TOPIC: NETWORK ADEQUACY AND MISREPRESENTATION OF PROVIDER NETWORKS

Background

A major difference between Traditional Medicare (TM) and Medicare Advantage (MA) is the use of provider networks as part of MA plans' financial and quality performance strategies. Most MA organizations have contractual arrangements with selected "in-network" providers and facilities to provide care for their enrollees and charge specified cost-sharing amounts. If enrollees seek care out of network, they generally face higher out-of-pocket costs up to the full cost of care. To ensure that MA enrollees have adequate access to all Part A and B covered services, MA plans are required to meet certain standards for provider network adequacy (e.g., having contracts with enough providers in geographic locations accessible to most enrollees)[1] and provider directories (e.g., publication, interoperability, and update requirements).[2,3] The Centers for Medicare & Medicaid Services (CMS) advises beneficiaries to check whether their providers are in network before enrolling in a plan and before scheduling appointments.[4] Whether providers are in network is a key factor driving beneficiary selection of MA plans,[5] and difficulty accessing, or not receiving, needed health care is associated with enrollees' decisions to switch to TM.[6] Disputes between providers and MA organizations are increasingly common and can result in providers withdrawing from plans,[7] and, in turn, increasing the risk of insufficient provider networks.

Key Points

- MA plans are required to meet certain provider network adequacy standards and provider directory requirements.
- Risks of FWA include intentionally misrepresenting provider networks via inaccurate provider directories and submitting inaccurate data to CMS for network adequacy reviews.
- Mitigation strategies include improving oversight of network adequacy, ensuring provider directory accuracy, creating a national provider directory, verifying that providers are actively treating patients, requiring reimbursement for costs incurred due to inaccurate directories, improving information available to beneficiaries, allowing special election periods following network changes or directory inaccuracies, and aligning network adequacy and provider directory oversight.

Potential for FWA

Fraud and abuse risks may arise if MA organizations *intentionally* misrepresent their provider networks by publishing inaccurate provider directories or by inaccurately conveying their network composition when submitting data to CMS for network adequacy reviews. Provider directories containing inaccurate contact or practice information, significant numbers of providers that do not have a current contract with the plan to provide services to plan enrollees, and/or providers who do not exist are referred to as "ghost networks."[8] Inaccurate representation of certain provider types' availability or in-network status, especially providers of frequently utilized or expensive services (e.g., behavioral health) may force enrollees to seek more expensive out-of-network care. Such misrepresentation may be unintentional due to the challenges of managing dynamic data (both provider networks and providers' telephone and address details can change mid-year). In other cases, such inaccuracies can be intentional neglect of network data due to maintenance costs or even intentional misrepresentation of certain provider information to reduce utilization or meet network adequacy standards. These inaccuracies may also nudge enrollees who develop conditions associated with high spending and utilization to disenroll from the plan if they have difficulty obtaining needed care from in-network providers (see also the chapter on favorable selection).

Mitigation Approaches

Improve oversight of network adequacy. CMS could improve oversight of network adequacy by reviewing networks more frequently than every 3 years, auditing submissions for accuracy, and imposing stronger penalties. CMS currently conducts network adequacy reviews as part of the application process for issuers to offer new plans and every 3 years for existing plans.[9] For these reviews, MA organizations submit provider network data, and CMS assesses networks against established provider network adequacy standards (e.g., minimum number of providers and time and distance from a proportion of beneficiaries in the applicable county) for certain types of providers and facilities.[10] MA organizations can also request exceptions to network adequacy standards in some situations, such as if there are no available providers within the minimum required time and distance.[11]

In addition, CMS could explore options to make network adequacy standards simpler and more transparent, such as by assessing network adequacy at the plan rather than the contract level, tightening the requirements to approve exception requests, reducing the options for "credits" (e.g., for plans offering telehealth services), and publishing information about the use of exceptions and credits along with other network adequacy metrics and results. For example, when a plan's members are eligible for a special enrollment period due to significant network changes, CMS could share that information publicly, along with its assessment as to whether the plan remains compliant with network adequacy standards after the change.[12] CMS also

could improve communication with state insurance commissioners and state health insurance assistance programs when special enrollment periods are available.[13] CMS development of simpler standards and increased transparency could help enrollees understand where or why a plan's network may be more limited and reduce the risk of MA organizations submitting fraudulent network data.

