

MedPAC Holds September 2025 Meeting

On September 4 and 5, 2025, the Medicare Payment Advisory Commission (MedPAC) held a virtual public meeting. Sessions included:

- 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;
- The association between changes in Medicare Advantage enrollment and hospital finances.

The full agenda for the meeting and the presentations for the sessions are available [here](#).

MEDPAC TACKLES IMPROPER PAYMENTS

Every year, MedPAC makes recommendations to improve the accuracy of the payment systems for Medicare fee-for-service(FFS) and Medicare Advantage (MA) plans. In preparation for the Comptroller General’s session to follow, this session described improper payments in Medicare plans and presented past MedPAC recommendations to align prices and curtail lost funds.

Improper payments to CMS can be due to over or underpayments, payments to an ineligible recipient, payments for ineligible services or items, duplicate payments, or payments lacking documentation. Improper payments are not all necessarily due to fraud. While the percentage of payments that are improper is relatively small, due to the size of the Medicare program, this small percentage of improper payments accounts for a significant amount of waste for CMS. In Fiscal Year (FY) 2024, improper payments accounted for \$4 billion with an improper payment error rate of 3.7 percent, primarily due to missing documentation.

Medicare Administrative Contractors (MACs) are employed by CMS to enroll providers, process claims, perform prior authorization and pre-claims approval, audit cost reports,

and perform the first level of appeals for improper payments under Medicare's FFS payment model.

After presenting an overview of improper payments and the role of MACs, the presentation shifted to MedPAC's previous recommendations on the subject:

- Payment levels for post-acute care are too high relative to costs and therefore should be reduced.
- Ambulatory Surgical Centers (ASCs) should submit cost data to CMS.

MedPAC highlighted work to identify other opportunities to improve efficiency, including recommendations of increasing bundling of similar drugs in the Outpatient Prospective Payment System (OPPS), improving payment for non-emergency ambulance transports, evaluating alternative approaches for addressing potentially low-value care, evaluating rapid growth of Medicare spending on skin substitutes to determine if payment reforms are needed, expanding competitive bidding, better aligning payments across ambulatory settings toward site neutrality (for more information see [MedPAC's 2023 recommendation](#)), and improving the validity of Medicare Advantage encounter data and diagnoses submitted for risk adjustment. Staff noted though the quality of Medicare Advantage encounter data has improved in the past several years, it remains an issue, and directed listeners to their June 2024 Report to Congress for additional details.

MedPAC has recommended aligning payment rates across ambulatory settings since 2014 and recommended that Medicare move towards more site-neutral payments for ambulatory services when doing so does not pose a risk to access. The Government Accountability Office (GAO) has also recommended site-neutral payments for Evaluation and Management (E&M) services across settings since 2016.

After reviewing recommendations, the group turned to a wide-ranging discussion. One commissioner opened the conversation by asking how co-payments are handled by the MACs. Another commissioner answered that the MACs pay what Medicare owes, and the doctor then bills the patient for their portion of the co-payment. Discussion also focused on geographical variation across MAC regions as there are twelve across the nation. One commissioner noted the origin of these regional differences is a historical belief that CMS should allow for regional differences in medical care to best serve beneficiaries, though cited more recent discussions around nationally standardizing how MACs process claims. However, one commissioner clarified that while many MACs across regions meet and discuss key issues, there are currently no mandates for standardization. Another commissioner noted that complexity within the Medicare system fuels payment inaccuracy, whether it is fraud or unintentional. He offered the following two examples to highlight his point: hospitals increasing markup on their

billed charges and the risk adjustment process for Medicare Advantage. He argued simplifying systems reduces the opportunity for improper payments.

When discussing future topic areas for MedPAC's work, automation in the field dominated the discussion. The Wasteful and Inappropriate Service Reduction (WISer) model, introduced by Center for Medicare & Medicaid Innovation (CMMI) is set to begin in six states different states in January 2026, and utilizes AI and machine learning to approve or deny prior authorization requests. This represents the first significant expansion of prior authorization in FFS Medicare, which had previously been limited to a select number of services, and certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). One commissioner emphasized perceived positive aspects of the model to advocate for, while others discussed the potential harm automating the prior authorization process may cause to beneficiaries.

