Silent PPO – Dead or Alive?

Presentation for South Texas HFMA ANI

Presented By:

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It Is Easy to Overlook A Threat

- "There's no chance that the iPhone is going to get any significant market share. No Chance." (Steve Ballmer, Microsoft CEO April 2007
- iPhone has been running 15% - 20% of new phones

Providers Are Not Immune

"White space is defined as medical billed charge volume incurred by a health plan member outside of the payer's owned or leased primary networks. At this time, that charge volume is estimated to be over $50 billion in commercial volume and an additional $14 billion in dollar volume in the Blues environment."

Tom Bartlett,

President Concentra Network Services, Concentra, Inc.

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"Silent PPOs" are alive and well

They just have changed their methods

Today's Session

- Understanding and defining the Silent PPO and the current market dynamics
- Challenges of the ever-changing reimbursement game
- Strategies to manage "revenue drain"
- Questions and answers

Current Market Dynamics – Motivating Factors

- Recent Trends- Commercial Plans
  - Aetna, which also raised its full-year forecast on Thursday, is the latest health insurer to easily top profit expectations this quarter following stronger-than-expected reports from UnitedHealth Group Inc (UNH.N), WellPoint Inc (WLP.N) and Humana Inc (HUM.N). (REUTERS 4/29/10)
- Future Pressures
  - Healthcare reform impact on medical loss ratios, expect additional "managed care" to hit providers

"Managed Cost" – The Effective Rate of Reimbursement

- Case Study with State Hospital Association
  - Reviewed 3 years of historic payments across 20 hospitals
  - Effective Rate averaged 90.1% of contracted/expected rates
  - Revenue well below projections and hospital incurs the added expense of challenging
- Identifying the delta between expected and effective reimbursement is the first step
  - Will not always direct you to "lost" revenue such silent ppo
  - What is a write off vs a true contractual – are the smaller contracts modeled?

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The Defense - Do You Have the Right Rulebook?

- Historic focus – rates, rates, rates and yet the majority of hospitals are bleeding red ink or working on razor-thin margins
- Explicit contract language can be more important than a rate inflator - "Silent" provisions rarely benefit the provider
- The games have changed… shouldn't the rule book be updated

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The Web Begins - Silent PPOs

- An estimated $65+Billion annual unregulated industry
- Many different names:
  - Continuous Fee Negotiation Agreements
  - Complementary Networks / Rental / Wrap Network
  - Out-of-Network
- All Payers have access to repricing activity -accessing discounts without provider, patient or regulatory knowledge
- One contract could lead to hundreds of payers accessing provider
- Access lowest contractual/accepted rates
- Increasingly sophisticated and deceptive contracting methods

Key Source AMA 9/12/2006

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Market Demand for Cost-Savings

Excerpts from Meeting Minutes - City of Stevens Point, WI

Rocheleau questioned the implementation of the "silent PPO" which means the City would reimburse employees who seek services outside of the [HMO] network.

Rackow pointed out…. The City of Stevens Point is self-insured so it serves the city's interest financially to keep the claims at a minimum.

We are saving money, asked Mayor Wescott ?

Treasurer Schlice stated, "Projected overall the City will have a net savings of about $100,000."

Seiser moved, Rackow seconded, to approve the implementation of a [silent] Preferred Provider Program. Nays: None. Motion carried.

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Defining a "Silent" PPO

- A network PPO exists to market contractually discounted rates to third-party payers
- May also rent the network to entities such as "network brokers" or "repricers" whose sole purpose is finding and applying the lowest discounted rates, often without provider authorization
- Limited control over claim payment

The Classic "Silent PPO" Game

- Members lack financial incentives to visit "preferred providers" (quid pro quo)
- In fact, the Member may not even be aware that they are part of a network
- Compare to Retail Coupons

Sample Benefit Plan

Out of Network = "Same as In Network"