Ensure provider directory accuracy. Implementing changes to ensure the accuracy of provider directories has the potential to produce significant improvements in directory accuracy and to reduce the risk of misleading beneficiaries in their decisions about MA enrollment and provider selection. CMS requires MA plans to publish provider directories showing the names, addresses, phone numbers, specialties, and cultural and linguistic capabilities of their contracted providers. MA plans must update directories within 30 days of receiving or making changes to provider information.[14,15] However, there is no current requirement for regular verification of provider directory information and directory requirements are enforced inconsistently. In addition, the last published directory audit was conducted between November 2017 and July 2018.[16] As of 2028, and consistent with requirements for other health insurance products under the federal No Surprises Act and other recent proposals,[17,18,19,20] MA plans will be required to verify provider directory information every 90 days, update the information if necessary, note in the directory that information may not be up to date if it could not be verified, and remove a provider from the directory within 5 business days after determining that the provider is no longer in network.[21] CMS will have discretion to allow for directory verification less frequently for hospitals and other facilities, but verification must be done at least once every 12 months.[22] These requirements for proactive updates should help with directory accuracy. The new law also expands the types of information that directories must include for each provider, including whether the provider is accepting new patients.[23] This is important because it will reduce the risk of misleading beneficiaries who may be looking for new providers as part of their enrollment decision.

Additional proposals to improve the accuracy and oversight of provider directories (for MA and other programs)[24,25,26,27,28] have included the following:

- The imposition of financial penalties by CMS for inaccurate directories or incentives for accurate directories such as adding a directory accuracy metric to Star Ratings or leveraging better plan data;
- CMS publication of select metrics (such as directory accuracy scores) from the audits or reports;
- Regular audits of provider directory accuracy, either by CMS, MA organizations, or independent auditors contracted by MA organizations;

- Regulations or guidance describing audit methodology, including items such as:
  - Calculating the proportion of directory listings with inaccurate information,
  - Calculating the proportion of enrollees using out-of-network providers for covered services,
  - Reviewing the resources the plan offers to help enrollees find in-network providers that are accepting new patients, and
  - Collecting documentation to verify that directory updates are conducted as required.
- Studies by the U.S. Government Accountability Office (GAO) of the implementation and impact of directory accuracy initiatives and evaluations and audits by the Department of Health and Human Services Office of the Inspector General.

Directory audits could play an important role in enhancing consumer protection and in reducing the risk of fraud and abuse due to intentionally inaccurate directories. However, implementing such audits could be costly for both CMS and MA organizations and would likely require additional funding for CMS. Directory inaccuracies due to underlying problems with the data would continue to be a problem, but over time, it is possible that pressure from audits would result in greater efforts to improve accuracy.

For plans offered in 2028 and beyond, MA organizations will be required to submit to CMS reports containing results of their analysis of plan directory accuracy.[29] Analyses must contain an accuracy score, which CMS will post publicly and which MA organizations will be required to post on their directories as of plan year 2029.[30] The law also requires the GAO to study and report on the issue, and for CMS to host a stakeholder meeting and publish guidance for MA organizations and providers to support improvements in directory accuracy and burden reduction.[31]

Create a national provider directory. A national provider directory could serve as a powerful tool for improving the accurate representation of provider networks.[32] Although such a directory would not be perfect, it would help to reduce inadvertent inaccuracies in provider directories (both for MA and other health insurance products) because issuers could refer to the directory when building networks and updating provider information.[33] CMS could use it as a "gold standard" when validating plans' data. In addition, reducing the number of unintentional inaccuracies would enable CMS to focus on the inaccuracies that are more likely to be intentional. A national provider directory could also streamline the process used by providers and plans to update directories, thereby reducing the burden on both MA organizations and providers.[34] CMS has been considering a national provider directory since at least 2018,[35] requested information on a national provider directory in 2022,[36] introduced a pilot in Oklahoma to inform potential future development of a national directory,[37] and has

announced plans to build a national directory.[38] Although there is broad support for this proposal, there are also concerns about its cost, technical difficulty, timeliness, and other implementation challenges.[39]

Related proposals include standardizing how health plans collect information from providers,[40] creating standards for data quality and interoperability of provider directories,[41] identifying ways for plans to differentiate between locations where providers regularly practice versus those where they are contracted to practice but are not regularly practicing,[42] building on existing data sets, and initially focusing federal efforts on creating a limited national data set that prioritizes accurate provider location information.[43]

Verify that providers are actively treating patients. Beginning in 2025, when MA plans include nurse practitioners, physician assistants, or clinical nurse specialists in their network submissions to meet new outpatient behavioral health requirements, CMS requires these plans to verify that these providers have delivered or will deliver relevant services to at least 20 patients within a recent 12-month period.[44] CMS could introduce similar requirements for other specialties to ensure that providers listed in network submissions can provide applicable services to plan enrollees. To fulfill the 2025 verification requirements, MA organizations can use information such as health care provider claims, prescription drug claims, or electronic health records demonstrating services delivered by the applicable provider.[45] This provision is aimed at ensuring that the mid-level providers in network submissions have the necessary skills, training, and expertise to deliver outpatient behavioral health services and to prevent ghost networks for this specialty.[46] The requirement also will reduce the risk of plans intentionally padding their networks with providers that cannot deliver the required services. Due to the compliance costs associated with enacting similar requirements for other specialties, this approach could be tested initially with the specialties that enrollees report having the most difficulty finding an in-network provider. Priority specialties could be identified from complaints or by adding targeted questions to the MA and Prescription Drug Plan Consumer Assessment of Healthcare Providers and Systems survey. Alternatively, CMS could introduce provider activity verification as a remediation requirement for MA plans that are found through audits to have high rates of directory inaccuracies.

