National Rural Health Association

MedPAC June Report to Congress: Medicare and the Health Delivery System

MedPAC submitted its annual June Report to Congress, which includes recommendations and discussion around Medicare beneficiary enrollment decisions, Medicare Advantage enrollment and provider finances, improving payment incentives in Medicare, identifying improper payments, an assessment of the Medicare Ground Ambulance Data Collection System, and access to services for end-stage renal disease (ESRD) beneficiaries. Please find the full report here.

Improving payment incentives in Medicare

Medicare has numerous approaches to paying for health care: Medicare fee-for-service (FFS), alternative payment models (APMs), and Medicare Advantage (MA). MedPAC focuses on recommendations to disincentivize overprovision of services (in FFS) and overpayment (in APMs and MA), while preserving beneficiary access to quality care. In the June 2026 report, MedPAC found:

- Medicare spending totaled $1.1 trillion in 2024, equivalent to 3.8 percent of GDP. By 2032, Medicare spending is projected to increase to over 5 percent of GDP.
- To lower Medicare spending per beneficiary, policymakers must either change Medicare's payment formulas or try to influence the volume and intensity of covered services and items that Medicare beneficiaries receive.

MedPAC does not offer new recommendations to improve payment incentives in this Report. In the past, MedPAC has recommended the following:

- Lowering or eliminating cost sharing for high-value services in Medicare FFS.
- Slightly increasing hospital outpatient, hospital inpatient, and the physician fee schedule rates; slightly decreasing payment rates for outpatient dialysis services and hospice services; and substantially decreasing payment rates for post-acute care providers.
- Adopt site-neutral payment rates for certain services that can be safely provided in more than one ambulatory setting.
- Operate a smaller number of APMs designed to work together.
- Improving MA benchmark calculations.
- Developing a new MA risk adjustment methodology that uses two years of FFS and MA diagnostic data and does not include diagnoses from health risk assessments from FFS or MA.

The complexity of Medicare enrollment decisions for beneficiaries.

In the June 2026 report, MedPAC examined the complex coverage choices that beneficiaries must make during Medicare enrollment periods, including the decision between Traditional Medicare and MA. Findings include:

- MA marketing may contribute to beneficiary confusion. Beneficiaries receive lots of marketing from MA organizations and some may be misleading.
- Beneficiaries have increasingly made complaints about aggressive MA marketing.

Estimated association between Medicare Advantage enrollment and hospitals' and post-acute care providers' finances.

In the June 2026 report, MedPAC analyzed the relationship between MA enrollment changes and providers' finances, with a focus on hospitals, home health agencies (HHAs), and skilled nursing facilities (SNFs). Findings include:

- MedPAC did not find evidence of a statistically significant association between MA penetration and hospital, SNF, or HHA margins.

- MA enrollees had a longer average hospital length of stay compared with FFS beneficiaries. MA enrollees had an average length of stay in FY 2024 that was 11.2 percent longer than that of FFS beneficiaries.
- No statistically significant association between market-level MA penetration and all-payer operating margins, revenues, and costs for inpatient prospective payment systems hospitals or critical access hospitals.
- Increases in MA penetration were associated with small declines in total facility days at SNFs but with no statistically significant declines in HHA total visits or patients.
- Increases in MA penetration were associated with small declines in revenue and costs among SNFs and HHAs. But MedPAC did not find statistically significant effects on all-payer margins, on average.