

MedPAC Holds October 2026 Meeting

On October 8 and 9, 2026, the Medicare Payment Advisory Commission (MedPAC) held a public meeting, which included the following sessions:

- Physician participation in Medicare Advantage provider networks: Comparing provider directories with encounter data,
- Issues affecting the payment accuracy of the physician fee schedule and the clinical laboratory fee schedule,
- Clinician quality initiatives in fee-for-service Medicare,
- Medicare's late-enrollment penalties, and
- Workplan: Assessing the accuracy of the skilled nursing facility and home health prospective payment systems.

The full agenda for the meeting and presentations for the sessions are available [here](#).

COMPARING PROVIDER DIRECTORIES WITH ENCOUNTER DATA

MedPAC staff presented a descriptive analysis comparing Medicare Advantage (MA) provider directories with encounter data, supplemented by interviews with seven National Cancer Institute (NCI) Designated Cancer Centers (NCI-DCCs) and five MA plans. Encounter data indicated that 97 percent of active Medicare primary care physicians (PCPs) and 98 percent of specialists provided meaningful care to MA beneficiaries in 2023, though nearly 10 percent of physicians appeared in encounter data without being listed in any MA directory. In a separate February 2023 analysis, 32 percent of encounters involved a rendering physician absent from the beneficiary's own plan directory, although staff could not determine how much reflected directory inaccuracies versus out-of-network care.

Interviewed MA plans reported varied experiences with their perceived market power as it pertained to contract terms. NCI-DCCs with greater perceived market power prioritized payment rates, payment timeliness, and administrative burden, whereas some were interested in participating in MA but found that plans would not contract

with them. Staffers also investigated the potential implications of mid-year contract changes for MA enrollees, with some cancer centers reporting that MA contract terminations occurred only in extreme circumstances, and others attributing terminations to center-driven factors in some instances and plan-driven factors in others. Centers generally received payments within a few points of FFS Medicare payments, and centers with greater market power reported instances in which they were better able to negotiate higher rates, while other cancer centers reported concerns that rates offered by MA plans were insufficient to cover costs.

Staff noted that nearly all NCI-DCCs interviewed about MA reported requirements for prior authorizations for most services, which were almost always approved, albeit potentially delaying care. Prior authorizations were characterized as particularly burdensome for the centers because of their use of experimental or advanced procedures. MA coverage policies were also noted as opaque, at times conflicting with accepted standards of care. Plans stressed their adherence to Medicare coverage rules, though they recognized the burden of prior authorizations on providers and enrollees and indicated efforts to streamline the process.

Overall, cancer-center interviews highlighted market-driven contracting, prior authorization burdens and potential delays, and differing coverage policies. In cases where centers were out-of-network, interviewees cited reliance on single-case agreements to maintain service for MA enrollees.

Commissioner Discussion

Commissioners broadly supported the analysis but asked staff to better distinguish administrative discrepancies from actual access barriers. Requests included stratifying results by HMO versus PPO, examining timing differences between directories and encounters, and incorporating billing NPIs and facility or group relationships to improve network-status identification. Several commissioners called for stronger directory accountability, discussing centralized provider information, alignment of contract cycles with plan years, and potential quality-measure incentives. The absence of a usable in-network/out-of-network flag in encounter data was also highlighted. Commissioners also urged staff to make the limitations regarding the exclusion of nurse practitioners (NPs) and physician assistants (PAs) more prominent and to explore sensitivity analyses or alternative data sources.

The cancer center discussion focused on continuity of care, administrative burden, and whether current arrangements provide equitable access to specialized treatment. Commissioners repeatedly asked who qualifies for single-case agreements, how much patient advocacy is required, whether agreements cover a complete treatment course, and why one center's reported volume of more than 10,000 agreements had not resulted in standing contracts. Several expressed concern that mid-year contract

terminations could disrupt treatment and increase the financial burden on patients, requesting clarification on special enrollment periods and continuity-of-care protections. Commissioners also suggested expanding interviews beyond payer-strategy staff to operations personnel, additional plans, community cancer centers, and patient advocates.

