



Maximizing Value: Best Practices and Future Trends in Provider Network Management

June 15, 2009

PPO: The acronym and definition

- Preferred Provider Organization
- A healthcare delivery system in which providers contract with an organization (known as PPO) at various reimbursement levels in return for consideration.*
- A managed care organization of medical doctors, hospitals and other healthcare providers who have covenanted with an insurer or third-party administrator to provide healthcare at reduced rates to the insurer's or administrator's clients.*

*Source: AAPPO – PPO Definition April 2009

*Source: Wikipedia



The History of PPOs

- Emerged in 1980's as a viable option for payors
- Currently, over 193 million Americans enrolled in a PPO... 69% of all insured Americans*
- Popularity of PPOs by payors are a result of:
 - Flexibility of Benefits
 - Choice
 - Access
- Popularity of PPOs by providers are a result of:
 - Increased patient population
 - Ability to negotiate different reimbursement levels per PPO based on benefits offered
 - Less interference in provider-patient relationship

*Source: AAPPO – PPO Resources April 2009

PPOs – Current Trends

- **More and more payors appear frustrated that providers leverage unfavorable contract terms to maximize reimbursement.**
 - **Percentage off charges**
 - **Per diem**
 - **Case rates**

- **A shift in leverage from the payor to the provider has occurred in many markets.**
 - **Provider may decide he/she does not need to contract with a PPO network**
 - **Provider may move from favorable reimbursement rates to less favorable rates**

- **More and more companies create and offer courses for providers to teach them how to “maximize their reimbursements through coding”.**
 - **Adjudication specific**
 - **Service specific**

- **Regulatory market is now impacting PPOs**



Key Considerations When Evaluating PPOs

Provider Reimbursement – What are you actually receiving?

- Breadth of Directory vs. Depth of Discounts
- Low Cost vs. High Cost
 - PPO Reimbursement Terms
 - Plan should stipulate lesser of billed charges or PPO reimbursement
 - Plan should have audit rights for both quantity and reasonableness
- High Quality vs. Low Quality
- Greater Savings Often Does Not Equate to Most Cost Efficient



Key Drives for Cost Variations

- PPO contracts may not keep pace with providers charge inflation/increases
- PPOs often do not utilize low cost/high quality providers
- PPOs may not allow for the adjudicator to perform clinical and code edits using AMA and CMS guidelines
- PPOs may have conflicts that exist between ASO plan demographics and at risk demographics

Why Contract Structure Matters

Type of Contract	Advantages	What to Watch For
Straight Percentage Discount	<ul style="list-style-type: none"> • Easy to explain • Permits “comparisons” between networks 	<ul style="list-style-type: none"> • % Discount more expensive than usual and customary fees • Inability to dispute unreasonable charges • “Nickel and Dime” billing • Lax audit procedures from adjudicator
Per Diem	<ul style="list-style-type: none"> • Bill clarity – eliminates some transactional billing • Incentive to deliver appropriate care on a per-diem basis 	<ul style="list-style-type: none"> • In-ability to manage length of stay • Creates an economic reward for poor outcomes • High carve-out expenses
Case Rate	<ul style="list-style-type: none"> • Clarity of Billing • Incentive to provide appropriate care on a case basis 	<ul style="list-style-type: none"> • High carve-outs expenses • Risk of being discharged prematurely • Impersonal, high volume focus

Term length and contract structure often vary significantly between PPO networks!



