

CHAMBER HILL

INSIGHTS

MedPAC

October Public
Meeting Day One

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On October 8, 2026, the Medicare Payment Advisory Commission (MedPAC) [met](#) for its second meeting of the 2026-2027 analytic cycle. During the meeting, Commissioners discussed several topics, including physician participation in Medicare Advantage (MA) networks, issues affecting the payment accuracy of the Physician Fee Schedule (PFS) and the Clinical Laboratory Fee Schedule (CLFS), and ways to improve clinician quality incentives in Fee-for-Service (FFS) Medicare.

PHYSICIAN PARTICIPATION IN MA PROVIDER NETWORKS: COMPARING PROVIDER DIRECTORIES WITH ENCOUNTER DATA

This session began with MedPAC staff providing an overview of MedPAC's previous work on physician participation in MA networks and background information on provider directories. Staff then discussed physician participation in MA at the program level and beneficiaries' use of services from physicians not listed in provider directories. Staff highlighted that over 95% of Medicare physicians provided care to MA enrollees in 2023; however, almost a third of MA encounters had a rendering physician not listed in the MA enrollee's plan provider directory. Staff concluded the presentation with an overview of their interviews with National Cancer Institute (NCI) Designated Cancer Centers and MA plans, which covered contracting practices, coverage policies, payment rates, and prior authorization concerns.

Commissioner Discussion

Commissioners opened with clarifying questions about staff work. When asked who participated in the cancer center interviews, staff said most participants were payer strategy and finance staff. When asked about the data used in the analysis, staff explained that the program-wide participation analysis used a full year of encounters, while the plan-directory comparison used only February 2023 encounters to avoid lags in directory updates. Several Commissioners asked whether results differ between Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), since going out-of-network carries very different consequences in each. Staff confirmed that breakout of this data by plan type is underway, along with work using billing National Provider Identifiers (NPIs) and taxpayer identification numbers (TINs) to separate true out-of-network care from directory errors. Staff also confirmed that a physician's participation status applies across all of Medicare, so a provider cannot participate in MA if they do not participate in FFS, and that non-participating providers can bill up to 115% of the FFS rate.

Commissioners also discussed how to understand gaps in an MA provider directory. One Commissioner said plan explanations for outdated directories should be treated as problems to fix, not accepted as reasonable. Another said the industry should be held to high accuracy standards, suggesting plans could use artificial intelligence to reconcile directories with their contract databases. However, another

Commissioner urged caution, arguing that directory inaccuracies should not be equated with barriers to care and that managed care's value in coordinating care and controlling costs should be preserved. An additional Commissioner noted that a high participation rate overall does not guarantee network adequacy in a given local market.

Several Commissioners suggested treating physicians who practice at an in-network facility, such as emergency physicians, radiologists, anesthesiologists, and hospitalists, as in-network so beneficiaries are not surprised by a bill after choosing an in-network hospital. One Commissioner cautioned that a similar idea proved highly contentious in recent federal debates over surprise billing in the commercial insurance market.

The cancer center findings drew the most varied reactions. Some Commissioners suggested requiring plans to include an NCI-designated cancer center in their network, but others were skeptical. One noted there are not centers in every state and argued that a network requirement would give centers even more market power. It was also suggested centers may limit MA patients in favor of commercial patients who pay two to three times FFS rates. Another Commissioner noted that episode costs at these centers often run higher because of repeated imaging and testing. Others argued that modern cancer care is subspecialized, multimodal, and team-based, and that service-by-service prior authorization and site-of-service rules are fundamentally incompatible with that model. One Commissioner argued that the volume of single-case agreements points to a de facto contract that should simply be made a standing one. Another noted that one-time agreements often fail to cover the years of follow-up care that cancer patients need. MedPAC staff and the Chair reiterated that the interviews reflected what centers and plans reported and that the scope of this work is descriptive, not a review of network adequacy for cancer centers or any other sector.

Mid-year contract terminations were another recurring concern. One Commissioner called mid-year network changes unacceptable and a straightforward problem to fix by holding networks constant through the plan year. Another pointed out that switching plans mid-year resets out-of-pocket spending and suggested out-of-pocket spending should follow the beneficiary.

Several Commissioners pushed back on excluding nurse practitioner (NP) and physician assistant (PA) data from analysis, as they provide a growing share of primary care in rural, geriatric, and safety-net settings, and an increasing share of specialty care. Staff noted that MedPAC recommended direct billing for these clinicians in 2019, instead of billing under a supervising physician.

