PRACTICE MANAGEMENT CENTER

AMA
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Tiered and narrow physician networks

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I. Introduction

The "preferred provider" strategy, used in tiered and narrow networks, is not a new concept. For decades, the term "preferred provider" has been defined by the managed care industry as a physician, hospital or other health care provider that provides health care services to patients usually at a discounted fee. Today, in an attempt to curtail health care costs, some health insurers and other payers are deploying products that stratify physicians and other health care providers into tiered or narrow networks that are based primarily on cost of care. Patients also face cost control pressures, as the formation of a tiered physician network involves dividing physicians into levels or tiers and designating patients' co-payments and co-insurances accordingly. If quality-of-care information is considered, it usually plays a secondary role in the formation of these networks.

This booklet provides definitions of tiered and narrow physician networks, explains how they work, quantifies problems that may be associated with their use, and concludes with a table that models some tiered and narrow networks. The tiered and narrow network samplings that appear in the table were chosen because either they are offered by large health insurers or they affect a significant number of physicians. Although it is generally health insurers that implement tiered and narrow networks, it is frequently employers, paying the greatest share of health insurance premiums, that are pressuring health insurers to use these networks and other cost-saving strategies.

II. Definitions

A "tiered physician network" assigns physicians into two or more separate tiers. A "narrow physician network" is a small or select network of physicians within a larger physician network. With narrow network plans, patients are only allowed to see physicians in the narrow network. Tiered and narrow networks attempt to differentiate between physicians primarily based on their relative cost of care. Tiered and narrow networks are usually associated with preferred provider organizations (PPOs) but may be applied to other benefit plan designs. Like tiered pharmaceutical benefit plans, which set different patient co-payments for generic, brand-name and non-formulary drugs, tiered physician networks differentiate patient costs based on the patient's choice of physician.

Tiered and narrow networks either use co-payments or co-insurance differentials or other incentives to try to steer patients to physicians in the least costly tier(s) or require patients to see only physicians who are in an exclusive network. In exchange for a narrower choice of physicians in the preferred tier(s) or select network, patients are offered a lower out-of-pocket cost. Some health insurers view tiered and narrow networks as a way to cause patients to think about the cost implications of the care they choose to receive. The use of tiered or narrow networks may also reduce insurance rates for employers. Some health care experts believe that tiered and narrow networks could be a good fit with consumer-driven health plans.

III. Network development using episode groupers

Most health insurers are profiling their network physicians to analyze and monitor cost of care. In order to determine cost of care, health insurers use their claim databases and analytic software systems to calculate and compare the actual cost of care, incurred by physicians in caring for patients, to the expected cost of the care provided. In economic theory, "efficiency" is defined as a measure of the relative resources required to achieve a given **level of outcome**. However, when payers and purchasers speak of "efficiency," they tend to focus on the cost of clinical resources for a specified set of services, without explicit reference to the benefits of care provided (clinical outcomes). Many health insurers erroneously refer to the use of efficiency measures when in actuality these are merely cost-of-care measures that are used to identify the physicians who use the least resources in caring for their patients.

The first step in cost-of-care profiling is to input the data from an insurer's claim database into an episode grouper (grouper) that partitions each patient claim diagnostically and demographically into episodes of care with the associated costs revealed. An episode of care is an interval of care provided by a health care facility or

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provider for a specific medical problem or condition. An episode of care may be continuous, or it may consist of a series of intervals marked by one or more brief separations from care; it can also identify the sequence of care (e.g., emergency, inpatient, outpatient), thus serving as one measure of health care provided.

The costs associated with the episode of care are then compared with the average cost of care for all patients with the given diagnosis within a determined population. The resulting profile compares the cost of care for one physician to treat an episode with the average cost of care incurred by specialty peers when treating episodes of the same condition. Currently there are three episode groupers in use: Ingenix's Episode Treatment Group (ETG), MedStat Episode Groups (MEGs) and Cave Consulting Grouper (CCG). Of these illness classification systems using groupers, the ETG methodology has 90 percent of the market.

