Kupersmit RESEARCH

MEMORANDUM

TO: Colorado Medical Society
FR: Mr. Benjamin Kupersmit
RE: 2015 Member Survey – Network Adequacy
DT: September 25, 2015

Introduction

Kupersmit Research is pleased to present this overview of the results of the 2015 CMS Network Adequacy Survey. The survey focused on physicians' experiences with payers on issues including:

- Ease and accuracy of determining in vs. out of network status
- Physician participation/access to networks and in-network specialists
- Perceptions regarding patient experience with out of network charges
- Experiences negotiating contracts, obtaining prior authorization and receiving payment
- Levels of support/opposition for various proposals CMS could consider to address these issues

We had a total of 870 CMS physicians complete the survey, resulting in a margin of error of ±3.5% at the 95% confidence level. The survey was conducted from to July 29-August 28, 2015.

2223 Gilpin St.
Denver, CO 80205
(303) 378-5856
fax: (866) 757-5787

Major Findings

- Three-quarters (78%) report insurance changes leading to interruptions in medication regimens
  - One-half (53%) have seen patients discontinue care because of changes to their insurance plan status, and 51% have turned away potential new patients because of insurance issues
  - One-third (32%) report difficulty finding in-network referrals for their patients

- One-in-five (21%) report difficulty determining their in or out of network status for a plan

- There is overwhelming support (over 80% for each, including 70% who "strongly" support) for:
  - ✓ Requiring insurers to publish accurate real time directories
  - ✓ Requiring written explanation when a practice is rejected/removed from a plan
  - ✓ Requiring insurers to give patients a card that can be swiped to readily identify payer information for the individual patient
  - ✓ Mandating standards for adequate numbers of specialty physicians in a given geographic area

- A majority (53%) say prior authorization has gotten harder, and two-thirds (66%) have seen adverse events due to interruptions in medication regimens because of prior authorization issues

- Three-quarters (72%) believe patients blame them at least partially for 'concerns with their billing or costs,' with 31% saying patients blame physicians "primarily" and 41% saying they blame physicians and insurers "equally"

- One-half (47%) have encountered payers who reject claims 'without clear explanation,' 40% have seen unnecessary delays to 'time sensitive referrals,' and 36% have experienced 'phone messages not returned in a timely fashion'

- One-third (33%) have hired new staff, one-quarter (28%) have increased hours for current staff, 19% have increased use of an 'outside billing company,' and 16% have increased use of 'collections agencies' in response to the issues raised in the survey

- In general, solo practitioners and owner/partners in physician practices are more likely to report encountering these issues with commercial payers

Perceptions of Payer Networks

Affiliation with Commercial Payers

- Nearly all CMS physicians accept commercial and government insurance, with 88% saying as such. Another 5% accept other insurance (mainly TriCare/military), 3% accept commercial insurance only, 2% are concierge/cash only and 1% accept only government insurance.
  - One-in-ten (9%) solo practitioners are in a concierge/cash only practice (while 75% accept both commercial/government insurance, 6% accept commercial only, 6% accept other insurance and 4% are government only). Upwards of 90% of those who are owner/partners in practices with two or more physicians, or who are employed in their practice, accept both commercial and government insurance.

- Among those who accept commercial insurance, at least three-quarters accept United Healthcare (83%), Anthem/BCBS (83%), Aetna (82%), Cigna (82%), Humana (78%) and Rocky Mountain Health Plans (76%). Just under half (43%) accept Kaiser Permanente, and 16% accept 'other' insurance.

- Among all CMS physicians, nearly one-half (44%) report that they provide at least some care that is billed out of network (between 1%-24% of their patients), while another 8% reported that 25%-49% of their patient care is provided out of network. Another 7% report that more than half of their care is provided out of network.
  - An additional 15% say that 100% of the care they provide is in-network with plans they contract with, and another 27% say they are unsure.

