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MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT TO CONGRESS ON MEDICARE PAYMENT POLICY

Washington, DC, June 15, 2026— Today, the Medicare Payment Advisory Commission (MedPAC) releases its June 2026 *Report to the Congress: Medicare and the Health Care Delivery System*. Each June, as part of its mandate from the Congress, MedPAC reports on improvements to Medicare payment systems, issues affecting the Medicare program, and changes to health care delivery and the market for health care services. This year's report examines how Medicare payment incentives affect spending and care delivery, explores challenges beneficiaries face when making Medicare enrollment decisions, reviews efforts to reduce improper payments, analyzes the association between Medicare Advantage enrollment and provider finances, evaluates access to certain palliative services under the hospice benefit, and recommends continuing and streamlining Medicare's Ground Ambulance Data Collection System.

| Improving payment incentives in Medicare. Medicare relies on three approaches to pay for health care services—stand-alone fee-for-service (FFS) Medicare, alternative payment models (APMs) layered on top of FFS Medicare, and Medicare Advantage (MA). The underlying financial incentives in these three payment approaches differ and can shape provider behavior, influence Medicare spending, and affect the value that beneficiaries and taxpayers receive from the program. Some of these financial incentives are inherent in the payment approaches; others reflect current design decisions. All three approaches play an important role in the Medicare program. Improving these approaches is essential to ensure that Medicare spending supports high-quality, efficient care and remains sustainable. The Commission regularly reviews Medicare's various payment systems with the goal of ensuring that they are structured to create incentives for the efficient practice of medicine. The Commission's recommendations are generally aimed at improving FFS Medicare incentives that encourage the efficient use of services and reducing APM and MA plan incentives that can result in higher Medicare payments.

| The complexity of Medicare enrollment decisions for beneficiaries. Once an individual becomes eligible for Medicare and during certain times of the year or after specified situations occur, they must make several complex enrollment decisions about their coverage. The complexity of the choices and numerous sources of information make it increasingly difficult for individuals to understand the requirements and relevant time frames so they can make the enrollment choices that are right for them. Beneficiaries must choose between receiving benefits from FFS Medicare or from private plans through MA. Beneficiaries who enroll in MA are typically subject to provider networks and utilization-management tools in exchange for lower premiums and a cap on out-of-pocket spending. By contrast, FFS Medicare offers a broader choice of providers with limited use of utilization-management tools but can expose beneficiaries to high out-of-pocket costs or higher premiums if they choose to acquire supplemental insurance such as Medigap. Beneficiaries consider numerous factors when making a choice of FFS Medicare or MA and the plans within those options, including financial protection, access to care, and extra benefits. To make enrollment decisions, beneficiaries rely on a variety of sources for information and advice. CMS has several tools to help beneficiaries navigate enrollment and coverage choices, including Medicare Plan Finder. The federally funded State Health Insurance Assistance Program (SHIP)

provides grants to states and territories to deliver objective information and assistance. Many beneficiaries also rely on insurance agents to help navigate their enrollment choices, but some stakeholders have voiced concern over financial incentives to direct beneficiaries toward certain plans over others.

| Medicare payment operations and their role in identifying improper payments. The Department of Health and Human Services' annual agency financial report for fiscal year 2025 stated that Medicare was responsible for an estimated \$56.7 billion in improper payments. 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. CMS and its contractors have several mechanisms in place designed to identify and reduce improper payments and fraud.

| Estimated association between Medicare Advantage enrollment and hospitals' and post-acute care providers' finances. Medicare's capitated payments to MA plans create incentives for plans to find lower-cost ways to provide care. MA plans typically have flexibility to negotiate payment rates with providers, manage the use of some services through tools such as prior authorization, and provide incentives for beneficiaries to seek care from lower-cost providers. While plans' actions may be consistent with efficient care, providers have raised concerns about detrimental effects on their finances and potential impacts on patient care. These concerns have intensified now that MA enrollees make up a substantial share of many providers' patients and revenues. However, in an analysis of the relationship between MA enrollment changes and providers' finances, we found no statistically significant association between MA penetration and hospital, skilled nursing facility (SNF), or home health agency (HHA) margins, on average. We urge caution in attributing the estimated associations between providers' finances and changes in MA enrollment, due to limitations of the analytical method. Additionally, we found that MA enrollees had a longer average hospital length of stay compared with FFS beneficiaries and that Medicare's uncompensated care (UC) payments may be mistargeted and benefit hospitals with more MA patients. For freestanding SNFs and HHAs, we found that increases in MA penetration were associated with small declines in total facility days at SNFs and small declines in revenue and costs among SNFs and HHAs. We also found that the MA share of IRF days was substantially lower than overall MA enrollment in markets with IRFs and that the clinical conditions differed between MA and FFS beneficiaries admitted to IRFs. Lower volume and revenues under MA relative to FFS Medicare is not necessarily evidence of inappropriate reductions in care. Ongoing monitoring of access, outcomes, and beneficiary experience is critical as MA enrollment continues to grow.