The basis of the clinical logic for the ETG methodology is a series of diagnosis and procedure code tables. A diagnosis and procedure code(s) is mapped to each of the ETGs, with the exception of the evaluation and management (E/M) codes. The ETGs are designed to measure the provision and financing of health care services. By feeding adjudicated health care claim data into the ETG "engine," patient claims related to an episode of care are grouped together. ETGs strive to use pharmaceutical and laboratory data; however, these data may not always be available.

The ETG grouping software evaluates the expense line(s) of a submitted claim and links each expense with the corresponding diagnosis and/or procedure code. Relative weights, individually calculated based on gross charges per episode, measure the costs associated with each ETG. These costs are then used to rate the cost of care of the physician providing the associated service(s). This creates a unit of analysis based on an episode of care, spanning both inpatient and outpatient settings.

IV. Concerns with the use of grouper methodologies

Cost-of-care profiling systems using grouper methodologies attempt to move away from looking at isolated encounters and instead look at an entire episode of care. However, an episode of care can encompass multiple diagnostics and treatments provided by a number of physicians working together to treat the patient. Determining which physicians are responsible for which costs can be problematic, and the underlying claim data can be inaccurate and incomplete.

The strategies and processes that health insurers use to select or deselect physicians for tiered and narrow networks often lack transparency (a black box process) for physicians and patients. The use of claim data may be insufficient to make determinations about a physician's performance. Cost-of-care, service and resource utilization data are dimensions used in defining tiered and narrow networks and are often placed above quality-of-care factors.

Defining and measuring effectiveness, efficiency and quality can be problematic. In an "open access" product, such as a PPO, physicians may have little or no control over the use of health care services, and their associated costs, by other health care providers. An appropriate patient sample size is required to assure the validity of physician profiling results. Analysts question whether examining a small amount of data can provide an accurate assessment about the quality and cost of care. Some health insurers determine physician participation in their tiered and narrow networks by analyzing data on as few as 10 episodes of care over a two-year time frame.

In addition, the risk adjustment component of profiling systems frequently does not take into account all of the patient factors that must be considered for valid risk adjustment. Patient factors, such as health plan benefit type or socioeconomic status, which may affect access and/or adherence to care, are usually not included in risk adjustment and/or physician profiling processes.

Multiple comorbidities and unresponsiveness to, or non-compliance with, treatment are other factors that are generally not considered in these processes.

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Researchers at the University of Michigan performed a study to investigate whether using different risk adjustment methodologies and economic profiling metrics produce variability in practice efficiency rankings for a set of primary care physicians. Results of the study identified inconsistent and conflicting physician efficiency rankings among the measures used in risk adjustment systems. The researchers recommended that health insurers be careful in how they use practice efficiency information.[1]

V. Unintended consequences of tiered or narrow networks

Tiered and narrow networks may provide some cost-saving advantages for health insurers; however, these networks only affect the health care cost for insured patients who are covered under these health plans. In addition, only a small percentage of physicians may be in an insurer's select network, thereby placing a tremendous burden on these physicians to provide care for too many patients. Many geographical areas, such as rural communities, have single or limited access to specialists or complex procedures for patients. Network redesign would place further strains on patient access to care in these areas.

Many physicians are uncomfortable with the tiered and narrow network concept. Chronically ill patients typically have long-standing relationships with their physicians who have treated their condition(s) for years. Tiered and narrow network approaches add further complexity to the health care system for patients and risk undermining the patient-physician relationship when patients are restricted from seeing some physicians or are faced with choosing their physicians based on cost tiers.

VI. Consequences for teaching hospitals and their physicians

Academic hospitals tend to have higher cost of care because these systems support the education of medical students and residents, and they provide a great deal of health care for Medicaid and uninsured patients. These institutions may also provide care for sicker patients who use more and/or higher-intensity health care services. Tiered and narrow networks may therefore result in a preponderance of teaching hospitals and their practicing physicians residing in the tiers with the highest deductibles and co-payments or being excluded from narrow networks.