Using a Baseline to Measure PPO Performance – Proprietary Fee Schedule Comparison

Billed Charges	Reasonable Allowance	Proprietary Fee Schedule Baseline %	PPO Discount %	Significant Areas of Reduction
\$22,937.71	\$11,995.43	48%	<10%	O/P surgical procedure reduction
\$733,036.41	\$216,145.00	71%	<10%	ICU room charges & pacemaker / coronary care reductions
\$90,582.60	\$45,865.03	49%	<10%	Pharmacy & radiology reductions
\$31,140.73	\$19,565.71	37%	<10%	Radiology & pharmacy reductions
\$115,996.06	\$98,515.00	15%	<10%	Pharmacy, MRI
\$59,659.00	\$55,073.00	8%	<10%	Pharmacy
\$22,399.27	\$12,684.94	43%	<10%	Radiation Therapy
\$183,715.89	\$83,153.61	55%	<10%	Pharmacy reduction; CT scan & radiation therapy reductions
\$135,152.70	\$93,975.00	31%	<10%	Intensive care & pharmacy reductions
\$307,234.32	\$149,484.00	51%	<10%	Trauma; med-surg; OR services



Establishing a Baseline to Evaluate PPO Options

- Baseline PPOs to a fee schedule or other available data to evaluate PPO selection as well as compare high and low cost provider participation.
- Baseline charges to encourage members to use lower cost providers
- Once Primary PPO is selected, continue to use a baseline to measure all Primary PPO reimbursements to gauge PPO performance
- Baseline all out-of-network charges to a fee schedule for either reimbursement calculation (as plan allows) or to compare how your out-of-network program is performing



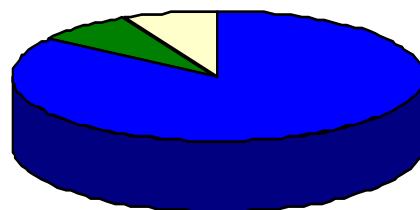
Major Trends in PPO Network Development & Their Impact

- The Primary PPO marketplace is shrinking by way of consolidation.
- Escalating charges for healthcare services
- Usual Customary & Reasonable (UCR) as we know it today is changing.
 - Attorney General of New York investigation
 - UHC's settlement regarding Ingenix
 - Settlements by major payors regarding UCR

Cost appears likely to be increasing for plans!

The Non-Participating Provider Payment Issue

- An increasing number of hospitals, physicians, and ancillary providers are electing not to contract with plans.
- Managed care has allowed plans to limit their exposure to non-participating claims, however, non-participating provider payments are significant.
- The issue is most common among Ambulatory Surgery Centers, DME providers, rural hospitals and providers, as well as hospital-based physicians – especially anesthesiologists, radiologists, emergency medicine providers and others.



- In-Network Participating Provider Cost
- In-Area Non-Participating Provider Cost
- Out-of-Area Non-Contracted Provider Cost

How can plans survive and continue to control costs in this changing environment?

Do primary PPOs provide payors enough differentiation to attract and retain plans and members?



