Healthcare Services Solutions

CMS' Medicare Advantage Network 'Crackdown': What You Don't Know Can Hurt You

On Jan. 10, 2018, the Centers for Medicare & Medicaid Services (CMS) released a memo in which it announced that it will now review Medicare Advantage organizations' networks on a three-year cycle. For the first triennial review cycle, CMS will pull a sample of active contracts, including contracts that have not undergone a full network review since contract initiation. CMS will provide the selected organizations at least 60 days' notice before the mid-June deadline to submit data on their networks.

This represents a significant change in operating procedure. Historically, CMS reviewed Medicare Advantage plans' networks for adequacy only at the time of initial application or service area expansion, or as a consequence of another triggering event (e.g., member network access complaints). The status quo was for each plan to attest that it would maintain its network to meet CMS' stringent travel time and distance standards.

During the triennial review, CMS will test each selected Medicare Advantage plan's health service delivery (HSD) table to determine whether the list of physicians and hospitals meets CMS' adequacy standards in each county in which the Medicare Advantage plan is approved to operate. CMS has not yet specified whether it will also audit the accuracy of the information included on Medicare Advantage plans' HSD tables (e.g., pull contracts, audit board-certified specialties listed, review accuracy of practice location addresses). Given CMS' recent accuracy audits of Medicare Advantage plans' online provider directories, plan leadership should strongly consider the possibility of CMS performing a similar review of HSD table accuracy.

How big of a deal is CMS' network "crackdown"? While readiness varies by plan, a sampling analysis of Medicare Advantage plans' published online provider directories indicates that many plans are not sufficiently prepared for a CMS network adequacy audit and could face a range of serious repercussions.

Even if their plan is not chosen for an audit in the first year, Medicare Advantage plan leadership should take proactive steps now to shore up their networks and implement required policies and procedures to ensure their network stays up to date and adequate going forward.

Provider networks change, HSD tables grow stale

The primary challenge with keeping a Medicare Advantage provider network up to date is that networks are living and breathing entities that grow stale quickly.

- Providers change — Doctors join or leave medical groups, retire, or move. Hospitals close and/or change the service lines they offer.
- Beneficiaries move — CMS bases Medicare Advantage adequacy reporting on its annual "Sample Beneficiary File," which estimates the number of Medicare beneficiaries at each longitude and latitude and measures access standards accordingly. As with all populations, Medicare beneficiaries' geographic density changes over time as local economies grow and decline and as the cost of living and tax rates change, among other factors.
- CMS' regulations change — Similar to movement in beneficiaries, CMS designations of urban versus rural counties, and commensurate time and distance adequacy requirements, change over time as demographics and density change.

As such, Medicare Advantage leadership must closely monitor the data they have in their provider systems not only for adequacy but also for accuracy (i.e., is Doctor Rajpal still with ABC Medical Group and practicing at one location on Main Street and another location at Rural Clinic B?).

Random sampling indicates a need to update networks

To estimate the degree of Medicare Advantage plan readiness for a potential network adequacy audit, L.E.K. Consulting devised a methodology to assess Medicare Advantage plans for network adequacy across five physician specialty types within a given state. While some Medicare Advantage plans are very close to adequacy, others might not pass a CMS network adequacy audit today based on their published online directories. We believe some plans need to assess and backfill their networks now as well as implement new policies and procedures to maintain adequate Medicare Advantage networks on an ongoing basis.

