



## MedPAC June 2026 Report to Congress Detailed Summary

The Medicare Payment Advisory Commission (MedPAC) released its June 2026 Report to Congress on June 15, 2026. The MedPAC is an independent congressional agency that advises the United States Congress on various issues affecting the Medicare program. This report fulfills the Commission's legislative mandate to evaluate Medicare payment issues and report to the Congress. MedPAC's mission is to preserve beneficiaries' access to high-quality care, control Medicare spending growth, and provide sufficient payment for efficient providers.

### Chapter 1: Improving payment incentives in Medicare

Medicare pays for health care through three main models: traditional fee-for-service (FFS), alternative payment models (APMs) built on FFS, and Medicare Advantage (MA) plans. Each approach creates different financial incentives that can influence provider behavior, overall spending, and the value delivered to patients and taxpayers. FFS tends to encourage higher service use, APMs promote efficiency but have delivered mixed results, and MA emphasizes cost control yet currently costs more than FFS due to risk-adjustment issues.

Medicare spending reached \$1.1 trillion in 2024 (about 18% of U.S. health spending and 3.8% of GDP) and is projected to exceed 5% of GDP by 2032, increasing pressure on federal finances and beneficiary premiums. Increases in the volume and intensity of services and items delivered to beneficiaries (including clinicians prescribing more services and/or more expensive services over time and changes in the use and price of physician-administered drugs) account for the majority of projected spending growth over the next 10 years.

The Commission stresses that improving all three approaches is critical to ensuring sustainable, high-quality care as enrollment and service use grow. Efforts focus on refining payment accuracy, reducing incentives for unnecessary care in FFS, and limiting payment inflation in APMs and MA, while continuing to evaluate reforms that enhance efficiency, maintain access, and safeguard taxpayer resources.

#### Fee-for-Service (FFS) Medicare

In 2025, less than a fifth of full-benefit Medicare beneficiaries (i.e., beneficiaries enrolled in both Part A and Part B) received their coverage through standalone FFS (in FFS Medicare without assignment to an APM). Relative FFS payment rates can become misaligned across services and settings due to the use of multiple payment systems with different data sources and formulas. As a result, FFS Medicare may pay more for the same service depending on the site of care, and some services may become mispriced relative to others, distorting incentives.



MedPAC recommends reforms to strengthen FFS Medicare by reducing cost sharing for high-value care, maintaining it for low-value services, and adding an annual out-of-pocket cap to better protect beneficiaries. To bring FFS Medicare's overall payment levels closer in line with providers' costs, the Commission currently recommends slightly increasing (above current law) payment rates for the hospital outpatient and inpatient PPSs and the physician fee schedule, modestly decreasing payment rates for outpatient dialysis services and hospice services, and substantially decreasing payment rates for post-acute care providers (Medicare Payment Advisory Commission 2026).

To improve how relative payments are set in FFS Medicare, the Commission has recommended using new data sources and formulas. MedPAC has also recommended that FFS Medicare adopt site-neutral payment rates for certain services that can be safely provided in more than one ambulatory setting (i.e., a freestanding clinician office, an ambulatory surgical center, and/or a hospital outpatient department) (Medicare Payment Advisory Commission 2023a).

#### Alternative Payment Models (APMs)

APMs were introduced on a large scale beginning in 2012 and as of 2025, about a quarter of full-benefit Medicare beneficiaries were attributed to an APM using a total-cost-of-care model. Alternative payment models (APMs) aim to improve efficiency by rewarding providers for keeping spending below targets and penalizing overspending, encouraging reduced use of low-value care and better care coordination. A key challenge for APMs is setting the right spending targets. If targets are too high, providers can earn bonuses without actually saving Medicare money. If targets are too low, providers may choose not to participate (especially in voluntary programs) or may lack the funding needed to improve care in mandatory ones, which could limit patient access. Results of APMs have been mixed, with some models increasing spending, others having no effect, and some producing modest savings, highlighting the importance of program design.

