American College of Radiology™

MedPAC March 2026 Report to Congress Detailed Summary

The Medicare Payment Advisory Commission (MedPAC) released their March 2026 Report to Congress on March 12, 2026. MedPAC is a non-partisan, independent legislative branch commission created to advise Congress regarding Medicare-related issues. The report presents MedPAC's recommendations for updating provider payment rates in fee-for-service Medicare for 2027, for acute care hospital and physician services, as well as providing updates on the Medicare Advantage (MA) program.

Chapter 1: Context for Medicare payment policy
In this chapter the Commission describes Medicare's overall financial situation and some ways that Medicare affects, and is affected by, the broader health care sector.

National health care spending usually grows faster than GDP
National health care spending increased rapidly in 2023 and 2024, growing by 7 percent in each year. The Commission attributed this growth to several post-pandemic factors, including a rebound in the volume and intensity of health care services, record-high health insurance coverage—reaching 92 percent of the U.S. population from 2022 through 2024—continued population growth, and rising medical prices. Over time, health care spending has also accounted for a growing share of the U.S. economy, increasing from approximately 13 percent of gross domestic product (GDP) in 2000 to about 18 percent in 2024.

Drivers of Medicare's spending growth
Medicare spending grew rapidly in 2023 and 2024, in part due to changes in Part D financing that shifted more of the cost of prescription drug coverage from beneficiaries to the federal government. By 2024, Medicare spending totaled $1.1 trillion equivalent to 21 percent of national health care spending and 3.8 percent of GDP. Growth in the volume and intensity of the services and items delivered to patients and growth in the average price of Part B drugs administered by clinicians are also projected to drive up Medicare spending.

Provider consolidation has been increasing
Ongoing consolidation among health care providers has had significant effects across the health care sector. This consolidation now extends beyond traditional hospital mergers and provider-driven vertical integration to include acquisitions by non-provider entities, such as private insurers, large corporate organizations, and private equity firms. These activities are driven by several economic incentives. In commercial insurance markets, larger and more consolidated provider systems often have greater leverage when negotiating payment rates with private insurers. The Commission also found that certain forms of consolidation can increase Medicare payments, particularly due to site-based payment differences. For example, when a hospital acquires a physician practice, it may bill Medicare both a

physician fee and an additional facility fee for services delivered in the hospital-owned practice. Vertical integration among providers can also encourage referrals within an integrated health system. Similarly, insurer-provider integration may allow insurers to better coordinate care and promote provider cooperation, such as encouraging the use of generic drugs and improving care coordination. Overall, consolidation among health care providers has been associated with higher payment levels in both commercial and Medicare markets.

Medicare draws on an increasing share of the country's tax revenues
Over the past decade, Medicare spending per beneficiary has grown faster for Part B services than for Part A or Part D. By 2024, Part B accounted for 49 percent of total Medicare spending, up from 45 percent in 2015, while Part A's share declined from 43 to 38 percent and Part D remained relatively stable at about 12 percent. This shift has eased pressure on Medicare payroll tax revenues, which finance Part A, but increased pressure on general revenues and beneficiary premiums, which fund Part B.

When Medicare spending increases, beneficiaries' costs also increase
Growth in Medicare spending affects beneficiaries' ability to afford care by increasing premiums and cost sharing. In 2023, beneficiaries' median household income was about $50,000, and 18 percent were food insecure. As a result, increases in Medicare provider payment rates also raise premiums and cost sharing for beneficiaries, many of whom already face financial challenges in affording health care.

Chapter 2: Assessing payment adequacy and updating payments in fee-for-service Medicare
MedPAC aims to ensure that Medicare pays health care providers in a way that supports beneficiaries' access to high-quality care while also promoting efficient use of taxpayer and beneficiary dollars. MedPAC emphasizes that appropriate payment begins with accurate base rates that reflect the costs of delivering care efficiently to the average patient, along with adjustments for differences in markets, services, and patient characteristics. Payment policy also serves broader goals, such as improving quality, protecting program integrity, and ensuring that beneficiaries can obtain necessary care.