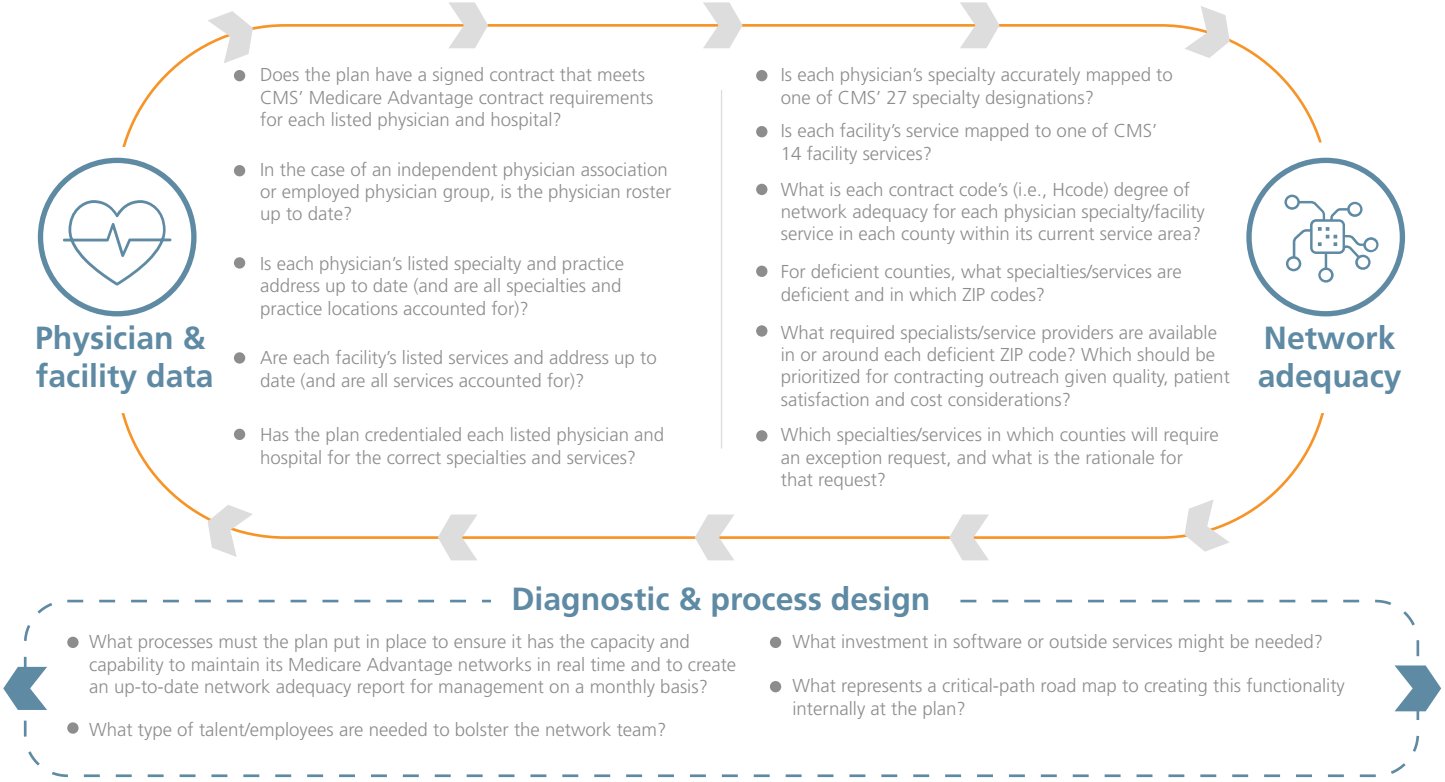
Penalties could hurt

CMS stated that organizations that fail to meet network adequacy requirements during their triennial review may be subject to "compliance or enforcement actions." The memo lists potential suppression from Medicare Plan Finder as well as the need to ensure access to specialty care by permitting enrollees to see out-of-network specialists at the individual enrollee's in-network cost-sharing level for those counties/specialties that fail to have an adequate network as two examples of potential actions.

While CMS has yet to clearly define "compliance or enforcement actions" and may not do so until it implements such actions, cautionary tales abound. In the Pacific Northwest, state regulators ordered a health plan's subsidiary to stop selling commercial insurance plans on the individual exchange after the health plan revealed its network remained deficient in several categories of providers. The health plan was able to resume selling plans after it agreed to pay a fine of more than $1 million and fix its network issues. Subsequently, a subset of the health plan's customers filed a class action lawsuit alleging that the health plan did not provide adequate access to doctors in multiple states.

Figure 1

Audit-readiness questions for Medicare Advantage plans



Source: L.E.K. analysis

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What Medicare Advantage plans can do to be proactive

A subset of L.E.K.'s Medicare Advantage plan customers is working to conduct soup-to-nuts reviews of their physician and facility network data to ensure that their provider contracts are up to date, that their providers are credentialed for the specialties and services listed, that their provider data is current, and that they can prove network adequacy in all counties within their approved service area.

In order to ensure they are ready and/or can react quickly to a CMS audit and maintain readiness on a real-time basis, Medicare Advantage plans need answers to the questions shown in Figure 1.

How L.E.K. can help

We have conducted holistic provider network reviews for a host of Medicare Advantage clients and have developed a tried-and-true process to generate adequate and accurate HSD tables and approved exception requests. We employ a data-driven approach to ensure each Medicare Advantage plan client receives maximum credit for its existing contracted network and then triage and prioritize contracting to backfill the network in weeks, not months.

L.E.K.'s approach most often expands beyond the near-term goal of adequacy to a strategic assessment of how a Medicare Advantage plan can deepen relationships with prioritized strategic providers in each county in which it does business, in order to improve quality, lower cost and enhance sustainable competitive differentiation.

Contact

For more information, please contact **healthcare@lek.com**.