To improve the basic design of Medicare's APMs, the Commission has recommended that CMS operate a smaller number of APMs designed to work together. The Commission has raised concerns that spending targets in Medicare APMs (especially the Medicare Shared Savings Program) can encourage excessive diagnosis coding and the selection of lower-cost providers to boost payments. CMS has responded by limiting how much coding can raise spending targets, allowing adjustments for patient demographics, and strengthening incentives for providers who treat higher-cost patients.

#### Medicare Advantage (MA)

MedPAC's analyses of MA plans' projected medical spending indicate that their spending on medical services (before including plans' administrative costs) is 15 percent to 18 percent below what would have occurred in FFS Medicare. However, Medicare currently



pays more for Medicare Advantage (MA) enrollees than it would under traditional fee-for-service, largely due to favorable selection and more intensive diagnostic coding that inflate payments. These higher payments have limited expected savings but allow MA plans to offer extra benefits, such as lower cost sharing, out-of-pocket caps, and reduced premiums, which can be attractive to beneficiaries.

MA plans rely heavily on tools like prior authorization to control service use and spending, allowing them to manage care more intensively than other Medicare models. While prior authorization can help limit unnecessary services, excessive or poorly targeted use may delay or restrict access to needed care, though safeguards and competition among plans help balance these risks.

The Commission recommends improving MA by refining geographic payment areas and strengthening data reporting to better assess performance and efficiency. Past reports also propose changes to payment benchmarks to better align plan payments with costs, reduce excess payments, and eliminate certain bonus structures. To improve payment accuracy, MedPAC calls for updated risk-adjustment methods to limit coding differences and a redesigned quality incentive program focused on population outcomes and more equitable comparisons across plans.

#### Future Commission Work on Payment Approaches

The Commission will continue to study Medicare payment approaches and identify ways to optimize the incentives they create. Possible future work on this topic includes analyzing Medicare spending trends to better understand sources of spending growth, opportunities to harmonize FFS Medicare payments across settings and service types, alternative methods for calculating payments to MA plans, MA plans' incentives to balance access to care with efficiency through networks and denials, potential improvements to the design and methods used to set payments in APMs, and new tools that could be used in FFS Medicare to reduce the use of low-value care.

### **Chapter 3: Medicare payment operations and their role in identifying improper payments**

The Department of Health and Human Services' annual agency financial report for fiscal year (FY) 2025 stated that Medicare was responsible for an estimated \$56.7 billion in improper payments, including \$28.8 billion from FFS Medicare, \$23.7 billion from MA, and \$4.2 billion from Medicare Part D. Improper payments include overpayments, underpayments, payments for ineligible services or recipients, and payments lacking sufficient documentation to determine appropriateness.

Across the Medicare program, most improper payments are due to lack of documentation or other errors, but some result from fraud, which is intentional deception or



misrepresentation of the information submitted on claims. Within CMS, the Center for Program Integrity (CPI) has the lead in preventing and detecting fraudulent activities. The CPI has a broad range of responsibilities for both Medicare and Medicaid. The Department of Health and Human Services Office of Inspector General (OIG) has responsibility for investigating and detecting fraud and for provider exclusions, barring an individual or entity from billing Medicare. The Department of Justice (DOJ) investigates and prosecutes fraud. Fraudulent activities have more than financial implications: Beneficiaries who are victims of Medicare fraud may experience real harm in addition to their own financial losses.

### Improper Payments in FFS Medicare

CMS processes FFS Medicare claims with the assistance of Medicare administrative contractors (MACs), which are private entities assigned to geographic jurisdictions. In FY 2023, CMS reported that MACs processed over 1.1 billion claims, totaling \$431.5 billion. CMS also uses additional contractors to analyze claims and recover improper payments; in FY 2025, FFS Medicare had a 6.6% improper-payment rate (about \$29 billion).

In addition to the pre- and post-payment reviews conducted by the MACs, CMS employs limited prior authorization, targeted pre-claim and pre-payment reviews, and post-payment audits to reduce improper payments. These tools target services with high risk for unnecessary utilization, such as cosmetic procedures, spinal surgeries, and nonemergency ambulance transports. Currently, CMS is testing pre-claim reviews with expanded use of its Fraud Prevention System models and in two limited demonstrations for home health agencies and inpatient rehabilitation facilities in specified states. Among other goals, the demonstrations aim to reduce the number of appeals and improve provider compliance with Medicare program requirements. The **Wasteful and Inappropriate Service Reduction (WiSeR) Model** started in 2026 and is using artificial intelligence and data analytics to test new prior authorization for selected services. Participating data companies will receive a percentage of the expenditures associated with averted wasteful, inappropriate care as a result of their reviews. The percentage will be adjusted based on the participant's performance on measures related to the process, including provider experience. The model is expected to end on December 31, 2031.