Commissioners requested the following additional analyses and context:

- A narrower encounter window to test whether timing explains some discrepancies
- A plan-level view showing what share of each plan's directory physicians appear in its encounter data
- A beneficiary-level analysis of primary care physician relationships to see whether mismatches cluster among certain plans or enrollees

- A survey of access and appointment wait times at NCI Designated Cancer Centers for Medicare versus commercial patients
- More interviews with cancer center operations staff, additional MA plans, community cancer centers, and advocacy groups such as the American Cancer Society to understand potential harms beneficiaries experience as a result of fragmented cancer care
- More detail on how single-case agreements are approved and continuity of care protections
- Use of grievances, appeals, complaint tracking data, and disenrollment to measure how directory errors affect enrollees
- Exploration of policy options, including aligning contract cycles with the plan year, centralized provider directories, and counting directory accuracy toward Star Ratings

The Chair closed by emphasizing that this session's work remains focused on fact-finding. The goal is to support informed beneficiary choice, separate from network adequacy and prior authorization, and MedPAC does not expect to make recommendations on this topic at the November meeting.

ISSUES AFFECTING THE PAYMENT ACCURACY OF THE PFS AND CLFS

MedPAC staff began this session with a background on the Commission's previous work on payment accuracy for PFS and CLFS before explaining payment types such as global surgical services and "incident-to" billing, which is when providers bill under the NPI of a supervising physician. Staff then discussed telehealth billing under the PFS and the appropriateness of payment rates for those services. The last section of the presentation covered the CLFS, including recent developments from Congress, MedPAC, and private payers.

Commissioner Discussion

When asked about beneficiary cost sharing on global surgical services, staff said beneficiaries currently pay 20% coinsurance on the full bundle and would pay less under either reform option suggested in the June 2025 Report to Congress. Those options were to either convert 10- and 90-day global surgical services to 0-day services and let clinicians bill separately for postoperative visits, or keep the current payment structure but adjust valuations for 10- and 90-day global surgical services to reflect the postoperative services actually performed. Staff explained that postoperative visit assumptions come from specialty society surveys reviewed by the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) and the Centers for Medicare and Medicaid Services (CMS). The Chair added that clinical guidance on the right number of postoperative visits is largely nonexistent and that care patterns have shifted since the bundles were designed. Staff also noted that RAND looked

beyond the bundle for visits furnished by other clinicians and still found the assumed visits were simply not happening, and that postoperative visits by an NP or PA in the surgeon's practice remain part of the bundle. On labs, staff said no cost data are available, that cost sharing was originally waived because tests were inexpensive, and that MA rates are included in the private payer data used to set CLFS rates.

On the reforms suggested in the June 2025 Report to Congress related to global surgical services, most Commissioners who weighed in favored keeping the bundle and lowering its valuation rather than converting to 0-day services. Several argued that unbundling could increase postoperative visits and run counter to efforts to coordinate care, and one Commissioner noted that keeping the bundle preserves the incentive for surgeons to find efficiencies. Commissioners supported phasing in any revaluation.

Commissioners reaffirmed the 2019 MedPAC recommendation to eliminate "incident-to" billing. Some Commissioners saw little need for more work on the topic, while others asked staff to identify which practices and patients still rely on incident-to billing where direct billing is allowed, and what barriers prevent practices from billing directly.

Telehealth drew the most interest, and several Commissioners called it a high priority, particularly with flexibilities set to expire at the end of 2027. One Commissioner said paying the same rate regardless of modality made little sense, while others disagreed. One Commissioner said that in close calls MedPAC should err on the side of access and avoid heavy regulation that could stifle care innovation. Another warned that lower telehealth payment could push more visits in person and strain access. In response to a question on audio-only telehealth visits, staff said audio-only visits now make up about 10% of FFS telehealth, that most telehealth occurs in the beneficiary's home, and that Medicare does not require a telehealth clinician to communicate with a beneficiary's primary care provider. Staff also confirmed that MedPAC has no mandated telehealth report and that the NP and PA scope of practice is governed by state law, not Medicare billing rules.

Commissioners requested the following additional analyses and context:

- Beneficiary out-of-pocket costs under each global surgical option
- Interviews with primary care physicians about surgeons shifting postoperative follow-up to primary care
- A closer look at postoperative care patterns for high-volume 10-day and 90-day procedures across all treating clinicians
- Analysis of the states where incident-to billing persists despite direct billing being allowed
- Separating clinician-assisted telehealth from telehealth delivered to beneficiaries at home
- Outcomes data comparing telehealth and in-person care, such as blood pressure and A1C control
- Monitoring of telehealth prescribing, including GLP-1 prescribing, for Medicare beneficiaries

The Chair closed by noting strong Commissioner interest in continuing the telehealth work, pointing out that the Commission already has standing recommendations on global surgical services, and saying staff will continue tracking incident-to billing.

