

# Physician participation in Medicare Advantage provider networks: Comparing provider directories with encounter data

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October 8, 2026

# Presentation roadmap

- ① Background
- ② MedPAC's prior discussion of clinician participation in MA networks
- ③ Program-level physician participation in MA
- ④ MA enrollees' use of services from physicians not in provider directories
- ⑤ Interviews with cancer centers and MA plans
- ⑥ Discussion and next steps

# Provider networks are a tool MA plans can use to manage care quality and costs

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- Medicare beneficiaries consistently report choice of provider as an important factor in their health care coverage
  - Many are willing to trade some degree of choice in exchange for benefits MA plans provide (e.g., lower cost sharing, additional benefits)
- Assessing MA provider networks is important to ensure that plans provide beneficiaries with adequate access to the full range of statutorily defined Medicare benefits

**Note:** MA (Medicare Advantage).

# MA program requirements related to networks

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- CMS maintains network adequacy standards to support access to the full Medicare benefit for MA enrollees
- Network adequacy currently monitored for 29 clinician specialty types and 14 facility types, based on county-level:
  - Provider-to-potential-enrollee ratios
  - Average time and distance from providers to potential enrollees
- MA plans are required to maintain accurate provider directories
  - Beneficiaries can access directories from plan websites
  - As of plan year 2026, some MA provider network information available on Medicare Plan Finder

**Note:** MA (Medicare Advantage).  
**Source:** 42 CFR 422.116; MedPAC, *June 2024 Report to the Congress: Medicare and the Health Care Delivery System*, Chapter 2.

# MA provider directories are important tool for beneficiaries, but can be inaccurate

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- Beneficiaries rely on directories when choosing coverage and when selecting a provider to address a health need
- Current system for generating and maintaining directories is complex, with documented inaccuracies
  - Providers must submit updated information to every plan they contract with, but some may have little incentive to do so
  - Plans and providers can contract at will (and clinicians move, retire, and change jobs), so networks can change throughout the plan year
- Errors or inconstancies in participation data diminish enrollees' ability to make informed decisions about their care and coverage

**Note:** MA (Medicare Advantage). NP (nurse practitioner). PA (physician assistant).  
**Source:** CMS 2018. Burman 2021. Zhu 2022. OIG 2025. Washington Post 2025.

# MedPAC's prior discussion of clinician participation in MA networks

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- In March 2026, commissioners discussed
  - Participation of PCPs and specialists in:
    - At least one MA plan
    - Multiple MA organizations
  - Change in network size and clinician entry/exit during the year
- Identified MA participation of clinicians using a database of provider directories compiled by Ideon
- Analysis included primary care NPs and PAs
  - Important providers of care to Medicare beneficiaries
  - CMS considers them PCPs when assessing network adequacy

**Note:** MA (Medicare Advantage). PCP (primary care provider). NP (nurse practitioner). PA (physician assistant). Ideon is a third-party vendor that compiles MA provider directory data.

**Source:** MedPAC analysis of 2023 CMS and Ideon data. MedPAC March 2026 meeting. <https://www.medpac.gov/document/provider-participation-in-ma-networks/>

