



Medicare Rights Center  
Statement for the Record

Submitted to the  
U.S. Senate Committee on Finance

Regarding the May 3, 2023, hearing

“Barriers to Mental Health Care: Improving Provider Directory  
Accuracy to Reduce the Prevalence of Ghost Networks”

## Improving Medicare Advantage Network Accuracy and Adequacy

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to submit a statement for the record on the May 3, 2023, Senate Finance Committee hearing, “Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks.” Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly three million people with Medicare, family caregivers, and professionals.

Based on this experience, we understand the toll inaccurate provider directories can have on people with Medicare and the program. They shift not only a core Medicare Advantage (MA) plan responsibility—network identification—onto enrollees, but also expenses. Affected plan members may have little choice but to pay higher out-of-network rates. While this may come at a substantial personal cost, plans stand to gain. Most policies cover such care less generously than in-network services. Medicare’s finances are also impacted, since enrollees who forgo care may need more costly interventions later, such as hospital and acute services paid for by Medicare Part A.

From worsening health outcomes to derailing economic security, inaccurate provider directories put enrollees at risk. For many, the challenges begin as early as their Medicare enrollment.

On our National Consumer Helpline, we frequently hear from people struggling to navigate the complex Medicare enrollment process. Regardless of whether they choose Original Medicare (OM) or MA, they may need help paying for and accessing care. In our experience, these challenges are more pronounced for MA enrollees. The MA plan landscape is cluttered, and the stakes are high. Often, there is no quick fix if a beneficiary finds their MA plan does not meet their needs because of unexpected or extreme costs, inferior quality, or networks that are too narrow or exclude their chosen providers.

To reduce these risks, MA plans must be high-quality and easy to compare, and beneficiaries must be empowered to select the best plan for their circumstances. We therefore recommend the following reforms to **(I) End Ghost Networks, (II) Support Beneficiary Decision-Making, and (III) Improve MA Networks.**

### I. End Ghost Networks

Among MA’s network accuracy and adequacy problems are so-called “Ghost Networks,” in which plans tout access to providers that are not in-network, accepting patients, clinically active, or otherwise meaningfully available.

MA ghost networks are typically the result of inaccurate provider directories. Though intended to be a useful decision-making resource, directories are frequently incorrect. For example, a 2018 CMS report found that 52% of physician listings in MA provider directories contained at least one inaccuracy. Typical errors included wrong phone numbers, errantly listing in-network providers as accepting new patients when they were not, and omitting in-network providers from directories.<sup>1</sup>

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<sup>1</sup> Michael S. Adelberg, et al., “Improving the Accuracy of Health Plan Provider Directories” The Commonwealth Fund (June 7, 2019), <https://www.commonwealthfund.org/publications/journal-article/2019/jun/improving-accuracy-health-plan-provider-directories>.

Provider directory inaccuracies thwart informed decision-making by obscuring the reality of MA plan networks, undercutting beneficiaries from the start. MA enrollees are advised to review their coverage each year. Some use CMS's primary consumer-facing tool, Medicare Plan Finder, to search for available plans, while others may work with brokers or plan entities. These searches can yield a dizzying number of options. For 2023, on average, beneficiaries had access to 43 MA plans, more than twice as many as in 2018.<sup>2</sup> Plans can vary on everything from costs to coverage, sometimes in subtle but important ways. For most beneficiaries, this makes close analysis both critical and impracticable.

Inaccurate provider directories only compound these comparison difficulties. As discussed during the hearing, directories may list providers who are in-network but not accepting new patients promptly or at all, as well as those who are not meaningfully available due to geographic or transportation barriers. They may also make contacting potential providers impossible due to outdated information, such as incorrect phone numbers and addresses. Uncovering and verifying the truth can take significant time and cause considerable stress. It also forces providers to field time-sensitive consumer inquiries about network participation and availability, creating additional administrative burdens.

When beneficiaries make good faith coverage choices in reliance on incorrect provider directories, the effects can be devastating. Some enrollees discover too late that their plan's network is too small, of low quality, or geographically distant—making care difficult to find, access, and afford. Others may enroll in a plan thinking their preferred provider is in-network or that needed care will be covered, only to learn otherwise after receiving a higher-than-expected bill.

