CHAPTER 2

Provider networks and prior authorization in Medicare Advantage

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Chapter summary

The Medicare Advantage (MA) program allows Medicare beneficiaries who are enrolled in both Part A and Part B to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. The Commission has long held that MA presents opportunities to achieve higher-quality care at lower cost. Beneficiaries who enroll in MA accept provider networks and utilization management tools such as prior authorization in exchange for additional benefits such as reduced cost sharing, limits on out-of-pocket spending, and other benefits that MA plans can provide. On the one hand, these tools have the potential to promote more efficient care, including better quality outcomes. On the other hand, misapplication of these tools could lead to beneficiaries struggling with delays or denials of needed care. CMS currently regulates certain aspects of both of these tools, but limitations persist in current data collection and enforcement mechanisms.

This chapter details MA plans' use of provider networks and prior authorization, CMS's regulation of the use of these tools, and the data that MA plans currently report in these areas. In future work, the Commission will explore the implications of provider networks and utilization management tools such as prior authorization on beneficiaries' access to care, quality of care, and cost.

In this chapter

Provider networks in MA

One key distinction between MA and FFS Medicare is that MA beneficiaries trade the free choice of any provider participating in Medicare for a more managed set of relationships with providers in an MA plan's network. Being "in network" means that a provider has agreed to furnish covered services to plan members at specified payment rates. Networks can have positive implications for both cost and quality, such as filtering out low-performing providers. However, it is important to ensure that plans provide adequate access to the full range of statutorily defined Medicare benefits.

CMS has network adequacy standards for MA contracts that consist of minimum numbers of providers, maximum travel time and distance to providers, and maximum wait times. Some of the standards vary by rurality. For example, beginning in contract year 2021, CMS reduced the percentage of beneficiaries who must reside within the maximum time and distance thresholds in non-urban counties. Lowering thresholds for network adequacy in rural areas may decrease barriers for MA plans to enter new markets, but the reductions likely result in access discrepancies between rural and urban beneficiaries.

Using a three-year review cycle, CMS verifies that Medicare Advantage organizations are compliant with network adequacy criteria at the contract level. Audits can also be triggered under special circumstances, including when an enrollee files an access complaint, and all new contracts and service area expansions must demonstrate network adequacy as part of the application process. When gaps in a network are identified, CMS notifies plans of their noncompliance and provides a list of suitable providers with whom to contract; MA organizations must then either expand their network of providers or seek an exception to the network adequacy criteria. CMS denies a majority of these exception requests. CMS has the authority to impose sanctions for noncompliance with network adequacy standards but has never done so. However, new applications have been denied on this basis.

For CMS to be able to assess network adequacy, plans' provider directories must be accurate. Accurate provider directories are also crucial for beneficiaries, who rely on them to make informed decisions about enrolling in a plan and to find new providers once they are enrolled. However, maintaining an accurate record of contracted providers can be administratively burdensome for both plans and providers. Because of the logistical challenges

associated with keeping provider directories up to date and the potential adverse consequences of not doing so, CMS has proposed maintaining a national provider directory.

Prior authorization in MA

MA plans can require enrollees to obtain prior authorization to access certain services, a practice that is not used to the same degree in FFS Medicare. Plans most often require prior authorization for relatively expensive services, such as certain Part B drugs, skilled nursing facility stays, and inpatient hospital stays (e.g., certain surgeries). A recent study found that the use of prior authorizations by MA plans increased from 2009 to 2019 for most service categories. In 2023, nearly all MA enrollees were in plans that required prior authorization for some categories of services; those requirements varied across MA plans. Because prior authorization requirements vary by service type and by plan, they can impact beneficiaries with certain conditions and some provider types and specialties more than others.

We analyzed the most recently available prior authorization determinations data that MA organizations report to CMS. In 2021, MA plans made about 37.5 million prior authorization determinations, or about 1.5 determinations per enrollee. Overall, we found that 95 percent of prior authorization requests had fully favorable decisions. The percentage of adverse prior authorization decisions varied across the largest MA organizations, with negative determination rates ranging from 3 percent to 12 percent. Providers or beneficiaries requested that MA plans redetermine 11 percent of negative prior authorization decisions in 2021. Eighty percent of those requests had fully favorable decisions. For those requests that had an unfavorable decision, an independent review entity upheld the MA plan's decision most of the time.

Prior authorization has been identified as a major source of administrative burden for many providers and can become a health risk for patients if policies affect the treatments that clinicians offer (e.g., step therapy requirements), inefficiencies in the process cause needed care to be delayed or abandoned, or poor decisions cause necessary care to be denied. Although only a small share of prior authorization requests have been denied, Office of Inspector General audits suggest that many denied requests should have been approved. CMS has recently finalized several regulatory changes

to address concerns about prior authorizations, such as requiring more transparency around MA organizations' internal coverage criteria and better communication of rationales for denied prior authorization requests. ■

The Commission has long held that Medicare Advantage (MA) presents opportunities to achieve higher-quality care at lower cost and to provide beneficiaries with choices to best meet their health care needs. Unlike traditional fee-for-service (FFS) Medicare, MA plans can use utilization management tools to contain spending and prevent beneficiaries from receiving unnecessary or low-value services. MA plans also have the ability to negotiate with individual providers to minimize cost and maximize quality. Beneficiaries who enroll in MA accept provider networks and utilization management tools such as prior authorization in exchange for additional benefits such as reduced cost sharing, limits on out-of-pocket spending, and other benefits that MA plans can provide.

However, aspects of the MA program need to be improved (Medicare Payment Advisory Commission 2024). Among other issues, the Commission has found that Medicare consistently spends more for beneficiaries enrolled in MA than the program would if the same beneficiaries were in FFS Medicare, by an estimated 22 percent in 2024 (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2023). The Commission has made several recommendations to improve the program, including:

- replacing the quality bonus program with a value incentive program that is budget neutral and evaluates MA organization performance at a local market level (Medicare Payment Advisory Commission 2020);
- addressing systematic differences between MA and FFS in the diagnostic coding on which the risk-adjustment model is based (Medicare Payment Advisory Commission 2016); and
- improving the accuracy and completeness of encounter data, which in their current state cannot be used to evaluate plan performance on multiple dimensions (Medicare Payment Advisory Commission 2019).

Managed care is premised on the idea that plans can both reduce low-value care and improve outcomes through increased oversight and coordination, selective negotiation with providers, and utilization and care management. To promote efficient care delivery, plans can use value-based purchasing arrangements, shared savings, and quality bonuses for providers. Plans can also offer enrollees rewards and incentives (e.g., gift cards for receiving a flu shot, a breast cancer screening, or a health risk assessment) to encourage healthy behavior, improve health outcomes, and reduce costs. MA plans use utilization and network management tools to control service use, thereby controlling costs.

Yet stakeholders have increasingly voiced concerns about access to care in MA, specifically with respect to network adequacy and prior authorization. Beneficiaries can struggle with barriers to access, including insufficient provider networks and inaccurate information about in-network providers and their availability to see new patients, especially in specialties such as behavioral health. Prior authorization has been identified as a major source of administrative burden for many providers and can become a health risk for patients if policies affect the treatments that clinicians offer (e.g., step therapy requirements), inefficiencies in the process cause needed care to be delayed or abandoned, or poor decisions cause necessary care to be denied.

The Commission has not yet conducted a focused review of these topics. This chapter details MA plans' use of provider networks and prior authorization, CMS's regulation of the use of these tools, and the data that MA plans currently report in these areas. In future work, the Commission will explore the implications of MA provider networks and utilization management tools like prior authorization on beneficiaries' access to care, quality of care, and cost.