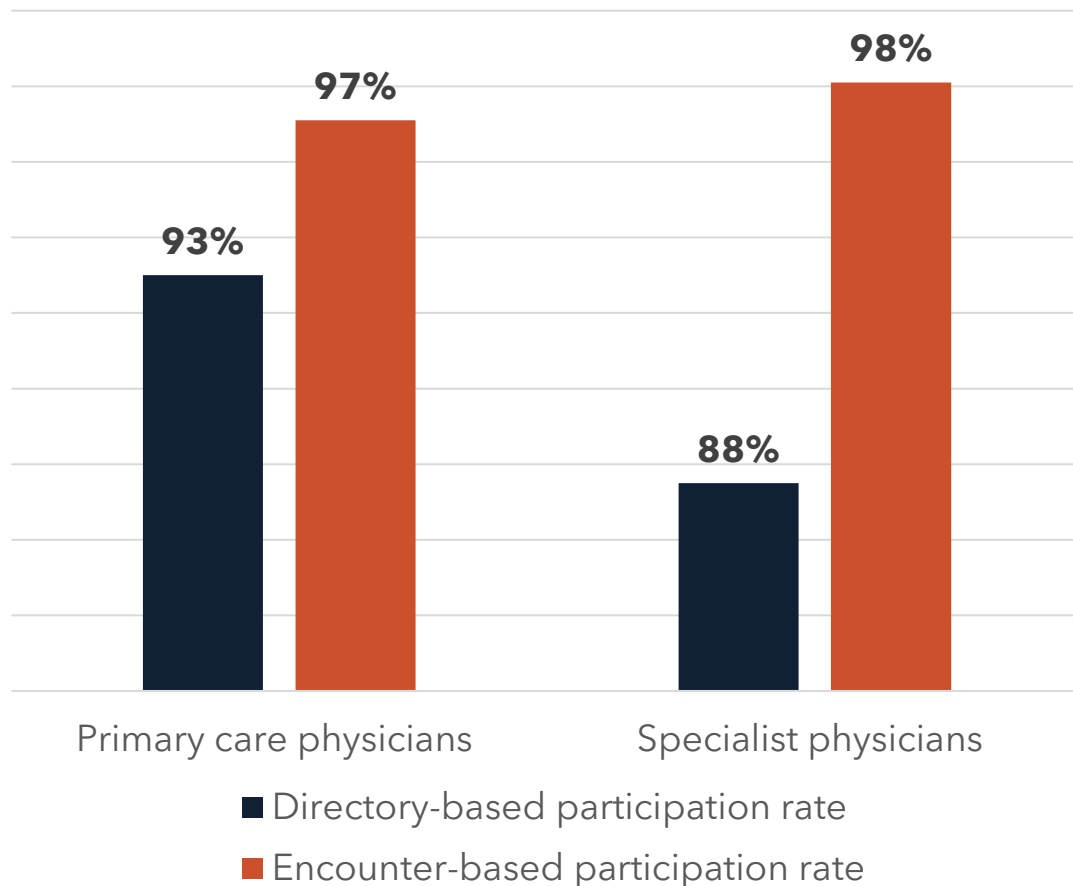
# Comparing provider directories with MA encounter data

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- Provider directories are meant to reflect the providers who are contracted to be in a plan's network
- Encounter data provides information about the clinicians who have delivered care to MA enrollees
- Our analysis is descriptive; we do not opine on the “right” level of participation in MA
- Excluded NPs and PAs from further analysis
  - Variation in recording of these providers in directories and other data sources
  - Inclusion would likely skew our understanding of PCP participation

**Note:** MA (Medicare Advantage). PCP (primary care provider). NP (nurse practitioner). PA (physician assistant).  
**Source:** MedPAC analysis of 2023 CMS and Ideon data.

# A large share of physicians participate in MA, per directories and encounter data



- *Directory-based participation:* Physician's NPI appears in at least 1 MA provider directory
- *Encounter-based participation:* Physician's MA claims volume is at least 5% of their total Medicare claims volume

**Note:** MA (Medicare Advantage), NPI (national provider identifier), FFS (fee-for-service). We excluded NPIs that did not see at least 100 unique Medicare beneficiaries in 2023, across MA and FFS. We analyze local MA coordinated care plans, excluding employer-sponsored plans.

**Source:** MedPAC analysis of 2023 NPPES, Ideon provider directory, FFS claims, and MA encounter data.

# Most physicians have some evidence of participation in MA

|                                | In MA encounter data | Not in MA encounter data |
|--------------------------------|----------------------|--------------------------|
| In provider directory data     | <b>88.4%</b>         | <b>1.6%</b>              |
| Not in provider directory data | <b>9.4%</b>          | <b>0.6%</b>              |

- Many physicians not listed in any MA provider directory are in MA encounter data
- Almost 10% of physicians who provide care to MA enrollees would not appear to be “participating in MA” by directories alone

**Note:** MA (Medicare Advantage). This analysis includes physicians who are active Medicare billers, defined as having seen 100 or more unique Medicare beneficiaries (in FFS and/or MA) in 2023 and local MA coordinated care plans, excluding employer-sponsored plans. “In provider directory data” means physician is found in at least one MA directory. “In MA encounter data” means 5% or more of total Medicare claims volume comes from MA encounters.

