Silent Inside PPOs

Here is who, what, where, when and how on a complex payer behavior that takes money out of your pocket. Get the details about one of the California Medical Association’s priority reforms. By Mark W. Rieger

The American Medical Association has been using the term “silent PPO” for more than 10 years, and the opportunistic behavior of payers, third-party administrators and their agent PPOs has been documented and understood longer than that.

The California Medical Association has been instrumental in enacting legislative reform to curb payer abuse. Its latest effort is an attempt to quash silent PPO activity. (See box at right.) The purpose of this article is to refamiliarize physicians with the issues and create interest in continuing efforts to reform payer behaviors.

PPOs’ Prominence

A PPO’s primary contribution to cost containment is based on its contracted discounts with participating physicians. Patients can choose any provider in the PPO or outside the PPO, but have a financial incentive to choose the former. In exchange for participation in the PPO, the provider agrees to offer services at a discounted fee-for-service rate.

Today, PPOs enjoy the lion’s share of all employer-sponsored health insurance plans at 43 percent of covered lives vs. HMOs with 30 percent of covered lives, according to the American Association of PPOs. The evidence for the past 30 years is that health plan purchasers and beneficiaries want broad provider networks.

Of the roughly 800 group health PPOs operating in the U.S. in 2002, about half qualify as a “leased PPO network” (LPN). LPNs are the focus of this discussion. The easiest way to differentiate an LPN is that the entity with which the physician holds the contract does not pay for services. Rather the LPN’s payer client “leases” access to the provider network and the associated discounts. More than 100 LPNs do business in California.

A review of agreements executed between physicians and LPNs reveals three contract terms that have led to opportunism by payers and physician dissatisfaction with this industry. The first two are nearly universal and the third is present only with directed networks.

1. The PPO is not financially responsible to pay the physician and can only make “best efforts” to insure that the responsible entity pays according to the terms of the LPN fee agreement.

2. The PPO can lease the rate with the physician to various entities without prior approval from the physician. These entities include third-party administrators, self-insured employers, financial institutions, associations, insurance companies, other PPOs, HMOs, and/or the clients of any of the preceding entities.

3. In exchange for the discount, the PPO agrees to publish a directory including the physician’s name and make best efforts to insure that its payer clients create financial incentives for patients to choose an “in-network” physician.

Innate Complexity and Opportunism

Over the past 20 years, an industry has developed involving 2,500 payers using one or more of 400 LPNs to access most of the nation’s physicians. The average physician has about 12 LPN agreements each with somewhere between a dozen and several hundred payer clients.

The explosion in the numbers of LPNs and physicians participating in multiple LPNs quickly led to the evolution of “nondirected” networks. The hallmark of these networks is the absence of

CMA-Sponsored Legislation

AB 757 (Chan) Silent PPO Reform

This bill would ensure that PPOs are no longer “silent” by, among other things, forcing transparency of profits, forcing PPOs to seek the provider’s affirmative permission before selling his or her name to another payer and, if agreed to, ensuring that the provider has actual knowledge of who that payer is. This bill will also ensure that a provider will not be forced to participate in any product or business line that is materially different from that to which the underlying agreement applies either as it relates to increased workload or other responsibilities imposed on the provider or decreased benefits conferred on the provider.

Status as of June 15: Held in the Assembly Appropriations Committee.
InsidePPOs

Instead, physicians are offered only an opportunity to market their participation in the PPO and the associated discount. In spite of this, these PPOs were no less successful in enrolling physicians.

In fact, a common practice for LPNs wishing to expand into a market is to sign first with the local IPAs often at above-market rates to quickly establish a presence. Then, over time, contract with the physician or physician groups individually, often at lower rates.

Beginning in the early ‘90s, payer behavior emerged that took advantage of loose contract language in LPN agreements and of providers’ inability to adequately police certain payer behaviors.

In order for a physician to measure payers’ compliance with current regulations, he or she must keep track of the current controlling entity for the LPN (for example, the contract may be with Community Care Network, but now it is owned by First Health), the current client list for that LPN (which may not be current when the claim is paid), and the third-party administrator for each of obligations by the payers to actively direct patients to participating providers.

This is a nearly impossible set of relationships for the physician to manage. And practice management systems are inadequate in tracking these relationships.

The sheer number of entities in the LPN marketplace and the means by which they compete with each other contributes to complexity. This complexity eventually results in the physician trying to sort out the relationships to see whether the parties are complying with the agreement that controls how the physician is paid.

Opportunism at Its Worst

Cherry Picking: Physicians often sign multiple LPN agreements at different rates. It’s called “cherry picking” when the payer takes advantage of the disparate rates by contracting with multiple PPOs that have overlapping provider contracts.

If the payer or its third-party administrator has control of repricing the claim, it can use its database of discount rates to find the PPO with the best rate and apply that rate to that claim. This means the rate associated with the PPO listed on the patient’s card is not necessarily the one used to reprice the claim. A review of client lists among the various LPNs with which the physician

WHERE COUNTY MEDICAL FOUNDATIONS STAND

When the silent PPO issue surfaced earlier this year, physicians raised questions about the behavior of their own network—the California Foundation for Medical Care and its county-based components. Here, Dolores Green, executive director of the Riverside County Medical Association and CEO of the Inland Empire Foundation for Medical Care, answers the concerns.

