

Transforming the Future of Health Care

A Proposal for Reform

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of Preferred Provider Organizations



**Today, 193 million Americans are
covered by PPOs**

Executive Summary

The American Association of Preferred Provider Organizations (AAPPO), the leading national association representing the PPO industry, believes a **successful platform for health care reform (HCR)** should include four guiding principles:

- a. It should provide medical care for all Americans.
- b. It should be built on the current employer-based system.
- c. It should provide national standardization of data and health care transactions.
- d. It should foster collaboration among all stakeholders.

AAPPO believes the **key components** of any reformed healthcare system should be:

1. Reducing cost
2. Advancing health information technology (Health IT), and
3. Increasing transparency to demonstrate to consumers that they are a true partner in the treatment process.

As the delivery system through which **69 percent** of Americans currently receive health care, the PPO industry is enthusiastic to participate and serve as a resource in the robust debate in which the nation is now embarking to determine the future of health care delivery in our country.

About AAPPO

Today 69 percent of Americans receive their health care through a PPO delivery system. AAPPO is the voice of the PPO industry.

AAPPO is the leading national association representing the PPO industry. AAPPO represents over 950 network-based preferred provider organizations and payers nationwide.

AAPPO's members represent diverse models of preferred provider networks (PPNs) and payers. PPNs are non-risk organizations with the sole purpose of creating broad based networks and are market, state or national organizations.

AAPPO's payer member organizations may have proprietary networks or may lease a percentage or all of their networks from PPNs to support providing varied PPO benefits to employers and individuals.

As the nation enters debate about comprehensive health care reform, AAPPO advocates for greater access to health care, greater choice and greater flexibility. We believe 2009 provides a new opportunity to bring all stakeholders together, reaching beyond traditional barriers, to find positive and efficient solutions to address this most critical health care challenge facing the people of our nation.

AAPPO is committed to working with consumers, employers, providers and lawmakers to ensure PPOs continue to provide a balance between the delivery of appropriate care and cost control.

Learn more about us at www.aappo.org.

Principles for Which We Advocate

AAPPO believes reducing health care cost, the advancement of health information technology, and the increase of transparency in contracts between providers, networks, and payers are essential components for creating a successful health care reform platform.

To support these essential components, AAPPO has developed the following four guiding principles:

- a. **Support reform that will provide medical care for all Americans:** Enhanced transparency will be needed in developing standards for the delivery and administration of care to support coverage for all.
- b. **Build upon the current employer based system:** Today 193 million Americans are covered by PPOs. It's a proven system upon which future reform should be built.
- c. **Provide national standardization of data and health care transactions:** Adopt uniform standards for reporting and health IT across public and private provider and payers sectors.
- d. **Foster collaboration among stakeholders that will reach beyond traditional barriers:** Ongoing collaboration is fundamental to any reform plan, to identify effective and efficient health care, and strengthen the health care safety net for all Americans.

Three Essential Components of Health Care Reform

AAPPO believes a successful new healthcare platform, no matter the form it takes, should contain and reflect three essential components.

1. Reduce health care costs

Reducing cost is a vital component to ensuring affordability for all. We have an opportunity as stakeholders to work together to identify measures to strengthen the health care safety net in providing coverage for all Americans while at the same time reducing cost.

AAPPO believes there is great opportunity to reduce cost while strengthening the health care safety net by aligning provider, payer, network and patient interest in support of more personalized care.

AAPPO's recommendations are as follows:

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Issue: Uniform Standardization of Coding and Claims Edits

Overview:

AAPPO has begun to see a trend at the state level to standardize coding and claim editing, which we support. However it will be very costly for all stakeholders for this to be done in each state with multiple standardization approaches.

Recommendation: Uniform Standardization of Coding and Claims Edit Position

As the cost of health care increases, AAPPO continues to work with its member organizations and other stakeholders to identify ways to increase the efficiency of the health care delivery system while maintaining high standards for quality of care. One area that has received significant attention is the cost added by the variation in health care claims processing and administration practices among payers. More specifically, there is a growing consensus among PPOs, payers and providers that the lack of standardization of coding and claims edit policies adds unnecessary complexity, increases the frequency of claims-related disputes, and generally increases the cost of health care without enhancing the patient experience or improving the quality of care. In our view, industry standard coding and claims edit policies will facilitate both consistent billing practices by providers and consistent adjudication by payers, resulting in increased efficiency, cost savings, and improved relationships between providers and payers.