Consider a recent Medicare Rights client, Ms. P, a 32-year-old Medicare enrollee with cardiac issues. Ms. P had a high-risk pregnancy. Since her MA plan's network did not include the cardiac specialists she needed, it was required to cover these services from out-of-network providers. After confirming this and seeing the specialists, her plan refused to pay. This caused Ms. P significant stress, leading to a panic attack while pregnant. Further, because she was unable to afford the excessive medical bill, it was sent to collections, saddling her with debt.

Another client, Ms. M, is 73 and has two stage 4 cancers. Seeking a mental health provider for assistance with end-of-life issues, she called every provider listed in her MA plan's network directory but could not contact many. Of those, few were accepting new patients, willing to see her, or otherwise available. She finally found a therapist and got the help she needed—until that doctor was suddenly no longer in the plan's network. Unable to afford the more costly out-of-network rates, Ms. M had to stop seeing her mental health provider. She has not yet found a new doctor.

These problems are widespread. As Chairman Wyden highlighted during the hearing, Senate Finance Committee staff operating as "secret shoppers" could successfully make appointments only 18% of the time.<sup>3</sup> More than 80% of the listed providers "were either unreachable, not accepting new patients, or not in-network." Similarly, Dr. Robert Trestman's written testimony previews a forthcoming *Psychiatric Services* investigation in which secret shoppers could schedule appointments with psychiatrists 11% of

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<sup>2</sup> Meredith Freed, et al., "Medicare Advantage 2023 Spotlight: First Look" (November 10, 2022), <https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/>.

<sup>3</sup> Senate Finance Committee, "Medicare Advantage Plan Directories Haunted by Ghost Networks" (May 3, 2023) <https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf>.

the time.<sup>4</sup> Nearly 20% of the phone numbers were wrong and over a quarter of the doctors were not accepting new patients.

Typically, there is little recourse available. Impacted enrollees may be stuck with their ill-fitting plan until the next open enrollment window. And because provider directory errors persist in the interim, finding care may remain a struggle.

### *Recommendation*

- **Make MA Provider Directories Accurate**—The Medicare Rights Center urges immediate action to address the long-standing problem of inaccurate MA provider directories.<sup>5</sup> This misinformation derails thoughtful coverage choices and access to care. It also prevents the Centers for Medicare and Medicaid Services (CMS) from conducting proper oversight, as insufficient data may hide non-compliance with network adequacy and other requirements. We recommend requiring accurate provider directories without delay, imposing financial penalties on plans for non-compliance, and holding beneficiaries harmless for any enrollment decisions they may make in reliance on provider directory-contained misinformation.

## **II. Support Beneficiary Decision-Making**

Most people new to Medicare are automatically enrolled because they are receiving Social Security when they become eligible, but a growing number are not.<sup>6</sup> These individuals must enroll on their own, considering specific timelines, intricate Medicare rules, and any existing coverage. Mistakes are common and carry serious consequences, including lifelong financial penalties, high out-of-pocket health care costs, disruptions in care continuity, and gaps in coverage.

People who choose MA face an additional hurdle: the plan selection process. As noted above, it is recommended that enrollees review their coverage options annually. But doing so can be complicated and intimidating, deterring engagement. Identifying and comparing dozens of plans and their exponential deviations, year after year, is a challenging and time-consuming task that few people with Medicare perform;<sup>7</sup> even fewer switch plans from one year to the next.<sup>8</sup> This inertia, and any underlying sub-optimal plan choices, can have detrimental and unanticipated results, like higher costs and problems accessing preferred providers. Enrollees who arguably have the most at stake—those who are older,

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<sup>4</sup> Robert Trestman, “Statement to the U.S. Senate Committee on Finance Re: Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks” (May 3, 2023),

<https://www.finance.senate.gov/imo/media/doc/Robert%20Trestman%20APA%20testimony%20050123%20FINAL.pdf>.