MA plans' provider networks

Medicare Advantage organizations (MAOs) administer the Medicare benefit on behalf of CMS, through contracts that can span multiple states and market areas, some of which are noncontiguous. In each of these areas, they must negotiate with provider organizations to secure health care services for their enrollees. In our annual MA status reports, the Commission analyzes trends in MA (enrollment, plan availability, payments, risk coding practices, etc.) by plan type. Like the March status reports, this chapter focuses on the two most widely available plan

types—health maintenance organizations (HMOs) and preferred provider organizations (PPOs).[1] MA HMO networks tend to include a smaller set of physicians than PPOs, but they also tend to have lower cost sharing (Jacobson et al. 2017). MAOs can be strategic about the providers they decide to contract with, and these decisions can be consequential for enrollees.

While Medicare beneficiaries consistently rate choice of provider as an important factor in their health care coverage, many are willing to trade some degree of choice in exchange for reduced cost sharing, limits on out-of-pocket spending, or other benefits that MA plans can provide, such as dental and vision coverage. In our annual focus groups, beneficiaries report that a key factor when picking among plans is whether their doctor is "in-network" (Campanella et al. 2023).[2] Problems can arise when major network changes occur. When MA enrollees face difficulties finding an in-network provider, they may seek to disenroll from MA. In one of our focus groups, a beneficiary living in a rural area noted, "Some of the medical providers do not accept the Advantage plan. And so I went back to traditional Medicare because that was more acceptable in this area."

Networks can have positive implications for both cost and quality, such as filtering out low-performing providers, but they are also complex entities, and access to health care is multifaceted. Thus, it can be difficult to ensure that plans provide adequate access to the full range of statutorily defined Medicare benefits. In this section, we provide background on network types in MA and discuss network adequacy and the accuracy of provider directories.

Payment responsibility and cost sharing across MA network types

MA plan types are permitted to have varying network designs and may apply different rules for seeking out-of-network care. HMOs, which in March 2024 enrolled 11.7 million of the 33.2 million MA enrollees nationwide, generally do not reimburse enrollees for care delivered by out-of-network (OON) providers.[3] They often require that enrollees select an in-network primary care provider (PCP), who manages referrals to specialists. However, HMO point-of-service (HMO–POS) plans allow their 6.8 million enrollees to seek care without a PCP referral or from an OON provider in certain circumstances, but these plans generally require higher cost sharing when enrollees pursue care via those routes. MA PPOs, which enrolled 14.6 million beneficiaries in March 2024, provide more flexibility for enrollees by not requiring a named PCP and allowing enrollees to see both in- and out-of-network specialists without a referral.[4] However, these plans generally have both higher premiums than HMOs and higher cost sharing for OON providers compared with in-network providers.

Unlike FFS beneficiaries, beneficiaries enrolled in MA have a cap on their out-of-pocket spending. In 2023, the average out-of-pocket maximum was $4,835 for in-network services across all plans and $8,659 across both in-network and OON services for PPO enrollees (Ochieng et al. 2023).

When an enrollee goes out of network for a service, beneficiary and plan liability vary by plan type. Table 2-1 summarizes the OON enrollee cost sharing and plan liability in different plan types for different scenarios. In the event that an in-network provider cannot be identified for a medically necessary service for an MA enrollee, CMS requires that the plan (whether HMO or PPO) allow the enrollee to pay in-network cost sharing to receive the service from a noncontracted provider.[5,6] The use of OON sources of care (especially by HMO enrollees) could be an important indicator of network adequacy.

Network adequacy

Statutorily, MA plans may use their discretion to specify the providers from whom their enrollees must receive services, provided that the network is sufficient for enrollees to reasonably access all Medicare-covered services (and contracted extra benefits).[7] What this discretion means in practice, however, is difficult to specify. A plan's network adequacy can be determined in a number of ways. For instance, standards can be defined in terms of:

- minimum provider numbers to meet the needs of a population
- maximum travel time and/or distance between enrollees and providers
- maximum wait times for receipt of services

TABLE 2–1 **Out-of-network coverage by plan type**

	Scenario	Enrollee liability	Plan liability
HMO	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
HMO–POS	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
PPO	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).

Source: Centers for Medicare & Medicaid Services 2016a; Centers for Medicare & Medicaid Services 2015.

- cultural, linguistic, and other competencies of providers
- inclusion of essential community providers

CMS has network adequacy standards for 13 facility types and 29 provider types, which are evaluated at the contract level rather than the plan level (Centers for Medicare & Medicaid Services 2023d).[8,9,10] (Unlike qualified health plans on the individual market, MA plans are not required to contract with a minimum number of "essential community providers" who serve primarily low-income and medically underserved populations (e.g., federally qualified health centers, critical access hospitals) (Kaiser Family Foundation 2022).) However, contracts must demonstrate network adequacy in each county in which they operate. CMS requires MAOs to contract with a minimum number of each type of provider and facility and requires that those providers and facilities be accessible to beneficiaries within maximum travel time and distance standards that vary by geographic designation (Counties with Extreme Access Considerations (CEAC), rural, micropolitan, metropolitan, large metropolitan). Generally speaking, longer times and distances between enrollees and providers are allowable in increasingly rural locations. Beginning in 2024, plans are also expected to demonstrate adequacy on the timeliness and communication competencies of providers.

Minimum number of providers

The minimum number of providers required to meet the standard in a service area is determined by the

product of the *minimum ratio* and the *number of beneficiaries required to cover*. The *minimum ratio* is the number of providers or beds required per 1,000 beneficiaries. Minimum ratios are developed for each provider specialty type and are based on several data sources, including FFS claims, association-led workforce and productivity surveys, U.S. Census Bureau data, and published literature. The *number of beneficiaries required to cover* is an estimate of potential enrollment in a plan. It represents the minimum population that a plan's network should be able to serve, such that:

Number of beneficiaries required to cover	=	*95th percentile base population ratio*	×	*total Medicare beneficiaries residing in county*

The 95th percentile base population ratio represents the share of beneficiaries enrolled in the plan with the 95th percentile of enrollment in the county (that is, 95 percent of plans in that county have fewer enrollees). In 2024, plan networks must be sufficient to serve at least 7.9 percent of beneficiaries in large metropolitan counties and at least 13.3 percent of enrollees in CEAC.

The minimum provider-to-beneficiary ratio is established nationally and varies by both specialty type and geographic designation.[11] Minimum ratios range from 0.01 per 1,000 beneficiaries for cardiothoracic surgeons in all areas to 1.67 for PCPs in urban areas, resulting in minimum numbers of 1 for most provider types in most areas. Minimum-number standards for primary care and for metropolitan areas are generally larger than for other providers and areas. For instance, the average minimum number of PCPs in large metropolitan counties is 29.4, compared with 8.4 PCPs in metropolitan counties and 1.2 in rural counties. By contrast, plans in large metropolitan counties must contract with at least 2.6 gastroenterologists on average, whereas in all other areas the minimum standard is 1.

Across all areas, CMS sets a minimum standard of at least 12.2 beds at contracted acute inpatient hospitals for every 1,000 Medicare beneficiaries.[12] No other facility types have a minimum number standard, but they do have maximum travel time and distance standards. By default, the lack of a minimum number standard means that the 12 other named facility types have a minimum number threshold of 1.

Maximum travel time and distance standards

Maximum travel time and distance standards vary by facility type and range from 20 minutes/10 miles in large metropolitan areas to 155 minutes/140 miles for some facility types in CEACs. To satisfy the time and distance standards, at least 90 percent of enrollees residing in metropolitan or large metropolitan counties must be able to access at least one in-network provider and facility of each type within the time and distance standards. Beginning in contract year 2021, CMS reduced the percentage of beneficiaries who must reside within the maximum time and distance standards from 90 percent to 85 percent in non-urban counties (CEAC, rural, and micropolitan). For example, 85 percent of the beneficiaries in a standard rural county would have to be within 40 minutes of a primary care provider and within 75 minutes of a skilled nursing facility (Centers for Medicare & Medicaid Services 2023d, Centers for Medicare & Medicaid Services 2020). In a CEAC, the same percentage of beneficiaries would have to be within 70 minutes for primary care and 95 minutes for skilled nursing facilities.