MEDPAC HOLDS QUESTION AND ANSWER SESSION WITH COMPTROLLER OF THE UNITED STATES

In this session, commissioners heard remarks then held a Question-and-Answer session with Gene Dodaro, Comptroller of the United States and head of the Government Accountability Office (GAO).

Comptroller Dodaro began the session with a historical background of program integrity in the federal government, with a focus on the Centers for Medicare & Medicaid Services (CMS), and the agency's previous work as the Health Care Financing Administration (1977-2001). Dodaro walked commissioners through how GAO's scope of work has changed based on new legislation, including requirements for the federal government to develop annual audited financial statements (1996), for agencies to estimate improper payments in high-risk areas (2002), and for agency-wide improper payment estimates (2003). The Comptroller also defined improper payments, highlighting the difference between fraud and improper payments. According to the GAO's official website, fraud is "obtaining something of value through willful misrepresentation", while improper payments are "payments that should not have been made or that were made in the incorrect amount; typically they are overpayments". The agency adds "While all fraudulent payments are considered improper, not all improper payments are due to fraud."¹ The Comptroller cited that all cumulative estimates of improper payments in Medicare since 1996 total \$880 billion.

With respect to CMS, the Comptroller discussed specific areas of concern for the agency, efforts to combat these, and the long-term outlook of healthcare spending in

¹ <https://www.gao.gov/fraud-improper-payments>

the nation. Comptroller Dodaro highlighted that according to work by CMS and GAO, high risk areas for improper payments are skilled nursing facilities, home health, and hospice, as well as some areas in outpatient and physician office settings. He referenced GAO's published materials throughout this presentation as reflecting their official positions and recommendations, while also drilling down into two primary categories for improper payments: documentation and medical necessity. For documentation he stressed that this is not just a "paperwork problem" and that enforcement actions only follow multiple attempts to gather additional documentation (or any documentation at all). Medical necessity is another significant category, representing approximately 17 percent of improper payments following medical review. Comptroller Dodaro also applauded efforts by CMS, including tripling the headcount for the Center for Program Integrity, implementing several GAO recommendations, coordinating with the DOJ on a special healthcare fraud taskforce (adjudicates \$2-5 Billion in fraud every year – excluding settlements and civil cases). He recommended the agency work closer with the Inspector General community and that the agency further examine overbilling, upcoding, provider enrollment verification, and combating systemic fraud from the pandemic. Turning to the future, Comptroller Dodaro highlighted how the Medicare Trust Fund is set to expire in 2033, and that interest costs for servicing the national debt continue to skyrocket. He lauded the Commission's recommendations regarding site neutrality and MA payment structures, as these mirror those produced by the GAO, highlighting the need for reform to ensure long-term fiscal stability.

After his remarks, Dodaro fielded wide-ranging questions from the commissioners. One commissioner asked about the new Wasteful and Inappropriate Service Reduction (WiSER) model, and the Comptroller responded with cautious optimism. He recounted negative personal experiences with prior authorization but stressed the importance of ensuring appropriate payment while not interfering with care delivery, and his view that regulators are often too influenced by provider lobbying efforts. This theme also echoed through several of his other comments, highlighting the need for appropriate distance between regulators and politicians, citing positive earlier reforms on site neutrality that ultimately ended up causing minimal financial changes due to the grandfathering of existing facilities.² Many other questions centered around the theme of recommended research the Commission could undertake to drive reform. The Comptroller's suggestions included a focus on how our system can create stronger incentive payments to drive behavior, comparisons of healthcare costs between the U.S. and other developed economies, the future of artificial intelligence, a greater focus on structural and regulatory changes rather than predominantly payment rate

² For more information on site neutrality and relevant reforms, see: <https://www.kff.org/medicare/five-things-to-know-about-medicare-site-neutral-payment-reforms/>

adjustments, and the creation of a joint MedPAC/MACPAC Medicare/Medicaid taskforce given the growing overlap between the programs. Commissioners asked about the role of telehealth (strong support with guardrails, particularly for mental health care delivery), Medicare versus MA spending per beneficiary (GAO research showed many beneficiaries switch from MA to Medicare at the end of their life where the greatest spending occurs), and the role of long-term care supports that are not considered “medical care” in improving quality of life (referred the commissioner to GAO’s existing research on the subject). Commissioner Chernew closed the session by thanking the Comptroller for his time and insight, particularly the acknowledgement of incentives and discussion of other ways the Commission can help better inform policy.