<sup>5</sup> See, e.g., Centers for Medicare & Medicaid Services, “Online Provider Directory Review Report” (March 2018),

[https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider\\_Directory\\_Review\\_Industry\\_Report\\_Round\\_3\\_11-28-2018.pdf](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf); Centers for Medicare & Medicaid Services, “Online Provider Directory Review Report (January 2018),

[https://www.cms.gov/Medicare/Health-](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf)

[Plans/ManagedCareMarketing/Downloads/Provider\\_Directory\\_Review\\_Industry\\_Report\\_Year2\\_Final\\_1-19-18.pdf](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf).

<sup>6</sup> See, e.g., Medicare Payment Advisory Commission, “Report to the Congress: Medicare and the Health Care Delivery System,” (June 2019),

[http://www.medpac.gov/docs/default-source/reports/jun19\\_medpac\\_reporttocongress\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0).

<sup>7</sup> See, e.g., Meredith Freed, et al., “More Than Half of All People on Medicare Do Not Compare Their Coverage Options Annually,” Kaiser Family Foundation (October 29, 2020),

<https://www.kff.org/medicare/issue-brief/more-than-half-of-all-people-on-medicare-do-not-compare-their-coverage-options-annually/>; Wyatt Korma, et al., “Seven in Ten Medicare Beneficiaries Did Not Compare Plans Past Open Enrollment Period,”

Kaiser Family Foundation (October 13, 2021), <https://www.kff.org/medicare/issue-brief/seven-in-ten-medicare-beneficiaries-did-not-compare-plans-during-past-open-enrollment-period/>.

<sup>8</sup> <https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-rarely-change-their-coverage-during-open-enrollment/>.

<sup>8</sup> <https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-rarely-change-their-coverage-during-open-enrollment/>.

have lower incomes, or have serious health needs—are also the least likely to review and change their coverage.<sup>9</sup>

### *Recommendations*

- Update Medicare Plan Finder—Beneficiaries are often confused about the differences between plans or how to compare them and lack sufficient tools and support for confident decision-making.<sup>10</sup> CMS can begin to address this by improving Medicare Plan Finder. Priority upgrades should include integrating accurate plan network information to enable beneficiaries to search by provider, individual claims history, more realistic and predictive estimated costs, and more information about supplemental benefits, like coverage and eligibility limits.<sup>11</sup>
- Ensure Beneficiary-Centered Materials—We also support updates to materials explaining the differences between OM and MA, and the trade-offs of each, to better reflect beneficiaries’ primary considerations. For example, one of the most vital decision points for many is provider choice. Most MA plans have ever-shifting networks that may exclude one’s provider at any given time, but this may not be well or widely understood. Even when it is, as discussed, discovering what providers are in network can be difficult.<sup>12</sup> As a result, MA enrollees are at risk of losing—or never even having—access to their preferred provider. Few resources make this plain, or that post-enrollment relief is limited.
- Individually Tailor the Annual Notice of Change—CMS should require MA plans to provide all enrollees a tailored Annual Notice of Change (ANOC). The individualized notice should be based on claims data and clearly describe how the enrollee’s plan and costs will change, if at all, in the coming year. This includes listing any of the individual’s providers who will no longer be in network, any prescription drugs that will no longer be on the plan’s formulary (for MA-PD plans), and new applications of utilization management tools.
- Support Enrollment Counselors—We urge greater investments in State Health Insurance Assistance Programs (SHIPs). For many beneficiaries, SHIP counselors are their sole source of objective, highly trained, one-on-one, Medicare counseling. Despite surging Medicare enrollment and an increasingly complex coverage landscape, the SHIP program remains woefully underfunded. The FY 2023 level of \$55.2 million is out of step with growing needs. If this investment had kept pace with population shifts and inflation over the past decade, it would exceed \$80 million. We support increasing funding to at least this amount (\$80 million) in FY 2024.
- Modernize Notification and Outreach—CMS and the Social Security Administration (SSA) should alert people approaching Medicare eligibility about important rules and deadlines. As documented by MedPAC, such notice could help prevent harmful enrollment errors, like lifetime

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<sup>9</sup> *Id.*

<sup>10</sup> National Council on Aging, “The Modernizing Medicare Plan Finder Report” (April 2018), <https://www.ncoa.org/public-policy-action/health-care/better-coverage-choices/medicare-plan-finder-report/>.

<sup>11</sup> Medicare Rights Center, “2019 Medicare Plan Finder Review” (September 18, 2019), <https://www.medicarerights.org/policy-documents/comments-2019-medicare-plan-finder-review>.