The 2021 revised standards also provide two routes for plans to receive "credit" toward meeting travel time and distance standards: (1) plans can receive a 10 percentage point credit toward the percentage of beneficiaries within time and distance standards by contracting with telehealth providers in 12 specialties (out of 29 specialties),[13] and (2) they can receive an additional 10 percentage points for affected provider and facility types in states that have certificate-of-need (CON) laws or other anticompetitive measures that restrict the number of providers or facilities in the state. These credits, along with the reduction in the percentage of beneficiaries needed to meet the rural threshold, are additive. For example, to satisfy network adequacy requirements for dermatology in a rural county in a CON law state, an MA plan that contracts with a telehealth dermatologist would only need to demonstrate that 65 percent of beneficiaries in that county would be able to reach an in-person dermatologist within the maximum travel time and distance. This reduced standard means that 65 percent of the beneficiaries in a typical rural county would have to be within 75 minutes of an in-network dermatologist (110 minutes in a CEAC).

These reductions in the thresholds to meet network adequacy standards reflect an effort by CMS to encourage the entry of new MA plans into rural areas (Centers for Medicare & Medicaid Services 2020). However, it is incumbent upon the Medicare program to ensure that MA plans can provide access to all services covered under the Medicare benefit. In cases where a medically necessary provider is not available in network (e.g., a subspecialist), plans must arrange for the enrollee to get those services on an ad hoc basis, with in-network cost sharing. Further analysis is needed to determine whether the "credited" standards are sufficient to support adequate access to care for rural enrollees.

Recent changes to CMS network adequacy requirements

Beginning in 2024, plans have one further opportunity to receive "credit" toward network adequacy requirements. Contracts applying for new or expanded service areas receive a 10 percentage point reduction in the required number of beneficiaries (potential enrollees) within travel time and distance standards in the provisional service area. New plans may use letters of intent (LOIs) cosigned by the MAO and provider organizations with whom they intend to negotiate contracts, in lieu of signed contracts, to demonstrate network adequacy. By the beginning of the applicable contract year, LOIs are no longer an acceptable means of meeting the network standards, and MAOs must have signed contracts with providers to comply with the standard.

Beyond these changes, CMS directs plans to establish standards for the timeliness of primary care services and to communicate these standards to contracting providers. For instance, plans may stipulate that urgently needed or emergency services must be accessible "immediately"; services that are not urgently needed but require medical attention must be rendered within 7 business days; and routine and preventive care must be accessible within 30 business days. As of this year, these standards have been codified and extended to behavioral health care services, meaning that this expectation is uniform across plans and providers. CMS has not proposed any new monitoring or enforcement mechanisms alongside these changes to adequacy standards. The agency has announced that it will continue to conduct triennial audits of network adequacy (discussed below) and to monitor complaints as indicators of potential access problems.

Network adequacy audits

MA plans are expected to maintain and monitor their networks for adequacy on an ongoing basis and to submit documentation demonstrating compliance when requested. Historically, MAOs were only required to attest to the adequacy of their networks once, at the application stage. A 2015 Government Accountability Office (GAO) report found that, from 2013 through 2015, CMS reviewed less than 1 percent of all MA networks (Government Accountability Office 2015). Since that time, CMS instituted a three-year review cycle (also known as the triennial audit) to verify that plans are compliant with the network adequacy criteria. Annually, CMS selects a subset of contracts for review, generally those with the longest time since the previous audit. Plans enter their provider network information into a web application, which generates an automated evaluation of their compliance with the standards. If they are found to be out of compliance at this stage, plans must either find additional providers with whom to contract or request exceptions to the criteria, for which they must submit additional supporting documentation.

In addition to the routine network adequacy audit conducted every three years, audits can be triggered under certain circumstances:

- An MAO applies to offer a new contract or expand the service area of an existing contract.
- A "significant" contract between an MAO and provider or facility is terminated.[14]
- CMS receives a network access complaint from or on behalf of an enrollee.
- An MAO identifies a network gap and discloses to CMS that their network is out of compliance.

In 2021, CMS audited about 25 percent of MA contracts (183 contracts) for network adequacy, covering about three-fourths of all U.S. counties (2,297 counties) across 49 states, Puerto Rico, and the District of Columbia.[15] MAOs were required to submit evidence of each contract's relationships with providers and facilities, which were evaluated against minimum number and

travel time and distance standards using the web application mentioned above. For cases in which the documented relationships were insufficient to meet standards, MAOs could either bring themselves into compliance by negotiating with additional providers and resubmit their information or they could request an exception to the criteria. Facility exception requests were submitted by 33 contracts, and provider exception requests were submitted by 64 contracts. In total, 448 exception requests were submitted. Table 2-2 summarizes the outcomes of exception requests by geographic designation, specialty type, and plan type.

In 2021, 259 out of the 448 requests for exceptions to the network adequacy requirements were denied (58 percent). Requests were fairly evenly distributed across geographic designations and specialty types (Table 2-2). For instance, the specialty for which plans requested exceptions most frequently, ophthalmology, comprised only 7 percent of requests, or 32 requests nationally. The volume of requests and their outcomes differed by plan type, however, with nearly 3 times as many requests from HMOs as PPOs (311 vs. 131, respectively). Further, a full two-thirds of requests by HMOs were denied, whereas only 35 percent of requests by PPOs were denied.[16]

The most commonly cited reason for denial of a network adequacy exception request was: "CMS identified provider(s)/facility(ies) located within CMS network adequacy criteria that [the MAO] failed to include on Exception Request and/or HSD [health service delivery] table(s)." In such cases, CMS supplied the names and addresses of said providers to the MAO alongside the denial. CMS has the authority to impose intermediate sanctions or civil monetary penalties for noncompliance with network adequacy standards, but it has never done so. However, new applications have been denied on this basis.

MA plans' provider directories and accuracy of plans' network information

Accurate information about the providers included in an MA plan's network is crucial for beneficiaries because it enables them to make informed decisions about, first, enrolling in a plan and, subsequently, seeking health care services. As described above, MA enrollees incur higher cost sharing when seeking care outside their plan's provider network. CMS requires MAOs to disclose information to enrollees about a plan's service area and contracted providers in the form of a provider directory at the time of enrollment and at least annually thereafter. This directory must also be made available through the Medicare.gov Plan Finder tool.

CMS network disclosure requirements

MA plan provider directories must include the names, specialties, addresses, and phone numbers of in-network providers, as well as indications of providers accepting new patients, providers offering medications for opioid use disorder, any restrictions on access to certain providers (e.g., providers that require a referral from a PCP), and, beginning in 2024, the language and cultural competencies of those providers (whether those are provided directly or through an interpreter). Plans must disclose the extent to which enrollees may choose their providers, including OON and POS coverage, procedures for enrollees to secure in-network cost sharing when a covered service cannot be accessed through a contracted provider, and provisions for emergency and urgently needed services.

MAOs must notify enrollees of changes in a provider network resulting from the termination—with or without cause—of a contract with a provider organization. For primary care or behavioral health provider changes, notice must be given at least 45 days prior to the termination of the contract. For specialist providers, this notice must be given at least 30 days prior to the termination effective date.[17] Enrollees who are impacted by provider terminations may contact 1-800-MEDICARE to request consideration for a special election period to switch to another MA plan or FFS Medicare (depending on the enrollee's circumstances and state of residence, they may not be eligible to purchase a Medigap policy or it may cost them more). Throughout the course of network transitions or disruptions, plans are responsible for ensuring network adequacy, which may entail allowing enrollees to incur in-network cost sharing for care from OON providers when a suitable provider is not accessible in network.

