Learn how to challenge flawed ratings, tiers

Payers have various rating, tiering, and ranking systems that attempt to assess a physician’s performance against his or her peers. Some of these systems may be tied to reimbursement rates, but mostly they are used to steer patients to physicians in the higher quality tier.

Often, say critics, the criteria on which the ratings are based are not disclosed to physicians in advance—when they could make changes in their practice. Moreover, many providers and consultants say the ratings are often incorrect, or at least imprecise. They also say the ratings may have more to do with cost than quality.

Josie R. Williams, MD, MMM, CPE, president of the Texas Medical Association (TMA), made those points in testimony earlier this year before the Texas House Insurance Committee: “Physicians’ professional reputations can suffer harm when incorrect ratings, rankings, tiering, or comparisons are made public prior to the ability of the physician to challenge the ranking.” Williams said, “Patients also are misled because the rankings are portrayed as a quality ranking when, in actuality, the ranking is a cost-efficiency ranking that is beneficial to the health plan.”

She reports that the TMA collects complaints from physicians each time a health plan publishes its rankings.

That matches the experience of those MCCRA interviewed, including Patricia A. Brown, administrator at Summit Medical Associates, PC, in Hermitage, TN. Of the list of patients and outcomes provided by the payer, “not one of them was correct,” Brown says. In fact, many of the patients listed were not affiliated with her practice at all.

Not surprisingly, Brown is skeptical of the rankings. “I don’t give credit to that at all,” she says. “As long as you base something on claims data, it’s just not worth it.” (Look for more from Brown on pay-for-performance efforts in a future MCCRA.)

Few dispute the importance of rewarding quality performance and giving patients the tools to make intelligent choices. But with incomplete or inaccurate information, it’s as important for providers to have recourse.

**Few dispute the importance of rewarding quality performance and giving patients the tools to make intelligent choices. But with incomplete or inaccurate information, it’s as important for providers to have recourse.**

Get it in writing

These rankings are an increasingly important part of marketing for health plans, so it’s unlikely you will be...
able to opt out of them, says Jeffrey B. Milburn, Colorado Springs-based independent consultant at MGMA Health Care Consulting Group. But you can probably include provisions in your contract to help ensure accuracy. Milburn says such provisions should include:

- **The opportunity to review how the program operates.** Ninety days would be ideal, but usually you can get 30–60 days notice, Milburn says.
- **Knowledge of the data they are using.** You want to be able to confirm that quality rankings are based on quality measures and not cost (efficiency) ones.
- **Knowledge of where data come from.** You want something more detailed than someone saying, “It comes from claims.”
- **Knowledge of their methodology.** How are they using the data?

- **Knowledge of the specific standards.** Are they using a legitimate third-party organization?
- **Consideration of acuity.** Too often, acuity isn’t considered. Milburn says. You don’t want the plan merely to acknowledge this; you want to see how it’s factored in. Otherwise, you may be placed in a different tier because you have more severely ill patients.
- **An opportunity to appeal before the rankings are published.** If you have concerns, you want them addressed before the rankings are made public.

### Meet with the payer

If you think the data are incorrect, ask for a meeting.

“I haven’t had anyone turn me down. If the representative is reluctant to meet, appeal to the plan’s medical director,” says Milburn. If the plan is unwilling to give you that access, you may have a problem.

And you may indeed have a problem if you are a small or midsize practice. There is power in numbers. Brown was able to get a payer to correct some ranking data because she worked with the Tennessee Coalition for Healthcare Executives. “We’re big enough to make them come to the table,” she says. Each coalition member provided data to representatives who met with the payer in question. And they convinced the payer to correct the information.

### Engage the patients

If your challenges fail but you still dispute the ranking, you want your protest duly noted and available to patients. In her testimony, Williams called on lawmakers to require the health plan to prominently display in its publication a symbol that indicates the physician disputes the rating, tiering, or ranking if the physician and health plan cannot reach some accord.

Milburn suggests objectively telling patients about how these ratings systems work. He recommends developing a brochure to put in the waiting room. In it, you can provide a balanced discussion of quality ratings and how they are determined.
Assess yourself

One way to make sure the data are accurate and your physicians are meeting their targets is to measure your own performance.

Plans often base grades on a proprietary system driven by claims data. Contact your payer representative and gain access to your physicians' ratings. Once you know what the payers’ criteria are, run your own analysis. This has a twofold advantage. You will have accurate data with which to challenge the rankings. Or you will identify a potential problem before the plan does and discover that your organization is indeed falling short.

Sometimes, you have a doctor who isn’t meeting the quality standards or is inefficient. You want to catch and repair the situation before it becomes an issue for the payer.