<sup>12</sup> Centers for Medicare & Medicaid Services, “Online Provider Directory Review Report,” (November 28, 2018), [https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider\\_Directory\\_Review\\_Industry\\_Report\\_Round\\_3\\_11-28-2018.pdf](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf).

financial penalties<sup>13</sup> and harmful gaps in coverage.<sup>14</sup> But today, no such notice exists. The bipartisan BENES 2.0 Act would correct this.<sup>15</sup> In so doing, it would advance the goals of the original BENES Act. Also bipartisan, CMS finalized its implementing rules this year, updating Medicare enrollment for the first time in over 50 years to end lengthy waits for coverage and align Special Enrollment Period (SEP) flexibilities across the program.<sup>16</sup> We similarly support strengthening remedies for mistaken enrollment delays, including through access to these SEPS and equitable relief.

- Update Enrollment Infrastructure—Medicare Rights strongly supports the recently proposed Medicare enrollment improvement pilot. This initiative would also further the goals of the BENES Act, by allowing SSA and CMS to work together to identify enrollment barriers and solutions, including for those who are not already collecting Social Security, and to explore opportunities to eliminate remaining post-enrollment coverage lags, such as the requirement to wait for a mailed Medicare card before connecting with one’s earned benefits.<sup>17</sup>

### III. Improve MA Networks

Even the best provider directory is only as effective as the network it captures. Here too, reforms are needed. Overly narrow MA networks can make care harder to find, access, and afford. This is especially true for mental health and substance use disorder (SUD) treatment.<sup>18</sup> On average, MA plan networks included only 23% of psychiatrists in a county—a smaller share than for any other physician specialty—and nearly 40% of plans had less than 10%.<sup>19</sup> By comparison, though psychiatry has the highest opt-out rate from OM of all medical specialties, only 7.5% of psychiatrists have done so.<sup>20</sup>

More broadly, a 2015 U.S. Government Accountability Office (GAO) report found “CMS’s oversight did not ensure that MAO networks were adequate to meet the care needs of MA enrollees.”<sup>21</sup> In June 2022, GAO testified that its recommendations to address these issues “had not yet been fully implemented.”<sup>22</sup> Rule changes in the intervening years further diluted this critical protection.<sup>23</sup>

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<sup>13</sup> In 2021, nearly 800,000 people were paying a Part B Late Enrollment Penalty. The average amount increased their monthly premium by nearly 30%. See Congressional Research Service, “Medicare Part B: Enrollment and Premiums,” (May 19, 2022), [https://www.everycrsreport.com/files/2022-05-19\\_R40082\\_143a23f28239eec6ef87bac952856d5a14d0a22e.pdf](https://www.everycrsreport.com/files/2022-05-19_R40082_143a23f28239eec6ef87bac952856d5a14d0a22e.pdf).

<sup>14</sup> Medicare Payment Advisory Commission, “Report to the Congress: Medicare and the Health Care Delivery System,” (June 2019), [http://www.medpac.gov/docs/default-source/reports/jun19\\_medpac\\_reporttocongress\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0).

<sup>15</sup> S. 3675, <https://www.congress.gov/bill/117th-congress/senate-bill/3675?s=1&r=43>

<sup>16</sup> Medicare Rights Center, “Medicare Rights Center Welcomes Passage of Key BENES Act Provisions” (December 22, 2020) <https://www.medicarerights.org/media-center/medicare-rights-welcomes-passage-of-key-benes-act-provisions>.

<sup>17</sup> See, e.g., U.S. Department of Health and Human Services, “Fiscal Year 2024 Budget in Brief,” page 8:

<https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf>

and The Office of Management and Budget, “Budget of the U.S. Government Fiscal Year 2024,” page 52: [https://www.whitehouse.gov/wp-content/uploads/2023/03/budget\\_fy2024.pdf](https://www.whitehouse.gov/wp-content/uploads/2023/03/budget_fy2024.pdf).

<sup>18</sup> Daria Pelech, *et al.*, “Medicare Advantage And Commercial Prices For Mental Health Services,” Health Affairs (February 2019), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05226>.