Challenges maintaining MA provider directories

Changes to provider networks happen routinely; annual negotiations between MAOs and providers in a local

TABLE 2–2

CMS denied more than half of the requests for network adequacy exceptions received in 2021

	Request approved		Request denied		Review not needed[a]		Total requests	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
County designation								
Large metropolitan	18	20%	69	75%	5	5%	92	21%
Metropolitan	40	26	76	49	40	26	156	35
Micropolitan	36	36	53	54	10	10	99	22
Rural	22	28	48	61	9	11	79	18
CEAC	8	36	13	59	1	5	22	5
Top 5 specialties[b]								
Ophthalmology	9	28%	15	47%	8	25%	32	7%
Cardiac surgery	9	35	16	62	1	4	26	6
Gastroenterology	9	39	10	44	4	17	23	5
Cardiothoracic surgery	9	41	11	50	2	9	22	5
Allergy & immunology	10	48	11	52	0	0	21	5
Plan type								
HMO/HMO–POS	53	17%	209	67%	49	16%	311	69%
PPO	71	54	46	35	14	11	131	29
Unidentified[c]	0	0	4	67	2	33	6	2
Total	124	28%	259	58%	65	15%	448	100%

Note: CEAC (Counties with Extreme Access Considerations), HMO (health maintenance organization), HMO–POS (HMO point of service), PPO (preferred provider network). Percentages may not sum to 100 due to rounding. Percentages are row-wise, except for "total requests," which are within each tranche (county designation, specialty, plan type).
[a]MA organizations proactively send in exception requests. "Review not needed" signifies that CMS has reviewed the submission but has determined that it was not necessary to request an exception in the particular case.
[b]"Top 5 specialties" refers to the specialties for which plans most frequently requested a network adequacy exception.
[c]Plans that made 6 out of 448 exception requests did not have an identifiable plan type in the enrollment file. This absence could indicate a new application that did not materialize.

Source: MedPAC analysis of CMS reviews of 2021 requests for network adequacy exceptions and 2022 enrollment data.

area may lead to different contracting decisions, with the inclusion of new providers and/or the exclusion of some that were previously in network. Individual clinicians may move offices, retire, switch jobs, or change names over the course of the year. However, the current system for generating and maintaining provider directories is costly and inefficient. Plans maintain their own directories, and provider groups must submit their information to every plan they contract with. Practices must submit directory data to, on average, 20 separate payers.

Yet plans have little recourse if providers do not update their information regularly. Many plans rely on third-party vendors to validate the data that providers submit, but inaccuracies are rampant. In a 2018 evaluation of the accuracy of MAOs' online directories, CMS found that roughly half of directories had at least one inaccuracy, and inaccurate listings

comprised up to 93 percent of one directory (Centers for Medicare & Medicaid Services 2018). In 2021, CMS began publicly reporting the names and national provider identifiers of providers whose contact information was incomplete or out of date. However, Butala and colleagues found that the reporting requirements alone have been insufficient to remedy the inaccuracies of provider information (Butala 2023). They found that, by the second half of 2022, 81 percent of directory entries (covering nearly 500,000 physicians) still contained inaccuracies.

Accuracy of provider directories and network adequacy

The accuracy of provider directories is not fully separable from the issue of network adequacy. In a 2022 report, GAO highlighted a health insurance phenomenon—which stakeholders termed a "ghost network"—in which mental health care providers might be listed in a directory but on further investigation were found to be either out of network or not taking new patients (Government Accountability Office 2022). This discrepancy resulted in enrollees being functionally unable to access behavioral health services. This finding, for both MA and other insurance markets, has been replicated in academic studies (Burman and Haeder 2022, Busch and Kyanko 2020, Haeder et al. 2016, Zhu et al. 2022). The problem of widespread inaccuracies leading to inaccessible service lines has been observed in dermatology as well (Resneck et al. 2014).

Some academics advocate for more proactive monitoring on the part of CMS and—more importantly—stiffer enforcement mechanisms and penalties for noncompliance (Burman and Haeder 2021). The compliance actions issued to MAOs as a result of the 2018 CMS directory accuracy report were, in order of increasing severity, 22 notices of noncompliance, 19 warning letters, and 12 warning letters with a request for a business plan (Centers for Medicare & Medicaid Services 2018). Potential opportunities to address these concerns and logistical challenges include establishing a national provider directory, as discussed in a 2022 CMS request for information (Centers for Medicare & Medicaid Services 2022c), or allowing beneficiaries to search by provider in the Medicare.gov Plan Finder, to ensure that they are able to make informed plan choices.

Prior authorization in MA

Utilization management tools are another way health plans can coordinate and manage care and control service use. Prior authorization (also called "precertification" and "preservice determination") is an example of a utilization management process by which a provider requests approval from a payer before performing a service, providing a medical item, or prescribing a drug. Prior authorization is designed to help health plans determine the medical necessity of services and minimize unnecessary services, thereby helping to contain costs and protect patients from receiving unnecessary care. Prior authorization policies can also deter providers from offering low-value care.

MA plans can require enrollees to obtain prior authorization to access certain services, a practice that is not used to the same degree in FFS Medicare.[18,19] Nearly all MA enrollees are in plans that require prior authorization for some categories of services, and those requirements can vary across MA plans. In 2021, MA plans fully approved the vast majority of prior authorization requests they reviewed. When a provider or beneficiary asked the MA plan to reconsider an unfavorable decision, MA plans approved the majority of those reconsiderations. For those reconsiderations that had an unfavorable decision, an independent review entity upheld the MA plan's decision most of the time. Prior authorization has been identified as a major source of administrative burden for providers and can become a health risk for patients if policies affect the treatments clinicians offer (e.g., step therapy requirements), inefficiencies in the process cause needed care to be delayed or abandoned, or poor decisions cause necessary care to be denied. Because MA plan prior authorization requirements vary by service type, they can impact beneficiaries with certain conditions and some provider types/specialties more than others.

Medicare coverage requirements for MA plans

The Medicare program covers a wide range of health care services when they are medically necessary for beneficiaries.[20] MA plans are required to provide the same set of benefits that are available under FFS Medicare, except that FFS Medicare covers hospice care and certain services associated with clinical trials under Medicare's Clinical Trials Policy for MA enrollees.

MA plans must follow Medicare's national and local coverage policies. When Medicare coverage criteria are not fully established, MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature (Centers for Medicare & Medicaid Services 2023e, Centers for Medicare & Medicaid Services 2016a). MA plan clinical criteria are typically more detailed than Medicare coverage rules and are intended to assist with clinical decision-making. MA plans must provide beneficiaries with an annual Evidence of Coverage document that gives an overview of coverage requirements and beneficiary cost sharing. MA plans are also required to make available their coverage criteria on a publicly accessible website. (Some of these requirements are recent changes; see below (p. 84).)

The MA prior authorization determinations and appeals process

The MA prior authorization and appeals process is complex and involves multiple levels (Figure 2-1, p. 80). MA determination and appeal procedures apply to all benefits offered under an MA plan, including optional extra benefits. MA plans must establish procedures for making decisions about whether to approve or deny prior authorization requests (Centers for Medicare & Medicaid Services 2022b). MA plans' clinical staff review prior authorization requests to determine whether items and services are medically necessary and reasonable for the beneficiary and whether they meet Medicare and MA plan coverage rules. Typically, the process begins when a provider submits to an MA plan a request for prior authorization for an enrollee to receive a health care service or item (e.g., durable medical equipment). Once the request is received, the MA plan must decide as expeditiously as the enrollee's health condition requires. An MA plan must provide notice of its prior authorization determination within 72 hours after receiving an expedited request or 14 days after receiving a standard request. If the enrollee or their provider believes that waiting 14 days could seriously harm the enrollee's life, health, or ability to regain maximum function, they can request an expedited decision.