AAPPO believes that it is both feasible and desirable to achieve greater uniformity in coding and claims edit policies. We further believe that this goal will best be met by the adoption of federal level legislation that requires uniformity, to the extent feasible. Only a national initiative will truly result in enhanced systemic uniformity and avoid the inevitable inconsistency that would result from a piecemeal, state-by-state approach. The development of a standard approach, based on the National Correct Coding Initiative (NCCI) Policy Manual with the collaborative commitment

to enhance the NCCI platform to support transparent standards on an ongoing basis will address the complaints of providers, who claim that, in some cases, the variability among payers' edits can make it difficult for them to determine up front what they will be paid for a particular service.

AAPPO and many of its' member organizations support the development and implementation, through legislation, of a national platform for coding and claims edit policy standardization. We believe that NCCI policy provides the best foundation on which to build this initiative. The key considerations used in selecting the NCCI platform are as follows:

- NCCI, and the resultant CCI edits, were specifically developed to control improper coding leading to inappropriate payment, which is a key concern for providers;
- The NCCI platform provides a standard that most preferred provider networks (PPNs) and payers can support; and
- Due to existing widespread use of NCCI policy, the likely cost of implementation is lower than it would be if other platforms were selected.

The selection of NCCI policy as a "common ground" platform will ultimately provide a level playing field for all public and private providers and payers, regardless of size or market dominance.

We believe that through the increased standardization of coding and claims edit policies, we will improve system efficiency and minimize costly and often acrimonious claims-related disputes. It is our hope that other interested stakeholders will join us in this worthwhile endeavor.

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Issue: Providing a Performance-Based Preferred Provider Network (PPN) Option for Medicare

Overview:

Medicare is facing many immediate and future challenges. As health care cost continue to grow, and the first of the 78 million baby boomers begin accessing the Medicare system, a cost-effective and efficient alternative to traditional fee-for-service (FFS) Medicare option is needed. Such an option will provide seniors at a time in their life when greater access, choice and flexibility to medical services are of considerable value as they age.

Recommendation:

Preferred Provider Networks (PPNs) are non-risk organizations with the sole purpose of creating broad-based networks. They are state, regional or national organizations with a proven track record in achieving significant savings for enrollees that stay in-network in the private sector. AAPPO urge HHS and CMS to consider a PPN option as an alternative to a traditional FFS Medicare option with enhanced benefits and competitive pricing due to lower administrative cost compared to risk plans.

For purposes of our recommendations, AAPPO has labeled this proposed alternative "Performance Risk PPN" (PRPN). Like leading edge products emerging in the private sector, it would offer plan incentives for higher quality, better customer service and benefits, improved

outcomes and program savings, and penalize PRPNs that do not perform well on these measures.

With respect to benefit plan differential and cost sharing, in and out-of-network, AAPPO recommends utilizing an approach that is flexible and intended to encourage competitive choices for cost-effective in-network and primary care utilization through a “medical home” approach to health care delivery, without discouraging appropriate out-of-network and specialty care where warranted by medical need. As a result, the PRPNs participating would offer a wide variety of options for beneficiaries.

All PPN options would offer a range of out-of-network benefits although, in some cases, not all Medicare-covered services may be available on an out-of-network basis.

Referrals would not be required for accessing out-of-network care, although in some cases there may be pre-certification requirements.