The most repeated themes were the need for reliable beneficiary-facing information, clearer interpretation of directory–encounter mismatches, and stronger understanding of protections when network relationships change; commissioners did not agree that every mismatch demonstrated an access failure. In closing, the Chair emphasized the importance of informed beneficiary choice and protection, identifying special enrollment periods, care continuity, single-case agreements, and data limitations as recurring areas for follow-up. The Chair reiterated that this work is distinct from establishing network adequacy requirements or evaluating prior authorization policy, and that remaining data gaps should limit policy conclusions. The Commission does not expect to make recommendations at the next presentation. Staff plan to return in spring with refined estimates, HMO–PPO comparisons, additional identifier matching, and analyses of other provider types for a June 2027 report chapter.

PAYMENT ACCURACY OF THE PHYSICIAN FEE SCHEDULE AND THE CLINICAL LABORATORY FEE SCHEDULE

During this session of the October 2026 meeting, MedPAC staff presented issues affecting the accuracy of Medicare (FFS) payment rates under the Physician Fee Schedule (PFS) and Clinical Laboratory Fee Schedule (CLFS). Staff discussed four primary areas for potential improvement: global surgical services, “incident to” billing, telehealth, and clinical laboratory payments.

Staff outlined options to convert 10- and 90-day global surgical services to o-day services, raising questions about whether to bill postoperative visits separately or retain the existing bundled payment structure while adjusting valuations. The payment unit for global surgical services was found to be broader than most services under PFS. To set the relative value units (RVUs) for them, CMS assumes a specific number and type of postoperative visits occur. Staff found, however, that furnished postoperative visits were far outpaced, on average, by services included in the valuation.

“Incident to” billing allows certain individuals to bill under a supervising physician’s NPI. Staff identified how this practice creates issues for Medicare, including reducing transparency and impeding program integrity, inhibiting accurate PFS valuations, and limiting evaluations of services furnished by NPs and PAs. In 2019, MedPAC recommended requiring direct billing for advanced practice registered nurses (APRNs)

and PAs, eliminating “incident to” billing for their services. Beginning this year, CMS allows for supervision of “incident to” services via audiovisual telecommunications. In 2027, a modifier for telehealth visits furnished “incident to” will be required.

Staff also discussed telehealth use in FFS Medicare, finding it has stabilized following post-public health emergency (PHE) decline. At present, Medicare pays the same rate for in-person and most telehealth visits, though MedPAC has suggested CMS pay lower rates for telehealth services while collecting data on their cost. Recent data support this, suggesting that adopting lower rates for evaluation and management, consistent with their lower costs, would have reduced 2025 FFS spending by an estimated 20 percent, or \$278 million.

CLFS

In 2025, Medicare spent approximately \$9 billion on CLFS tests, which are typically furnished by three categories of labs: independent, hospital, and physician office. CLFS spending contributes to Part B premiums, though beneficiaries do not have cost-sharing for CLFS tests. As Medicare’s rates were significantly higher than private payers, Congress enacted payment reform, with CLFS test use remaining stable following the 2018 implementation of rates based on private payers. CMS conducted a second round of data collection in 2026 from labs, accounting for a higher share of CLFS spending than in the first round, and has projected that preliminary rates based on the new data would reduce 2026 CLFS rates by 16 percent, on average.

Preliminary analysis of the new private-payer data suggests that some reductions are projected because the first-round reductions have not yet been fully phased in. Overall, analyses showed that a long, incomplete phase-in resulted in Medicare’s rates remaining above private-payer rates, increased Medicare spending, and less accurate payment rates. Analyses also demonstrated that the required caps on rate reductions in 2027 will prevent full payment reductions for nearly 800 tests.

Commissioner Discussion

The Commission emphasized the importance of accurate payment rates to maintain beneficiary access and discussed ways to limit financial burdens on beneficiaries, while examining inappropriate payment incentives.

Commissioners first discussed whether global surgical payment bundles accurately reflect the care provided after surgery and how potential changes could affect beneficiary cost-sharing. Staff explained that Medicare’s current valuations assume a greater number of postoperative visits than clinicians typically furnish, potentially resulting in overpayment for global surgical services. Commissioners considered whether converting to o-day global services or adjusting the existing bundled payments would better reflect actual utilization. Most supported preserving the bundled payment

plans for a more comprehensive approach to care. Distribution of postoperative services among surgeons, PCPs, NPs, and PAs was also of interest. MedPAC staff noted that CMS is reviewing postoperative visit data to better understand the number of visits furnished. Ensuring that payment adjustments reflected actual services delivered, rather than expected utilization alone, was one consideration.