CLINICIAN QUALITY INCENTIVES IN FFS MEDICARE

The session began with MedPAC staff offering a background on previous MedPAC work on quality measurement in Medicare and the 2 current incentive pathways: the Advanced Alternative Payment Models (A-APMs) and the Merit-based Incentive Payment System (MIPS). Staff then explained concerns with MIPS, which MedPAC previously recommended eliminating in 2018, including burdensome reporting requirements, physician eligibility concerns, and performance differences across physician types. Staff then gave an overview of published literature on ways to incentivize clinician quality and some suggestions of potential analytic work. These suggestions included further analysis of MIPS participation and performance data; stakeholder interviews about experiences with MIPS, including benefits and challenges; and lessons from other performance-incentive programs.

Commissioner Discussion

Commissioners were nearly unanimous in their criticism of MIPS. One Commissioner pointed out that the reporting burden on physicians does not justify the pay benefits and urged Medicare to measure far fewer indicators, focused on outcomes, patient experience, and avoidable utilization at the practice or accountable care organization (ACO) level. Another Commissioner argued that MIPS bonuses are financed by penalties on the small and solo practices that most need resources, said the program may be contributing to consolidation, criticized CMS for being slow to retire topped-out measures, and cautioned that larger incentives can drive gaming, as seen in MA Star Ratings. A third Commissioner called for dissolving MIPS rather than tweaking the program, describing up to tenfold variation in clinician performance within a network and proposed a mandatory program built on evidence-based guidelines with meaningful rewards for high performers and penalties, or removal from Medicare, for persistent low performers.

Another Commissioner noted that 88% of physicians received a positive adjustment in 2024, that the advanced APM bonus has fallen from 5% to 1.9%, and that research found nearly four out of five quality measures do not crosswalk across FFS, ACO, and MA. This Commissioner proposed a single Medicare-wide system with capped measures, three categories (population health, beneficiary and workforce satisfaction, and cost), star ratings graded in 0.1 increments, and comparisons at a common geographic level. Several other Commissioners also supported a unified quality framework across FFS, ACOs, and MA.

Other Commissioners suggested reframing what quality measurement is for. One argued that after 25 years of modest results, policymakers should stop expecting pay-for-performance to improve quality and

instead use measurement to identify low-quality outliers, while rewarding measures tied to broad structural change. Another Commissioner proposed using existing patient surveys to flag physicians performing two standard deviations below the mean, citing a Vanderbilt program in which about 85% of outlier physicians improved after intervention. The Chair noted that identifying the lowest performers requires far smaller samples than distinguishing among clinicians in the middle of the distribution. Another Commissioner suggested scrapping MIPS for small practices, possibly keeping only an interoperability measure, while holding very large practices to a zero-sum program on a core measure set with a simple socioeconomic adjustment. Other proposals included using unplanned hospital admissions as a shared outcome measure, measuring teamwork and staffing, and having CMS field patient experience surveys directly rather than requiring practices to do so.

One Commissioner called for abandoning both MIPS and the current Medicare Shared Savings Program (MSSP) structure, arguing that ACO quality thresholds have been lowered so far that many ACOs report at about the 50% level, that payments per beneficiary have more than doubled, and that the program now rewards coding over care improvement. The Commissioner urged a return to Pre-Pathways to Success program rules and called for an all-payer claims database that patients can use directly to compare quality and cost.

Other Commissioners were more cautious. One cautioned that reliability at the individual clinician level can be as low as 6% and rarely exceeds 50% to 60%, compared with 70% to 90% at the group level, and urged staff to separate flaws specific to MIPS from challenges any replacement would face. The Chair clarified that any further analysis would inform future policy options, not judge whether MIPS works, since the Commission's 2018 recommendation still stands.

Commissioners requested the following additional analyses and context:

- A breakdown of the 764 MIPS measures by specialty
- A side-by-side comparison of MIPS Value Pathways (MVPs) and traditional MIPS scores for clinicians who report both, along with early experience from the heart failure MVP used in the Ambulatory Specialty Model beginning in January
- Measure-level performance distributions and collection types over time
- Analysis of persistent low performers, tested against other Medicare data and for sensitivity to patient mix and sample size
- Interviews on what practices actually do to improve scores on current measures
- An explanation of why Congress has not acted on the 2018 recommendation to eliminate MIPS
- An estimate of MSSP's current net cost or savings to Medicare
- Policy options for replacing MIPS, including the feasibility of a unified quality framework across FFS, ACOs, and MA

We trust you found this summary useful. Please reach out to [us](#) with any questions.

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