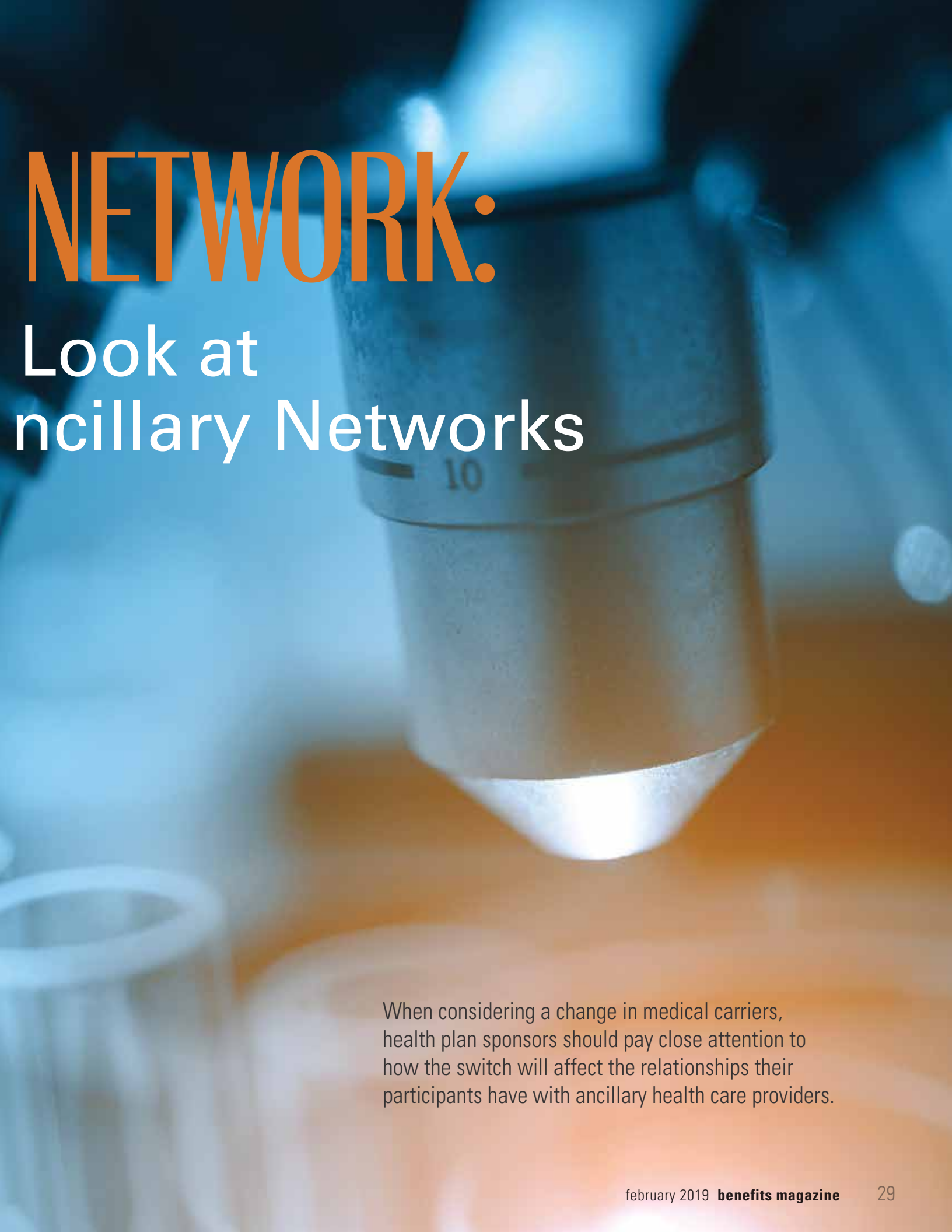
THE FORGOTTEN

Taking a Second Health Plan A

by | **Robyn Bartlett**

benefits MAGAZINE



NETWORK:

Look at ncillary Networks

When considering a change in medical carriers, health plan sponsors should pay close attention to how the switch will affect the relationships their participants have with ancillary health care providers.

Experienced benefits professionals know that switching from one medical carrier to another is an enormous undertaking that often creates anxiety and uncertainty throughout the workforce. In the months leading up to the change, plan sponsors and their advisors engage in many activities designed to understand the scope of the new provider network and to reassure plan participants that, "yes, your doctor is in the network." Like all major benefits initiatives, the goal is to overcommunicate the details surrounding the change, to provide a solid education on any new concepts and to lessen the possibility of employee surprise.

In spite of good intentions, however, plan sponsors may forget one critical part of the network—ancillary health care providers such as physical therapists, urgent care centers and home health care providers. Plans should evaluate whether a change in medical carriers will disrupt the relationships participants have with these providers.