Our four recommended elements of a **Performance Risk PPN Model (PRPN)** include:

1. Performance Risk PPN Model Summary: AAPPO supports the establishment of an alternative reimbursement design that is modeled after that of the Chronic Care Improvement Organization program in Section 721 of the MMA (CCIO-I). CMS would negotiate a PRPN administrative fee in exchange for medical management and medical home network access services including preventive care, as described below. Medicare would continue to adjudicate and pay provider claims via its administrative contractors. PRPNs would bear performance risk for potentially all of their administrative fees, depending on the objective results of their financial, customer service, quality, network, and enhanced benefit operations. Beneficiary and provider satisfaction surveys would be an integral part of enlisting independent judgment of plan quality, access and cost improvements, and AAPPO would support evaluation of performance by an independent contractor to CMS, similar to the process for CCIOs. Cooperation with the provider in the patient’s medical home will focus on preventive care and appropriate health benefit use for traditional and palliative care. This proven approach will result in lower overall health care costs to the Medicare program.
2. Network contracting, credentialing and management, including enhanced networks (such as centers of excellence), guaranteeing quality access to all Medicare Part A and Part B covered services to include:
 - a. Robust disease management, prevention management, and wellness assessment in cooperation with the patient’s medical home provider;
 - b. Case management;
 - c. Utilization management;
 - d. Claims repricing; and
 - e. Access to extensive panels of health care providers and facilities.
3. Enhanced Performance Risk PPN Services. In addition, to carrying out all medical management services and arranging for network providers to deliver all Part A and Part B services, in order to encourage enrollment, PRPNs would be required to offer access to a credentialed provider network through which they would arrange for significantly discounted “enhanced benefits.” AAPPO proposes that PRPNs be required to offer access to at least three enhanced benefit discounts, and be permitted to offer as many

as CMS may approve, provided that the programs comply fully with CMS or accreditation criteria for discount percentages, credentialing, quality and access.

These elective and preventive services could include discounted access to:

- a. Routine dental services and preventive checkups;
- b. Routine eye care, glasses and preventive checkups;
- c. Routine hearing exams, audiology services and hearing aids;
- d. Complimentary medicine, including chiropractic and acupuncture; and
- e. Other non-covered services including discounts on fitness centers/health clubs, elective surgery, non-covered DME, and over-the-counter drugs.

Or they could include increased benefits, if a PRPN exceeds financial savings expectations.

4. Payment to PRPNs and Performance Incentives and Disincentives for Enhanced Services.

- a. Payment of Fees. AAPPO proposes a fee that will be negotiated with CMS for all PRPN beneficiaries who elect discounts on enhanced benefits, the amount of which shall be negotiated with CMS.
- b. Performance Incentives and Disincentives. AAPPO also supports a performance fee-risk approach to that would reward or penalize PRPNs based on quality, extent of discounts, and the results of beneficiary and provider satisfaction surveys.

Rationale: AAPPO believes that there is a crucial need for PRPNs, as a cost effective option, to offer greater access and choice to seniors. AAPPO would like to encourage further discussion with HHS and CMS in consideration of a “Performance Risk PPN” Medicare option.

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Issue: Current Medical Liability System:

Overview:

If we as stakeholders are to consider the reduction of health cost in framing the debate for health care reform it is difficult not to recognize the ongoing increase in cost that our current medical liability system adds to the rising cost of health care. Unfortunately the abuse of unsubstantiated lawsuits and excessive litigation are driving up cost for patients, continue to threaten access to quality health care and are forcing more and more good doctors to shut down their practices in communities across the nation due to double-digit increases in medical liability premiums. This liability crisis is not just impacting the private sector, the federal government direct and indirect cost last reported were over 28 billion a year, adding cost to Medicare and Medicaid

Recommendation:

A new dispute-resolution process should be adopted that would provide fair compensation for patients, eliminate windfalls for trial lawyers and protects doctors if best practice protocols were followed.

2. Advance Health IT

To be successful in controlling future health care cost, it is hard to ignore the benefits and efficiencies that the advancement of Health IT could provide in supporting the efficient exchange of patient information.

The economics of health IT adoption has always been a barrier for physicians. AAPPO believes that before a successful Employee Health Record (EHR) can be developed there must be agreement on the roles of the federal government, private sector (payers/networks) and the provider community with respect to the process. It is the opinion of AAPPO that the federal government must be responsible for the development of the EHR standards based on the data elements that the provider community recommends and the private sector – payer/network community should be responsible for implementing EHR protocols to support the exchange of patient information which is key to building an efficient health IT infrastructure.

Standardization of EHRs and the further advancement of health IT infrastructure would reduce both clinical errors and administrative burdens that continue to plague our current delivery system.