Keep in mind that the payer is working from claims data, which, by their nature, are incomplete, says Robert Capobianco, director of marketing at Portico Systems, a Blue Bell, PA–based provider of integrated provider management solutions. Claims data reflect only what’s paid, not what’s done. For example, there’s no code for “did you discuss how to take this medication,” Capobianco says.

Likewise, patients who go out of network to fill a prescription or for a test may not show up in claims data. You want to be able to collect all relevant information in one place (for example, on a spreadsheet) and send it to the plan, Capobianco says. Electronic medical records can be particularly helpful in this regard, he says, noting that a retroactive chart review is costly and time-consuming.

Some quality measures, such as satisfaction, may be made available only once per year—when it’s too late to act on it, says Matias Klein, vice president and general manager of collaboration and tools at Portico. There’s considerable lag time between when an event occurs and when a provider’s status is affected, Klein says. “That’s why real-time monitoring and analytics are important.”

You can always assess real-time patient satisfaction on your own, says Milburn. A simple phone survey can give you a sense of what your patients may be reporting elsewhere. If you want to take a more sophisticated approach, you can use a touch-screen kiosk to gather that information, say Capobianco and Klein.

Whichever method you use, collecting and monitoring data should be part of your internal process regardless.

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Angie and Zagat chime in on ratings

What about rankings that aren’t tied to a payer? Opinions vary on how to handle them.

Some providers have required patients to sign agreements stating that they won’t criticize them online. A few have even sued over complaints. Medical Justice, based in Greensboro, NC, will provide a standardized waiver agreement for a fee. It also provides guidance on its Web site, www.medicaljustice.com/internet-libel-physicians.aspx.

But short of suing or silencing patients, what should providers do?

Patricia A. Brown, administrator at Summit Medical Associates, PC, in Hermitage, TN, doesn’t worry about such posts. Thanks to her location and her patient base, it’s unlikely patients are going to be swayed by those comments. And she doesn’t give them much credence, given that some disgruntled employees could skew the results.

On the other hand, Jeffrey B. Milburn, Colorado Springs–based independent consultant at MGMA Health Care Consulting Group, thinks you should monitor Angie’s List and similar sites on a regular basis.

Pay attention to what’s being said on the more popular lists. You can’t monitor everything, Milburn says, but Googling your practice name or the names of your physicians may provide additional insights. He suggests setting up a system to check selected sites every three months. A front-office staff person can pull up the pages during a slow period and print the results.

Ideally, you want to find out how to respond to or appeal inappropriate ratings. You may have no recourse, but at the very least, you are forewarned and you can prepare your physicians for potential adverse rating publicity, Milburn says. At best, you know where to make changes in your practice.
Patients don’t complain; California probes claims practices

Frustration with reimbursement, claims payment, and related issues continue to make headlines. A recent scholarly article finds that, often, patients don’t voice concerns with their health plans—even when the problems are costly. Meanwhile, California regulators plan to review HMO claims practices.

Patients don’t complain to insurers

If your patients are frustrated with their health plan, they may not speak up, according to a new study.

Most patients do not complain formally about problems with their health plans, even if those problems have significant consequences, such as costing them thousands of dollars out of pocket or denying them essential care, according to a report in the September The Milbank Quarterly.

According to the study by Brian Elbel, PhD, of New York University and Mark Schlesinger, PhD, of Yale University, “relatively few consumers voice their concerns through formal complaints or exit their health plan in response to even the most severe problems.”

The researchers analyzed formal complaints and exits from health plans using information from a 2002 telephone survey of 5,000 consumers.

Fewer than 40% of those surveyed complained to their plan about a problem, even when that problem cost the patient $1,000 or more out of pocket or led to a serious health problem. Fewer than 15% of those consumers switched plans in response to such serious problems.

California regulators increase scrutiny

California regulators and the state attorney general plan to scrutinize how HMOs review and pay claims.

The examination of the payment practices of the state’s seven largest health plans comes in response to complaints from physicians and hospitals.

Six of the state’s largest insurers rejected 45.7 million claims for medical care, or 22% of all claims, from 2002 to June 30, 2009, according to a report from the California Nurses Association/National Nurses Organizing Committee.

The report also provided claims denial rates by the following leading California insurers for the first six months of this year:

- PacificCare: 39.6%
- Cigna: 32.7%
- HealthNet: 30%
- Kaiser Permanente: 28.3%
- Blue Cross: 27.9%
- Aetna: 6.4%

Reference
Silent PPOs, unintended discounts, and your bottom line: Learn how to identify and address leased networks

Chances are, your organization is providing discounts to a PPO to which it doesn’t even belong, and of which you probably aren’t even aware.