| Access to hospice and certain complex palliative services for beneficiaries with end-stage renal disease or cancer. The Medicare hospice benefit covers palliative and supportive services for terminally ill beneficiaries who choose to enroll. When a beneficiary enrolls in hospice, the hospice provider assumes all financial risk for costs of services that are reasonable and necessary for palliation of the patient's terminal condition and related conditions. Questions have been raised about access to certain complex services that may be palliative for some hospice beneficiaries, such as dialysis for those with end-stage renal disease (ESRD) and radiation and blood transfusions for those with cancer. Our interviews with stakeholders found general consensus that dialysis, radiation, and blood transfusions can provide symptom relief for some hospice patients and that some patients with ESRD or cancer who wish to enroll in hospice do not enroll or enroll very near the end of life due to concerns about ceasing such treatments. Our data analyses showed less hospice use and/or shorter stays among decedents with ESRD and those with blood cancer, and we estimate that certain complex palliative treatments could represent a substantial share of hospice payments, which may create incentives to avoid furnishing those services. Policymakers could consider several options to improve payment accuracy and beneficiary access to certain complex palliative services under the hospice benefit,

including collecting data on the use of such services, modifying the hospice payment system, or implementing a transitional program that would allow hospice enrollees to receive certain services for some finite period, paid for outside of the hospice benefit.

| Mandated report: Assessment of the Medicare Ground Ambulance Data Collection System.

The Commission recommends the continued collection of ground ambulance cost and revenue data, though with a more streamlined approach to focus on data essential to assessing the accuracy of Medicare payments and Medicare beneficiaries' access to care. The GADCS is a good first step toward a dataset that policymakers can use to effectively evaluate the adequacy of Medicare's payments. Since 2002, Medicare has paid for ground ambulance services provided to FFS Medicare beneficiaries using the ambulance fee schedule (AFS). The Bipartisan Budget Act (BBA) of 2018 directed MedPAC to assess and analyze the GADCS data, assess the burden on ambulance organizations of reporting the data, and recommend whether CMS should continue the data-collection effort or revise it. The GADCS contains a rich set of variables, and the data are sufficient to allow policymakers to assess the appropriateness of the AFS payment adjustments. However, measures of payment adequacy should be viewed cautiously because a majority of ground ambulance organizations receive a large share of revenue from sources unrelated to billing for such services, and there has been concern that the data contain reporting errors.

We find that the strongest driver of cost per transport was the volume of transports that an organization provides. As the number of transports increased, costs grew at a much lower rate, which suggests economies of scale. In addition, we find that cost per transport was lower for for-profit organizations relative to nonprofit and government-owned organizations. Cost per transport was also lower for organizations that used a dynamic staffing model (meaning that the number of fully staffed ambulance units varies by day, time, or season) compared with those that used a static staffing model. When controlling for other factors that affect costs (such as volume of transports), we found that organizations with rural service areas had lower cost per transport than organizations with urban service areas. However, rural organizations are more likely to be low volume and isolated, so they would benefit from payment adjustments targeted to low-volume organizations that serve isolated areas. As ambulance organizations become more experienced with collecting and submitting cost data to CMS, the GADCS should be sufficient to allow analysts to evaluate whether aggregate AFS payments are adequate to ensure beneficiary access and whether AFS payments are accurate across patient severity levels or geographic locations.

The full report is available at MedPAC's website (<http://www.medpac.gov>).

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The Medicare Payment Advisory Commission is an independent, nonpartisan Congressional agency that provides policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and health plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.