Each year, MedPAC conducts a comprehensive, statutory review of Medicare fee-for-service (FFS) payment adequacy across seven major sectors: acute care hospitals, physician and other health professional services, outpatient dialysis facilities, skilled nursing facilities (SNFs), home health agencies, inpatient rehabilitation facilities, and hospices. Using the most recent available data (2024 for this report), they assess four core areas: beneficiaries' access to care, quality of care, providers' access to capital, and the relationship between Medicare payments and provider costs. MedPAC also projects what payments and costs will look like in 2026, taking into account statutory updates, expected

cost growth, and other policy changes. Based on these analyses, they recommend whether FFS payment levels for each sector should increase, decrease, or remain unchanged for 2027.

MedPAC acknowledges that health care markets vary widely and that some providers perform better than others. Recommendations aim to ensure adequate resources at the sector level rather than address every individual provider circumstance. When persistent differences between providers threaten access to care, MedPAC may develop targeted policy proposals outside of the annual update process. Examples include earlier recommendations to redistribute payments within SNFs to better serve medically complex patients, to refine dialysis facility adjustments for isolated low-volume providers, and to reform hospital safety-net payments using a more accurate Medicare Safety-Net Index.

Although MedPAC's update work focuses on sectors individually, the Commission also supports "site-neutral" payment policy—paying similar rates for the same service regardless of where it is delivered when safety and quality allow. This approach is intended to reduce unnecessary spending and encourage care in the most efficient setting.

In assessing payment adequacy, MedPAC evaluates several indicators:

- **Access to care:** This includes provider availability, service volume trends, and survey data on beneficiaries' ability to obtain needed care.
- **Provider capacity and supply:** Changes in provider entry, staffing, and technology adoption can reflect whether payment rates are aligned with costs.
- **Service volume:** Rising volumes may indicate adequate access—or, in some cases, incentives that drive unnecessary utilization. Declines may signal financial pressure on providers or substitution across sites of care.
- **Quality of care:** MedPAC considers whether payment changes would meaningfully affect quality, noting that traditional FFS systems have offered weak incentives for quality improvement.
- **Providers' access to capital:** Especially for capital-intensive sectors like hospitals, all-payer margins, investment levels, and credit indicators help gauge financial health.
- **Medicare margins:** For providers with cost report data, MedPAC compares FFS payments to allowable costs to determine whether payments are covering the cost of treating Medicare patients.

After analyzing these indicators, MedPAC recommends annual payment updates. These updates are expressed as percentage changes to the base payment rate for each sector. They may be recommended relative to the previous year's payment level or relative to the amount specified in current law. Importantly, MedPAC's recommendations do not

automatically change policy—Congress or the Secretary of Health and Human Services must act for them to take effect. If no action is taken, current law remains in place.

Chapter 3: Hospital inpatient and outpatient services
In this Chapter, MedPAC recommends the following update to payment rates for hospitals:

The Congress should:

- **For 2027, update the 2026 Medicare base payment rates for general acute care hospitals by the amount specified in current law; and**
- **Implement the Medicare Safety-Net Index (MSNI) described in MedPAC's March 2023 report, with $1 billion added to the MSNI pool.**

This recommendation would increase spending relative to current law by $750 million to $2 billion in one year and by $5 billion to $10 billion over five years.

Assessment of Payment Adequacy
Indicators of payment adequacy for FFS Medicare beneficiaries were mixed in FY2024. While beneficiary access to care remained good overall and hospitals' all-payer margin was improved, quality indicators continue to be mixed. FFS Medicare beneficiaries' risk-adjusted mortality rate improved in 2024, but their readmission rate worsened, and most patient experience measures remained stable. Hospitals FFS Medicare margin remained negative but improved slightly to -12.1% in aggregate and to -1% for the median relatively efficient hospital.

Beneficiaries' access to care
Indicators suggest that FFS Medicare beneficiaries have maintained good access to care; hospitals continued to have available capacity in aggregate. The supply of hospitals was relatively steady, though eight more hospitals closed than opened in each of 2024 and 2025. Overall hospital employment continued to increase, reaching 4.8 million FTEs in FY2024.

FFS Medicare beneficiaries' use of inpatient and hospital outpatient services increased in 2024.

- The majority of growth in inpatient stays was attributed to infectious and parasitic diseases, as well as for diseases of the kidneys and urinary tracts.
- The majority of growth in outpatient hospital encounters was from an increase in evaluation and management (E&M) services, specifically clinic services. All other categories of hospital outpatient services also increased in CY2024, led by imaging and tests.