TRADITIONAL PLAN PPO Network: Beech Street/CAPP CARE

Deductible $250 Individual/ $750 Family OOP: $1,450

NETWORK BENEFITS	% PAID BY PLAN	OUT-OF-NETWORK BENEFITS *20% additional co-insurance*	% PAID BY PLAN
*Inpatient: Medical/Surgical/Maternity	80%	Same as In Network	
*Outpatient Surgery	80%	Same as In Network	
*Outpatient: MRI/CAT, Diagnostic testing(Lab & Radiology)/ Routine Testing	80% Routine100%	Same as In Network	
Office Visit-Routine Adult: $500 max. every 3 years. No deductible Ages 6 yrs. and up	100%	Same as In Network	
Office Visit-Routine Child: Ages: 0-6 yrs. N[illegible] deductible See booklet for specifics	100%	Same as In Network	
[illegible]e Visit-Primary Care (PCP):	80%	Same as In Network	
*Office Visit-Specialist:	80%		
*Therapies; PT/OT/ST; 60 days max. or 39 visits per yr. *Radiation/Chemo. has no max.*	80%	Same as in Network	
*Rehabilitation Services:	80%	Same as In Network	
Podiatry: $500 calendar yr. max for non-surg	80%	Same as In Network	
Chiropractic: 39 visits or $2,000 cal. yr. max.	80%	Same as In Network	
*Home Health Care: Within 7 days of hosp. confinement	80%	Same as In Network	
*Hospice Services:	80%	Same as In Network	
*Skilled Nursing: Within 7 days of hospital confinement. 90 day max.	80%	Same as In Network	
*Durable Medical Equipment: Pre-cert if over $500	80%	Same as In Network	
*Inpatient Psych:$320 day max. approved $200 day max. non-approved	80% 50%	Same as In Network	
Outpatient Psych: $72 visit max. approved $45 visit max. & 50 visits non-approved	80% 50%	Same as In Network	

Should this plan get the same rate as a steered plan?

The New (not so) SILENT PPO

- BCBS "Joint Administered" programs via local TPAs
- Aetna Signature Administrators
- Cigna "co-administration"

Hospitals sue Horizon, self-insured

Fiserv Health and Aetna help employers control health care costs

Initiative directed at employers with third-party health care admin.

WTN news • Published 08/18/04
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WAUSAU, Wis.— Fiserv Health announced Wednesday it has entered into an agreement with Aetna Signature Administrators to gain access to Aetna's PPO network and stop-loss services for the clients of Wausau Benefits, a Fiserv Health company. This initiative is directed at self-funded employers with 100 to 3,000 eligible employees who traditionally use third-party administrators.

These products reduce the efficiencies of volume discounts

No-Risk vs. Risk Entities

- The payer foxtrot – the State takes one step forward and the Feds take two steps back
  - Fully-Insured Plan subject to state insurance regulations (e.g. prompt payment, appeals, etc.)
  - Self-Funded Plans are outside the State governance, preempted by Federal ERISA regulations
    - Only CA, TX and NJ courts specifically allow providers to pursue self-funded payers for contractual breach

White Space Management

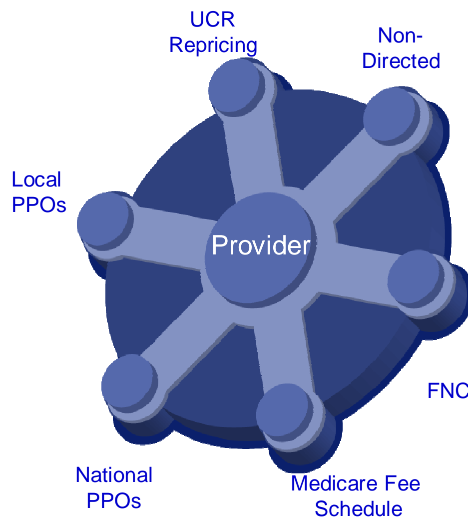
Numerous Access Points into Providers for Discounting

Utilizing Aggressive Multi-Tiered Repricing Strategies

Low Push Back by Providers

Payers improve profits at Provider's expense

Reference "Who's Managing Your Black Space", Hammer & Phillips, **hfm**, NYP



Providers lose control – Once claim is submitted

- Common Managed Care Contracts (Payer and Provider)
  - It is not unusual for a providers to have 50 to 100 contracts
- Payers dictate parameters and timeliness of payments.
  - Inappropriate PPO access and discounting
  - Fee Negotiations (in and out of network claims)
  - Audits
- Provider's response is costly and reactive
  - Balance billing payer and/or member
  - Zero balance auditing
  - Legal resolution
- Providers administrative resources are overtaxed