Does CFMC participate in silent PPOs?

Absolutely not. CFMC will take any steps necessary to stop the use of its networks in any way that results in silent PPO activity. The CFMC board and local components feel that such use is unethical and illegal.

How do the foundations ensure transparency?

All terms of the physician contract are clearly spelled out, including each and every payer (client list) that has access to the network. The contract includes the reimbursement rate that the provider will be paid by any client leasing the CFMC network. All contracts are nonexclusive and physicians are free to participate in any other network or program they choose.

Upon termination of a client leasing the network, notification is sent to all local foundations to communicate with the providers. The client list is updated and posted online for physicians to view 24/7. A sample client contract is also on the CFMC site.

What is required in the foundation contract?

The foundation client contract has multiple stipulations to protect the physician. Included in the contract is a clause that assures the provider that the foundation will maintain control of its contracts and will not allow them to be resold or otherwise find their way into the “contract cascade” that has been so problematic for physicians.

In addition to the clause about maintaining control, the contract has several other stipulations to protect the provider. Foundation clients are required to identify their enrollees to the provider. This is generally done on an ID card with the foundation’s logo included. Clients are also required contractually to include incentives to their enrollees to access the providers contracted in the network. These incentives range from a lower co-pay to a decreased co-insurance or no co-insurance. The explanation of benefits forms must have foundation identification, and there must be a toll-free number for providers to call for eligibility, benefits and network access.

A copy of the fee schedule in place is attached to the contract so that the physician is aware of how he or she will be reimbursed. All of the foundation clients are contractually bound to pay according to the fee schedule.

If the physician chooses to terminate his or her agreement with the foundation, there is a reasonable process in place to accomplish termination of his or her contract. When termination notice is received from a physician, the local foundation is responsible for updating the provider database to reflect the termination. The provider database is updated on the Web site monthly. Depending on when the notice is received, the longest that a provider should remain listed online is 60 days. Most foundation contracts have a 60-day termination clause, which allows ample time between the notice of termination and the effective date of termination to remove the provider from the database.

How does the foundation ensure contracts are adhered to?

Prior to approving a client contract, the foundation determines whether or not a client/payer is able to load the foundation fee schedule into its claim system. If a client/payer’s claim system cannot pay under the RBRVS methodology, CFMC will require that claims be sent to its office to determine correct payment based on the contracted rate and then returned to the payer for payment.

If a physician feels he or she has been improperly paid for a claim, provider relations specialists at the foundations can help. These specialists will intervene to determine whether a client/payer is abiding by the terms of its contract. If not, the foundation will take steps to terminate the contract and discontinue access to its network database.
is contracted will almost always expose the overlap.

**Stacking:** LPNs have attempted to create exclusivity with their clients in order to protect their market share and direct patients to their contracted physicians. However, in the tug of war between LPNs and their payer clients, another subterfuge called “stacking” emerged.

Here the payer contracts with a primary PPO, but fails to honor exclusivity and contracts with several other PPOs in the same market in order to reduce out-of-network claims. The payer loads all of the PPOs into its computer, effectively eliminating out-of-network providers. This waters down the physician’s quid pro quo with the LPN to direct patients in exchange for a discount. The physician is especially disadvantaged both in detecting the practice and leveraging the LPN to police the behavior of its clients.

**Silent PPOs:** Silent PPOs occur where, unbeknownst to the contracted physician, an LPN leases the physician’s contract to a client—giving the third party the advantage of the discount the LPN negotiated with the physician. A distinguishing characteristic is that the LPN’s client is relieved of certain obligations to the physician contained in the LPN’s provider agreement.

One typical form of silent PPO activity is indemnity plans (such as a medical benefit rider on an auto insurance policy) leasing discounts through LPNs. These plans do not issue “preferred provider” directories and make no effort to steer patients to a particular physician. In essence, the discount is taken because it is easily obtained from the LPN eager to receive a shared savings fee.

**Fixes for the Problem**
To reverse this pervasive and insidious problem, physicians must leverage the single most important item they bring to the table: the discount. Physicians must make access to the discount contingent on certain terms and conditions. Failure to comply should cause forfeiture of the discount.

Regulatory reform should focus on business practices within the LPN industry—especially extra-contractual discount practices and payment behavior. Specifically, relationships should be transparent and it should be easy to connect the LPN, the payer, the discount and the PPO listed on the patient’s insurance card for any claim at the time of payment.

In general, market-based reform will always be more efficient and more satisfactory. The market is open to a solution where access costs for payers can be reduced and physicians can regain some control over the terms and conditions under which they offer their discount. If physicians want to take the lead, they must get comfortable with how to offer the market a competitive price for services. Things like the HIPAA claim and remittance file formats, newer low-cost repricing technology, and creating an electronic marketing portal for payers and consumers can combine to make this more realistic than ever.

The effect would be to drive payers seeking discounts into legitimate access agreements and most importantly restore honesty and integrity to the LPN industry.

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