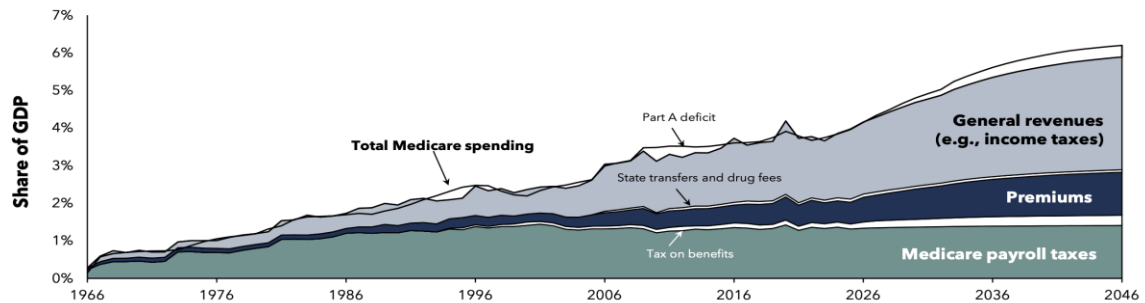
MEDPAC PROVIDES HIGH-LEVEL CONTEXT FOR MEDICARE PAYMENT AND POLICY

MedPAC presented its context chapter for Medicare payment and policy, which will serve as the foundation for the Commission’s 2026 report. The chapter discussed Medicare spending trends, drivers of spending growth, Medicare’s funding, consolidation trends, and the health care workforce.

In 2023, national health care spending reached \$5 trillion, or 17.6 percent of GDP, returning to historical patterns after a short decline at the beginning of the pandemic. This growth was driven by record-high insurance coverage, increasing service volume and intensity, and a rebound in utilization.

The aging of the baby boom generation into the program is expected to be the main driver of Medicare spending growth, with enrollment projected to reach 75 million people by 2029. The Commission also noted that demographic mix of beneficiaries had not driven increased spending—since beneficiaries are, on average, healthier than prior Medicare populations. Instead, growth is now fueled by a steadily increasing volume of services. Given statutory payment formulas, the Commission also ruled out Medicare price growth as a factor. However, they projected the adoption of new technologies and more expensive treatments will raise spending by approximately 3 percent per year over the next 10 years.

Medicare’s funding sources have also shifted due to the change in the mix of services beneficiaries use. Slower growth in Part A spending has reduced reliance on payroll taxes, while growth in Part B has increased reliance on general revenues and beneficiary premiums. As a result, general revenues have become the largest source of program funding (see figure below).



With the growth in Part B spending, beneficiary premiums and cost sharing have also increased. The Commission highlighted concern that most beneficiaries have modest resources, with an average income of \$43,000 per year and average lifetime savings of \$110,000. Many already struggle to afford care, with 6 percent of beneficiaries reporting difficulty paying medical bills. This burden is even higher among vulnerable groups such as partial dual-eligibles, those qualified for low-income subsidy, and disabled beneficiaries. These trends underscore growing fiscal pressures on beneficiaries as Part B expands.

The Commission also highlighted consolidation trends—both vertical and horizontal—across 3 areas: provider-to-provider, payer-provider, and private equity-provider consolidation. Overall, 63 percent of hospital markets are considered “super concentrated,” meaning that a single organization or hospital controls nearly all hospital-based services in a given area. With this, only 42 percent of practices remain solely physician-owned. They argued this consolidation trend is driven by increased bargaining power, site-based payment differentials, ability to increase coding intensity and increased patient referrals. The Commission found the effects of consolidation on access to care and quality to be ambiguous or mixed at best, citing the need for further research.

Lastly, the Commission discussed the healthcare workforce, increasing trends, and current issues. Currently, approximately 2 million physicians and practitioners work with over 14 million healthcare staff—including pharmacists, therapists, health technicians, and direct care workers. The composition of the healthcare workforce has changed, with an increasing number of home/personal health aides, technicians, and registered nurses. Hiring patterns have also shifted to reflect greater demands for workers with formal training, certifications, and licenses. One key issue is the increasing turnover rate among direct care workers, including nursing aides, due to high physical demands and strain from the job. Reflecting these concerns, the Commission discussed differences in payment structure including packaged, prospective payments, value-based care, and staffing incentives.