**Source:** MedPAC analysis of 2023 NPPES, Ideon provider directory, FFS claims, and MA encounter data.

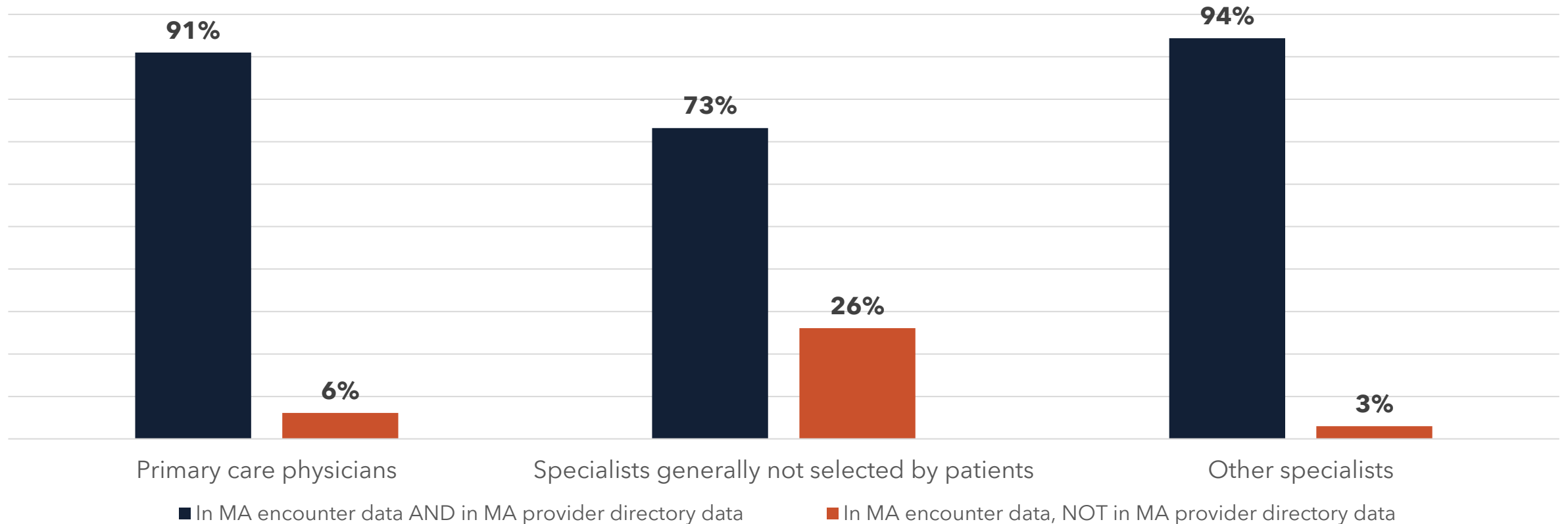
# Some specialists may be less likely to appear in provider directories

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- Behavioral health providers are less likely to participate in networks across all payers
- Some specialists generally not selected by patients, e.g.:
  - Emergency medicine, radiology, anesthesiology, hospitalists, pathology, nuclear medicine, and critical care medicine
- These specialty types may be less likely to appear in directories
  - May be less likely to contract with MA plans
  - Plans and providers may have less of an incentive to keep directories up-to-date for provider types that beneficiaries do not choose

**Note:** MA (Medicare Advantage), OIG (Office of the Inspector General).  
**Source:** Burman 2021. Zhu 2022. OIG 2025.

# Encounter-based and directory-based participation rates vary by specialty



**Note:** MA (Medicare Advantage). “Specialists generally not selected by patients” include Emergency Medicine, Radiology, Anesthesiology, Hospitalist, Pathology, Nuclear Medicine, and Critical Care Medicine. Percents do not sum to 100 because the figure does not show the small share of physicians who are not in encounter data at all. This analysis includes physicians who are active Medicare billers, defined as having seen 100 or more unique Medicare beneficiaries (in FFS and/or MA) in 2023 and local MA coordinated care plans, excluding employer-sponsored plans.

**Source:** MedPAC analysis of 2023 NPPES, Ideon provider directory, FFS claims, and MA encounter data.

# MA enrollees' use of services from physicians not listed in provider directories

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- The previous slide showed program-level participation in MA
- More salient for beneficiaries is whether the physicians providing care to MA enrollees are in their own plan's directory
- We analyzed MA encounter data for February 2023
  - Identified the rendering physician and plan associated with each encounter
  - Searched for physician NPI in the plan's provider directory
  - Analyzed encounters with in-directory physicians compared with non-directory physicians

