Provider Network Development for Medicare Advantage Expansion



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Problem to Solve

Across the country, patient interest in Medicare Advantage plans is booming, with an all-time high of 36 percent of national Medicare beneficiaries expected to be enrolled in Medicare Advantage in 2019, according to CMS. It's easy to see the growth drivers.

As CMS notes, overall average Medicare Advantage premiums are declining while plan choices and benefits are increasing. Compared with traditional Medicare, Medicare Advantage patients pay less out-of-pocket, have shorter in-patient stays, are less likely to be readmitted after discharge and require fewer health care services, according to a recent study.

Recognizing the new business potential and patient benefits of Medicare Advantage, a leading health care system and Medicare Advantage insurer agreed to partner to deliver Medicare Advantage options for Medicare-eligible residents in 10 regional counties. This would be a new initiative for both partners. However, gaining CMS approval for this partnership's products would require the health care system to identify and organize targeted providers for a new network – a massive contracting effort.

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Lacking sufficient in-house resources with experience in new network contracting, the health care system turned to Freed Associates (Freed) to develop and manage its contracting efforts. Freed, which would operate as the health care system's network contracting project manager, gained this work based on its network contracting experience, as well as its specific familiarity with the interests of this health care system.

Strategy and Tactics

Offered by CMS-approved insurers, Medicare Advantage plans cover everything included in traditional Medicare, such as hospital costs, doctors' visits and outpatient care. To increase their appeal, these plans also frequently offer additional benefits such as prescription drug coverage and vision, dental and hearing exams.

The health care system's proposed Medicare Advantage partnership, if approved, would capitalize on its existing network of affiliated and aligned physicians and facilities. Meeting CMS requirements for plan adequacy would require these physicians and facilities to contractually agree to participate in the proposed new Medicare Advantage plans.

In consultation with representatives from the client's managed care contracting and legal departments, Freed divided this project into three principal phases over a year's time:

- **Phase 1**: Developing a master list of potentially eligible downstream providers, and determining the legally required contracting needs for each one
- **Phase 2**: Coordinating contract mailing efforts to all designated providers, and subsequent tracking of all issued contracts through completion
- **Phase 3**: Preparing the final roster of fully contracted providers for the health care system's insurance partner, demonstrating CMS adequacy guidelines

This project's scope and scale compounded its degree of difficulty – and illustrated why a single new contract for the proposed new Medicare Advantage offerings would not work equally well for all providers. Freed and the client's legal team identified more than 3,000 providers that would either need a new contract or contract modification to participate. Over several years and business changes, the health care system had created multiple types of contracts with these 3,000-plus providers, meaning each existing contract type would need to be individually reviewed by the client's legal team to determine if it could be modified or needed to be re-done.

Once this foundational contracting review work was complete, Freed created a coordinated communication and outreach plan to the targeted 3,000-plus providers, detailing what was being asked of them and the provider advantages of opting into the proposed new Medicare Advantage offerings. Each of the providers would be sent a revised or new contract, materials addressing their most likely questions, and a list of individuals within the network contracting department to contact with specific questions.

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As the provider packets were mailed, each needed to be individually tracked until the new contracts had been completed and returned by the provider. Freed established a client protocol for working with providers who were delayed or failed to return their completed contracts by the requested deadline.

More than three months after packet mailing started, and with nearly all completed provider contracts in-hand, Freed worked with the health care system and its insurance partner to create data files for use when filing for CMS approval. These data files denoted contracted providers in each of the counties targeted for the proposed new Medicare Advantage offerings. The goal was to demonstrate sufficient network adequacy to gain CMS approval.

Results and Conclusion

Work by Freed across all three principal phases of this program, including facilitating the review of existing contracts, coordinating the mailing and return of the revised and new contracts, and packaging all information for CMS review, was completed efficiently and on-time. With no apparent provider coverage gaps in the counties targeted for the proposed new Medicare Advantage products, it appears the health care system and its insurance partner are well-prepared to begin offering a new array of health care and insurance coverage options to Medicare-eligible residents. This effort has proven to be an efficient, cost-effective way for both partners to potentially expand their respective businesses.

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