REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-A-19

Subject: Ban on Medicare Advantage "No Cause" Network Terminations

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

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INTRODUCTION

At the 2018 Annual Meeting, the House of Delegates (HOD) adopted Policy D-285.961, "Ban on Medicare Advantage 'No Cause' Network Terminations," with a progress report back at the 2019 Annual Meeting. This policy asks that:

> Our American Medical Association (AMA) develop a set of reform proposals addressing the way that Medicare Advantage plans develop and modify their physician networks with the aim of improving the stability of networks, the ability of patients to obtain needed primary and specialty care from in-network physicians, physician satisfaction, and communication with patients about network access with report back to the House of Delegates at the 2019 Annual Meeting.

This report provides background on the issues involved in Medicare Advantage (MA) physician networks and concerns that physicians have raised about the ways that plans form and manage these networks, as well as their communications with patients about their networks. The report recommends that the AMA adopt a set of reform proposals and advocate their adoption. The HOD also reaffirmed existing AMA Policies D-285.998, "Creation of Joint AMA Committee with Representatives from the America's Health Insurance Plans," which it further strengthened, Policy H-285.908, "Network Adequacy," and Policy H-285.991, "Qualifications and Credentialing of Physicians Involved in Managed Care," which directly dealt with termination issues as part of the overall action and consideration of this whole issue.

BACKGROUND

MA plans are health insurance plans offered to people with Medicare by private companies that contract with the Medicare program. MA plans must provide all Medicare Parts A and B benefits, they may provide Part D prescription drug coverage, and they often offer extra benefits that traditional Medicare does not cover, such as vision, hearing and dental care coverage. In 2018, over 20 million Medicare beneficiaries, or 34 percent, were enrolled in MA. The Congressional Budget Office estimates that MA enrollment will continue expanding its market share with MA plans projected to include about 42 percent of beneficiaries by 2028.[1]

There are relatively few insurers in the MA market, with most MA enrollees in plans operated by UnitedHealthcare, Humana, or BCBS affiliates.[2] On average, seniors have a choice of 21 plans,[3] with up to 40 in some large metropolitan areas and fewer in rural areas.

*Narrow Networks*

Narrow network plans have become increasingly common in private health insurance markets, including MA. Generally, such plans offer enrollees a narrow set of physicians and hospitals in a geographic area in exchange for lower premiums.[4] Traditional Medicare allows seniors to access any physician or hospital that accepts Medicare patients, but MA access is limited to physicians and hospitals within plan networks. More than one in three MA enrollees are in a narrow physician network, which is defined as less than 30 percent of physicians in the county participating in the plan. Another 43 percent of enrollees are in medium networks, defined as 30 to 69 percent of physicians in the county participating.[5] On average, MA networks include less than half of all physicians in a given county.

Narrow networks give insurers greater leverage to negotiate physician payment rates and to select those providers that the insurer believes deliver high quality of care.[6] However, MA plans state that, because they already pay providers at or near Medicare fee schedule rates, negotiating lower payment rates is not a significant consideration.[7] Instead, they achieve lower total costs by focusing on utilization.

The AMA and other physician groups have raised concerns that narrow physician networks create challenges for patients seeking care and pose potential patient protection issues. Specifically, a narrow network might have shortages of specific specialties, and plans may purposefully understaff specialties to avoid attracting enrollees with expensive pre-existing conditions like cancer and mental illness.[8] Access to psychiatrists is more restricted than other specialties. On average, only 23 percent of psychiatrists in a county participate in MA plans, and 36 percent of plans include less than 10 percent of psychiatrists in their county.[9] Limited access to specialists extends beyond psychiatry to cardiothoracic surgeons, neurosurgeons, radiation oncologists, and others.

*Star Ratings*

Star ratings are a key reason for forming narrow networks. MA plans' star ratings affect payment and enrollment, and higher star ratings help increase plan revenues.[10] Plans with high star ratings receive bonuses to their benchmarks and payments from the Centers for Medicare & Medicaid Services (CMS). Total bonuses paid to MA plans have more than doubled over the last four years from $3 billion to $6.3 billion,[11] due to increases in MA enrollment and in the number of plans receiving bonuses. Importantly, MA plans with five-star ratings can enroll beneficiaries at any time throughout the year, not simply during open enrollment or initial eligibility, which is a competitive advantage.[12]

MA plans rely on physicians to achieve their high star ratings by delivering services such as screening tests and vaccines, managing chronic conditions, and cooperating with the plan. Because plans have broad authority to exclude physicians as long as they meet CMS network adequacy requirements, insurers may form narrow networks around already high-performing physicians that have proven track records of quality and utilization management. CMS data show that five-star ratings have been achieved only by vertically integrated and provider-led narrow networks.[13]

Insurers recognize that risk adjustment is another critical component of star ratings. Narrow networks can limit the number of physicians that plans need to coordinate with and educate about diagnosis coding for risk adjustment, which increases plan revenues by increasing the apparent severity of patient conditions compared to traditional Medicare.[14]

DISCUSSION

To improve the way that MA plans develop and modify their physician networks, the Board offers several policy proposals focused on network directory accuracy, network adequacy, network stability, communications with patients, and establishment of an external advisory group to better inform CMS regarding MA network issues.

