Preferred Provider Organizations

(health delivery systems, occupational therapy, reimbursement)

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The 1980s has marked the beginning of a new alternative health care delivery system: the preferred provider organization (PPO). This system has developed from the health maintenance organization model and is predominant in California and Colorado. A PPO is a group of providers, usually hospitals and doctors, who agree to provide health care to subscribers for a negotiated fee that is usually discounted. Preferred provider organizations are subject to peer review and strict use controls in exchange for a consistent volume of patients and speedy turnaround on claims payments. This article describes the factors leading to the development of PPOs and the implications for occupational therapy.

In the early 1970s, steadily increasing health care costs and the criticism of the health insurance industry that resulted led to the emergence of health maintenance organizations (HMOs). In 1973, federal legislation authorized financial support for HMOs that met federal requirements, which furthered their growth. The marketing message in the 1970s was that this type of plan offered the consumer a choice. “HMOs enrolled members on a prepaid basis. For a fixed sum at regular intervals, the enrollee is entitled to any or all of the benefits offered without having to pay anything extra out of his own pocket.” (1, p. 67) Consumers were enrolled for a specific period of time, usually one year. Although HMOs offered a choice over other health care insurance, the consumer was limited to HMO providers. If consumers wanted the health care services of a nonparticipating HMO provider, no part of that provider’s charges were paid.

The growth of the HMO, the first radical change in the provider-insurer relationship, paved the way for the latest alternative delivery system: the preferred provider organization (PPO), which began in 1980 in California and Colorado.

Willis Goldbeck, executive director of the Washington Business Group on Health, Washington, D.C., explains, “A PPO is not an entity, as an HMO is, (rather) it is an arrangement, a negotiation between a payer and a seller,” (2, p. 59) and, as with other buyer and seller arrangements, “purchasers negotiate with those who seem to do a better job.” (2, p. 67) Although the majority of PPOs have been started by physicians (3), others have been developed by hospitals, businesses, insurers, or firms such as Ad Mar Corporation, which currently operates PPOs primarily in California. Ad Mar acts as a negotiator or facilitator between hospitals, doctors, consumers, and the marketplace. The firm negotiates contracts and pays claims (2).

Although PPOs differ in many ways, they do share certain common characteristics. For example, each has a “provider panel” that consists of hospitals and physicians designated as preferred providers. Each PPO makes a commitment to utilization review (UR), claims review, or other quality assurance methods. Each has a negotiated fee schedule, which in many cases includes a discount. Subscribers to a PPO receive a financial incentive and still have the flexibility to choose nonpreferred providers. Finally, other shared characteristics include claims that are paid quickly and primary care physicians as the entry point to health care services.

Starting a PPO

To get started, a PPO initially identifies a panel of providers. These may include hospitals, physicians, or other small groups of service providers. The PPO then arranges service contracts with these providers, usually at a discounted fee for service. The PPO promises to increase the provider’s volume of patients, and in turn the provider discounts the price of the service. The providers are most commonly hospitals and physicians, but could also be nursing homes and home health agencies.

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The PPO subscriber is given incentives to use the preferred providers, which may include reduced deductibles, no copayments, or additional benefits such as free physical examinations or free well-baby care. The subscriber is not locked into an enrollment period as is typical of the HMO. Also, the PPO subscriber can choose a provider not on the preferred provider panel, which is again different from the HMO. In making this choice, however, the subscriber incurs a copayment.

**Reasons for PPO Development**

Several factors have influenced the development of PPOs. Business coalitions representing major employers have increasingly sought less expensive employee health care insurance. They have pressured the insurance industry to search for a way to end spiraling medical costs and have independently investigated alternatives such as PPOs.

Probably the most important factor has occurred in areas of the country where there is an over-supply of physicians or hospital beds. Providers in these areas have lost a major share of the patient market. In an attempt to regain their market share, hospitals in partnership with physicians have formed PPOs to market their services to employers or insurance companies. Although prices are discounted, the PPO providers believe consumers will choose their health care services over non-PPO services, thereby increasing the physician caseload and filling empty hospital beds.

**Key to PPO Success**

The key to the success of PPOs is a combination of cost savings and maintenance of quality care. Like the present health care system, the PPO system works on a fee-for-service basis and there is a tendency to provide more services, which are sometimes unnecessary, rather than fewer services. For this reason, a strong UR component must monitor patient care both on an inpatient and outpatient basis. Physicians judged by their peers as "overusers" are informed and potentially eliminated from the provider panel. At the same time, quality of care must be maintained, and again the UR process monitors outcomes of each provider. Utilization review activities include the monitoring of not only hospital medical records, but also private practice physician records. Physicians involved in PPOs to date emphasize the need to include physicians whose style is characterized by a low utilization of services. They also emphasize the need to have physicians manage the UR process. Many physicians believe this preferred practice style and management involvement will ensure quality care.