A rising proportion of hospital outpatient visits are now occurring in off-campus provider-based departments and emergency rooms. By 2024, nearly 20 percent of FFS Medicare outpatient encounters took place at these off-campus sites, up from 17 percent in 2019.

Quality of Care
Quality of hospital care in FY2024 was mixed. FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved, but the risk-adjusted readmission rate worsened. Most patient-experience scores remained the same in 2024.

MedPAC reaffirmed its March 2019 recommendation that Congress replace Medicare's existing hospital quality programs with a single, outcome-focused quality-based payment system. The proposed Hospital Value Incentive Program (HVIP) would create a balanced approach to rewards and penalties and could further strengthen hospital quality performance. Consolidating the current programs into one HVIP would also simplify the system, eliminate overlapping requirements, and reduce the reporting burden on providers.

Providers' Access to Capital
Hospitals' access to capital strengthened in 2024 and appears to be improving further in 2025. All-payer operating margins rose to 6.5 percent in 2024, and early data from several large systems indicate continued gains in 2025. Other indicators, such as higher investment income and slightly lower risk premiums on hospital bonds, also point to improved or stable access to capital.

FFS Medicare Payments and Providers' Costs
In 2024, FFS Medicare payments remained well below hospitals' overall costs, though margins were much closer to break-even for the most efficient hospitals. The aggregate FFS Medicare margin was -12.1%, a slight improvement from 2023, while relatively efficient hospitals had a median margin of -1%. By 2026, margins are projected to rise to about -10% overall and to 1% for the median relatively efficient hospital.

Medicare Safety-Net Index
The Commission found that the Medicare Safety Net Index (MSNI) continues to outperform the current Disproportionate Share Hospital (DSH) metric in predicting hospitals' financial performance. Because hospitals with higher MSNI scores often already have higher Medicare margins, using the MSNI would better target resources to hospitals that are essential providers for low-income Medicare beneficiaries and face financial pressure. Under the Commission's recommended approach, MSNI-based payments would support hospitals serving both FFS and Medicare Advantage patients, recognizing that safety-net definitions for other programs (such as Medicaid or 340B eligibility) may differ.

Mandated Report on Rural Emergency Hospitals (REHs)
The Consolidated Appropriations Act (CAA), 2021, created a new rural emergency hospital (REH) designation, effective January 2023, and requires the Commission to report annually on payments to REHs. During CY 2024, there were 38 REHs, and they received over $100 million in enhanced Medicare payments, almost all of which were from fixed monthly payments intended to help to cover the standby costs for REHs.

Site Neutral Payments
MedPAC has long observed that Medicare often pays very different rates for the same ambulatory services depending on the setting—hospital outpatient departments (HOPDs), ambulatory surgical centers, or physician offices. These payment gaps encourage hospitals to acquire physician practices and shift services to higher-paid settings, raising Medicare spending and beneficiary cost sharing without improving outcomes. To address this, MedPAC has repeatedly recommended moving toward site-neutral payments that align rates for services that can be safely delivered in multiple settings.

Medicare has implemented several site-neutral policies for off-campus hospital outpatient departments, phasing in reduced payment rates that approximate the physician fee schedule. CMS has also extended site-neutrality to clinic visits in excepted off-campus locations (beginning in 2019). In CY 2024, about 1,000 hospitals had one or more excepted off-campus PBDs that provided a clinic service subject to this site-neutral policy, and the policy applied to 6.8 million clinic visits by FFS Medicare beneficiaries, both slightly below the levels in 2023. FFS Medicare and its beneficiaries paid about $350 million for these visits, and MedPAC estimates that this policy reduced FFS Medicare payments by about $520 million in 2024. Starting in 2026, site neutral policies were extended to drug administration services. CMS estimates reductions of about $290 million during CY 2026. Together, these changes address areas where payment differences had encouraged migration of services to higher-paid HOPDs.

