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MEDICARE ADVANTAGE

Actions Needed to Enhance CMS Oversight of Provider Network Adequacy

GAO Highlights

Highlights of GAO-15-710, a report to congressional requesters

Why GAO Did This Study

MAOs contract with a network of providers to manage health care delivery to their enrollees. MAOs can initiate or terminate contracts with providers at any time for any reason. Recently, some MAOs have been narrowing their provider networks, prompting concerns about ensuring enrollee access to care and CMS's oversight of MAO compliance with network adequacy criteria.

GAO was asked to review how CMS ensures adequate access to care for MA enrollees. This report examines (1) how CMS defines network adequacy and how its criteria compares with other programs, (2) how and when CMS applies its criteria, (3) the extent to which CMS conducts ongoing monitoring of MAO networks, and (4) how CMS ensures that MAOs inform beneficiaries about terminations. GAO reviewed CMS and other guidance on network adequacy, federal regulations, and standards for internal control. GAO also interviewed CMS officials and representatives of medical associations and beneficiary advocacy groups, and analyzed CMS data on oversight of MAO provider networks for contract years 2013 through 2015.

What GAO Recommends

The Administrator of CMS should augment oversight of MA networks to address provider availability, verify provider information submitted by MAOs, conduct more periodic reviews of MAO network information, and set minimum information requirements for MAO enrollee notification letters. HHS concurred with the recommendations.

View GAO-15-710. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) is the agency within the Department of Health and Human Services (HHS) responsible for overseeing the Medicare Advantage (MA) program—Medicare's private plan alternative. Since 2011, CMS has defined an adequate MA provider network as meeting two criteria: a minimum number of providers and maximum travel time and distance to those providers. To reflect local conditions, the requirements are specific to different county types and a range of provider types. However, the MA criteria do not reflect aspects of provider availability, such as how often a provider practices at a given location. In contrast, other network-based health programs use provider availability measures to assess network adequacy. For example, federal Medicaid managed care rules address providers' ability to accept new patients and TRICARE criteria address appointment wait times for active duty servicemembers. Without taking availability into account, as is done in some other programs, MA provider networks may appear to CMS and beneficiaries as more robust than they actually are.

CMS applies its network adequacy criteria narrowly. Rather than assessing all county-based provider networks against its criteria, CMS limits its annual application of the criteria to provider networks in counties that MA organizations (MAO)—private organizations that offer one or more health benefit plans—propose to enter in the upcoming year. From 2013 through 2015, CMS's reviews accounted for less than 1 percent of all networks. To facilitate its review of these networks, CMS has established standardized data collection via an automated system. However, CMS does little to assess the accuracy of the network data in applications MAOs submit, even though the submissions contain the same data elements as in provider directories, which have been shown to be inaccurate in a number of government and private studies. Until CMS takes steps to verify MAO provider information, as outlined in federal internal control standards, the agency cannot be confident that MAOs meet network adequacy criteria.

For established provider networks, CMS does not require MAOs to routinely submit updated network information for review, but may learn of any adequacy issues through its broader oversight of MAOs. CMS recently required that MAOs disclose efforts to significantly narrow provider networks, allowing MAOs to determine when such disclosure is necessary. CMS also relies on complaints it receives to identify any problems related to network changes that are not otherwise identified. However, contrary to internal control standards, CMS does not measure ongoing MAO networks against its current MA criteria. Because a plan's providers may change at any time, CMS cannot be assured that networks continue to be adequate and provide sufficient access for enrollees until the agency collects evidence of compliance on a regular basis.

While CMS requires that MAOs give enrollees advance notice when a provider contract is terminated, the agency has not established information requirements for those notices and does not review sample notices sent to enrollees. This lack of scrutiny appears inconsistent with the agency's oversight of other Medicare beneficiary communications and with internal controls. Without a minimum set of required information elements and a check on adherence to them, the agency cannot ensure that MAO communications are clear, accurate, and consistent.