Private-pay patients may avoid receiving care from physicians practicing at these teaching facilities because of the higher out-of-pocket cost. Many of these academic centers will subsequently face even greater funding problems that could have unintended consequences on medical education, research, the ability to provide specialized services and patient access to care, especially for underinsured and uninsured patients.

VII. American Medical Association policy

The American Medical Association (AMA) does not have direct policy on tiered and narrow physician networks; however, the AMA does have policy on some of the components of these networks, as in the following summarized policies:

H-285.991 Qualifications and Credentialing of Physicians Involved in Managed Care

Selective contracting decisions should be based on professional competency, quality of care, and the appropriateness by which medical services are provided and not on a single criterion.

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[1] Thomas JW, Grazier KL, Ward K, Economic Profiling of Primary Care Physicians: Consistency among Risk-Adjusted Measures, Health Services Research, August 2004.

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H-406.994 Principles of Physician Profiling

The AMA advocates that payers actively involve physician organizations and practicing physicians in all aspects of physician profiling. Profiling data should be used primarily for educational purposes and shared with the physicians under review.

H- 406.996 Use and Release of Physician-Specific Health Care Data

The AMA supports the release of severity-adjusted physician-specific health care data from carefully selected pilot projects where the data may be deemed accurate, reliable, and meaningful to physicians, consumers and purchasers. The AMA urges that any published physician-specific data is limited to appropriate data concerning quality of health care, access to care, and cost of health care and opposes the publication of physician-specific data that do not meet these criteria.

H-406.997 Collection and Analysis of Physician-Specific Health Care Data

The AMA advocates that payers, and others that collect and analyze physician-specific health care data, adhere to the following principles:

a. The methods for collecting and analyzing the data should be disclosed to the physicians under review and the public.

b. The data should be valid, accurate, objective and used primarily for the education of both consumers and physicians.

c. The elements used in the collection of the data, including severity adjustment factors, should be determined by advisory committees that include actively practicing and specialty-specific physicians from the region where the data are being collected.

d. Statistically valid data collection, analysis, and reporting methodologies, including the establishment of a statistically significant minimum number of cases, should be developed and appropriately implemented prior to the release of physician-specific data.

e. The quality and accuracy of the data should be evaluated by conducting periodic medical record audits.

The AMA believes that health care coalitions that include physicians as full-voting members are an appropriate forum for undertaking health care data collection and analysis activities; in consideration of the potential for misinterpretation, violation of privacy rights and antitrust concerns, it is recommended that charge or utilization data provided to such entities by government, third-party payers and self-insured companies be in the form of ranges or averages and not be physician-specific.

H-450.961 Health Plan "Report Cards"

The AMA supports the development and appropriate use of health plan performance standards that are developed, evaluated and refined by actively practicing physicians and physician organizations and include: appropriate mix of process and outcomes measures; statistically significant sample size; severity of illness adjustment; differences in case-mix and other variables such as age, sex, occupation and socioeconomic status; and verification through external audits. This information should be provided to physicians with an adequate opportunity to review and respond to the data before its use or disclosure.

VIII. A sampling of tiered and narrow networks

The following table highlights some tiered and narrow networks and is intended to give examples of how these types of networks have been implemented. This listing is not intended to be a comprehensive compendium, but just a sampling of how some of these networks operate. The information in the table has been taken from a variety of publications, articles, conferences and public Web sites and is correct to the best of our knowledge, but it has not been reviewed by program sponsors for accuracy or program modifications.

