



MedPAC Releases June 2026 Report to Congress

The Medicare Payment Advisory Commission (MedPAC) submitted its annual June Report to Congress, which examines several key Medicare policy issues, including beneficiary enrollment decisions, Medicare Advantage (MA) enrollment and provider finances, Medicare payment incentives, improper payments, the Medicare Ground Ambulance Data Collection System, and access to services for beneficiaries with end-stage renal disease (ESRD).

The following summarizes key findings related to Medicare payment policy, beneficiary enrollment, and the financial impact of Medicare Advantage.

Improving Payment Incentives in Medicare

Medicare pays for health care through several approaches, including traditional fee-for-service (FFS), alternative payment models (APMs), and Medicare Advantage. MedPAC continues to focus on policies that discourage the overprovision of services in FFS and reduce potential overpayments in APMs and MA while preserving beneficiary access to high-quality care.

Medicare spending totaled \$1.1 trillion in 2024, equal to 3.8 percent of gross domestic product (GDP), and is projected to exceed 5 percent of GDP by 2032. MedPAC noted that reducing Medicare spending per beneficiary will require policymakers to either modify Medicare payment formulas or influence the volume and intensity of services beneficiaries receive.

The June 2026 report does not include new recommendations on payment incentives. However, MedPAC has previously recommended:

- Reducing or eliminating beneficiary cost sharing for high-value services in traditional Medicare;
- Modestly increasing hospital inpatient, hospital outpatient, and physician payment rates while reducing payment rates for certain other provider sectors;
- Adopting site-neutral payments for services that can be safely provided in multiple ambulatory settings;
- Operating a smaller, more coordinated portfolio of APMs;
- Improving MA benchmark calculations; and
- Developing a new MA risk-adjustment methodology using two years of FFS and MA diagnostic data while excluding diagnoses obtained through health risk assessments.

Complexity of Medicare Enrollment Decisions

MedPAC also examined the increasingly complex coverage decisions beneficiaries face, particularly when choosing between traditional Medicare and Medicare Advantage. The Commission found that the volume and nature of MA marketing may contribute to beneficiary confusion, with some marketing potentially misleading consumers. Beneficiary complaints regarding aggressive MA marketing have also increased.

Medicare Advantage Enrollment and Provider Finances

MedPAC analyzed whether changes in MA enrollment are associated with the financial performance of hospitals, skilled nursing facilities (SNFs), and home health agencies (HHAs).

The Commission found no statistically significant association between market-level MA penetration and all-payer operating margins, revenues, or costs for either inpatient prospective payment system hospitals or critical access hospitals. MedPAC also found no statistically significant association between MA penetration and average all-payer margins for SNFs or HHAs.

However, several operational findings are notable. In FY 2024, MA beneficiaries had an average hospital length of stay that was 11.2 percent longer than that of traditional Medicare beneficiaries. Increased MA penetration was also associated with small declines in total facility days at SNFs and modest reductions in revenue and costs among SNFs and HHAs. Overall, MedPAC's analysis did not identify a statistically significant relationship between higher MA penetration and provider margins. However, the findings suggest that continued growth in MA enrollment may influence hospital length of stay, post-acute care utilization, and provider operations in ways that warrant continued monitoring.