**Note:** MA (Medicare Advantage), NPI (National Provider Identifier).

# MA encounter records frequently include physicians not listed in the enrollee's plan directory

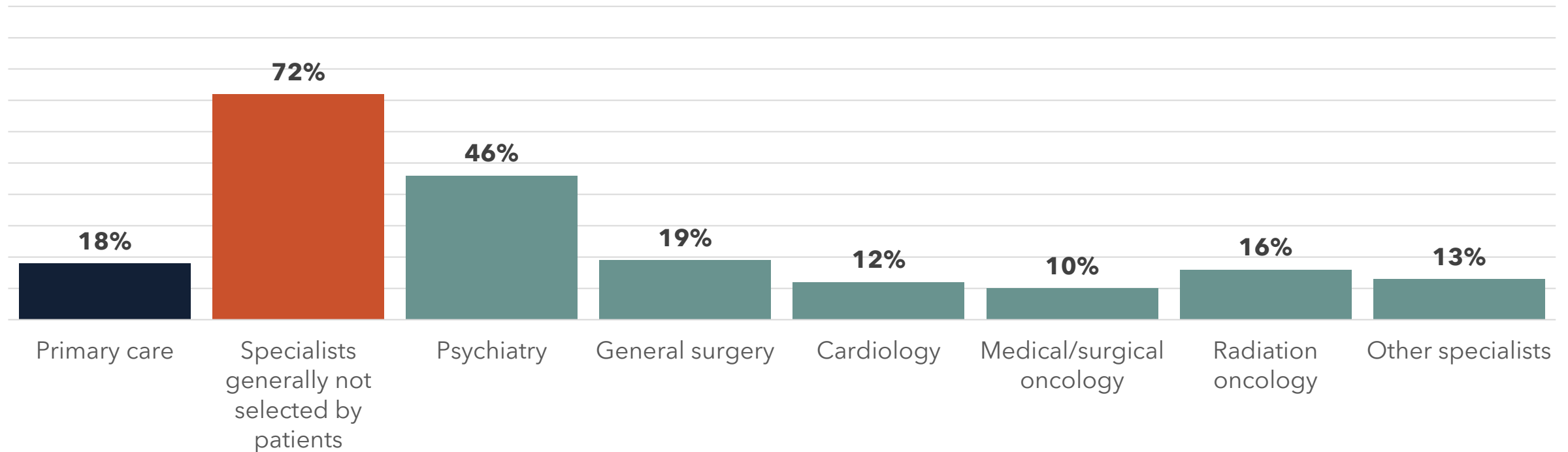
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- 32% of encounters in February 2023 had a rendering physician that was not in the enrollee's plan directory. This could reflect:
  - The directory was incomplete, lagged in updates, or otherwise inaccurate
  - The physician could have been OON with the beneficiary's plan at the time of service
- Evidence on prevalence of OON care in MA is limited
  - One study showed that between 15% and 22% of MA claims were OON

**Note:** MA (Medicare Advantage), OON (out-of-network). This analysis includes physicians who are active Medicare billers, defined as having seen 100 or more unique Medicare beneficiaries (in FFS and/or MA) in 2023 and local MA coordinated care plans, excluding employer-sponsored plans.

**Sources:** MedPAC analysis of February 2023 MA carrier encounter, Ideon provider directory, and CMS data. Pelech, D. M. 2018. Prices for physicians' services in Medicare Advantage and commercial plans. *Medical Care Research and Review* 77, no. 3 (June 25).

# Share of MA encounters with non-directory rendering physicians varies by specialty



**Note:** MA (Medicare Advantage), OON (out-of-network). "Specialists generally not selected by patients" include Emergency Medicine, Radiology, Anesthesiology, Hospitalist, Pathology, Nuclear Medicine, and Critical Care Medicine. This analysis includes physicians who are active Medicare billers, defined as having seen 100 or more unique Medicare beneficiaries (in FFS and/or MA) in 2023 and local MA coordinated care plans, excluding employer-sponsored plans.

**Source:** MedPAC analysis of 2023 NPES, Ideon provider directory, FFS claims, and MA encounter data for February 2023.

# Summary of findings on physician participation

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- Over 95% of Medicare physicians provided care to MA enrollees in 2023, as evidenced by MA encounter data
- These physicians often do not appear in provider directories
  - Nearly 10% of physicians were not in any MA provider directory, yet the MA share of their Medicare claims volume was greater than 5%
  - Nearly one third of MA encounters had a rendering physician that was not listed in the MA enrollee's plan provider directory
- Beneficiaries rely on directories when choosing coverage and when selecting a provider to address a health need

**Note:** MA (Medicare Advantage). This analysis includes physicians who are active Medicare billers, defined as having seen 100 or more unique Medicare beneficiaries (in FFS and/or MA) in 2023 and local MA coordinated care plans, excluding employer-sponsored plans.