If the MA plan's prior authorization review results in a determination that is adverse to the enrollee's request, the enrollee has several options. They might elect not to receive the service, elect to receive the service and pay for it out of pocket, or request a reconsideration from the plan. Plans are required to send a written denial notice that informs enrollees of their right to file a reconsideration request and their right to be represented by a relative, attorney, or other party. The reconsideration must be requested within 60 days of the coverage determination. A reconsideration consists of a review of an adverse initial determination, the evidence and finding on which it was based, and any other evidence that the parties submit or that is obtained by the plan. If the initial denial was based on a lack of medical necessity, then the reconsideration review must be performed by a physician with expertise in the appropriate field of medicine for the item or service in question.

If the MA plan upholds the adverse decision after reconsideration, the MA plan must automatically forward the case file and its decision to an independent review entity (IRE), which is an outside organization under contract with CMS. The IRE is required to issue a reconsideration decision notice that contains specific reasons for the entity's decision and, in the case of an adverse decision, information for the enrollee regarding their right to proceed to an administrative law judge (ALJ) if the claim (e.g., cost of the service) exceeds the amount in controversy (AIC) threshold.[21] If the enrollee remains dissatisfied and their case involves an amount that meets a predetermined AIC threshold ($180 in 2024), they may appeal to an ALJ. The enrollee must file a request for a hearing within 60 calendar days of the written notice of a reconsideration.

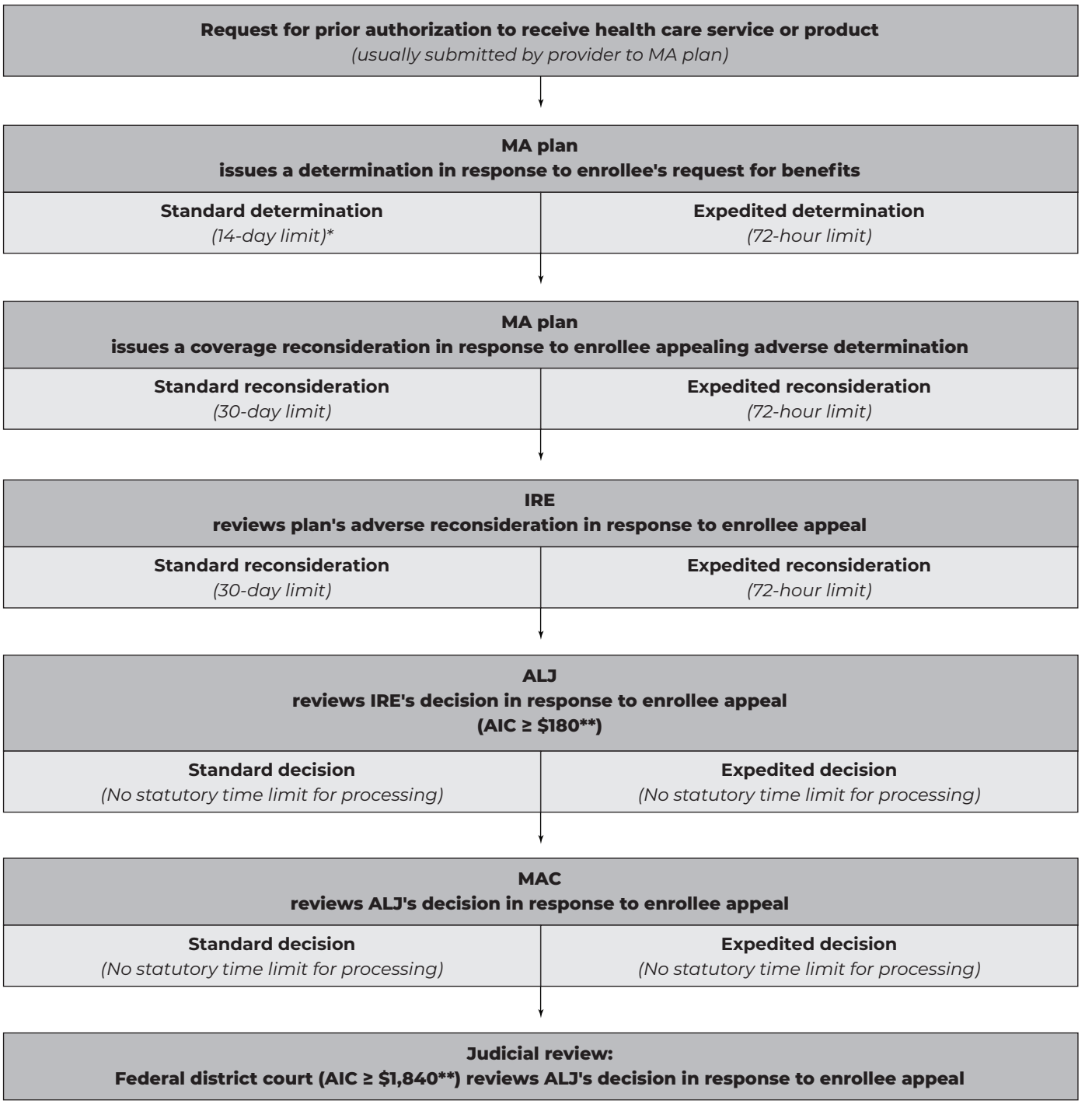
The next phase of the appeals process is the Medicare Appeals Council (MAC), an independent review board that issues final decisions for CMS. There is no set amount in question required to proceed to this level of appeal. A request for a review from a MAC must also be filed within 60 calendar days of the receipt of the ALJ's written decision notice. Finally, the enrollee may take the claim to federal district court, as long as the AIC exceeds the specified dollar threshold ($1,840 in 2024). The case must be initiated in the judicial district in which the enrollee lives or the MAO is located.

CMS oversight of MA plan prior authorizations

CMS has several tools to oversee MA plans' use of prior authorization. First, each year, CMS audits a sample

FIGURE 2-1

Medicare Advantage prior authorization and appeals process



Note: MA (Medicare Advantage), IRE (independent review entity), ALJ (administrative law judge), AIC (amount in controversy), MAC (Medicare Appeals Council). A request for a coverage determination or an appeal can be submitted by an enrollee, the enrollee's prescribing physician, or the enrollee's authorized representative. The time periods in parentheses are the amount of time the entity has to make its decision. If, at any level of the appeals process, a decision is fully favorable (i.e., service fully approved for coverage and payment), then the appeals process for that request ends.
*Beginning in 2026, MA plans will have seven days to respond to standard determination requests.
**AICs shown are for 2024.

Source: CMS managed care appeals flow chart (Centers for Medicare & Medicaid Services 2022b).

of MAOs in several program areas, including coverage determinations and appeals, to measure compliance with the terms of its contract with CMS. During the audits, CMS reviews a sample of MA plan denials to determine whether they were appropriate, but CMS does not calculate a rate of inappropriate denials. CMS requires MAOs to implement corrective action plans to address any audit violations and to demonstrate that they have substantially corrected deficiencies before the audit is officially closed. CMS may impose civil monetary penalties and sanctions for serious violations identified through audits.

Second, as described in more detail below, MA contracts are required to report the number of determinations and reconsiderations for services requested by enrollees and the outcomes of the reviews. CMS can use these data to oversee MA contracts' overall denial and appeal rates. Third, CMS collects and publicly reports on Medicare.gov's Plan Finder two administrative measures of the decisions in the IRE step of the appeals process: (1) whether a health plan makes timely decisions about appeals (how fast a plan sends information for independent review) and (2) the fairness of the health plan's appeal decisions as assessed by an independent reviewer (how often the independent reviewer found the health plan's decision to deny coverage to be reasonable) (Centers for Medicare & Medicaid Services 2022a). These measure results are used in calculating the star ratings and are assigned the highest weight when calculating the ratings.