Considering a Carrier Change

When considering a carrier move, the first step is to conduct what is aptly named a *disruption analysis.* A disruption analysis is largely an analytical exercise. Benefit plans receive a claims extract of the most recent participant claims and identify the providers utilized by the plan participants over the last year or two. That list of providers is then compared with the proposed carrier's network to identify any gaps. Stated otherwise, will some of the providers frequently seen by plan participants not be included in the new network? If these types of gaps exist, and the plan still wants to move forward, the health plan carrier might be asked to do some provider recruiting. If recruitment efforts do not close the gap, plans locate and notify impacted employees and give them an opportunity to make alternate plans before their next medical appointment.

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The disruption analysis focuses heavily on hospitals and physicians. Employers and advisors review whether primary care physicians and specialists currently used by plan participants will be available in the new plan. Usually, the result is favorable and reassuring. Although provider negotiations can be protracted, in the end, hospitals and physicians generally reach an agreement to participate in most major commercial networks. With this positive finding, the change moves forward. Plan sponsors create implementation plans, launch detailed communications about plan design changes and expect a smooth transition. But then the transition is not so smooth. After the effective date, distraught employees call to report that certain providers are no longer in network despite assurances to the contrary. What happened?

Ancillary Care—The Forgotten Network

In spite of good intentions, one critical part of the network was forgotten. Issues will emerge if plans do not also review the scope and sufficiency of the health plan ancillary network. *Ancillary care* is defined as the nonphysician providers in a health plan network who provide support to the primary physician. There are three distinct categories: diagnostic, custodial and therapeutic. Diagnostic includes laboratory, imaging and radiology. Custodial includes skilled nursing facilities, hospice, urgent care centers and home health services. Therapeutic includes individuals who provide one-on-one care to their patients, and carrier network variations are the most common in this category. Speech therapists, physical therapists, occupational therapists and social workers are among the most frequently used providers in this category.

The Growing Role of Therapeutic Ancillary Care

To understand the gravity of the issue, one must understand the increasing importance of this provider type to an individual's care plan. Therapeutic ancillary care has experienced significant growth in the last ten years. As health care costs rise, primary care physicians are increasingly using therapeutic ancillary providers as a cost-effective way to manage rehabilitation. Not surprisingly, ancillary providers are reimbursed at a significantly lower rate than physicians. For those primary care physicians who have risk-based contracts that establish a per patient budget, having a therapist on the care team is an efficient way to manage the total cost of medical care.

takeaways

- When switching medical carriers, plan sponsors should consider the impact it will have on their network of ancillary health care providers.
- Ancillary care is provided in three categories: diagnostic, which includes laboratory, imaging and radiology; custodial, such as skilled nursing, urgent care and home health services; and therapeutic, such as speech, physical and occupational therapy.
- Therapeutic ancillary care is being used more frequently by primary care physicians to manage rehabilitation.
- If a health plan does not consider ancillary care when switching medical providers, it may disrupt the often close relationships between ancillary care providers and plan participants.
- To minimize disruption, plan sponsors should ask medical carriers to recruit additional ancillary providers to their networks. Impacted plan participants should be notified in advance if their ancillary care provider will no longer be included in the provider network.

The shift to therapeutic care is more than a financial strategy: Clinical evidence supports the benefits of utilizing therapeutic ancillary care in advance of other interventions. Musculoskeletal diagnoses often comprise the highest clinical spend by plan participants, and lower back pain is one of the most challenging diagnoses. It consistently drives individuals to the emergency department and causes productivity losses. Clinical trials evaluating exercise therapy for adults with lower back pain found that such treatment can decrease pain, improve function and help people return to work.[1] Carrier medical directors have embraced these clinical findings and incorporated them directly into the clinical criteria used to make coverage decisions. For example, insurers typically require documentation that six to eight physical therapy sessions were conducted without progress before an individual with a first-time complaint of lower back pain can obtain high-tech imaging or surgical intervention.

The opioid crisis has further highlighted the importance of therapeutic treatment for pain management. As the American Physical Therapy Association explained in a recent white paper, the health care system has traditionally employed an approach to pain management that focuses on the pharmacological masking of pain, rather than treating the actual cause of the pain.[2] The U.S. Centers for Disease Control and Prevention (CDC) in its "Guideline for Prescribing Opioids for Chronic Pain" states that "[n]on-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain."[3] CDC, after reviewing the evidence, concluded that treatments provided by physical therapists are especially effective at reducing pain and improving function in cases of lower back pain, fibromyalgia and osteoarthritis.[4]

Carrier Variation in Ancillary Networks

The growth and demand for a strong ancillary network are very understandable, but why is there so much carrier variation in the size and scope of this network? The reasons are numerous. Often health plans maintain a specifically sized ancillary network and do not routinely accept newcomers because of the administrative burden of credentialing and contracting. On the flip side, some ancillary providers refuse to contract with certain insurers as a result of perceived inadequate rates or unwanted administrative hurdles. Other ancillary providers do not have sufficient office staff to keep up with the contracting and are forced to pick and choose between carriers. Although ancillary providers are being recruited into hospital systems at a record pace, many still practice in what is often referred to as a "single shingle" environment where the ancillary provider might serve as the practitioner, scheduler and administrator.