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Managing Revenue Drain

1. Close the Gaps in Your Managed Care Agreements

- Audit effective payment rate
  - Standard Terms, Rate Sheet and codes (review bundling policy)
- Contract should specifically include the wording of (not just citation) any regulation that makes sense… and apply to ALL plans accessing the rates
  - "This Agreement shall be governed by all applicable State and Federal laws and statutes" is not enough
  - Historically, payers would pick & choose (e.g. balance billing, continuation of service, etc.)
  - Breach of Contract vs. Insurance Regs
- Require network/payer listings

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Contracting Pitfalls

- **"Participation.** Hospital shall accept compensation in accordance with this Agreement … regardless of whether Hospital is a Participating Provider in such Plan."
- **Obligations.** [PPO] will assure that all of its Client have available to them for use by its Members **one or more of the mechanisms** as noted below to increase member utilization at its network facilities. They include, but are not necessarily limited to:
  - Benefit Differentials, Shared Saving Program, Client's Referral Line, [PPO's]Referral Line, On-Line access to [PPO] Facility and Practitioner Directories, Hard Copy Directories, Free Transfer from Non-network to Network Facility

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Managing Revenue Drain

2. Include Registration Team in Process

- Copy both sides of the Patient ID card
- Participating networks are identified.
- When in doubt, call to confirm (eg multiple logos)
- Validate benefits / steerage (the reason for the contract)

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Does Not Match Registration

CLAIM/PATIENT BREAKDOWN

Claim number	Patient	SSN	Date of service	Proc	Charge	Ded/Coins	Inelig	Paid	Ref
[illegible]	[illegible]	[illegible]	[illegible]	121	47,189.04	0.00	41,689.04	5,500.00	1

PAYMENT SUMMARY

Total	Charge	Ded/Coins	Inelig	Paid	
	47,189.04	0.00	41,689.04	5,500.00	

REFERENCES

Ref #	Explanation
1	This is a PPO Provider discount. You are not responsible for this amount.

"PPO Discount"

Managing Revenue Drain

3. Have Protocol in Place in the Business Office

- Limit authority for discounting
  - *WSM* use trained negotiators to obtain most favorable discounts.
  - Only those with special negotiating skills should authorize non-prime discounts.
- Reject allegations of excessive UCR rates
  - Fee negotiating is a favorite tactic of *WSM.*
  - CA: Medicare not "reasonable payment" for out-of-network payer.
  - MA, NY and NJ have all challenged use of UCR methodology, reducing conflict of interest and increasing transparency

Managing Revenue Drain

4. Use employer plan terms for leverage

- If benefit plan states than out-of-network claims will be paid at "UCR" (should be defined) and payer will pay xx% and patient liable for remainder
- Alternate - negotiate for reduced rate for claim paid as in network.

Managing Revenue Drain

5. Manage and Measure

- Audit three months of historic paid claims
  - Identify employer & employee (Card)
  - Payer at submission (Claim)
  - Payment and timeliness (EOB)
- Check effective rate and what was the nature of the discount
- Result will surprise you!

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Summary – Manage Revenue Drain

1. **Close the Gaps in Your Managed Care Agreements**
2. **Include Registration Team in Process**
3. **Have Protocol in Place in the Business Office**
4. **Use employer plan terms for leverage**
5. **Manage and Measure**

Questions
&
Answers

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Gregg is a Senior Vice President with NHPN. NHPN helps hospitals improve profitability by analyzing and negotiating managed care agreements, ensuring contract compliance, and driving additional reimbursement from non-contracted payors. Previously, Gregg was the Chief Operating Officer of the MedAssets Revenue Cycle Services Division. In this role, Gregg had general oversight of the daily operations including Accounts Receivable Services and Managed Care Services. Gregg has held several senior management roles across a spectrum of healthcare organizations including Vice President of Hospital Strategy of MagnaCare, Vice President of Network Development of NPPN, and Director of Strategic Planning of Universal American Financial where he was actively involved in the design and rollout of specialty managed care products. Gregg began his professional career at Parke-Davis Pharmaceuticals where he worked on the sales and marketing team and focused on managed care programs. Gregg earned his B.S. from Cornell University and his M.B.A. from New York University.

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