Use of prior authorization and appeals in MA

MA contracts are required to report to CMS what categories of health care services require prior authorization. MA contracts must also report the aggregate number of determinations and reconsiderations for services requested by enrollees or providers, as well as the outcomes of the reviews.[22] CMS also reports on the decisions in the IRE step of the appeals process. However, there are several gaps in the information that CMS currently collects from MA insurers. For example, MA contract-level reporting does not allow us to compare rates of prior authorization and outcomes by plan type (e.g., HMO and HMO-POS, which can be governed under the same contract). Also, because MA contracts are required to report aggregate data, we are unable to report prior authorization requests or outcomes by service type, specialty, or beneficiary characteristic.

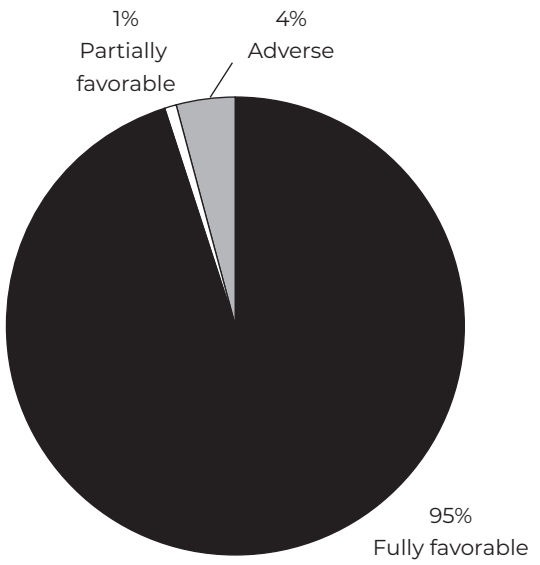
A recent study found that the use of prior authorizations by MA plans increased from 2009 to 2019 for the majority of service categories (Neprash et al. 2024). In 2023, nearly all MA enrollees (99 percent) were in plans that required prior authorization for some categories of services (Ochieng et al. 2023). Prior authorization is most often required for relatively expensive services, such as certain Part B drugs, skilled nursing facility stays, and inpatient hospital stays (e.g., certain surgeries), and is rarely required for preventive services. Prior authorization is also required for the majority of enrollees for some extra benefits (in plans that offer these benefits), including comprehensive dental services, hearing and eye exams, and transportation.

Relative to FFS, a large number of the services sought by MA enrollees (or by providers on their behalf) may be subject to prior authorization. In a recent study, Schwartz and colleagues studied the scope of prior authorization by applying a private insurer's MA prior authorization rules to the medical services provided to FFS Medicare beneficiaries under Medicare Part B (Schwartz et al. 2021). They identified medical services that would be subject to prior authorization, but not the outcome of the prior authorization (i.e., approval or denial). They found that 41 percent of FFS beneficiaries in their sample received at least one service per year that would have been subject to prior authorization under an MA plan's prior authorization requirements. Part B drugs/injectables accounted for the largest share of prior authorization services, followed by radiology services, then musculoskeletal services. Physician specialties varied widely in rates of services that required prior authorization, with the highest rates among radiation oncologists (97 percent), cardiologists (93 percent), and radiologists (91 percent) and lowest rates among pathologists (2 percent) and psychiatrists (4 percent). Thus, beneficiaries with certain conditions and certain physician specialties are more subject to prior authorization policies than others. Researchers also applied to Medicare FFS claims prior authorization policies for five insurers that service most of the beneficiaries covered by MA plans and found similar findings (Gupta et al. 2024). They also concluded that

FIGURE 2–2

Vast majority of MA prior authorization determinations were fully approved, 2021

Total = 37.5 million MA prior authorization determinations



Note: MA (Medicare Advantage). MA organizations submit the required data at the contract level to CMS, and CMS performs a data validation check. There are three types of determinations resulting from an MA plan's prior authorization review: (1) fully favorable (i.e., service fully approved for coverage and payment), (2) partially favorable (i.e., coverage and payment for service approved at a reduced level or another service altogether is approved, such as 5 therapy visits approved instead of the 10 visits requested); or (3) adverse (i.e., denial of coverage and payment).

Source: MedPAC analysis of determinations and reconsiderations—Part C data from the CMS Part C and Part D reporting requirements public use file, 2021.

prior authorization policies varied substantially across insurers, suggesting little consensus on what specific services require prior authorization.

MA plans made about 37.5 million prior authorization determinations in 2021, which is about 1.5 determinations per enrollee.[23] The number of prior authorization determinations varied across the five largest MAOs, from 0.3 determinations per enrollee to 2.8 determinations per enrollee.

In the CMS-collected data, there are three types of determinations resulting from an MA plan's prior authorization review: (1) fully favorable (i.e., service fully approved for coverage and payment); (2) partially favorable (i.e., coverage and payment for service approved at a reduced level or another service altogether is approved, such as 5 therapy visits approved instead of the 10 visits requested); or (3) adverse (i.e., denial of coverage and payment). Though a substantial number of services may be subject to prior authorization, overall we found that 95 percent of prior authorization requests in 2021 had fully favorable decisions. Just 1 percent of prior authorization requests had partially favorable decisions, and 4 percent had adverse decisions (5 percent partially or fully negative) (Figure 2-2). However, the percentage of negative prior authorization decisions varied across the largest MAOs, with negative determination rates ranging from 3 percent to 12 percent (data not shown).

As described above, enrollees and providers can appeal negative prior authorization determinations if they disagree with the MA plan's coverage decision. In 2021, MA plans reconsidered about 229,000 initial determinations, or 11 percent of initial partially favorable and adverse prior authorization decisions (Figure 2-3). Eighty percent of the reconsideration requests had fully favorable decisions, 1 percent had partially favorable decisions, and 18 percent had adverse decisions. The share of initial partially favorable and adverse prior authorization decisions that were appealed and subsequently reconsidered varied across MA organizations, from 2 percent to 21 percent of negative decisions reconsidered.

As noted above, if the MA plan upholds the adverse decision after reconsideration, the case file must be forwarded to the IRE. The appeals data that the IRE reports to CMS are structured differently from the reconsideration data that MA plans report, so we cannot clearly identify how many of the adverse MA prior authorization reconsiderations are reviewed by the IRE.[24] We can report that cases reviewed by the IRE mostly upheld MA plan determinations. In 2021, 96 percent (or about 50,000) of the expedited and preservice cases reviewed were decided unfavorably by the IRE (i.e., the IRE upheld the MA plan's determination) (Centers for Medicare & Medicaid Services 2023c). CMS also publishes short summaries of the IREs' decisions on all Part C appeals (Centers for Medicare & Medicaid Services 2023b). We reviewed and categorized the summaries of the appeals for a snapshot of time. We found that about half of the upheld IRE decisions were requests to preapprove

acute inpatient rehabilitation facility admissions and services, 20 percent were for durable medical equipment, and 10 percent were for acute inpatient surgeries. Again, beneficiaries with certain conditions and certain providers may be more affected by prior authorization policies.