Health IT advancement would provide a platform to support the exchange of patient information to:

- **Improve safety** of medications and services through seamless information technology, adoption of best practices for medical and surgical safety, and increase coordination across providers.
- **Control costs** by improving efficiency of services and investing in the advancement of health IT infrastructure to ensure the exchange of patient and medical service data to further prevent unnecessary hospital admissions and re-admissions that result in higher cost.
- **Support wellness behaviors** and behavior change through internet based health education, motivational counseling, and social networking.
- **Prevent complications** by early detection, treatment and ongoing tracking of medical conditions through care coordination, medical home and disease management programs.

3. Enhance Transparency

In providing coverage for all Americans it will be essential to demonstrate to consumers that they are a true partner in the treatment process and in achieving better outcomes. Enhanced transparency in rulemaking, quality of care, data exchange, coverage options and education will be critical.

- **Rulemaking** – As part of the health care reform Congress will need to address the underpayment to physicians and hospitals by public programs that shift billions in annual cost to private insurers. In addition, transparency will be crucial to the development of uniform standards for the assessment of care and for the exchange of patient information across public and private sectors with respect to provider, payer and network information.
- **Quality of Care** – Improving the quality of care should be focused on improving preventive health care and addressing the need for additional evidence with an emphasis on programs that promote wellness and healthy behaviors that will prevent disease, reduce complications, and reduce long term care health care costs. Health Care is a personalized intervention based on patient need, values and the health care providers' recommendations, within the context of the best available evidence. It should be noted that the evidence based tools available today will not support making benefit decisions based on inflexible guidelines.
- **Health IT** – Uniform standards for the transmittal of data and connectivity to support real time eligibility and claims adjudication are essential to reducing cost and administrative burdens in exchanging information with respect to accurate provider reimbursements.
- **Coverage Options** – In providing coverage to all Americans a coordinated industry approach to providing consistent information concerning coverage options will be vital.
- **Education Tools** – Enhanced education tools will be critical in assisting employees and other consumers in accessing medical services that support making informed health care choices.

Conclusion

If health care reform is going to be successful, it will mean that all stakeholders will have to take a fresh approach to collaboration in order to find much needed solutions to support reducing cost, health IT and transparency. This will force all stakeholders to look at their positions in a different light. It will mean addressing topics that have previously been non-negotiable. As stakeholders we may discover that the process is uncomfortable...but important to ensure health care coverage for all Americans.

AAPPO Leadership

Executive Committee

Richard Hannon (*Chairman*), Senior VP, Marketing and Provider Affairs, BCBS Arizona
Keith Vangeison (*Chair-Elect 2009*), Executive Vice President Network Development, Viant, Inc.
Kenneth Hamm (*Treasurer*), CEO, First Choice Health
William Ross (*Secretary & PAC Chairman*), Executive Director, SBIPMG
Thomas Baker, Esq. (*AAPPO Legal Counsel & Rules, Bylaws, Nominations Chairman*), Troutman Sanders, LLP
George Bennett, President, First Health
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Thomas Press, President and CEO, Midlands Choice
Alan Rosenberg, M.D., VP of Medical Policy, Technology Assessment, and Credentialing, WellPoint
Al Schubert (*NASHO Past Chairman*), Vice President Managed Care & Health Policy, VSP Vision Care
Michael Taddeo, VP National Network Development, Medical Mutual of Ohio

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Dolores Green, Immediate Past President, HCAA and CEO, Foundation Administrative Services
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Gary Hutchins, CEO, 1st Medical Network
Richard Lungen, President, The Lungen Group, LLC
Robin Lutka, VP Legal and Public Policy, First Choice Health Network
Paul Marchetti, Head of National Networks and Contracting Services, Aetna
David Mauzey, Chief Operating Officer, ppoONE
Michael Morrone, President & CEO, Consolidated Services Group (CSG)
James Pennington, President, HealthSmart
Sean Smith, Chairman and CEO, Coalition America
April Stiles, COO, VIIAD
Sid Stolz, Executive Vice President, Healthcare Solutions, Inc.
Tim Stumpff, Vice President Network Development, Principal Financial Group
Nan Wallis, President, PPOplus

About Karen Greenrose

President and CEO, AAPPO

Karen Greenrose has more than 25 years of diversified healthcare experience, the last 12 at the senior management level. Her experience includes leadership roles in managed care with responsibility for profit/loss, mergers and acquisitions, framing healthcare policy, and developing customer and employee programs to support managing change in the industry.