These “silent PPOs” can access a provider’s discounted rates without the provider’s permission or knowledge. Some MCOs lease out their provider lists and associated discounts to third parties, such as small health plans, workers’ compensation plans, TPAs that process claims for self-insured employers, and insurance companies that are too small to afford their own.

Jeffrey B. Milburn, Colorado Springs–based independent consultant at MGMA Health Care Consulting Group, has heard of another type of entity trying to access these discounts: companies that offer consumer discount cards.

Sometimes, the provider doesn’t even know it’s happening, hence the “silent” PPO.

Making matters worse, these third parties sometimes shop around, looking for the lowest rates in a particular region and then leasing access to that network, says Milburn.

The silent PPO can expand its geographic coverage—without development costs. It takes no financial risk; it just rents the network. And it’s not only an issue for practices. “It is huge for hospitals,” says Dennis Hursh, Esq., principal at Hursh & Hursh, PC, in Middletown, PA.

Hursh tells of one silent PPO that negotiates a small discount from the hospital in year one, then carefully tracks the services that received a discount. “It then goes into the hospital in future years and obtains a larger discount, based on all the business it is generating for the hospital,” he says.

Increased scrutiny

The practice is coming under increasing scrutiny. Currently, 14 states have some form of legislation barring silent PPOs. And in late 2008, the National Conference of Insurance Legislators adopted a model law for states considering regulating networks. (See www.ncoil.org/schedule/2008/DraftRentalNetworkModel.pdf.)

The AMA Model Managed Care Contract (www.ama-assn.org/ama/no-index/advocacy/9559.shtml) spells out that an MCO cannot rent or lease the terms of its contract to other entities, except in the case of a self-funded employer.

But it’s still a serious issue for providers. And your staff must be prepared.

Deciding to respond

Sometimes, it may not be worth the effort to track down and challenge all silent PPOs, says Milburn. For one thing, you may have to go after the affected patients, which could mean balance billing, but it could also mean suing them.

Also, Milburn says, if one of your largest payers is renting out the network, how far do you want to push the issue? Before you can make such decision, you have to find out just how serious a problem it is for your organization, he says. There are several ways to do this.

Start with the contract

Perhaps the simplest way to see whether you are vulnerable to silent PPOs is to review your payer contracts.

Not all leased networks are truly silent. You may have actually contracted to take on these patients. Many contracts allow assignment of the discount to other entities at the direct payer’s discretion, says Penny Noyes, president of Health Business Navigators in Bowling Green, KY. “Those are very scary. Be very careful when negotiating,” Noyes says.

Look for language that lets the payer bring in affiliates or associates, says Milburn. Other terms to watch out for

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Silent PPOs  
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include "assignment," "related business entity," or even "other products."

That "other products" clause can open the door to other insurance offerings in the insurer's product line, including plans with a different fee schedule than the one to which you agreed, says Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE, consulting manager at Pershing Yoakley & Associates in Clearwater, FL.

Get a list

Sometimes, it's easy to find out which entities will be accessing the discounts: Some payers are up front about renting access to their network. In these cases, you may decide to deal with leased networks; what you don't want is the unexpected surprise of a silent PPO.

Every payer should know every company that accesses its provider network. You want to obtain a complete and current list of organizations that have access to the PPO's network, says Hursh.

The contract with the payer should carefully define who is entitled to the discount, he says. Moreover, the payer should agree that its name or logo will be on all identification cards presented by patients.

A more extreme option, of course, is to reject contracts that allow assignment. But that's not always feasible.

Why fight it?

Regular PPOs connect providers contractually with insurance companies that send providers patients, thus increasing their volume. In exchange, providers offer payers discounts on their billed charges. Silent PPOs get the discounts without fulfilling any steerage obligations, says Hursh.

Milburn agrees. These third parties generally don't generate much business. So why should they get a preferential rate?

They can also create adjudication headaches. You don't have a contract with the third party outlining how to deal with disputes. And the payer you do have the contract with is likely to wash its hands of the matter, says Milburn.

For example, in your contract with the direct payer, you may have a 45-day payment clause. On day 50, you contact the third party, and it tells you it pays in 60 to 90 days. You may not have much recourse.

Know what to expect

You should always know what the fee schedule is for each of your contracted payers, says Milburn. If the contract is vague on reimbursement (e.g., "at our going rate"), the third party can be vague, too. You need to know what the payer is supposed to pay.

When the third-party reimbursement payment comes in, you can determine that it's at least as much as the network discount.

Spotting the silent PPO

Of course, to hold these silent PPOs to the contracted rate, you need to know who they are. Ideally, of course, they will be listed in your contract. But that's not always the case.

You want to train your business office staff members to spot them. That way, you can ensure that you are being paid the contracted rate or, if you decide you don't want to deal with leased networks, you can appeal the claim, says Milburn.