Employers often dismiss ancillary therapeutic providers as commodities. If one physical therapist is not in the network, the employee can surely find another. That is rarely the employee's reaction. Parents are devastated when they learn that their autistic daughter's beloved speech therapist is not in the network. Similarly, if a physical therapist has guided a participant through a left hip surgery, that physical therapist is the only provider that is desired for the right hip surgery. Is this level of attachment surprising? It shouldn't be.

The ancillary therapeutic provider is uniquely positioned in many ways to develop the strongest relationship with the patient. The care model is based on longer sessions, consistency and one-on-one work. Many ancillary therapeutic providers see their patients for an hour at a time, multiple times a week. Consider a patient who has endured a car accident and injured her neck. She

bio

Robyn Bartlett is a senior consultant and health care vertical leader for Marsh & McLennan Agency (MMA) in Boston, Massachusetts. She has advised clients for more than 20 years on various health care-related issues, including employee benefits and risk. Prior to joining MMA, Bartlett worked at Tufts Health Plan where she was most recently the director of provider contracting. During her 15-year tenure, she also served as the director of key accounts, business performance lead and associate general counsel. Bartlett also practiced law for eight years, managing commercial disputes and advising on complex health care transactions. She holds a B.A. degree from Wesleyan University and a J.D. degree from Suffolk University.

will spend a fraction of her recovery time with a doctor but hours with her physical therapist. Topics such as family support and frustrations are often shared. For those reasons, ancillary therapeutic providers serve an important role to the primary care physician as "eyes" on the patient—often being the first to detect subtle changes in emotional and physical well-being. They treat using modalities other than prescriptions. In today's world, there is little argument about the merits of this alternative approach.

Minimizing Disruption

Plans contemplating a carrier change can deploy tactics to minimize employee disruption. First, the scope of the ancillary network should be a part of the initial disruption analysis. Plan sponsors shouldn't assume that the absence of an ancillary provider will remain unnoticed by participants. Self-funded plans have particular leverage in reviewing the sufficiency of the network. If they find gaps, plan sponsors should ask their carrier to undertake a focused recruitment effort to enhance the ancillary network. Ancillary contracts are typically based on a straightforward fee-for-service payment model that does not require protracted negotiations. Often the providers are paid a daily payment maximum or a fee based on the Medicare fee schedule. Carriers may be able to supplement their ancillary networks more quickly than expected, given a list of specific providers and a firm deadline.

Impacted employees should be identified and notified in advance of the coverage effective date. Often, the employee actually convinces the ancillary provider to join the new network. Remember, these are often strong relationships. If recruitment efforts are not successful, the employee should be offered the time to process the situation, discuss it with the ancillary provider and plan for an alternative. The ancillary therapist may recommend a colleague with whom the employee could arrange to meet. If the ancillary provider is unwilling to join the network, a self-funded plan may consider the propriety of a grace period in which out-of-network claims are paid for a finite period of time, allowing employees to conclude treatment or thoughtfully find another provider.

Taking a Second Look at Ancillary Networks

As an important part of the health care delivery system, the ancillary network may deserve a second look.

As every benefit professional knows, the worst-case scenario is when an employee is caught off guard without a Plan B. And the first notice is often a daunting "denial" in an already confusing explanation of benefit document from the carrier. This is quickly followed by a bill from the ancillary provider. This series of events can feel catastrophic for employees with ongoing health concerns.

Even plans that are not contemplating a carrier change shouldn't forget about the ancillary network. A self-funded plan desiring to promote a healthy workforce should regularly assess the strength and scope of the ancillary network by benchmarking against other plans and conducting employee surveys. As the health care delivery system changes, ancillary providers are becoming increasingly important.

Endnotes

1. *Beyond Opioids: How Physical Therapy Can Transform Pain Management to Improve Health,* June 1, 2018. American Physical Therapy Association. Citing Hayden, J.A., van Tulder, M.W., Malmivaara, A., Koes, B.W. "Exercise therapy for treatment of non-specific low back pain." *Cochrane Database of Systematic Reviews.* 2005; Jul 20(3):CD000335. Available at www.ncbi.nlm.nih.gov/pubmed/16034851. Accessed April 2, 2018.

2. *Beyond Opioids: How Physical Therapy Can Transform Pain Management to Improve Health,* June 1, 2018. American Physical Therapy Association.

3. "Centers for Disease Control and Prevention. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016." *MMWR Morbidity and Mortality Weekly Report.* 2016;65(1). Available at www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf. Accessed April 2, 2018.

4. Ibid.

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