### Improper Payments in MA

Medicare Advantage (MA) pays private plans risk-adjusted capitation based on enrollee demographics and diagnosis codes that are converted into CMS-HCC risk scores. Improper payments are measured by verifying whether submitted diagnoses are supported by medical records, with CMS estimating a 6.1% error rate (about \$23.7 billion) for 2023. While related, improper payments differ from coding intensity, counting only unsupported diagnoses. CMS also conducts RADV audits to validate diagnosis data, historically using limited samples and finding notable overpayments, with most errors (about 85%) driven by documentation issues. Although audits have been limited and recoveries delayed, CMS is



expanding and accelerating RADV audits, introducing extrapolation methods, narrowing some audit populations, and planning to audit all plans annually while clearing the backlog by early 2026.

#### Improper Payments in Part D

Medicare Part D pays private plans through risk-adjusted capitation and cost-based reimbursements with risk-sharing features, and reconciles payments based on actual spending. Improper payments estimated at 4.0% (\$4.2 billion) in 2023 primarily result from inaccurate prescription drug event (PDE) records, especially missing or insufficient documentation. CMS measures these errors through sampled data and oversight by MEDIC contractors, while diagnosis coding errors are not included in Part D improper payment estimates and are generally budget neutral.

#### **Chapter 4: Estimated association between Medicare Advantage enrollment and hospitals' and post-acute care providers' finances**

The Commission's analysis examines how rising Medicare Advantage (MA) enrollment is associated with the financial performance of hospitals and post-acute care (PAC) providers, including skilled nursing facilities (SNFs), home health agencies (HHAs), and inpatient rehabilitation facilities (IRFs). Because MA plans are paid on a capitated basis, they have strong incentives to manage costs through tools such as negotiated provider payments, care coordination, and prior authorization. Research cited in the chapter suggests MA plans generally achieve lower medical spending than traditional fee-for-service (FFS) Medicare while maintaining similar levels of access and patient satisfaction, implying some efficiency gains. At the same time, providers have raised concerns that these cost controls may reduce revenues, increase administrative burden, and affect care delivery, particularly as MA enrollment has grown to represent a larger share of their patient base.

Overall, the Commission finds no statistically significant relationship between increasing MA enrollment and average profit margins for hospitals, SNFs, or HHAs. Providers in areas with faster MA growth experienced similar changes in revenues, costs, and margins as those in slower-growth markets. However, the Commission emphasizes that these findings do not establish causation and should be interpreted cautiously. Several factors may explain the lack of clear financial impact: MA's effects may be relatively modest compared to providers' total revenues; providers may offset pressure by cutting costs; and in some cases, MA-related payment adjustments or supplemental payments may partially counterbalance revenue reductions.

Hospital representatives reported that MA plans more frequently deny or downgrade claims, limit access to post-acute care, and pay rates below FFS Medicare for certain services. MA plans, in contrast, argue that these practices reduce unnecessary care,



address inappropriate billing, and often include offsetting payments tied to coding intensity or quality performance. For post-acute care providers, the financial effects of MA appear somewhat different but still inconclusive at an aggregate level. Providers report that prior authorization requirements restrict patient volume, lower payment rates, and increase administrative costs. MA plans contend these tools improve efficiency, especially in settings with wide variation in use, such as IRFs.

The Commission notes that lower utilization under MA should not automatically be interpreted as reduced access or poorer care. FFS Medicare has historically paid relatively high rates for post-acute care, creating incentives for higher service volume, so reductions under MA may reflect more efficient care management. However, the report underscores that reduced use does not necessarily equate to improved efficiency. Continued monitoring is essential to ensure that beneficiaries retain timely access to necessary services and that care quality and outcomes are not compromised as MA enrollment continues to expand.

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