*Enhance CMS Efforts to Ensure Directory Accuracy*

MA plans are required to maintain accurate provider directories on a real-time basis, but they are currently only required to submit provider directories to CMS when the plan first begins operations in an area, and then every three years unless CMS requests a review based on significant terminations of contracts or complaints. Since CMS has begun conducting triennial reviews of directories, it has found significant inaccuracies, which justifies more frequent reviews and more significant penalties. MA plans could reduce the administrative burden on themselves and on physicians if they would use a common system for updating provider directory information, such as the AMA/Lexis-Nexis VerifyHCP system.[15]

The AMA could urge CMS to enhance its efforts to ensure directory accuracy by:

- Requiring MA plans to submit provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network;
- Auditing directory accuracy more frequently for plans that have had deficiencies;
- Publicly reporting accuracy scores on Medicare Plan Finder;
- Taking enforcement action against plans that fail to maintain complete and accurate directories, or to have a sufficient number of physician practices open and accepting new patients; and
- Offering plans the option of using AMA/Lexis-Nexis VerifyHCP system to update provider directory information.

*Ensure That CMS Network Adequacy Standards Provide Adequate Access for Beneficiaries and Support Coordinated Care Delivery*

Current standards do not assess the extent to which physicians in the network are willing and able to see new patients or the extent to which patients want to use the physicians in the network. If most plan members are receiving services only from a subset of physicians in the network, that subset may not represent the "true" network that is available to patients. Additionally, CMS has not released or sought public comments on the standards for the Minimum Provider Ratios and Maximum Time/Distance. In addition, current adequacy standards are established separately for each specialty and there is no requirement that physicians who work together must all be included. For example, there is a requirement to include at least one hospital which offers cardiac catheterization services and at least one cardiologist, but there is no requirement that the network cardiologist be able to perform cardiac catheterizations or that the network cardiologist has privileges at the network hospital.

*Ensure Lists of Contracted Physicians Are Made More Easily Accessible*

Finding out whether a patient's physicians are in each plan's network requires going separately to each health plan's website, finding the directory, and searching it. If a patient receives care from multiple physicians, this requires considerable time and effort. The plans are already required to submit their initial list to CMS in an electronic form that includes the physician's National Provider

Identifier (NPI), so it should be feasible to not only make the lists downloadable, but also to link the information in the lists to Physician Compare. There is also currently no simple way for a physician to determine whether they are being accurately reported as in-network by the plans with which they currently contract and as out-of-network by other plans. A physician could use a Physician Compare linkage to find which plans say they have contracts with the physician.

*Simplify the Process for Beneficiaries to Compare Network Size and Accessibility*

It is difficult for patients to determine which plans will have physicians available nearby if new conditions arise or their existing conditions worsen. It is very difficult to compare plans based on the relative size and specialty structure of their networks.

*Measure the Stability of Networks*

Patients need to know whether they are likely to need to keep changing physicians if they choose a particular plan. There is currently no way to determine if MA plans tend to have the same physicians in-network each year or their networks change significantly from year-to-year.

Physicians have outlined many concerns with the processes that MA plans use to narrow their networks. Plans often send notices to physicians terminating their participation in the network with no explanation, and they do not take steps to ensure that patients can complete their treatment plan and/or find an in-network physician who can take over their care. The lack of explanation for the change, often referred to as "no cause terminations," also makes it impossible for physicians to successfully challenge plans' decisions. As transitions in care are where many adverse events occur, a more cautious approach with more active management of the transition process and more emphasis on supporting established physician-patient relationships would be a major improvement.

There is another side to this story, though, and there are also medical practices who see great benefit in the move to narrower networks. Participants in accountable care organizations (ACOs), for example, may find that they have better opportunities to appropriately manage care for patients assigned to the ACO if the network is largely comprised of other ACO-participating practices. Other practices may benefit from having a higher volume of patients insured by a particular MA plan, and may find that they have more leverage to negotiate better terms and conditions with the plan because the plan's subscribers cannot easily move to a different, out-of-network practice.

The AMA could urge CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by: Requiring plans to report the percentage of the physicians in the network who actually provided services to plan members during the prior year:

- Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy;
- Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together; and
- Evaluating alternative/additional measures of adequacy.

*CMS Needs to Develop an Effective Communication Plan*

CMS should create a plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients. Additionally, CMS should update the Medicare Plan Finder Website to ensure the website is user-centered.