Policymakers could also consider expanding site-neutral payments to other outpatient services provided in excepted off-campus locations. In CY2024, FFS Medicare beneficiaries received 13.2 million OPPS services in excepted off-campus PBDs (inclusive of the drug-administration services), with payments of $3.5 billion. MedPAC estimates that expanding site-neutral payments (i.e., 40 percent of OPPS rates) to these 13.2 million services would have decreased FFS Medicare payments by about $2.1 billion in CY 2024. This $2.1 billion reduction would have been equivalent to a 4.2 percent reduction in payments for remaining OPPS services; therefore, applying a budget-neutral adjustment would require a uniform increase of 4.2 percent to the payment rates for all remaining OPPS services. After applying a budget-neutrality adjustment, there would be no change in aggregate FFS Medicare payments for hospital outpatient services if volume remained the same, but there would be distributional effects. For example, urban and nonprofit hospitals

would lose a small amount of revenue while rural hospitals and for-profit hospitals would gain a small amount.

MedPAC's June 2023 framework offers another approach: systematically aligning payment rates across HOPDs, ASCs, and physician offices when clinically appropriate, with safeguards to protect access and budget-neutral adjustments that could strengthen emergency and standby capacity. MedPAC emphasizes targeting services suitable for alignment, monitoring access closely, and prioritizing payment levels that reflect the resources needed in the most efficient care setting.

Chapter 4: Physician and other health professional services
In this Chapter, MedPAC recommends the following update to payment rates for physicians and other health professionals:

Recommendation:

- **For calendar year 2027, the Congress should increase payment rates for physician and other health professional services by 0.5 percentage points more than current law.**

In 2024, traditional fee-for-service (FFS) Medicare's physician fee schedule (PFS) paid for about 9,000 types of medical services provided by clinicians across a variety of care settings. The Medicare program and its beneficiaries paid $93.8 billion in 2024 for fee schedule services billed by about 1.5 million clinicians, accounting for just over 15 percent of spending in FFS Medicare. Spending on clinician services by FFS Medicare and its beneficiaries was $1.4 billion higher in 2024 than in 2023, representing a 1.5 percent increase in total spending. This increase is largely attributable to 4.1 percent growth in spending per FFS beneficiary, which was partially offset by a 2.5 percent decrease in the number of beneficiaries enrolled in FFS Medicare.

Assessment of payment adequacy
The Commission's indicators of the adequacy of clinician payments have remained positive or improved since last year, although input cost inflation remains slightly elevated.

Beneficiaries' access to care
In the Commission's 2025 survey, Medicare beneficiaries reported access to clinician services that was generally better than that of privately insured people. Consistent with other national surveys, the Commission found that people ages 65 and older, almost all of whom have Medicare coverage, report better access to care than younger adults. Surveys indicate that the share of clinicians accepting Medicare is comparable with the share accepting private insurance, despite private health insurers' higher payment rates. Very few

clinicians forgo all Medicare payments by electing to "opt out" of the program; these clinicians may collect the full amount they charge to patients.

The Commission found that over the last several years, the number of primary care physicians billing the PFS has slowly declined, the number of specialists has steadily increased, and the number of advanced practice registered nurses (APRNs) and physician assistants (Pas) has climbed rapidly.

Over the last 40 years, the number of applicants to U.S. medical schools has grown, exceeding population growth, and applicants to medical school continue to far exceed first-year enrollment. The number of APRNs and PAs has grown rapidly.

From 2023 to 2024, the number of evaluation and management (E&M) services per FFS beneficiary increased by 10.9 percent, while treatments and nonmajor procedures increased by 7.6 percent and 3.6 percent, respectively. Imaging, tests, major procedures, and anesthesia saw somewhat smaller growth of 3.3 percent, 3.2 percent, 3.1 percent, and 1.7 percent, respectively.

Quality of care

The Commission found that the quality of clinician care has remained relatively stable.

Clinicians' revenues and costs

The MedPAC is unable to calculate clinicians profit margins from delivering services to Medicare beneficiaries or to their full panel of patients. PFS spending per FFS beneficiary grew for most types of services in 2024, despite payment rates for many types of services declining from 2023 to 2024. Among general service categories, growth rates were 5.1 percent for E&M services, 4.0 percent for imaging, 2.2 percent for other (i.e., nonmajor) procedures, 4.9 percent for treatments, and 3.7 percent for tests.

Growth in clinicians' input costs as measured by the Medicare Economic Index (MEI) has moderated from recent highs during the coronavirus pandemic and is expected to moderate further in the coming years. Currently, MEI growth is projected to be 2.7 percent in 2025 and 2.2 percent in 2026.

