CHAMBER HILL

INSIGHTS

MedPAC Sessions on Medicare Advantage Networks and Payment

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On March 2, 2026, the Medicare Payment Advisory Commission (MedPAC) held the first day of its March meeting. The Commissioners held two sessions on the Medicare Advantage (MA) program, where they discussed the impacts of provider networks for beneficiaries as well as possible risk-adjustment policies. While the Commission is not planning to publish the work presented in these sessions in future reports to Congress, it was noted that the conversations would help guide future work by the Commission.

PROVIDER PARTICIPATION IN MA NETWORKS

MedPAC staff began the session by offering a comprehensive overview of MA networks and the beneficiary experience. Staff noted that provider participation in specific networks can change mid-year, which can greatly impact the beneficiary experience. Through 2023 claims and encounter data, MedPAC staff found that most clinicians participated in at least 1 MA network, with 75% of providers participating in 3 or more networks. Staff highlighted how mid-year provider network changes can be disruptive for enrollees as beneficiaries need to find new providers. MedPAC staff found that from February 2023 to June 2023, MA networks experienced a net increase in providers, with a 3% increase in primary care providers (PCPs) and a 1% increase in specialists. However, providers still left networks, with 6% of PCPs and 4% of specialists exiting by mid-year.

Commissioners were most interested in understanding the level of access beneficiaries have to providers, noting that provider participation in a network does not directly translate into beneficiaries having access in a reasonable amount of time. Some suggestions for ways to better measure access included understanding the types of care beneficiaries receive out of network, analyzing Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores for correlation rates, and offering structured interviews with beneficiaries, providers, and hospitals.

A few Commissioners suggested that future work could examine reasons why providers left a network, with one Commissioner pointing out that a large decrease in provider availability in a single network may be due to a larger system deciding not to renew a contract. One Commissioner who works in the space shared that, in his opinion, there are significant differences between data from 2023 and data from 2026 due to changes that reward clinical performance. The Commissioner explained that many MA plans are taking actions to steer beneficiaries towards high-performing but lower-cost care options, and removing higher-cost providers, which may have an impact on network robustness.

The Chair wrapped up the session by sharing that overall, the core value of the health system is being able to see a provider when care is needed, and conversations about MA provider networks can be difficult due to data completeness issues.

CONSIDERATIONS FOR IMPLEMENTING MA ENCOUNTER DATA IN RISK ADJUSTMENT

The MedPAC staff member provided an overview of how risk adjustment affects payments to MA plans and policy decisions that would need to be made in order to calibrate a risk adjustment system. There were 3 options presented. Under the first option, MA and Fee-For-Service (FFS) scores would be calculated from an MA-based risk model. Under the second option, MA and FFS risk scores would be calculated from separate MA-based and FFS-based risk models. Under the third option MA spending-based benchmarks would be calculated from existing MA data sources. Each option had different impacts on coding intensity and favorable selection, as well as partially or fully delinking MA payments from FFS data.

The Commissioners were very receptive to the presentation. No Commissioners expressed support for the first option, while options 2 and 3 were both of interest for future consideration. There was a desire from many Commissioners to create an external anchor for calculating payments, with a fear that if there is not an external source, it could be very easy for payments to increase drastically.

Commissioners had a few other considerations for a possible model, including clearly defining what constitutes an encounter, understanding the effects of different coding intensities, and separating benchmark and risk-adjustment policies. Commissioners shared the sentiment that moving towards a risk-adjustment model would improve plan data collection and reporting, which could be beneficial for other analyses.

Overall, the Commissioners were supportive of the options presented but wanted more pressure testing to better understand the possible implications for beneficiaries before a recommendation could be discussed.

We trust you found this summary useful. Please reach out to us with any questions.