**Source:** MedPAC analysis of 2023 NPPES, Ideon provider directory, FFS claims, and MA encounter data.



# Interviews with cancer centers and MA plans

# NCI-designated cancer centers and MA

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- CMS has NA standards for some cancer care providers:
  - Medical/surgical and radiation oncologists (2 of 29 specialty types)
  - Chemotherapy providers and infusion centers (2 of 14 facility types)
  - No minimum number requirement for subspecialists or cancer centers
- Commissioners have expressed interest in cancer care in MA
- NCI has identified cancer centers that meet research standards
- We interviewed 7 NCI-DCCs and 5 MA plans

**Note:** NCI-DCC (National Cancer Institute-Designated Cancer Center). MA (Medicare Advantage). NA (network adequacy).

# The process of negotiating contracts between MA plans and NCI-DCCs often reflects local market dynamics

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- Plans reported varied experiences with their perceived market power when negotiating contract terms
- Centers with greater perceived market power described prioritizing payment rates, timeliness of payment, and administrative burden
- Some centers expressed interest in participating in MA but reported that plans were unwilling to contract with them

**Note:** MA (Medicare Advantage), NCI-DCC (National Cancer Institute-Designated Cancer Center).  
**Source:** MedPAC analysis of interviews with NCI-designated cancer centers and MA plans.

# Plans and providers generally contract with each other on cycles not tied to MA enrollment periods

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- Commissioners have expressed interest in the potential implications of mid-year contract changes for MA enrollees
  - Centers and plans reported a range of contract cycles, which often, but not always, coincide with the plan year
  - Enrollees generally may not switch plans outside of a defined enrollment period
- Some cancer centers reported that termination of contracts with MA plans only occurs in extreme circumstances, such as plan bankruptcy
  - Other centers recalled instances where terminations did occur, sometimes driven by the cancer center and sometimes driven by the MA plan
  - Plans and centers acknowledged that the potential for contract termination could be stressful for patients

**Note:** MA (Medicare Advantage).  
**Source:** MedPAC analysis of interviews with NCI-designated cancer centers and MA plans.

# Cancer centers generally receive payment rates that are aligned with FFS Medicare, but with variation

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- Most plans and centers reported that payment rates were within a few percentage points of FFS Medicare
  - Some cancer centers are exempt from the PPS and receive cost-based payments in FFS, which may complicate their negotiations with MA plans
- Centers with greater market power reported sometimes being able to negotiate higher rates
- Other cancer centers cited concerns that the rates offered by some MA plans did not cover their costs

**Note:** FFS (fee for service), PPS (Prospective Payment System), MA (Medicare Advantage).  
**Source:** MedPAC analysis of interviews with NCI-designated cancer centers and MA plans.

# Nearly all NCI-DCCs we interviewed raised concerns about MA prior-authorization requirements

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- Cancer centers reported that MA plans require prior authorization for most services
  - These authorizations are almost always approved but may delay care
- Centers noted that prior authorization requirements are particularly burdensome for cancer centers given their utilization of experimental or advanced procedures
- Plans recognized these burdens on providers and enrollees and cited efforts to streamline prior authorization processes

**Note:** NCI-DCC (National Cancer Institute-Designated Cancer Center), MA (Medicare Advantage)  
**Source:** MedPAC analysis of interviews with NCI-designated cancer centers and MA plans.

# Centers and MA plans had varied experiences with coverage policies for cancer care

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- Several centers described MA coverage policies as opaque and sometimes conflicting with accepted standards of care
  - Plans may require step therapy or for some care to take place in a particular setting
  - Some centers also noted that MA plans have unique formularies, prior authorization requirements, and preferred treatment pathways
- Plans stressed that, while there may be differences in how coverage policies are operationalized, they follow Medicare coverage rules

**Note:** MA (Medicare Advantage)  
**Source:** MedPAC analysis of interviews with NCI-designated cancer centers and MA plans.