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Table 1: *Aexcel*			
Program name and sponsor	**Program strategy**	**Program description**	**Other**
Aexcel Aetna	Specialty care is considered a "cost driver" for this insurer. Aetna uses ETGs[2] to evaluate physician cost of care. *Aexcel* is focused on 12 specialties (cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics and gynecology, orthopaedics, otolaryngology, neurology, neurosurgery, plastic surgery, vascular surgery, and urology).	Based on an analysis of clinical measures of effectiveness (hospital readmission rates over a 30-day period and reduced rates of unexpected complications by hospitalized patients) and use of health care resources, Aetna identifies best-performing physicians and places them in the discrete *Aexcel* network. Aetna uses a four-step process to determine physician selection for *Aexcel:* 1. A specialist must have at least 10 common episodes of care in Aetna's database. 2. Clinical quality indicators are reviewed. 3. Physician cost of care is determined with claims data analysis. 4. Patients and physicians are matched geographically.	Two *Aexcel* options, *Aexcel* and *Aexcel* Plus, are available to self-insured employers. In *Aexcel*, members must use physicians in the narrow network *(Aexcel).* In *Aexcel* Plus, members pay differential charges based on three tiers of physicians: ■ Physicians in the *Aexcel* network ■ Physicians who have contracted with Aetna but are not in the *Aexcel* network ■ Physicians who are not contracted with Aetna As of January 2006, *Aexcel* programs had a membership of 470,000 and were available in 20 markets.

[2] Episode Treatment Groups

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Table 2: *Signature Value Advantage*

Program name and sponsor	Program strategy	Program description	Other
Signature Value Advantage PacifiCare Health Systems (now merged with UnitedHealth Group)	In late 2001, PacifiCare initiated the tiered concept with a two-tiered hospital network, *Selected Hospital Plan*. In 2002 the insurer replaced this product with "value HMO," which offered a narrow network of physicians and hospitals in exchange for a significantly lower premium. In 2003 this product was renamed *Signature Value Advantage.* The selection criteria for the initial tiered network looked only at hospital cost. Although *Signature Value Advantage* has evolved to include quality measures, PacifiCare rates physicians on cost of care before it evaluates their clinical performance.	PacifiCare's quality measures include 10 indicators of physician group performance. The clinical measures include: ■ Breast and cervical cancer screening ■ Childhood immunization rates ■ Diabetic and coronary artery disease care metrics Physician performance is also rated on five service and satisfaction measures derived from CAHPS[3]. Patients receiving care from physicians in *Signature Value Advantage* pay a 10 percent co-payment for services compared with a 30 percent co-payment for services received outside the smaller network.	PacifiCare estimates that 50 percent of its standard HMO network physicians are in its *Signature Value Advantage* network. According to PacifiCare, health care costs are approximately 20 percent lower and quality is approximately 20 percent higher than its standard plan. Annual premium savings are 8 to 10 percent. Updated annually, PacifiCare reports that there is less than a 10 percent change in the composition of the physicians in the smaller network each year.

[3] The Consumer Assessment of Healthcare Providers and Systems program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

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Table 3: *UnitedHealth PremiumSM*			
Program name and sponsor	**Program strategy**	**Program description**	**Other**
UnitedHealth Premium ***SM*** UnitedHealth Group	The *UnitedHealth Premium* designation program is focused on the following physician specialties: allergy, cardiothoracic surgery, cardiology, endocrinology, family medicine, infectious disease, internal medicine, nephrology, neurosurgery, oncology, orthopaedic surgery, pulmonology and rheumatology. Physician specialties for which the insurer has no quality criteria are excluded from the designation program. UnitedHealth Group bases its tiered network on cost and quality measures.	The *UnitedHealth Premium* designation program uses quality and cost-of-care criteria to rate physicians on 20 chronic and complex conditions. Physicians must have a minimum of 10 patients, with a specified diagnosis, in order to qualify for a quality review. Ratings are designated by no stars, one star (quality only) or two stars (quality and cost of care). Physicians who have an insufficient number of patients for rating are designated by a triangle next to their name in the plan's directory listing. Quality ratings are based on HEDIS[4] measures as well as the AQA[5] starter set of measures. The cost-of-care criteria are based on ETGs[6] and APR-DRGs.[7]	*UnitedHealth Premium* is the successor to the *UnitedHealth Performance Program* that was tested in St. Louis in 2005 and has been discontinued because of harsh criticism for its primary focus on cost of care. UnitedHealth Group has two tiered programs: *UnitedHealth Premium* designation program focuses on physicians, while *Premium Network* is for facilities only. In spring 2006, *UnitedHealth Premium* began pilot programs in Chicago and Cleveland that increased fee schedules for two-star physicians.