Concerns about MA prior authorization

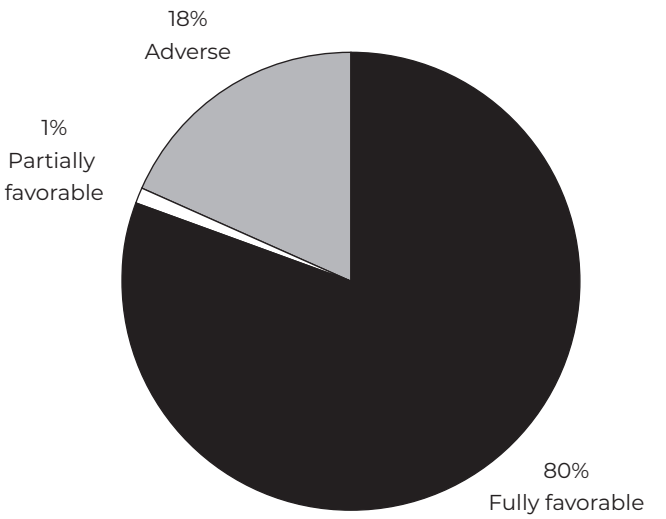
Over the years, stakeholders have increasingly voiced concerns about MA prior authorization requirements and processes: specifically, that MA plans are inappropriately denying prior authorization requests; that providers find prior authorization to be an increasing burden; and that prior authorizations may cause enrollees to delay care, abandon care, or pay out of pocket (American Medical Association 2023, Office of Inspector General 2022).

Although only a small share of prior authorization requests are denied, CMS audits suggest that many denied requests should actually have been approved (Office of Inspector General 2018). The Office of Inspector General (OIG) found that CMS cited about half of audited MA contracts in 2015 for inappropriately denying prior authorization requests, for sending insufficient denial letters, and for missing required information such as why the request was denied or how to appeal. OIG also found that 75 percent of denial appeals were fully or partially successful, raising concerns that MA plans were denying services and payments that should have been approved initially. A 2022 follow-up OIG report examined a subset of denied prior authorization requests to assess the extent to which the denied requests met Medicare coverage rules and thus would likely have been allowed in FFS Medicare (Office of Inspector General 2022). OIG's case file review found that among the prior authorization requests that MA plans denied, 13 percent met Medicare coverage rules: In other words, these services likely would have been covered for these beneficiaries under FFS Medicare. OIG identified two common causes of these denials. First, MA plans used clinical criteria that are not contained in Medicare coverage rules (e.g., requiring an X-ray before approving more advanced imaging), which led the plans to deny requests for services that OIG physician reviewers determined were medically necessary. (Note that beginning in 2024, CMS prohibits MA plans from applying clinical criteria that are not contained in traditional Medicare coverage policies (Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2023e). These changes to regulations are further discussed later in the chapter.) Second, MA plans indicated that some prior authorization requests did not have enough documentation to support approval, yet OIG reviewers found that the beneficiary medical records that were already in the case file were sufficient to support the medical necessity of the services.

FIGURE 2–3

Majority of MA prior authorization reconsiderations were fully approved, 2021

Total = 229,000 MA prior authorization reconsiderations



Note: MA (Medicare Advantage). MA organizations submit the required data at the contract level to CMS and CMS performs a data validation check. There are three types of determinations resulting from an MA plan's prior authorization review: (1) fully favorable (i.e., service fully approved for coverage and payment), (2) partially favorable (i.e., coverage and payment for service approved at a reduced level or another service altogether approved, such as 5 therapy visits approved instead of the 10 visits requested), or (3) adverse (i.e., denial of coverage and payment). Components do not sum to 100 percent due to rounding.

Source: MedPAC analysis of determinations and reconsiderations, Part C data from the CMS Part C and D reporting requirements public use file for contract year 2021.

Providers find prior authorization to be an increasing burden. Some providers and physician specialties may face the weight of prior authorization policies more than others. In the Commission's annual focus groups with physicians, nurse practitioners, and physician assistants, many clinicians brought up, without prompting, the negative effects of prior authorizations (Campanella et al. 2023). Many clinicians expressed frustration with the number of prior authorizations from insurance companies generally, with several noting that their practices have hired dedicated staff members to manage this administrative burden. In a focus group conducted in 2023, one physician said:

> For the past year to two years, we went from a manageable amount of prior authorizations or denials to an absurd amount of denials right off the bat, which is really impacting. . . . We've had to hire staff just to deal with [authorizations] and denials. Most of the time, it's coming from these Advantage plans that flat out deny, and you can't appeal until you essentially get on a peer-to-peer [phone call], and oftentimes that's not easily accessible during the course of the day, either.[25]

Some insurers are taking steps to reduce the administrative burden on providers, but it is too soon to determine the effects of these actions. As an example, one of the largest MAOs recently implemented a two-phase approach to eliminate the prior authorization requirement for many procedure codes (United Healthcare 2023). They estimate that these code removals account for nearly 20 percent of the organization's prior authorization volume. As another example, some commercial insurers are increasingly using "gold carding," which selectively waives or reduces prior authorization requirements for high-performing providers. In a survey of commercial health insurers, the majority of plans reported that gold carding worked better for some services than others, such as when there are clear and consistent clinical standards of care (e.g., high-tech imaging) (America's Health Insurance Plans 2023). While varying by specialty and geography, common criteria for accepting providers in gold-card programs included low prior authorization denial rate and participation in a risk-based contract. Insurers reported mixed reviews of the programs: Some cited improved provider satisfaction but also said that the program was administratively difficult to implement and reduced quality/patient safety.

Another physician in our focus groups said that the "red tape" of prior authorizations from MA plans can cause inordinate delays in care and tension between patients and their doctors, noting:

> [The patient] had a lung mass that I needed to biopsy, and I had to do the robotic navigational protocols. And she showed up to get her scan, and she was very nervous. And then [the scan provider] said, "Your insurance actually denied it." And so, she was lost to follow-up for me for eight months, because she was so frustrated that she worked up the courage to go for the scan, and then they said, "Sorry, it's not worked out yet with your insurance." Eight-month delay in her care.

Recent regulations governing use of MA prior authorization

In April 2023, CMS finalized several regulatory changes to address concerns about MAOs' use of prior authorizations and its effect on beneficiary access to care (Centers for Medicare & Medicaid Services 2023e). The rules took effect in 2024. First, CMS requires that MA plan prior authorization policies be used only to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary. Second, MA plans must comply with national and local coverage determinations and with general coverage and benefit conditions included in FFS Medicare statutes and regulations, as interpreted by CMS. MA plans cannot deny coverage of a Medicare-covered item or service based on internal, proprietary, or external clinical criteria not found in traditional Medicare coverage policies. When there are no applicable coverage criteria in Medicare statute, regulation, or national and local coverage determinations, MAOs may create internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available to CMS, enrollees, and providers. Third, prior authorization approval given by an MA plan is required to be valid for as long as necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation. Fourth, MA plans must establish a utilization management committee to review policies annually and ensure consistency with FFS Medicare's national and local coverage decisions and guidelines.

In January 2024, CMS finalized a number of changes that apply to MA plans and other federal programs, including Medicaid managed care plans, that are meant to make prior authorization processes more efficient and transparent (Centers for Medicare & Medicaid Services 2024). CMS will require MA plans to build and maintain an open-source interface that would automate the process for providers to determine whether a prior authorization is required, identify prior authorization information and documentation requirements, and facilitate the exchange of prior authorization requests and decisions from electronic health records or practice management systems. This automation requirement will be implemented on January 1, 2027, and has the potential to reduce the administrative burdens of prior authorization for providers. Beginning in 2026, MA plans will be required to include a specific reason when they deny a prior authorization request, regardless of the method used to send the prior authorization decision, to facilitate both better communication and understanding between the provider and payer and, if necessary, a successful resubmission of the prior authorization request. Also beginning in 2026, MA plans will be required to send prior authorization decisions within 7 calendar days for standard (i.e., non-urgent) requests, instead of the current 14-day requirement. Finally, MA plans are required to publicly report prior authorization metrics on their websites beginning in 2026. ■

Endnotes

1 We do not focus here on plans that are available only to certain subsets of beneficiaries: private FFS plans, which are offered in an increasingly small fraction of counties; Medicare Savings Account plans, which are offered only in some states, and for which dual Medicare–Medicaid beneficiaries are ineligible; special needs plans, which are tailored to specific populations; or employer group plans.

