PROVIDER NETWORK REQUIREMENTS IN MEDICARE

FACT SHEET JANUARY 2021

BETTER MEDICARE ALLIANCE

Key Facts

- A provider network is a defined group of health care providers that contracts with a plan to provide care to enrollees.
- Medicare Advantage offers beneficiaries several plan options with various types of provider networks.
- Provider networks are strictly regulated to ensure access to all covered benefits.

BMA Policy Recommendations

CMS should eliminate unnecessary barriers that prevent plans from offering customized, high-value provider networks to their enrollees, especially for programs focused on those with chronic conditions as well as to increase access to Medicare Advantage in rural areas. Additionally, CMS should work with stakeholders to improve the accuracy of provider directories.

Medicare Advantage allows beneficiaries to choose from a high-value network of providers that must meet strict standards to ensure access to care. Provider networks enable plans to better coordinate care and improve health outcomes while creating efficiencies in the program.

Provider Networks

- A provider network is a defined group of health care providers with whom a plan contracts to provide care to its enrollees.
- Provider networks vary according to the type of plan:
  - Health Maintenance Organizations (HMOs): HMOs have defined provider networks from whom its enrollees must receive care. Primary care physicians manage specialist referrals.
  - Preferred Provider Organizations (PPOs): PPOs have defined provider networks, but enrollees may see specialists without a referral. Networks may be local or regional, depending on the type of PPO.
  - Private Fee-For-Service (PFFS): PFFS plans may have defined networks, or they may offer beneficiaries an "open network," in which they may receive care from any provider that accepts Medicare.
- Some Medicare Advantage plans may cover care received from out-of-network providers, but out-of-pocket expenses for enrollees may be higher.

Provider Network Requirements in Medicare

- Medicare Advantage plans must adhere to network adequacy requirements to ensure beneficiary access to all covered services through the network.
- The Centers for Medicare & Medicaid Services (CMS) establish standards on provider networks based on distance and beneficiaries' clinical needs. Networks must include at least 27 provider specialty types and 13 facility specialty types within a certain distance to beneficiaries' homes to ensure proper access to care.
- Medicare Advantage plans are required to maintain provider directories that enable enrollees to review available providers in their plans.
- FFS Medicare does not have provider networks and beneficiaries may see any provider who accepts Medicare payments. Out-of-pocket costs for beneficiaries vary depending on provider, service, location, diagnosis, and additional coverage a beneficiary may have purchased.

Benefits of Provider Networks in Medicare Advantage

- Medicare Advantage plans monitor and evaluate the quality and efficiency of providers in their networks, ensuring access to the highest-value providers.
- Provider networks ensure needed providers are available to enrollees and allow doctors to coordinate beneficiaries' care, reducing duplication and unnecessary costs and facilitating improved outcomes and patient satisfaction.
- Research shows that poor coordination leads to duplicative tests and services, conflicting information between providers, and higher re-hospitalization rates of FFS Medicare beneficiaries. These unnecessary or duplicative services account for $130 billion of the estimated $765 billion of annually wasted health spending.