During the discussion, commissioners raised a range of questions and offered feedback aimed at refining and expanding the chapter. One key theme was the need to clarify definitions and data sources. For example, a commissioner requested a clearer definition of “intensity,” and suggested the report differentiate how intensity is defined by CMS versus the Congressional Budget Office (CBO). There were also several questions regarding the methodology behind Medicare Advantage (MA) spending estimates, particularly the breakdown between Parts A and B. One commissioner noted that MA payments are reported as mechanical information in the Medicare Trustees Report and recommended clarifying this in the text.

Several commissioners focused on beneficiary experiences and variations in coverage. One commissioner emphasized the need to acknowledge state-level variation in the treatment of partially dual-eligible individuals, noting that while federal standards exist, states retain discretion, which can lead to uneven experiences. Another raised concerns about rising costs for beneficiaries, pointing out that as overall Medicare costs rise, beneficiary spending rises in tandem. They also highlighted the “induced effect” of Medigap coverage, where the absence of cost-sharing for roughly 10 million beneficiaries may drive up utilization and overall program costs. This led to further discussion on the demographics of Medigap enrollees and the need to distinguish between beneficiaries in traditional Medicare and those who purchase Medigap.

In Round 2 of the discussion, commissioners shifted to the broader implications of workforce dynamics and Medicare modernization. One commissioner emphasized that this chapter stands apart from past chapters by expanding focus beyond physicians to include physician assistants (PAs), nurse practitioners (NPs), and direct care workers. They noted that the mismatch between the number of registered nurses and the overall workforce signals deeper issues that require policy attention and incentives for better working conditions.

Workforce challenges were a recurring concern. A commissioner cited that nearly one-third of responding agencies serving the direct care workforce reported turning away referrals due to staffing shortages, which poses serious implications for care access. Another commissioner raised the issue of a looming pharmacist shortage, explaining that many pharmacists are underutilized and end up handling administrative claims work instead of practicing at the top of their license.

Demographic shifts were also discussed, with commissioners noting that the current uptick in Medicare enrollment, driven by the leading edge of the baby boomer generation, is contributing to increased spending. Although beneficiaries may appear healthier today, this is likely a temporary effect, as the population will age into more costly years of care.

Consolidation remained a major topic. While some commissioners acknowledged potential efficiencies, most emphasized that consolidation often leads to higher prices without measurable quality improvements. A few pointed out that pharmacy benefit managers (PBMs) warrant greater attention in the chapter, noting that while there are 66 PBMs in the U.S., three control 80 percent of the market, often operating within large insurers, creating a lack of transparency and potential for abuse. Others called for more attention to rural implications, citing how nearly 30 percent of rural hospitals are now part of systems, which may reduce local treatment options, especially for services like cancer care.

Finally, commissioners encouraged deeper exploration of vertical and horizontal integration, including the decline of independent practices, the effects of the Stark law and self-referral, and the potential consequences of payer-provider integration. While some saw theoretical benefits, most agreed that real-world impacts are mixed, and called for more research into when integration serves patient interests and when it merely increases costs. Several commissioners expressed support for retaining and expanding the chapter's focus on workforce and consolidation, noting that these are critical structural issues that will shape the future of the Medicare program.

Toward the close of the discussion, commissioners reflected on broader questions raised by the chapter, particularly whether MA is making the system more efficient or if cost reductions are coming at the expense of care quality. One commissioner noted that MedPAC is not taking a position on this at the moment, nor is the chapter meant to prescribe policy. Instead, the focus is on presenting a clear, transparent overview of current trends, strengths, and limitations.

MEDPAC EXPLORES EFFECTS OF MEDICARE ADVANTAGE GROWTH ON PROVIDERS

This session provided the Commission's preliminary research on the estimated associations between changes in rapid MA enrollment and hospital revenues, costs and profit margins.

The Commission's annual hospital site visits indicate that MA plans increase costs and lower revenues for hospitals. Hospital industry analyses have also found that MA patients typically have lower payment-to-cost ratios compared to FFS patients. However, prior research on the effects of MA enrollment changes on hospitals has been limited, mixed, and frequently focused on rural hospitals, with some studies showing improved financial conditions and others reporting mixed impacts on inpatient stays.