The following are tips for uncovering a silent PPO:

➤ Check the card. Look at the patient's card. It may bear the logo of the direct payer (e.g., Anthem), but indicate that you bill another entity.

For example, you may see XXX Employer's Group and the Anthem logo. At that point, it's pretty obvious, says Milburn. Have front-office staff copy any unfamiliar-looking insurance cards and the billing department compare them to the EOBs.

➤ Check EOBs. Randomly check EOBs and compare them to the copy of the card. If the payer's logo isn't on
the card, then “it looks like a silent PPO is at work,” says Hursh. From there, you can check all other EOBs from that payer, he says.

Often, you won’t find any hint of a discount until the EOB arrives, says Milburn. The patient comes in and is part of a self-insured group with no suggestion any other entity is involved. You send the claim to the self-insured plan. The payment then comes back indicating a contractual discount. “That’s why they call it silent but deadly,” Milburn says.

➤ **Review payment records.** “Look for payments being made by an entity you have never heard of,” says Milburn. Noyes agrees: “Have a staff member flag low payments that do not match a known contract amount,” she says.

➤ **Do an internal audit at least once per year.** “Smoke out the fact that someone is paying you incorrectly,” says Milburn.

➤ **Ask your attorney.** A healthcare attorney with managed care experience can help you identify which payers have faced litigation in the past over silent PPOs, says Mac.

➤ **Be especially careful after termination.** You should always be diligent, but sometimes you need to redouble your efforts. One such time is immediately after you terminate a payer, says Noyes. “If a provider terminates with a large payer, you can expect that payer to try to access a discount through a leased network,” she says.

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**Advisor sources**

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**Payer consolidation may have minor effect on reimbursement, premiums**

Providers, among others, have raised concerns that private health insurance industry consolidation could affect reimbursement rates as well as what consumers and employers pay. The U.S. Government Accountability Office (GAO) set out to measure the effect, but its findings are far from conclusive.

*Private Health Insurance: Research on Competition in the Insurance Industry,* released August 31, looks mainly at HMOs and suggests that competition may affect price and reimbursement rates. (You can find the report at [www.gao.gov/new.items/d09864r.pdf](http://www.gao.gov/new.items/d09864r.pdf).)

GAO researchers looked at 41 peer-reviewed articles concerning the effects of the level of HMO competition and prepared the review for Sen. Herbert Kohl (D-WI), chair of the Senate Judiciary Committee’s antitrust subcommittee.

Researchers looked at several areas, including the following:

➤ **Reimbursement.** One study, which focused on markets in California, found that market concentration did not appear to affect physician rates. However, it did seem to be associated with a reduction in hospital rates.

➤ **Premiums.** The studies generally found that more competitive markets were associated with lower premium rates, but consolidation did not necessarily lead to significant or sustained increases in premiums.

➤ **Quality of care.** There was no consensus among the studies.

➤ **Utilization.** Consolidation may have increased the utilization of primary and specialty care services.
Ask the advisor

Experts identify some costly common contracting mistakes

Editor's note: MCCRA asked experts the following question: What are some of the most costly payer-related contracting mistakes you see providers make? Look for more answers next month.

Alice G. Gosfield, JD, Alice G. Gosfield and Associates, PC, Philadelphia

The worst mistake I see is the physicians’ failure to understand the scope of the applicable fee schedule and the termination clauses. Many physicians believe they can terminate on 60 or 30 days notice, when, in fact, the termination clause specified they may terminate only 60 or 30 days prior to the end of the then-current term. This means that if the fee schedule is bad or gets bad and you miss the window to terminate at the end of the year, you then have to stay in for another year.

Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE, consulting manager, Pershing Yoakley & Associates, Clearwater, FL

▶ Failure to define the scope of the permissible post-payment utilization review:
  - Submission of requested documentation (e.g., who pays for copies?)
  - Scope of review (Medical necessity? Coding accuracy? Both?)
  - Standards applied for determination of an error and subsequent repayment obligations
  - Failure to include billing staff members (e.g., giving them details about what the contract states about coding guidelines and appeals process and failure to solicit their input in identifying past issues and problems)
  - Failure to include details about payment requirements, including:
    - A definition of “timely filing”
    - A definition of “clean claim”
    - Setting a specific number of days for payment
    - Establishing specific guidelines for secondary payer rules
  - Failure to spell out that if the payer isn’t meeting the deadlines, it is violating the contract
  - Failure to account for the “nuisance factor” (i.e., factoring in slow pays, multiple denials, etc. into the agreed-upon rates)—failing to track these issues is also a common problem

Dennis Hursh, Esq., principal, Hursh & Hursh, PC, Middletown, PA

Physician practices do not obtain an auditable methodology for calculation of fees, which allows the managed care plan to continually reduce compensation.