2 We annually conduct focus groups with beneficiaries and clinicians in different parts of the country to provide more qualitative descriptions of beneficiary and clinician experiences with the Medicare program. During these discussions, we hear from beneficiaries and providers about variation in experiences accessing care. In summer 2023, we conducted four focus groups with Medicare beneficiaries in each of three urban markets. Two of the groups in each market were composed of beneficiaries dually eligible for Medicare and Medicaid. We also conducted three virtual focus groups with beneficiaries residing in rural areas. We also conducted three clinician focus groups in each of the three urban markets, with primary care physicians, specialist physicians, and primary care nurse practitioners and physician assistants.

3 All MAOs, including HMOs, are financially responsible for emergency and urgently needed services, regardless of the network status of the provider of those services (Centers for Medicare & Medicaid Services 2016a).

4 Enrollment figures reflect the fact that our analysis of CMS enrollment files excluded enrollment in cost plans, employer group plans, Medicare Savings Account plans, and Program of All-Inclusive Care for the Elderly plans.

5 During the coronavirus public health emergency that expired on May 11, 2023, MA plans were responsible for covering all medically necessary, Medicare-covered services, and plans were to charge enrollees no more than in-network cost sharing.

6 Medicare participating providers "accept assignment," meaning they accept Medicare rates for services provided to Medicare beneficiaries. Participating providers are prohibited from balance billing either beneficiaries or plans, and they agree to accept the FFS rate for a service as payment in full when a contract is not in place. A very small number of clinicians (about 2 percent) do not accept assignment; in the rare circumstances in which they provide services to a Medicare beneficiary, these providers collect up to 109.25 percent of FFS rates (Medicare Payment Advisory Commission 2024). An even smaller number of providers (about 1 percent) opt out of Medicare entirely. When a beneficiary receives a service from an opt-out provider, they enter into a private contract with that provider, and there is no limit to the amount the provider can charge. In all cases, providers must disclose payment liability before providing services.

7 CMS uses the term "provider" in this context to refer to individual clinicians and "facility" to refer to organizations or physical entities.

8 Required facility types are acute inpatient hospitals; cardiac surgery programs; cardiac catheterization services; critical care services/intensive care units; surgical services (outpatient or ambulatory surgery center); skilled nursing facilities; diagnostic radiology; mammography; physical therapy; occupational therapy; speech therapy; inpatient psychiatric facility services; and outpatient infusion/chemotherapy.

9 Required provider types are allergy and immunology; cardiology; cardiothoracic surgery; chiropractic services; clinical psychology; clinical social work; dermatology; endocrinology; ear, nose, throat/otolaryngology; gastroenterology; general surgery; gynecology/obstetrics; infectious disease; nephrology; neurology; oncology, medical/surgical; oncology, radiation; ophthalmology; orthopedic surgery; physiatry/rehabilitation medicine; plastic surgery; podiatry; primary care; psychiatry; pulmonology; rheumatology; urology; and vascular surgery.

10 Beginning in 2025, a new facility-specialty type will be added: Outpatient Behavioral Health. This hybrid designation will include a range of providers, such as marriage and family therapists, mental health counselors, opioid treatment program providers, and community mental health centers or other behavioral health and addiction medicine specialists and facilities, including addiction medicine physicians.

11 The most recent reference file for network adequacy standards can be found at https://www.cms.gov/files/document/2024-hsd-reference-file-updated-10182023.xlsx.

12 MA organizations report in the Network Management Module (NMM) the number of Medicare-certified beds per 1,000 for critical care services, skilled nursing facilities, and inpatient psychiatric facilities in addition to acute inpatient hospital beds. However, the minimum criteria for number of beds (12.2 per 1,000) is applied only at the acute inpatient level.

13 The 12 specialties are allergy and immunology; cardiology; dermatology; endocrinology; gynecology/obstetrics;

infectious diseases; nephrology; neurology; ophthalmology; otolaryngology; primary care; and psychiatry.

14 "Significant" changes are considered changes that affect or potentially affect large groups of enrollees, such as changes that result in terminated relationships with multispecialty group practices. MAOs must notify CMS of a significant termination at least 90 days prior to the effective date.

15 There were 730 contracts for HMO, HMO–POS, and PPO plans in 2021. No contracts audited in 2021 covered the state of Alaska.

16 Pearson's chi-squared tests showed that differences for each of the three dimensions we analyzed (county designation, specialty type, and plan type) were statistically significant at $p < 0.001$.

17 Only enrollees who are affected by the change must be proactively notified. All enrollees assigned to a particular PCP and any enrollees who have received services from that PCP within the past three years must be notified of any changes in that provider's status. Concerning behavioral health, any enrollees who have received services from the PCP or behavioral health provider within the last three years must be notified. Concerning specialists, enrollees who currently receive care or have received care from the provider within the past three months must be notified.

18 MA prescription drug plans and stand-alone Part D plans can also use prior authorization before covering Part D drugs, but in this chapter, we focus on prior authorization for health care services. More information about Part D exceptions and appeals can be found in the Commission's March 2018 report to the Congress (Medicare Payment Advisory Commission 2018b).

19 FFS Medicare has adopted prior authorization to reduce the unnecessary use of certain types of durable medical equipment (Medicare Payment Advisory Commission 2018a). CMS has tested the use of prior authorization to reduce unnecessary use of hyperbaric oxygen therapy in FFS Medicare; however, it has not been widely adopted by FFS Medicare (Centers for Medicare & Medicaid Services 2016b). Prior authorization for repetitive, scheduled nonemergent ambulance transport (RSNAT) is voluntary; however, if an ambulance supplier elects to bypass prior authorization, applicable RSNAT claims are subject to prepayment medical review (Centers for Medicare & Medicaid Services 2023f).

20 Medicare coverage rules are outlined in national coverage determinations, local coverage determinations in the geographic area in which the MA plan operates, the Medicare Benefit Policy Manual, the Medicare Managed Care Manual, legislative changes in benefits applied through notice-and-comment rulemaking, and other coverage guidelines and instructions issued by CMS. The Commission's June 2018 report to the Congress includes more detail on Medicare coverage policy (Medicare Payment Advisory Commission 2018a).

21 The Office of Medicare Hearings and Appeals (OMHA), a staff division within the Office of the Secretary of the U.S. Department of Health and Human Services, administers the nationwide administrative law judge hearing program. OMHA seeks to ensure that Medicare beneficiaries and the providers and suppliers that furnish items or services to the beneficiaries and MAOs have a fair and impartial forum to address disagreements with Medicare coverage and payment.

22 MA plans are also required to report data on organization determinations and reconsiderations for claims (retrospective cases); our focus is on prior authorization (preservice requests). For preservice requests, MA plans are also required to report the aggregate number of determinations (and their outcomes) requested by (1) enrollee/representative or provider on behalf of the enrollee and (2) noncontract providers.

23 We analyzed data from the CMS Part C and Part D reporting requirements public use file, 2021. CMS has since removed the data files from its website and is currently reevaluating their policy for making these data available to researchers and the public.

24 For example, IREs report counts of decisions by priority, which includes expedited, preservice, and retrospective, compared with MA plan reporting of determinations for services (prospective) and claims (retrospective).

25 The insurance peer-to-peer review is a scheduled phone conversation during which an ordering physician discusses the need for a service with the insurance company's medical director to obtain a prior authorization approval or appeal a previously denied prior authorization.

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