<sup>19</sup> Gretchen Jacobson, *et al.*, “Medicare Advantage: How Robust Are Plans’ Physician Networks?” Kaiser Family Foundation (October 5, 2017), <https://www.kff.org/report-section/medicare-advantage-how-robust-are-plans-physician-networks-report/>.

<sup>20</sup> Nancy Ochieng, “Most Office-Based Physicians Accept New Patients, Including Patients With Medicare and Private Insurance,” Kaiser Family Foundation (May 12, 2022), <https://www.kff.org/medicare/issue-brief/most-office-based-physicians-accept-new-patients-including-patients-with-medicare-and-private-insurance/>.

<sup>21</sup> U.S. Government Accountability Office, “Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy,” (August 31, 2015), <https://www.gao.gov/products/gao-15-710>.

<sup>22</sup> U.S. Government Accountability Office, “Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight,” (June 28, 2022), <https://www.gao.gov/products/gao-22-106026>.

<sup>23</sup> 85 FR 33796, 33855.

## Recommendations

- Strengthen Network Adequacy Rules—We support rescinding the May 2020 rule changes that weakened network adequacy requirements and further improving consumer protections by requiring MA plans to demonstrate they can meet enrollee care needs before they are permitted to offer plans in the area.<sup>24</sup> If a plan does not have enough providers in network to realistically serve enrollees in a geographic area, then CMS should not allow the plan to operate in that region. The solution to inadequate plan networks is not for CMS to lower the bar.
- Address Supplemental Benefits—We also recommend establishing network adequacy requirements for supplemental benefits. Without this basic guardrail, there is no way to measure plan capacity to deliver promised benefits.
- Ensure Meaningful Provider Availability—Network adequacy standards must consider a provider’s in-network status and their meaningful availability. We specifically support the adoption of two additional quantitative metrics: (1) the number of providers and facilities within a given specialty that have submitted a claim over a certain period, such as six months; and (2) the number of providers that are accepting new patients. Plan submission and CMS verification of these data points would better protect enrollee access to care.
- Capture Timeliness— Similarly, the existing metrics for MA network adequacy fail to capture whether timely care is available. To address this, we support aligning MA wait time standards with those that will apply to Marketplace plans beginning in 2024; similar timelines were recently proposed for Medicaid managed care plans.<sup>25</sup> Accordingly, we were disappointed that in the 2024 C&D rule, CMS instead set a wait time standard at 30 business days for routine mental health and SUD care—well beyond the 10 business day standard for Marketplace plans and under consideration in Medicaid.<sup>26</sup> Once more, we urge policymakers to establish consistent standards across payment systems and to require MA plan compliance.
- Promote Network Stability—MA enrollees must be able to count on stability in their plan networks and the knowledge that their doctors will be there when they need them. We urge CMS to work with plans to minimize the practice of dropping doctors without cause in the middle of the plan year. When such changes are necessary, affected enrollees must receive adequate notice and relief, including access to a Special Enrollment Period.
- Reduce Provider Burden—As Dr. Jack Resneck noted in his testimony, providers face significant administrative burdens, most notably compliance with MA prior authorization requirements: “Practices are completing 45 prior authorizations per week per physician, adding up to two business days per week spent on prior authorization alone.” He further explains this requires “hours spent on the phone with insurance companies, endless paperwork for initial reviews and appeals, and constant updating of requirements and repeat submissions just to get patients the care they need.”<sup>27</sup> We urge a reduction in the services subject to prior authorization—such as

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<sup>24</sup> *Id.*

<sup>25</sup> 87 FR 27208, 27329.

<sup>26</sup> 88 FR 22120.

<sup>27</sup> Jack Resneck, “Statement to the U.S. Senate Committee on Finance Re: Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks” (May 3, 2023),

prohibiting repeated prior authorization during a course of treatment—as well as better oversight and enforcement to ensure existing guardrails—like the requirement to cover all OM services—are effective. These reforms would improve enrollee access to care by minimizing unnecessary waits for coverage and reducing provider burdens in a way that could lead to increased network participation.

Thank you for your bipartisan consideration and leadership. These are critical issues for millions of Americans. The Medicare Rights Center looks forward to continued collaboration on improving health care access and affordability.

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