[4] Health Plan Employer and Information Data Set
[5] Ambulatory Care Quality Alliance
[6] Episode Treatment Groups
[7] All Patient Refined Diagnosis Related Groups

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Table 4: *Power Select HMO*

Program name and sponsor	Program strategy	Program description	Other
Power Select HMO Blue Cross of California (licensee of WellPoint, Inc.)	Blue Cross of California's narrow network targets employers with more than 51 employees throughout 22 counties in California. The insurer may expand the program to small groups and individual markets in the future. *Power Select HMO* is predicted to cost an average of 15 percent less than other HMO products in the market.	Members in the *Power Select HMO* are not required to obtain a referral to see a specialist in the same medical group as their primary care physician.	The *Power Select HMO* network consists of approximately 30 percent of the insurer's full physician network. Physicians accept lower reimbursement to be designated in the *Power Select HMO* group.

Table 5: *Premera Dimensions*

Program name and sponsor	Program strategy	Program description	Other
Premera Dimensions Premera Blue Cross, Washington State	*Premera Dimensions* organizes the PPO[8] network into four tiers. Medical practices and hospitals that are cost-competitive with their medical community can join the *Dimensions* network.	Premera pioneered tiered networks in 2002. Currently the insurer uses cost-effectiveness as the sole criterion for its PPO network selection. Premera uses ETGs[9] to determine physician cost of care.	Eighty percent of the physicians contracted with Premera are in the *Premera Dimensions* network.

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[8] Preferred provider organization
[9] Episode Treatment Groups

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Table 6: *BlueChoice Solutions®*			
Program name and sponsor	**Program strategy**	**Program description**	**Other**
BlueChoice Solutions® Blue Cross Blue Shield of Texas [a division of Health Care Service Corporation (HCSC)]	*BlueChoice Solutions* is a narrow network within the insurer's large PPO network that is targeted at its small- to medium-group business. Cost of care is the primary determinant for *BlueChoice Solutions*. Compared with their peers, physicians in the narrow network are judged on their ability to provide care at or below the average cost of care. HEDIS[10] measures are used to determine quality ratings.	For the first two years of this program, the insurer used ETGs to determine cost-efficiency ratings; however, it now uses MEGs.[11] The insurer claims that MEGs outperform ETGs particularly on burden of illness. The risk-adjusted cost index for a physician is calculated from a minimum of 30 episodes of care comparing the physician's actual cost of care with the average cost of care for the specialty. Blue Cross Blue Shield of Texas offers its customers lower premiums and higher benefit levels for *BlueChoice Solutions*, compared with its other PPO plans.	About 70 percent of physicians from the insurer's traditional PPO network are in the *BlueChoice Solutions* network.

[10] Health Plan Employer Data and Information Set
[11] MedStat Episode Groups

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Table 7: *SMARTNET*

Program name and sponsor	Program strategy	Program description	Other
SMARTNET Humana	Humana markets its high-performance network of physicians and hospitals, *SMARTNET*, to employer groups as an effort to reduce premium cost by 5 to 12 percent. The program is offered to both insured and self-insured employers. *SMARTNET* is a smaller network within Humana's traditional PPO and POS[12] networks focused on 14 specialties: allergy, cardiology, cardiovascular surgery, dermatology, gastroenterology, general surgery, neurology, oncology, ophthalmology, orthopaedic surgery, otolaryngology, pulmonary medicine, thoracic surgery and urology. Primary care specialists are also reviewed.	In order to determine cost-of-care ratings, Humana uses ETGs to compare episodes of care. Humana has announced that it will study quality and cost data to evaluate and choose *SMARTNET* physicians, but no public information can be found on the quality measures that are used for the network selection. At least one Humana pilot program is known to be based solely on cost of care. Patients have the option of choosing physicians either in Humana's traditional PPO network or in *SMARTNET*; however, patient deductibles and co-payments are higher if physicians are not in *SMARTNET*.	Humana estimates that 75 percent of its contracted PCPs[13] and 50 percent of other specialists, now in the traditional Humana PPO network, will also be in the *SMARTNET* network. *SMARTNET* has been launched in 15 highly-concentrated markets (as defined by Humana) with additional markets under development.