In her current position as President and CEO of the American Association of Preferred Provider Organization (AAPPO), Ms. Greenrose is responsible for advancing the AAPPO mission and building a value proposition for the Association's more than 400 members and prospective members nationwide. She provides strategic leadership in all aspects of Association management and leads a collaborative effort involving industry leaders and experts to support products, services and information encouraging PPO best practices. Ms. Greenrose launched a PPO branding initiative to educate legislators, regulators and employers about PPOs immediately after she joined AAPPO in July 1999. That effort produced *Rise to Prominence, The PPO Story*, published in 2000, an industry resource on PPOs for which she was Executive Editor and a contributing writer. Under her direction, the association launched an affiliate association in 2003, the National Association of Specialty Health Organizations, and the AAPPO Academy, an online education program designed specifically to support healthcare professionals. In addition, to further enhance member services and meet the changing needs of payers and preferred provider networks (PPNs) Ms. Greenrose on behalf of AAPPO developed formal business partnerships with the Disease Management Association of America (DMAA) in 2007 and the Health Care Administrators Association (HCAA) in 2008. The last two years Ms. Greenrose has been instrumental in fostering collaboration between industry stakeholders and the American Medical Association (AMA), state legislators and local medical associations to support physician education and a pre-service notification mechanism for physicians. Most recently Ms. Greenrose on behalf of AAPPO entered into a co-educational agreement with the AMA to further provide physician education and to participate in the CAQH CORE effort in creating a real-time eligibility mechanism to support physician pre-service notification.

In July 2004, Greenrose was appointed to serve on the U.S. Department of Health and Human Services State Pharmaceutical Assistance Transition (SPAT) Commission. The 24-member commission was created to help ensure low-income Medicare beneficiaries will not lose state benefits under the Medicare prescription drug benefit set to start in 2006. Ms. Greenrose and her co-members worked to develop legislative and administrative proposals aimed at easing the transition of low-income Medicare beneficiaries from state pharmaceutical assistance programs (SPAPs) to coverage under the new Medicare drug benefit. The commission delivered its report to President Bush and Congress in January 2005.

Prior to AAPPO, Ms. Greenrose was President of Preferred Plan, a non-risk PPO. She directed the initial start-up of the PPO in 1992, providing a strategic approach with many competitive advantages and benefits for the organization including providing EDI capabilities to support real-time claims adjudication for hospital claims. Her leadership and direction created explosive growth for the PPO, leading to profitability within two-and-one-half years of its inception.

Ms. Greenrose has served as an officer of three national HMOs, assumed leadership roles in several successful start-ups, and aggressively managed positive financial turnarounds for a number of insurance companies. As Chairman and CEO of TakeCare's Indiana HMO, HealthPlus she was responsible for the sale and enrollment of the HMO's largest customer, General Electric. Her overall leadership of HealthPlus, including a positive financial turnaround within nine months of becoming CEO subsequently led to a profitable sale of the HMO.

Ms. Greenrose has developed many successful working relationships with corporations and insurance companies, designing custom tailored benefits for their specific employee base. She has extensive experience in mergers and acquisitions within the healthcare industry. Her experience includes direct responsibility for the due diligence process and participation in the sale of eight HMOs which significantly

increased the initial investment. In addition, Ms. Greenrose participated in the due diligence and sale of two national HMOs, TakeCare and FHP. Ms. Greenrose has a reputation for leading lean, fast-paced, thriving organizations that can adjust quickly to a changing environment.

As an advocate for improving the delivery of healthcare, Ms. Greenrose has worked closely with local, state and federal representatives in promoting and providing education in support of the framing healthcare policy. Ms. Greenrose served on the Board of the American Accreditation Healthcare Commission/URAC, and AnyWare Group, Inc. She currently serves on the advisory board of the Women Business Leaders of the U.S. Health Care Industry Foundation.

Ms. Greenrose graduated from Jefferson College, receiving her nursing degree in 1979.



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