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Healthcare IndustryPulse

April 2005

Print Newsletter



Contents

California PPO Marketplace

The Need for Internal Audit in
Healthcare Organizations

OIG and Hospitals: Ensure That Your
Compliance Plan Successfully
Addresses Recently Released OIG
Risk Areas

Featured Healthcare Advisory
Services Consultant – Susan Stone,
MBA

Our first edition of the *Healthcare Industry Pulse* was a success! Many readers were quick to inform us that they found our newsletter articles both timely and relevant. We have kept the momentum going, and are pleased to present the second edition, which includes a resourceful piece on the PPO marketplace, an article on the significant need for internal audits and an informative summary of the Office of the Inspector General's recent hospital compliance guidance. We hope you find these articles informative and enjoyable.

For more information about the articles or the topics discussed, please call or e-mail Arthur R. Nemiroff, National Director of Healthcare Advisory Services, BDO Seidman, LLP at (714) 957-3200, anemiroff@bdo.com.

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California PPO Marketplace

By Susan B. Stone, Director, Healthcare Advisory Services

The 1990s was a period of rapid HMO growth. The healthcare market focus shifted from fee-for-service reimbursement, i.e. indemnity and PPOs (preferred provider organizations) to managed care and capitation reimbursement. At-risk medical groups rapidly formed during this time period in order to capture managed care membership. Also during this time period, the PPO business was ignored by most physicians, medical groups and other providers of health care services.

However, during the past few years, the healthcare market once again is witnessing another paradigm shift in delivery models, refocusing on the PPO model. Today, PPOs are the largest and fastest-growing sector of the health benefits market and half of the insured population is covered by PPOs. Today's PPO networks are formed to serve different markets, such as workers' compensation, health savings accounts (HSAs), HMOs, self insured employers, etc. PPO networks vary in size, ranging from narrow (previously called exclusive provider organizations or EPOs) to very large provider networks.

PPOs are typically wholesalers that lease provider networks to employers. Employers contract with PPOs for a fee. Typically, a third-party payer is retained for claims payment, utilization management and eligibility issues.

Some HMOs developed national PPO networks to serve national employers, i.e. United Health Care, Cigna and Aetna, while California-based HMOs developed regional PPO networks.

In January 2003, Medicare (CMS) sponsored a PPO demonstration for the purpose of expanding the range of private health plan choices available to Medicare beneficiaries, to include "looser forms of managed care-namely PPOs." PPO products offer beneficiaries flexibility to seek out-of-network healthcare services, although many benefit plans are designed to encourage

enrollees to remain in-network.

As major players in the healthcare arena prepare for the new wave of provider fee-for-service reimbursement and various new benefit plans, it's important for providers to understand the financial impact of PPOs on their revenue stream and determine which appropriate measures are required to ensure maximum revenues. Providers should be aware of the extent of business derived from each PPO and determine if reimbursements are fair, and at a minimum, at market rates. Providers should review all payers' revenues and reimbursements on a quarterly basis, and when appropriate, renegotiate the contracts' rates and language clauses. Payment types vary and include percent of Medicare (currently most common), CRVS, or a set fee schedule determined by CPT billing code. Providers should produce routine financial reports to include patient volume, gross revenue, future growth and CPT code utilization.

Providers should identify which PPOs bring the greatest patient volume for the highest reimbursement. Inquire within your organization if these payers are reimbursing your organization on a timely basis and according to contract terms. Confirm the last time your organization reviewed its PPO contracts' terms and reimbursement rates and when the last time your organization received rate increases. It is not uncommon for PPO contracts to be lost or misinterpreted. Determine if your contracts are direct with the payer or health plan, through an IPA, or PPO. I suggest requesting copies of these agreements if your organization is unable to locate them in order to better understand your obligations and payment terms. Determine if your patients are accessing PPO networks through silent lease networks. Your organization may not be aware that it signed over the rights to a PPO to sell your discounted agreed upon reimbursement rates to other PPO networks. Make certain the payer or PPO does not have the ability to lease your organization's rates to other entities without your knowledge and prior written consent.

Each contract should include termination language. It is common for provider organizations to exercise their right to terminate agreements with the intent to renegotiate in good faith. By sending a termination notice, it puts the payer or PPO on notice that you are serious about your intent to renegotiate. Other areas within the agreement should include claims filing limits, referral and authorization utilization management procedures, etc. Beware of penalty language associated with failure to comply with utilization processes and guidelines. It is common to see references made to provider and utilization manuals. Often, language is incorporated into these agreements binding the provider and organizations to statements referenced in these manuals. Do not agree to these clauses until you have reviewed and understand your organization's obligations. Pay special attention to billing guidelines, appeal procedures, and utilization review and referral procedures. Obtain copies of these manuals, review carefully, and share the information with the office staff.

A word of caution: Some PPOs offer multiple products with different fee schedules, i.e. group and workers' comp insurance. The PPO may offer what appears to be an attractive group insurance rate, but in return, negotiates a steep discount for workers' comp. Be certain to ask which product they are truly selling and what is the expected volume. You want to avoid volume from low paying products. Do not sign an agreement without a detailed fee schedule included. Understand the difference between RBRVS, your organization's RBRVS geographic region, RBRVS calendar year and Medicare's national fee schedule, etc. After reviewing fee schedules, compare PPO rates with your organization's billed charges and any enrollee's financial obligation. Make certain the payers do not make unilateral rate payment changes without your prior written consent. When evaluating PPO reimbursement rates, identify your most frequent billing codes and compare with PPO rates negotiated in the

agreement or from EOB's (explanation of benefits).

A worthwhile exercise is to determine if reimbursements reconcile with terms stated in the PPO agreements. Make note of reoccurring denials of specific billing codes, bundled codes with other codes or down coding. These are common methods used to reduce payments to providers. Each payer is unique. Negotiate Medicare or state payment guidelines into the agreement. Add interest payment penalty language when payment is past due. California law defines prompt payment rules and regulations. If you are successful in negotiating higher rates, review your charge master and make appropriate changes. Payments by payers are typically made based on the lesser of the physician's fee schedule or the contract rate. Eliminate any language that allows unilateral rate changes made by the payers.

It is very important to clarify with the PPO that only one contract agreement exists. It is not uncommon for a PPO to have more than one contract with your organization. One contract prevents payers from selecting the lowest available contract rates. If you elect to renegotiate your PPO agreements, agree with the PPO in writing on the effective date that your organization's increased rates take effect.

PPO and other health plans are offering new products to attract the young and healthy enrollees and to keep premium increases reasonable by offering high deductible products such as health saving accounts. Providers should be prepared to serve these new plan offerings by participating in contracted PPO networks. Innovative and creative strategies could (and should) be implemented that would increase your opportunities for a successful relationship.



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