Require reimbursement for costs incurred due to inaccurate directories. Beginning in 2028, MA plans will be liable for costs incurred due to inaccurate directories. When enrollees receive care from a nonparticipating provider or facility due to inaccuracies in provider directories, those enrollees will be entitled to in-network cost sharing, and plans will be required to notify enrollees of these protections.[47] This aligns with similar requirements in the No Surprises Act (part of the Consolidated Appropriations Act of 2021)[48] that apply to other health insurance products. MA regulations currently require that plans "arrange for and cover any medically

necessary covered benefit outside of the plan provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet an enrollee's medical needs."[49] This change could further incentivize MA organizations to ensure that provider directories are accurate and to help CMS narrow attention to remaining inaccuracies as potentially intentional misrepresentation of provider networks.

Improve information available to beneficiaries. The risks of fraud and abuse due to misleading or inaccurate provider directories could be reduced by empowering beneficiaries with better information. CMS proposed in 2024, and finalized in 2025, changes that would allow MA provider directories to be integrated into the Medicare Plan Finder[50] tool.[51,52] This policy is being implemented in 2026, and in the interim, CMS incorporated provider directory information from a third-party provider into Medicare Plan Finder for most plans for the 2026 open enrollment.[53] For plans that were included and provide their data, this system enabled prospective enrollees to search for plans based on provider name, and CMS expected directory files to be submitted weekly.[54] Under the new rule, MA organizations will be required to attest, at least annually, that directory information is accurate,[55] and, as discussed earlier, directory verification requirements will increase further as of 2028.[56] The frequently updated information and search capability should help beneficiaries make informed enrollment decisions and avoid abuse by actors that might try to steer beneficiaries into plans that do not include their regular providers. However, it is unclear whether the improved accessibility of the directory information and attestation requirements will drive improvements in accuracy. Indeed, early rollout during 2026 open enrollment has confirmed that accuracy remains a challenge with this approach.[57]

Allow special enrollment periods following network changes or directory inaccuracies. Recognizing the potential for inaccuracies in Medicare Plan Finder directory data, CMS announced that individuals will be eligible to switch to a different plan or to TM under a special election period if they enroll in an MA plan for 2026 after using Medicare Plan Finder provider directory information and discover within 3 months that their preferred provider was not actually in the MA plan's provider network.[58] Assuming beneficiaries are aware of this provision, it may incentivize MA organizations to ensure that their directory data are correct and reduce the impact on beneficiaries if they are misled by inaccurate information during plan selection. CMS extension of the provision beyond the 2026 plan year, for longer than 3 months, and to all directory information published by MA organizations, rather than just that presented in Medicare Plan Finder, could increase the incentive for MA organizations to ensure their directory information is accurate.

CMS allows special election periods for various other reasons, including when beneficiaries are affected by a significant change in their MA plan's provider network.[59] Significant changes

might include hospital systems or large medical groups leaving the network, but smaller changes, such as individual providers relocating or ceasing to practice, occur frequently and also have an impact on beneficiaries. CMS therefore requires MA organizations to notify enrollees when one of their providers is terminated from the plan's network, and enrollees can subsequently request a special election period.[60,61] CMS proposed strengthening this rule by requiring MA organizations to notify enrollees of their eligibility for a special election period when a provider is terminated, but did not finalize this provision for 2027.[62,63] Although these special election periods and notification requirements should help beneficiaries make informed choices based on provider network changes, they are unlikely to have much impact on the misrepresentation of provider networks, and improved notification requirements could increase transparency.

Align network adequacy and provider directory oversight. Regulation and oversight of provider network adequacy is independent of regulation and oversight of provider directories. This confers a risk that MA organizations could include providers in their network data submissions to CMS to meet network adequacy requirements while excluding some providers from published directories. To prevent misalignment between approved networks and enrollee information about available in-network providers, directories could be evaluated for alignment with network adequacy standards, or CMS could require use of MA plans' published directories (instead of a separate provider network data set) for network adequacy reviews. These strategies would require changes to regulations and CMS processes for assessing network adequacy. In 2024, CMS proposed requiring MA organizations to attest that directory information submitted to CMS is consistent with plans' network adequacy data submissions.[64,65] CMS did not finalize this proposal, determining that it was appropriate to distinguish network adequacy from provider directory accuracy and noting that MA organizations are already required to attest that they have adequate networks.[66]

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