The Commission examined clinician compensation levels as a rough proxy for all-payer profitability. Based on compensation data from 2023 to 2024, median physician compensation increased 6 percent to $369,000. The Commission noted that clinician compensation is only an indirect measure of Medicare's payment adequacy since Medicare payments constitute only a portion of the revenue most clinicians receive, and many employed physicians' compensation may not be directly tied to fee schedule payments.

In 2024, preferred provider organizations' payment rates for clinician services were, on average, 147 percent of FFS Medicare's payment rates, up from 140 percent in 2023. A 2024 survey by the American Medical Association (AMA) suggests that providers are increasingly consolidating into larger organizations to improve their ability to negotiate higher payment rates from private insurers.

Payment Rates for 2027
Current law calls for PFS payment rates to decline by 1.7 percent for qualifying clinicians in advanced alternative payment models (A-APMs) in 2027. All other clinicians will decline by 2.2 percent. These reductions reflect the net effects of two statutory provisions: (1) the expiration of a one-year increase of 2.5 percent that applies in 2026 only, and (2) positive updates of 0.75 percent and 0.25 percent for qualifying clinicians in A-APMs and all other clinicians, respectively, in 2027 pursuant to the Medicare and CHIP Reauthorization Act of 2015 (MACRA).

Chapter 12: The Medicare Advantage program: status report
MedPAC reports that the MA program is quite robust, with growth in enrollment, considerable plan offerings, and a record-high level of supplemental benefits. In 2025, 55% of eligible Medicare beneficiaries enrolled in MA, up from 54% in 2024 and 37% in 2018. In 2025, the MA program included 5,492 plan options offered by 164 organizations, enrolled about 34.9 million beneficiaries, and paid MA plans an estimated $537 billion (not including payments for drug coverage offered by MA plans). In 2026, on average, a Medicare beneficiary can choose from 39 plans offered by an average of eight organizations.

Medicare Payments to Plans
In 2026, Medicare's payments to MA plans are projected to be $615 billion. MedPAC estimates that Medicare is projected to spend about 14 percent ($76 billion) more on Medicare Advantage (MA) enrollees in 2026 than it would if those beneficiaries were in traditional FFS Medicare (roughly 12% of total MA payments). These higher payments vary widely across MA organizations and do not represent plan profits, but they do finance the supplemental benefits that many beneficiaries say drive their choice of MA. MedPAC estimates that Part B premiums will be about $11 billion higher in 2026 (approximately $175 more per beneficiary per year) due to higher MA spending.

Favorable Selection
Favorable selection refers to the tendency of beneficiaries with lower spending than predicted by their risk score to enroll in MA. The effects of favorable selection (prior to any coding differences) have consistently caused the risk scores of MA enrollees to overpredict what their spending would have been in FFS Medicare. MedPAC projects that in 2026, favorable selection will increase MA payments by roughly 11% above what the program

would have paid under FFS Medicare, or $57 billion of the $76 billion in higher total payments to MA plans.

Risk Adjustment and Coding Intensity
Coding intensity refers to the tendency for MA plans to record more diagnosis codes for their enrollees, which causes risk scores and Medicare payments to be higher. Documenting additional diagnosis codes increases plan rebates and can distort competition among plans. MedPAC estimates that in 2026, MA risk scores are projected to be about 10% higher than those of comparable FFS beneficiaries. After CMS applies its 5.9% coding-intensity adjustment, the remaining net increase is about 4%, which translates to roughly $22 billion in additional MA payments.

Quality in MA
The MA Quality-Bonus Program (MA-QBP) rewards contracts with a high star rating by increasing their benchmark. In 2026, the MA-QBP will add about $16 billion to plan payments, with 64% of enrollees in plans receiving a bonus. The program raises benchmarks for high-rated contracts, and MA enrollees continue to report high and stable satisfaction with their coverage.

The Commission has long held that MA presents opportunities for innovation to achieve higher-quality care at lower cost. The inability of the MA–QBP to meaningfully characterize the quality of care that MA enrollees receive makes it difficult for beneficiaries to make informed choices and for policymakers to assess the value that private plans bring to the Medicare program. MedPAC has discussed several flaws in the current quality approach in previous reports to Congress, identifying issues with measure sets, reliance on MA contract-level reporting, methods for comparing performance across plans, and funding with additional program dollars.