Oscar Health Care is a New York-based health insurance company focused on delivering care through telemedicine, health care focused technological interfaces, and transparent claims pricing systems.[16] Recently, the America's Health Insurance Plans (AHIP) highlighted "How Oscar Guides Its Members Through the Health System," noting the ease with which users can enroll. Members can sign-up for health insurance in under 10 minutes using the Oscar-created platform (as opposed to brokers or exchanges), which showed a 30 percent increased probability of matching with a plan that optimizes for expected behavior. In an interview with the Oscar Health Care *Head of Product*, Eddie Segal noted that in building the online platform the company prioritized simplicity, incremental navigation, information reduction, and informed, data-driven design.

User-centered design is an iterative process in which architects of said technology or platform focus on the users and their needs, in each phase of the design process. User-centered design requires the involvement of applicable users throughout this process via a variety of research and design techniques in order to create highly usable and accessible products.

The need for user-centered design has become increasingly important, as more health care professionals and patients are exposed to, rely on, and operate within electronic platforms for information related to treatment and diagnosis, disease management, prescription drug coverage, health insurance, and general health care delivery. In 2006, 80 percent of internet users, or approximately 93 million Americans, searched for a health-related topic online, with 25 percent of that population seeking information regarding health insurance – although that number has likely increased significantly during the past 13 years.[17] Of note, between 2000 and 2013, internet and technology usage among seniors rose from 14 to nearly 60 percent.[18]

Medicare patients continue to report frustration and difficulty comparing plans (both fee-for-service and MA) using the "Medicare Compare" tool. They avoid switching plans due to the complexity surrounding initial set-up and voice concern in accessing their preferred physicians and providers.[19] Further interrogation of the Medicare Plan Finder by the National Council on Aging found that poor plan selection and patient confusion often flows from poorly presented information and outdated, misleading user design.[20] Improved and intuitive user-centered design application can enable and empower patients to successfully shop for Medicare plans that meet both clinical need and financial reality.

The AMA could recommend several policy changes to improve communications with patients about MA plan networks. These could include:

- Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur;
- Post the lists on the Medicare Plan Finder website;
- Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician;
- Expanding the information for each MA plan on Medicare Plan Finder to include number of contracted physicians in each specialty and county, extent to which networks exceed minimum standards in each specialty and county, and percent of physicians in each specialty and county who participate in Medicare that are included in the plan's network;
- Measuring and reporting on the stability of networks; and
- Urging CMS to develop a plan to effectively communicate with patients about network access and any changes to MA networks that may directly or indirectly impact patients.

*Process Improvements for Recurring Physician Input Regarding Network Policies*

Finally, CMS should initiate a Network Adequacy Task Force to meet twice a year with relevant stakeholders, including practicing physicians, trade associations and specialty societies, to both review current policy and develop new policies to address network adequacy issues.

- The American Medical Association could urge Centers for Medicare & Medicaid Services to create a network adequacy task force in order to obtain ongoing input from physicians on needed improvements.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) urge Centers for Medicare & Medicaid Services (CMS) to further enhance the agency's efforts to ensure directory accuracy by:

    a. Requiring MA plans to submit provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network.
    b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies.
    c. Publicly reporting the most recent accuracy score for each plan on Medicare Plan Finder.
    d. Indicating to plans that failure to maintain complete and accurate directories, as well as failure to have a sufficient number of physician practices open and accepting new patients, may subject the MA plans to one of the following: 1. civil monetary penalties; 2. enrollment sanctions; or 3. incorporating the accuracy score into the Stars rating for each plan.
    e. Offering plans the option of using AMA/Lexis-Nexis VerifyHCP system to update provider directory information. (Directive to Take Action)

2. That our AMA urge CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by:

    a. Requiring plans to report the percentage of the physicians in the network who actually provided services to plan members during the prior year.
    b. Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy.
    c. Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together.
    d. Evaluating alternative/additional measures of adequacy. (Directive to Take Action)

3. That our AMA urge CMS to ensure lists of contracted physicians are made more easily accessible by:

    a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form. (Directive to Take Action)
    b. Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician. That our AMA urge CMS to

simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include: A. the number of contracted physicians in each specialty and county; B. the extent to which a plan's network exceeds minimum standards in each specialty and county; and C. the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan's network. (Directive to Take Action)

4. That our AMA urge CMS to measure the stability of networks by calculating the percentage change in the physicians in each specialty in an MA plan's network compared to the previous year and over several years and post that information on Plan Finder. (Directive to Take Action)

5. That our AMA urge CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website. (Directive to Take Action)

6. That our AMA urge CMS to develop process improvements for recurring input from in-network physicians regarding network policies by creating a network adequacy task force. (Directive to Take Action)

7. That our AMA rescind Policy D-285.961, which directed the AMA to conduct the study herein. (Rescind AMA Policy)

Fiscal Note: Less than $3,500.

REFERENCES

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