# Many centers reported serving MA plan enrollees even when they were out of network, primarily via single-case agreements

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- Single-case agreements are one-time contracts between a health plan and an OON provider
  - These agreements allow centers to accept more patients, but they can be burdensome for providers
- One center noted that single-case agreements for HMO enrollees can, in some cases, be more favorable for patients than relying on PPO out-of-network benefits
  - Other centers recommended PPO plans to their patients to protect them from losing all coverage if their plan goes out of network with a center
- Several centers discussed having a process for educating patients on their network status and coverage choices

**Note:** MA (Medicare Advantage), OON (out of network), HMO (Health Maintenance Organization), PPO (Preferred-Provider Organization),  
**Source:** MedPAC analysis of interviews with NCI-designated cancer centers and MA plans.

# Discussion and next steps

- Questions? Feedback?
- Planned next steps:
  - Continue to refine estimates and understand discrepancies between different sources of provider network data
  - Conduct similar analyses of MA participation of other provider types
  - Intended for June 2027 chapter



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# Out-of-network coverage varies by plan type

|                | Scenario                                                                          | Enrollee liability                                                    | Plan liability                                  |
|----------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------|
| <b>HMO</b>     | Medically necessary service or provider unavailable in network                    | In-network cost-sharing amount                                        | At least FFS amount, less enrollee cost sharing |
|                | Enrollee chooses to go out of network for any other reason                        | Full liability for provider charge (not to exceed 100% of FFS amount) | None                                            |
| <b>HMO-POS</b> | Medically necessary service or provider unavailable in network                    | In-network cost-sharing amount                                        | At least FFS amount, less enrollee cost sharing |
|                | Enrollee chooses to go out of network for a prespecified service or provider type | Fixed copay or coinsurance, usually higher than in-network amount     | At least FFS amount, less enrollee cost sharing |
|                | Enrollee chooses to go out of network for any other reason                        | Full liability for provider charge (not to exceed 100% of FFS amount) | None                                            |
| <b>PPO</b>     | Medically necessary service or provider unavailable in network                    | In-network cost-sharing amount                                        | At least FFS amount, less enrollee cost sharing |
|                | Enrollee chooses to go out of network for any reason                              | Fixed copay or coinsurance, usually higher than in-network amount     | At least FFS amount, less enrollee cost sharing |

**Note:** HMO (health maintenance organization), FFS (fee-for-service), HMO-POS (HMO point of service), PPO (preferred provider organization). Here, we summarize limits on plan and enrollee liability for Medicare participating providers. Limits are higher for the very small share of providers who do not accept Medicare assignment (less than 3 percent). This table appeared in the June 2024 report.

**Source:** Centers for Medicare & Medicaid Services. 2016. MA payment guide for out-of-network payments. <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf>.

# Out-of-network coverage varies by circumstance

| Service type                                 | Definition                                                                                                                                                                                                                                                                                                 | Enrollee cost sharing liability                                                                                                       |
|----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| Emergency services                           | Inpatient and outpatient Medicare-covered services needed to evaluate and stabilize emergency medical conditions, which are mental or physical conditions manifesting with acute symptoms that require immediate medical attention, regardless of the final diagnosis                                      | Lesser of plan's specified, in-network cost-sharing amount or CMS limit (in 2026, \$115-\$150, depending on the plan's MOOP category) |
| Urgent services                              | Nonemergent but urgently needed services provided when the enrollee is temporarily absent from the plan's service area or the plan's network is temporarily unavailable and the services are medically necessary and immediately required (like going to urgent care after spraining an ankle on vacation) | Lesser of OON amount specified by the plan or CMS limit (in 2026, 30-50% cost sharing, depending on the plan's MOOP category)         |
| Out-of-area dialysis                         | Maintenance dialysis when the beneficiary is temporarily outside the plan's service area                                                                                                                                                                                                                   | Plan's specified, in-network cost-sharing                                                                                             |
| Ancillary services at an in-network facility | Services provided by an OON provider when that OON provider works with an in-network provider (like a diagnostic lab or anesthesia)                                                                                                                                                                        | Plan's specified, in-network cost-sharing                                                                                             |
| Inadequate plan network                      | Medically necessary, covered services that cannot be provided in-network (such as specialized cancer treatment)                                                                                                                                                                                            | Plan's specified, in-network cost-sharing                                                                                             |

**Note:** MA (Medicare Advantage), OON (out-of-network), MOOP (maximum out-of-pocket), MAO (MA organization).

**Sources:** 42 CFR 422.113; *Medicare Managed Care Manual*, Chapter 4; CMS's 2022 final rule, "Medicare program; maximum out-of-pocket (MOOP) limits and service category cost sharing standards."