MA plans are incentivized to use utilization management techniques that reduce volume or shift care to lower-paid settings, including forming provider networks,

employing prior authorization, negotiating payment rates to providers below FFS rates, downgrading hospital admissions into observation stays, and denying claims for lack of medical necessity which are often overturned. Even when payment rates are equal, such practices may influence variable provider revenues and costs of providing services.

MedPAC estimated the aggregate impact of these incentives on 1) all-payer revenue (including FFS and MA), 2) all-payer costs, and 3) all-payer profit margins. Using hospital cost report data, the Commission examined whether hospitals in counties with faster MA growth experienced different growth rates in revenue, costs, and profits, accounting for financial integration and separately analyzing Inpatient Prospective Payment System (IPPS) hospitals and Critical Access Hospitals (CAHs).

The Commission's analysis employed linear regressions to estimate county-level MA penetration and associated changes in revenue, costs, and profit margins. Models included hospital fixed effects to capture changes within individual hospitals, year fixed effects to account for national trends, and controls for county-level demographics. MedPAC emphasized that the results show associations, not causal relationships, and noted limitations due to omitted factors for which data were unavailable that could affect both MA enrollment and hospital finances. The Commission also explored how hospital affiliations with MA plans affected these outcomes.

Overall, the Commission's analysis found no statistically significant association between MA growth and providers' profit margins, though some effects were observed for revenue and costs. Across all IPPS hospitals, a 10-percentage-point increase in MA penetration was associated with a 1.3 percent decline in revenue and a 1.2 percent decline in costs, roughly offsetting each other. These effects also varied by financial integration. For financially unintegrated hospitals, MA growth had no effect on profit margins but was associated with a larger-than-average decline of about 2 percent in revenue and costs. For financially integrated hospitals, there were no significant effects on profit margins and only minor, statistically insignificant changes in revenue (0.6 percent) and costs (1.4 percent), which were materially different from unintegrated hospitals. The Commission ascribed part of these differences to an increase in uncompensated care payments and discharges when MA payments increase more than the average.

For Critical Access Hospitals (CAHs), MedPAC found no material changes in costs, revenues, and profit margins due to two factors: 1) As CAH volume declines, payment per unit of service increases due to cost-based reimbursement, and 2) MA plans tend to pay CAHs per-diem payments rather than payments per stay — and because MA patients often have longer lengths of stay — this offsets other potential effects of MA expansion.

MedPAC noted that a decline in revenues and costs but not profits suggests that all costs are variable. One potential explanation is uncompensated care payments for inpatient services, which are added per discharge for both FFS and MA. FFS prices rise when MA volume declines rapidly, which can offset some of the lost revenue from declines in FFS admissions. Uncompensated care (UC) payments per discharge also increase when there is an above-average shift of discharges from FFS to MA, due to the formula for the FFS pricer: MA discharges x (FFS uncompensated care payments/historic average of FFS discharges).

Based on this formula, as MA discharges increase at hospital, MA uncompensated care payments increase. As FFS discharges decrease, MA uncompensated payments increase. MedPAC estimated that for every 10-percentage point shift from FFS to MA in a county, uncompensated care payments per FFS and MA discharge increases by about 13 percent relative to the national average change.

Commissioners followed the presentation with several comments, questions, and recommendations for future analysis. One commissioner expressed that hospital integration creates incentives to use savings to drive the overall business' margin. Another commissioner asked about the effect of new services brought in to offset decreased utilization, with staff responding that this analysis only looked at net effects. A third commissioner asked about prior authorization, and whether research had been done into whether certain procedures were being attempted or completed at lower rates because of the specter of dealing with prior authorization. The commissioner indicated this had not been studied. Several commissioners also highlighted potential areas to expand this analysis including the role of broker incentives, geographic variations, entity size, market penetration, and comparing inpatient vs. outpatient spending. MedPAC staff discussed how future work is planned regarding provider networks and associated changes over time, while Chairman Chernew emphasized this is the beginning of larger research on the effect of MA growth on providers.

This Applied Policy® Summary was prepared by [Hugh O'Connor](#) with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact him at hoconnor@appliedpolicy.com or at 202-558-5272.