Impact of Changes in Networks/Plans

- As Table 1 indicates, three-quarters of CMS physicians (78%) report changes in insurance that have led to patients needing to change medications, 53% report they have seen patients discontinue care because of changes to insurance and 51% report having turned away potential new patients because of issues with insurance. One-third (32%) report difficulty finding in-network referrals for their patients.
- Nearly all primary care physicians (92%) report that their patients have had to change medications because of insurance (versus 70% of specialists). Physicians in solo practice (87%) and those in practices with 1-3 physicians (88%) are more likely to report they are seeing patients change medications because of changes to their insurance.
- Primary care physicians are also much more likely than specialists to say they have seen patients discontinue care (68% vs. 46%). We see a divide between practices with 10 physicians or fewer (among whom 62% have seen patients discontinue care) and those with 11 physicians or greater (with 48% saying as such). This trend is much more pronounced in Denver Metro (61%) and other cities in Colorado (56%) than in town/rural areas (40%).
- The issue of patients being turned away is more pronounced among primary care than specialists (60%-48%), and in practices with 1-3 physicians (with 67%) and 4-10 physicians (with 59%), versus 40% of those in practices with 11+ physicians. This issue is also less pronounced in towns/rural (43%) than in Denver Metro (59%) or smaller cities (53%).
- Primary care physicians are also more likely to report challenges finding in-network referrals (38% vs. 29%), and are more likely to be a concern for solo practitioners than those with at least 2-3 physicians. Access to in-network referrals is more of a concern in towns/rural areas of Colorado (41%) than Denver metro (34%) and smaller cities (27%).

Table 1: Please indicate whether you have encountered each one, if applicable:	*Yes*	*No*	*Not apply*	*Not sure*
Patients having to change medications because current medications are not covered under their new plan, or because of new formularies for their existing plans	78%	4	13	5
Patients discontinuing care with you because you are no longer on their insurance plan	53%	17	18	12
Potential new patients being turned away from your practice because you are not on their insurance plan	51%	19	17	13
Difficulty finding an adequate number of in-	32%	37	22	9

network physicians to refer your patients to				

Determining In vs. Out of Network Status

- One-in-five CMS physicians (21%) report 'difficulty determining whether you are in or out of network for any of the plans or products offered by the following payers,' while a plurality (45%) say they are "unsure" and 34% say they are not facing such difficulty.
- Among those who are solo practitioners, 42% report such difficulty, while among those who are owner/partners in a practice, 24% say as such; among employed physicians, 16% report difficulty determining their status with a commercial payer.
- One-in-five (19%) are aware of problems with their 'listing in one or more health plan's directory of network providers,' while 36% say they are not aware of such problems, 11% say this "does not apply" to their practice and 33% are unsure.
- One-third (35%) of solo practitioners, and 29% of those in practices with 1-3 physicians, say they are aware of problems with their listing; physicians who are not employed in a hospital setting are also more likely to say they are aware of problems with their listing (27%).

Ideas for Increasing Transparency in the Era of Narrow Networks: Areas for CMS to Support

- As Table 4 on the following page indicates, there is overwhelming support for a series of ideas for CMS to consider regarding narrow networks: the minimum level of support is at 80% for each, and most of the ideas have nearly unanimous support (including upwards of 70% who "strongly" support most of these).
- 'Requiring insurers to publish…real time directories' with accurate, up to date listings receives support from 95% of CMS physicians, with 84% "strongly" supporting.
- 'Requiring health plans to explain in writing why a physician or practice has been rejected or removed' from one of the networks is supported by 94%, with 83% "strongly" supporting.
- 'Requiring insurers to give patients a card that can be swiped' to readily identify payer information for the individual patient receives 90% support, with 74% "strongly" supporting.
- 'Mandating clear standards...(for an) adequate number of physicians in a given specialty to serve a given geographic area' is supported by 89%, including 72% who "strongly" support.
- 'Requiring health plans to publish…requirements for physicians wishing to join their networks' is supported by 87%, including 70% who "strongly" support.
- 'Require health plans to send written, individualized notice' of changes in physician status is supported by 80%, with 54% "strongly" supporting.