Out-of-Network or Out-of-Area Cost Containment Tools

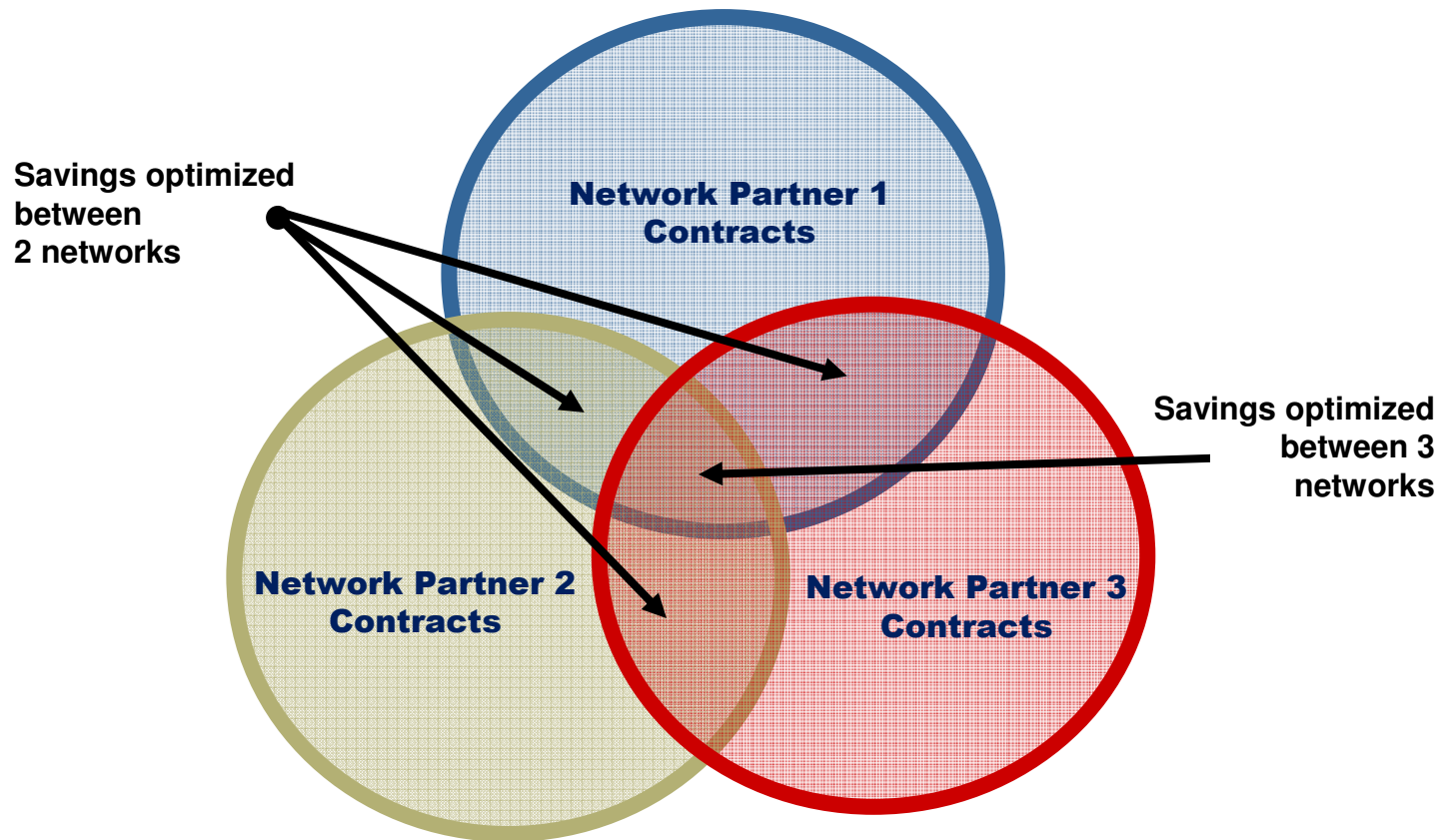
- **Supplemental Networks (Medical & Dental)**
 - Optimization to maximize savings
 - Look for breadth and depth of savings
 - Engage with companies that understand the regulatory landscape and are engaged with industry organizations

- **Provider Negotiations**
 - Remove thresholds
 - Engage providers prospectively by identifying high dollar claims through case management
 - Partner with companies that offer prospective negotiation services
 - Ensure flexibility in specific turn-around times by group

- **Fee Schedule Tools**
 - Provides benchmarking to assist with evaluating PPO performance
 - Provides benchmarking to assist with negotiations

Optimization Yields Greater Savings Over Simple Tiering

The Strategy: Optimizing Savings Yields
Increased Depth of Discounts and **Breadth of Coverage**





Member Advocacy and Negotiation Services

- A unique value add empowering members through an advocacy program
- Programs are typically a free service to plan
- Designed to discount the member responsibility portion of their medical bills
- Compliments HSA, min-med or other CDHPs



Comprehensive Cost Containment in Summary...

- Primary Network Selection
 - Provider contracting approach
 - Limitations on use of other cost containment strategies

- Supplemental Network Selection
 - Strategies to achieve greatest savings
 - Alignment of incentives

- Other Tools
 - Benchmarking for evaluation of networks and providers
 - Direct provider negotiation

- Member Advocacy & Negotiation Services

Thank you!

