargeted toward hospitals with higher shares of MA patients under the current FFS formula.

MedPAC conducted multiple hospital site visits and interviews with hospital representatives. Generally, the providers reported administrative burden and particularly high rates of claim denials and downgrades by MA plans relative to FFS Medicare, maintaining the view that MA growth has negatively impacted their finances. Hospital stakeholders also indicated that MA plans tend to increase hospital costs by extending inpatient stays and increasing staffing requirements to address insurance decisions and manage appeals.

MedPAC additionally investigated the impact of changes in MA enrollment on the current UC payment structure and the effect of MA penetration on hospital finances. UC payments are intended to aid hospitals disproportionately providing care to under-resourced populations. However, MedPAC maintains that the interaction between MA growth and the UC payment structure inadvertently undermines that goal. While the current UC payment structure may benefit hospitals with more MA patients, representatives from hospitals with extremely high FFS UC add-ons expressed concerns that MA plans have sought to exclude them from their networks, reflecting the broader issue of mistargeted UC payments. Overall, MedPAC found that UC payments became misdirected when UC dollars were shifted to hospitals based on their shares of Medicare patients in MA or FFS rather than targeted to hospitals based on their furnishing of UC. To remedy this, the Commission recommended removing all UC payments from MA benchmarks and paying hospitals directly for all Medicare patients, including those enrolled in both FFS and MA plans.

To determine the effect of market-level MA penetration on hospital finances, MedPAC conducted a regression analysis, examining IPPS hospitals and CAHs separately. Their findings suggested a general lack of association between MA penetration and changes in the average profit margins of both types of care institutions from 2013 to 2024. MedPAC interpreted its analysis to provide little support for the notion of a substantive net effect of increased MA enrollment on hospital profitability.

Although increased MA penetration has not yet led to a broad decline in provider margins, MedPAC concluded that the operational friction between plans and providers requires close monitoring to protect beneficiary access. Commissioners emphasized the need to ensure that utilization management tools lead to genuine clinical efficiency rather than merely shifting costs or denying necessary care. The importance of the UC payment structure was highlighted, along with its potential to prevent financial distortions as MA enrollment continues to rise. The Commission is not making formal recommendations on this topic in the June 2026 report. Future work will continue to

analyze Medicare spending trends and explore alternative methods for calculating payments to MA plans to balance access with efficiency.

MEDPAC EXAMINES ACCESS TO HOSPICE AND COMPLEX PALLIATIVE SERVICES FOR ESRD OR CANCER

In this chapter, the Commission explored whether the Medicare hospice payment structure may create barriers to accessing high-cost palliative services under the Medicare hospice benefit, including dialysis for beneficiaries with ESRD and radiation therapy, blood transfusions, and chemotherapy for beneficiaries with cancer, and discussed potential policy options.

The Medicare hospice benefit provides palliative and supportive services for beneficiaries with terminal illness who elect hospice care. Under the benefit, hospices receive a fixed daily payment intended to cover all services related to the beneficiary's terminal illness and related conditions. CMS recently sought feedback on whether the costs associated with certain complex palliative services may create challenges for hospices and limit beneficiary access, and MedPAC has also examined access to hospice and complex palliative care services for beneficiaries with ESRD and cancer.

Key Findings

MedPAC found that dialysis, radiation therapy, and blood transfusions can provide symptom relief for some patients, though there was less agreement on the role of chemotherapy. Stakeholders stated that the costs of these services often exceed hospice payment rates, which may be particularly challenging for smaller hospices.

Beneficiaries with ESRD were found to be less likely to enroll in hospice than beneficiaries in the broader Medicare population. In 2024, 31 percent of deceased individuals with Medicare (referred to as Medicare decedents) with ESRD enrolled in hospice compared to 53 percent of all Medicare decedents. Stakeholders reported that some patients delay or forgo hospice enrollment due to concerns about discontinuing treatments such as dialysis or blood transfusions. Interviewees stated that continued access to these services may help facilitate earlier hospice enrollment for some beneficiaries. Significant data limitations were also noted, as Medicare does not collect information on many of these services, making it difficult to evaluate utilization and access.

To better understand the financial impact of these services, MedPAC compared estimated treatment costs with hospice payments. The analysis found that dialysis and blood transfusions may account for a substantial share of total hospice payments, while radiation therapy may be more variable depending on treatment needs. Though prospective payment systems are designed to account for variation in patient needs,

high-cost services may create financial challenges for providers if payments do not adequately reflect the costs of care.

Policy Considerations

MedPAC identified potential policy options, including additional data collection to better understand utilization patterns and targeted payment adjustments for high-cost palliative services, but does not make formal recommendations in this report. MedPAC emphasized that future policy change should balance beneficiary access, payment accuracy, care coordination, and appropriate safeguards.

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