Commissioners moved on to discuss “incident to” billing and its implications for transparency and program integrity. Under current rules, eligible services billed incident to a supervising physician are reimbursed at 100 percent of the PFS rate, compared with 85 percent when nurse practitioners and PAs bill directly. Commissioners revisited the Commission’s previous recommendation to eliminate “incident to” billing for these providers and require direct billing. Telehealth was another major focus, with questions from Commissioners on utilization trends, clinical outcomes, prescription practices, and the distinction between audio-only and audiovisual services. Commissioners supported continued monitoring of telehealth and the consideration of appropriate guardrails.

The Commission questioned Medicare’s CLFS payment accuracy and why payment reductions took time to implement, given that it continuously pays more than private payers. Staff explained that Congressional limits on annual payments, including a pause to reductions in 2021 through 2026, have delayed the full implementation of lower rates. Commissioners discussed whether payment rates based on independent laboratory data could produce more accurate results. Staff also clarified that beneficiaries do not pay coinsurance or the Part B deductible for CLFS tests, although CLFS spending contributes to Part B premiums.

MedPAC will focus on continued analysis and discussion rather than recommendations.

CLINICIAN QUALITY INITIATIVES IN FFS MEDICARE

MedPAC staff reviewed whether Medicare’s clinician quality incentive programs improve care sufficiently to justify their costs and reporting requirements, with a focus on the Merit-based Incentive Payment System (MIPS).

Staff found that the issues underlying the commission’s 2018 recommendation to eliminate MIPS persist: reporting is complex and burdensome, clinicians can select measures that favor their performance, and scores may disadvantage safety-net providers. At present, 71 percent of MIPS-eligible clinicians are scored as a group, while 20 percent are scored as an Alternative Payment Model (APM) entity. Only 8 percent of clinicians are scored individually, though the estimate of Part B-billing clinicians who are exempt from MIPS has declined, and CMS estimates around 11 percent of Medicare billing clinicians will be exempt from MIPS in the payment year 2029. While some clinicians were found ineligible for the program or chose not to report, most received

small positive payment adjustments, with a median adjustment of 0.5 percent for 2024, raising questions about whether the incentives meaningfully influence care.

Staff also reviewed 12 systematic reviews of clinician pay-for-performance programs, which generally found small or no improvements in quality. No replacement model was proposed; staff sought guidance on further analysis and discussed CMS's proposal to replace traditional MIPS reporting with MIPS Value Pathways (MVPs).

Commissioner Discussion

Commissioners broadly agreed that MIPS needs fundamental reform, but emphasized that eliminating the program should not mean abandoning quality measurements or accountability. Their main concerns were the burden on practices, unreliable comparisons across clinicians, the limited usefulness of scores for beneficiaries, and penalties that may disproportionately affect safety-net providers. Several supported simpler, more consistent measures across FFS Medicare, accountable care organizations (ACOs), and MA, although they differed on whether a small core set or broader clinical standards would better capture quality and discourage gaming. Commissioners also discussed using existing claims and electronic health record data to reduce the reporting burden, while cautioning that measures should be clinically meaningful rather than merely easy to calculate.

A common theme was shifting the focus from rewarding small differences in performance to identifying poor care and ensuring safety standards. Commissioners highlighted patient experience, communication, care coordination, patient-reported outcomes, and workforce satisfaction as potentially useful indicators. Commissioners requested further exploration of these approaches, including measurement reliability and whether they provide useful information.

Discussion emphasized reducing administrative burden, preserving meaningful accountability, improving comparability, and making quality information useful to patients. Several commissioners questioned the need for additional analysis to demonstrate MIPS's flaws, noting broad agreement that it is flawed. Commissioners supported targeted work to help design a better alternative, including comparisons of MIPS and MVP scores and analysis of persistent low performers. The Chair clarified that future work should inform alternatives rather than revisit the existing judgment on MIPS, and emphasized the need to choose a measurement level that produces reliable results. No new recommendation was made or adopted in this session. Staff plan to return in March with additional participation and performance analyses and stakeholder interviews examining reporting burden, program benefits, and lessons for future approaches.