Table 4: The following are a list of ideas that have been suggested for CMS to pursue to address some of the challenges physicians have reported regarding payer networks.	*Strongly support*	*Somewhat support*	*Neither*	*Oppose (Strongly/ Somewhat)*	*Not sure*
Requiring insurers to publish and maintain accurate, real-time online directories for patients and providers, with a listing of the physicians who are in the network for each individual plan they offer	84%	11	2	0	2
Requiring health plans to explain in writing why a physician or practice has been rejected or removed from a network	83%	11	3	0	3
Requiring insurers to give patients a card that can be swiped or scanned at any office to determine eligibility, co-pay, deductible, etc. including a reader or app that will work for all Colorado health plans	74%	16	7	1	3
Mandating clear standards for the criteria to determine that a health plan's network has an adequate number of physicians in a given specialty to serve a given geographic area	72%	17	5	1	4
Requiring health plans to publish clear guidelines and requirements for physicians wishing to join their networks	70%	17	6	1	5
Require health plans to regularly send written, individualized notice to physicians of their participation status in each of the health plan's product offerings.	54%	26	14	2	5

- Generally, these ideas garner "strong" support across subgroups. There are few, slight differences in intensity (the percent who say "strongly" versus "somewhat") in some instances, but no clear trend that would suggest that these ideas would appeal to a given group more than any other within the CMS membership.

- A plurality of CMS physicians (41%) believe that patients tend to blame them and insurance companies "equally" when there is a concern with their 'billing or costs (for tests, labs and medications),' and another 31% believe they "primarily blame the physician/their employer." Another 20% believe patients "primarily blame the insurance company," while 7% say they are "unsure" or "does not apply."
    - Those in facilities with 50 or more physicians are more likely to believe patients only blame the insurance company (28%), versus 22% among those in practices with 11-50 physicians and 15% in practices with fewer than 10 physicians.

Unexpected Charges

- A majority (54%) of CMS physicians agree with a proposal to 'establish a ceiling on out of network charges to protect patients from receiving unexpected bills,' including 25% who "strongly" support such a proposal. One-quarter (25%) disagree, including 15% who "strongly" disagree (while 12% "neither agree nor disagree" and 9% are "unsure").
- Among physicians who provide hospital based or emergency services (n=600), nearly one-half (44%) report that their patients who receive out of network bills come to their staff (or to them) for an explanation; another 14% say this does not happen, and 41% are unsure.
    - Among physicians in smaller practices (fewer than 10 physicians), a majority (54%) say this happens, versus 40% of those in practices with 11-50 physicians and 32% of those in practices with 51+ physicians. Those in solo practice or owner/partners are likely to say this happens at identical rates (51% among both), versus just 34% for employed physicians.

- Physicians who provide hospital or emergency services (n=600) agree it would be difficult to 'advise the patient prior to providing care that you are out of network with their insurance' in a hospital setting, with 63% saying as such (including 44% who say "very" difficult); 16% believe it would be easy (including 7% who say "very" easy). Another 4% say "neither" and 17% say "not sure."
- CMS physicians are generally unfamiliar with Colorado's out of network protections afforded to consumers, with 79% saying as such; 3% say they are "very" familiar and 11% are "a bit" familiar.

Price Transparency

- CMS physicians generally support a proposal that would 'establish price transparency by having medical practices in Colorado publish their list of cash-pay prices for their most common procedures/services,' with 60% supporting and 16% opposing such a proposal. Support is not particularly intense, with 31% "strongly" and 29% "somewhat" supporting the proposal.
  - Support is higher among employed physicians (69%) than owner/partners (56%) and solo practitioners (49%); support also rises directly with practice size (with 47% of those in practices with 1-3 physicians supporting and fully 71% of those in facilities with 51+ physicians in support).
  - Support is also higher among primary care physicians (66%) than specialists (56%).

Other Payer Issues

Prior Authorization

- A majority of CMS physicians say that getting 'prior authorization for necessary procedures, tests and medications over the past year or two' has gotten harder, with 30% saying it has gotten "much" harder and 23% saying it has gotten "a bit" harder. Another 19% say there has been "no change," while just 7% say it has gotten "a bit" easier and 20% are unsure.
  - Among those in practices with 1-3 physicians (as well as among solo practitioners), fully two-thirds (64%) say things have gotten harder, including over 40% who say things have gotten "much" harder; among those in practices with 4-10 physicians, 60% say they have gotten harder, among those with 11-50 physicians, 50% say things have gotten harder, and among those in 51+ physician practices, 36% say they have gotten harder. The remainder of each typically says "no change," with fewer than 10% of any subgroup saying things are easier.