A sophisticated data collection system to track patient care and UR is another key to a successful PPO and will eventually prove the economic and quality care value of this new system. Currently, there are no data supporting effective or quality care aspects of PPOs. Most observers of the preferred provider concept are optimistic about its success, especially in those geographic areas with a surplus of physicians and hospital beds. They believe the PPO concept is just another aspect of this country's pluralistic health care system, capitalizing on the competitive model of reduced price for the same quality. Although the number of PPOs may increase rapidly in the coming years, most followers of this movement agree that it will never be the only health care service model used; it's just one more option for consumers.

**Legality of PPOs**

PPOs are legal, but each must be cautious about possible violations of state of federal antitrust laws. Many states do not have laws hindering the development of PPOs. To facilitate contractual arrangements, California enacted a law in 1982 allowing insurance companies to contract preferred provider arrangements with hospitals and other service providers. This legislation explains the number of PPOs in California and the state's recent rapid growth of PPOs. In general, the fewer legal restrictions present, the more favorable the climate for PPOs.

Preferred provider organizations can violate antitrust laws if they reduce competition rather than promote it. A PPO comprising 3 hospitals and 100 physicians in a community of 12 hospitals and 1,000 physicians is not cornering the market. On the other hand, in a rural community with one hospital and relatively few physicians, a PPO could easily be vulnerable to a charge of antitrust violation if it included that hospital and most of the physicians. This latter scenario is not likely to occur, however, because the rural hospital already has control of the market share, and thus there is no economic incentive to develop a PPO.

**Implications for Occupational Therapy**

The reimbursement system for PPOs encourages limits on the number of services ordered by the physician. Hospitals receive either a flat rate per day or per diagnosis.
In either case, there is no incentive to provide services such as occupational therapy, which would incur additional costs. Some hospitals and physicians understand the importance of the restorative services provided by occupational therapists; however, many others do not. Furthermore, on an outpatient basis the only possible preferred provider of occupational therapy in the typical PPO is the hospital, if it has an outpatient occupational therapy service. Without occupational therapy service providers being designated as preferred providers, there is no incentive to refer patients to occupational therapy. Nonphysician providers have typically not been identified by PPOs; however, at least one group in California is seeking preferred provider status by the Blue Cross/Blue Shield preferred provider plan.

Since the PPO concept usually develops at the local level, therapists need to determine whether the PPO concept is being considered in their community. If a PPO is being considered, the therapist needs to identify the sponsors. Is it the hospital, a local industry, insurance company, or a group of providers? The sponsor of the PPO will need to understand the importance of occupational therapy services before designating occupational therapists as preferred providers. Competition between therapists or facilities over price and quality of occupational therapy services will ultimately be an issue. A choice about who can provide quality occupational therapy services at a reduced price will have to be made from among the private practitioners, outpatient clinics, or rehabilitation centers.

Other developments in the health care system should be considered when evaluating the effect of PPOs on occupational therapy. A major factor will be the Medicare prospective payment system, which went into effect in October 1983. This system may decrease the number of hospital-based occupational therapy treatments and increase the use of outpatient occupational therapy. The PPOs, especially those paying hospitals on a discharge diagnosis-related grouping rate, will also have an incentive to discharge early and use outpatient services. This is another reason why outpatient occupational therapy preferred providers need to be designated as part of the provider panel.

The PPO system provides two challenges for occupational therapists. First, therapists need to be aware of what is happening in the community and be prepared to approach the PPO sponsor with information on the importance of including occupational therapy preferred providers, and second, they need to be prepared to compete with colleagues and/or their employers for preferred provider status.

Summary

The PPO is the latest health care alternative delivery model in this country's multifaceted health care system. Where the right economic and human resources exist, PPOs will develop. Some observers expect the growth of these arrangements to be rapid. Michael D. Bromberg, executive director of the Federation of American Hospitals, offers the following prediction:

I think probably the single most important thing which is going to impact the health field is not Washington... but probably... The preferred provider movement... you're going to see some sudden interest in Washington as well as in some state capitals in legislation to remove the barriers to preferred provider plans. (4)

REFERENCES

2. Kodner K: Competition: getting a fix on PPOs. Hospitals 56(22):59, November 18, 1982
3. Clearinghouse on Preferred Provider Organizations: Directory of Preferred Provider Organizations. Bethesda, MD: Institute for International Health Initiatives Affiliated with the American Medical Care and Review Association, 1983

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