[12] Point of service
[13] Primary care physician specialists

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Table 8: *CIGNA Care Network*

Program name and sponsor	Program strategy	Program description	Other
CIGNA Care Network CIGNA HealthCare	*CIGNA Care Network* is a tiered physician network that targets 21 specialties: allergy and immunology; cardiology; cardiothoracic surgery; colon and rectal surgery; dermatology; ear, nose and throat; endocrinology; gastroenterology; general surgery; hematology and oncology; infectious disease; nephrology; neurology; neurosurgery; obstetrics and gynecology; ophthalmology; orthopaedics and surgery; pulmonology; rheumatology; urology; and vascular surgery.	Specialty care physicians are selected for the *CIGNA Care Network* according to the following criteria: ■ A minimum of 20 episodes of care for CIGNA members. ■ Physicians receiving NCQA[14] recognition for providing high-quality care to diabetic and cardiac or stroke patients are automatically included in the network. ■ ETG analysis of efficiency rating (fee schedule, resource utilization and referral patterns to facilities with differing cost and quality are factors of this rating). Patient access to care within the local market. Patients are incentivized to access their care from the insurer's select specialists.	All physicians who are not in the targeted 21 specialties are in the *CIGNA Care Network*. *CIGNA Care Network* is available to self-insured employer groups in 16 markets. CIGNA is not tiering hospitals at this time; however, the insurer is looking at the relationship between the specialists in the select tier and the hospitals to which they refer patients. Although co-payment levels vary by employer, CIGNA estimates that members would see a differential of $10 to $30 per office visit between the standard in-network cost sharing and the fee for seeing a designated specialist. CIGNA has declined to disclose membership for this product.

[14] National Committee for Quality Assurance

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Table 9: *Distinctions*

Program name and sponsor	Program strategy	Program description	Other
Distinctions HealthPartners	With 30 percent market share and ownership of a large multi- specialty medical group and a hospital, HealthPartners created a tiered network (multiple benefit levels) in order to engage members in health care decisions that are based on both quality and cost.	HealthPartners has a three-tiered network that is based on clinical quality and service and total cost of care derived from episode of care analyses. Physicians and hospitals ranked highest in quality and lowest in cost are placed in tier one. Physicians and hospitals with either higher cost of care or lower quality scores are placed in tier two or tier three. Each tier has a corresponding patient co-pay or co-insurance rate, with tier one having the lowest rates. Primary care specialists and HealthPartners' top four volume specialists (cardiology; obstetrics and gynecology; ear, nose and throat; and orthopaedics) are targeted for benefit level differentiation.	Beginning in 2006, HealthPartners added a third tier to its network and doubled the number of measures used to rank physicians and hospitals on quality of care. Cost and quality rankings (designated by dollar signs and stars) for physicians and hospitals are posted on HealthPartners' Web site for member-only reference.

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Here are a few other products from the AMA Private Sector Advocacy unit that may be of interest:

- "**Pay for performance: A physician's guide to evaluating incentive plans**"
- "**Optimizing outcomes and pay for performance: Can patient registries help?**"
- "**Read your contracts: Is your practice losing revenue through rental network PPOs?**"
- "**Out-of-network payment challenges for the physician practice**"
- "**What to do about unfair payer practices**"
- "**Medicare Advantage: What it means for you and your patients**"
- "**Information technology solutions: Consider the potential savings**"

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For additional information and resources, there are three easy ways to contact the AMA Practice Management Center:

- Call **(800) 621-8335** and ask for the AMA Practice Management Center.
- Fax information to **(312) 464-5541**.
- Visit **www.ama-assn.org/go/pmc** to access the AMA Practice Management Center Web site.

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