- Two-thirds of CMS physicians (66%) report that their patients have 'experienced interruptions in medication regimens resulting in adverse events because of prior authorization issues,' including 18% who said this has happened "many" times and 48% who say it has happened "some" times.
  - Primary care physicians are more likely to say "some" or "many" with 72%, versus 59% for specialists, who are more likely than primary care physicians to say they are "unsure" (26%-10%).

- Physicians in practices with 51+ physicians are less likely to say they have seen such interruptions, with 48%, versus 74% of those in practices with 1-10 physicians and 63% of those with 11-50 physicians.

- CMS physicians are mostly unfamiliar with 'a 2014 act passed by the Colorado legislature that required payers to standardize their prior authorization practices,' with 76% saying they are "unaware" of this act, 18% saying they have heard "a little" about it and 3% saying they have heard "a lot."

Reimbursement

- One-in-five CMS physicians (19%) say that commercial payers reject or delay a claim they ultimately agree to 10% or 25% of the time, 17% say they see this 50% or 75% of the time and 5% see this 90% or 100% of the time. The remaining 57% say they are "unsure" how often this happens.

- As Table 5 below indicates, one-half (47%) of CMS physicians say they have encountered payers who reject claims 'without clear explanation,' 40% say they have seen unnecessary delays to 'time sensitive referrals,' and 36% have experienced 'phone messages not returned in a timely fashion.'
  - We see higher percentages among solo practitioners and owner/partners for each of these.

Table 5: In trying to get payment from insurance payers, which of the following have you encountered? Please choose all that apply:	*All*	*Solo*	*Owner/ Partner*	*Employed*
Claims rejected without clear explanation why or what needs to be done to remediate	47%	66%	56%	31%
Time-sensitive referrals experiencing unnecessary or unexplained delays	40	51	46	29
Phone messages not returned in a timely fashion	36	50	45	23
None of these	3	2	2	5
Not sure/not apply	44	21	36	62

Impact on Practices

- As Table 6 below shows, one-third of CMS physicians report they have hired new staff to respond to the issues raised in this survey; one-quarter (28%) have increased hours for current staff, 19% have increased use of an 'outside billing company,' and 16% have increased use of 'collections agencies.'
    - Solo practitioners are more likely to have increased hours for current staff, while owner/partners are more likely to report having hired new staff.

Table 6: What have you/your employer done in response to the issues raised in this survey? Please check all that apply.	*All*	*Solo*	*Owner/ Partner*	*Employed*
Hired new staff	33%	21%	47%	23%
Increased hours for current staff	28	33	35	17
Hired/increased use of outside billing company	19	28	23	12
Hired/increased use of collections agencies	16	18	25	5
None of these	11	23	8	10
Not sure/not apply	32	10	19	53

Conclusions

This survey confirms what the recent "Barriers to Care" survey began to hint at: the ability of physicians to care for patients is eroding in the face of increasing pressure to act as a financial intermediary on behalf of insurance companies; this is particularly true for those in physician-owned practices, and even more so for physicians in small practices.

Physicians' expectations are clear: physician directories that are accurate; prior authorization that is transparent, predictable and does not delay or harm patients; reimbursement processes that do not require hiring staff or outside contractors to collect payment that is already approved; guidelines on patient responsibilities explained by payers (perhaps with a swipe card or phone app for each patient) so physicians are not blamed for issues with co-pays or deductibles outside their control, etc. At a minimum, they expect phone calls will be returned a timely fashion.

It is not surprising that solo practitioners and owner/partners who have been subject to these hassles, and who have expended significant resources hiring staff/contractors in response, would support proposals to remedy their problems. What is noteworthy is that physicians across the board – including those employed in large facilities who might not face these issues day-to-day – feel very strongly that these issues should be taken on by CMS.

In short, CMS physicians of every stripe want to see CMS defend their profession and protect their role in caring for their patients without constant hassles and struggles with payers. Addressing these concerns is vital to members and should be placed front-and-center by CMS to the greatest extent possible moving forward.

Methodology

This survey was administered online by the Colorado Medical Society. The survey was in the field from July 29-August 28, 2015. A total of 870 Colorado Medical Society actively practice physician members (excluding med students and retired) responded to the survey, for a margin of error of $\pm$3.5% at the 95% confidence level.