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PRESS RELEASE

Axia Strategies Announces: Transplant Network Product Design: Are All Transplant Network Provider Contracts Created Equal?

While attending the April, 2009 UNOS Conference in Seattle, any lingering doubts this writer may have had specific to the financially detrimental impact transplant provider contract minimum payment provisions ("MPP's") can have on a payer's transplant costs were quickly dispelled during a series of conversations with three transplant center contract administrators. "Our transplant contracts are purposefully designed to allow the MPP to trigger 100% of the time-the fixed case rate never applies at our center," stated one proud administrator. "The presence of a MPP in a transplant contract provides our center the perfect opportunity to shift costs to a commercial payer," stated another administrator, justifying the practice based upon his hospital's heavy local dependence on Medicaid for reimbursement. "Any payer dumb enough to use a transplant network that frequently includes MPP contracts will experience what they financially deserve," laughed the third administrator, who added, "Why payers are not looking more closely at the contract terms included in these transplant network contracts is a mystery to us."

What are MPP's and why are transplant centers so eager to see them included in transplant network provider agreements? Essentially, MPP's are contingency language included in transplant network provider contracts that govern whether or not a fixed case rate applies to the most expensive phase of transplant care, the inpatient/transplantation phase. Typical MPP language such as "in no event will the provider receive less than ___% of billed charges" or "if billed charges exceed \$___, ___% of billed charges will be paid," when applied to the transplant claim, effectively eliminates the application of the fixed case rate. Instead, the claim reverts back to the first dollar at a percentage off charges, an amount always significantly higher than the original fixed case rate. Transplant centers enjoy the presence of a MPP in the provider contract because payer referral nurses, at the time of transplant patient referral, are oftentimes led to believe that the fixed case rate will always apply, unaware of the hidden presence of a MPP. Once the transplant center receives the patient referral, the presence of a MPP in a transplant provider contract provides a clear incentive for a hospital to inflate billed charges in an attempt to nullify the financial limitations of the fixed case rate, which in turn results in a significantly higher transplant paid claim. By the time either the payer or the payer's referral nurse becomes aware of the situation, the obligation to reimburse the center at a percentage off charges is already in place.

Why are payers utilizing transplant networks that include MPP's? For many payers, oftentimes the answer is that they are simply unaware of the presence and/or financial impact of MPP's. MPP's are relatively new transplant provider contract provisions (first introduced in 2003) and many payer executives have had little or no experience with them. For some payers, complacency is an issue,

especially among those that have rented the same transplant network for ten or more years without examining the underlying network contract format versus new transplant network alternatives that have recently emerged. Typically, transplant networks that include a high percentage of MPP's in their product "bury" their MPP language deep into their contract documents, making them difficult for the payer and/or their referral nurses to discern. These same "MPP Dependent" networks are typically very defensive when questioned about the presence and financial impact of MPP's, going to great lengths to justify, rationalize and disguise their presence. In fact, one network has gone so far as to market MPP's as *Maximum Allowable Discounts* or "MAD's," a truly apt description of how a payer will probably feel should a MAD be applied to their transplant claim!

What can a payer do to protect itself from the inflated transplant cost risk associated with the inclusion of MPP's in transplant network provider agreements? First, fully understand and explore the various transplant networks available in the marketplace for rental, seeking for use only those networks that avoid and/or minimize the use of MPP's in their product. Quantify each network's use of MPP's and examine your most frequently used hospitals, by network, for inclusion of MPP's-you will be surprised at the number of centers that vary their MPP inclusion by network. Do not assume based upon brand reputation or network longevity that a network is free of MPP's. When MPP's are discovered, ask your network for their MPP language per center and how frequently fixed case rates have actually applied to their caseload over the past three years. Consider the use of multiple transplant networks, as it is rare that any one network can consistently offer the "best of breed" contract solution at all of the centers you utilize. Make sure that your case management nurses in charge of making new transplant patient referrals understand the financial ramifications associated with MPP's and advise them against their use. Make sure that the transplant network websites accessed by your nurses clearly indicate the presence, contract language and conversion frequency of MPP's at every transplant center offered-basing a referral on incomplete information or training can result in a million-dollar over-payment.

In the final analysis, the emergence of MPP's and their inclusion in many of today's transplant network provider contracts presents a significant challenge for today's payer. Transplant networks vary significantly in terms of provider contract design and philosophy, which in turn, will drive very different cost containment results. The burden is on the payer to perform their due diligence in the analysis of each network's contracting approach while concurrently securing from each network the product transparency and disclosure necessary for prudent comparisons. However, as hospitals develop added revenue sources via new cost-shifting methods, transplant contract language and the network vendors that unwittingly promote poorly designed transplant agreements may be the newest conduit for increased hospital revenues. Based upon my experience recently in Seattle, many payers will need to respond quickly to these new challenges or, ironically enough, will be exposed to dramatically inflated transplant costs *as a result* of the very use of transplant network provider contracts depended upon to reduce these same costs.

About the Author:

Bob Ziomek is a Principal with Axia Strategies, a managed care consulting firm based in the Twin Cities. Since joining Axia Strategies in 2004, Mr. Ziomek has assisted payers in the identification, assessment and management of appropriately designed transplant network solutions. Mr. Ziomek has worked in the transplant network field for more than 20 years and currently provides transplant network consulting services to approximately 100 payer clients.

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