MEDICARE LATE-ENROLLMENT PENALTIES

In this session, MedPAC staff discussed the complexity of enrollment decisions facing Medicare beneficiaries and methods to increase fairness in the Part B and Part D late-enrollment penalties. Medicare requires certain beneficiaries to pay late-enrollment penalties if they do not enroll in Part B and Part D when they first become eligible. Although these penalties aim to discourage beneficiaries with relatively lower spending from delaying enrollment until they develop greater health care needs, commissioners shared concerns that beneficiaries may inadvertently incur penalties due to the complexity of Medicare's enrollment rules or continued enrollment in employer-based plans. They discussed potential options to reform late-enrollment penalties, including making penalties consistent across Part B and Part D, reducing their size, and limiting their duration.

Commissioner Discussion

During the discussion, staff raised concerns about the implications of late-enrollment penalties on those over the age of 65 who are still employed and those below the federal poverty line. Medicare enrollment requirements for those with employer-sponsored insurance vary depending on company size, causing some beneficiaries to be overinsured. They also discussed the affordability concerns late-enrollment penalties pose for those who fall below the federal poverty line. One commissioner suggested waiving the late-enrollment penalty for those who received drug coverage through a safety net program prior to Part D enrollment. Another suggested adding a late-enrollment fee calculator feature to the Medicare Plan Finder Tool.

They observed that the current penalty system is not justified based on its net impact on enrollees, taxpayers, and the healthcare system at large. Staff emphasized that although there is a lack of research available to determine adequate late-enrollment amounts and timelines, current penalties should be capped, and lifelong penalties should be eliminated. Commissioners expressed support for broadening the Part B Special Enrollment Period (SEP) to include retiree health coverage and COBRA. To avoid unintentional late enrollment, it was suggested that the Social Security Administration (SSA) notify those over 65 when they become eligible for Medicare. During the presentation, the Chair shared that Medicare is estimated to collect \$1.1 billion in penalties this year. One commissioner asked how potential losses in penalties would impact Medicare premiums for beneficiaries, with the Chair responding that next month's meeting will include an estimate. Several commissioners inquired about how the current penalty system was set, to understand if the methodology was based on existing adverse selection research.

Overall, commissioners agreed that maintaining penalties is important to avoid adverse selection and expressed support for eliminating unnecessary complexity in the current

penalty system by decreasing penalty duration, reducing penalty amounts, and creating symmetry between Part B and Part D late enrollment penalties. Although there were discussions about employer buy-in to Medicare as a potential solution, MedPAC emphasized that it is not currently considering this as a recommendation.

Next month, MedPAC will examine ways to better inform people when they become eligible for Medicare. A final recommendation may be drafted in March or April 2027.

WORKPLAN: ACCURACY OF THE SKILLED NURSING FACILITY AND HOME HEALTH PAYMENT SYSTEMS

In this session, MedPAC staff presented a work plan to assess the accuracy of the skilled nursing facility (SNF) and home health prospective payment systems (PPSs). Both systems were redesigned and implemented in 2020 to remove therapy as a payment factor, which had created an incentive for providers to furnish unnecessary therapy to increase payments. The redesigned systems rely more heavily on patient characteristics to determine payments. Staff plan to examine five years of implementation data, from 2021 through 2025, to assess payment accuracy at the case level. The analysis will address questions related to payment accuracy, patient selection, and coding practices.

Commissioner Discussion

Commissioners broadly supported the analysis. Much of the discussion focused on clarifications they believed would strengthen the research, including its purpose and whether it was exploratory or intended to test a specific hypothesis. Staff said they want to verify the accuracy of the PPSs and determine whether there are case-level selection biases. Commissioners also asked how access to care differs between FFS Medicare and MA. Staff clarified that the evaluation covers FFS Medicare only.

Commissioners generally agreed that the analysis should examine trends over time across case-mix groups while accounting for potential selection bias. For example, some facilities may have greater access to specialized services or equipment.

Results of the analyses will be presented beginning in fall 2027.

This Applied Policy® Summary was prepared by [Crystal Uba](#) with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact her at cuba@appliedpolicy.com or 202-558-5272.