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powering healthcare

Cost Management Services

Powering Healthcare. Empowering Employers.

Agenda

- **Background/Overview**
- **The Problem and the Broken System**
- **Physician Led Medical Bill Review (MBR)**
- ***Open Access* Medical Plan**
- **Care Navigation Services (Pre-Care)**
- **Proactive Member Advocacy**
- **Open Access Design/Program Options**
- **Implementation and Member Education**

Background

- **Career: ~ 25 Years of Cost Management Experience**
  - WC, Self-Funded Health, Imaging Facility Mgmt, Network Development
- **AMPS: Cost Management Industry Leader for 16+ years**
- **Mission – to establish a Fair system for *all* (employer and provider)**
  - AMPS becomes Co-Fiduciary to the Plan
- **Physician Led, Technology/Data Driven**
- **Medical Bill Review**
  - Core Function. Also embedded into the Open Access Model
- **Open Access Health Plan**
  - Largest Group: 120,000 Members, Smallest Group: 50 EEs
  - More than $1B in Claims in past 12 Months
- **Drexi Rx – Pharmacy Solution – Anthony Masotto**

The Problem

You run a Healthcare Business… like it or not

- "GM is a health & benefits company with an auto company attached."
  – Warren Buffet
- AND…..It spends more on healthcare than steel, as does Starbucks on coffee beans.
- For nearly all, the 2nd largest operating expense behind payroll.
- Even billion $ organizations like Amazon/JP Morgan/Berkshire Hathaway cannot sustain healthcare costs.

How's your healthcare business doing?

The Problem

You run a Healthcare Business… like it or not

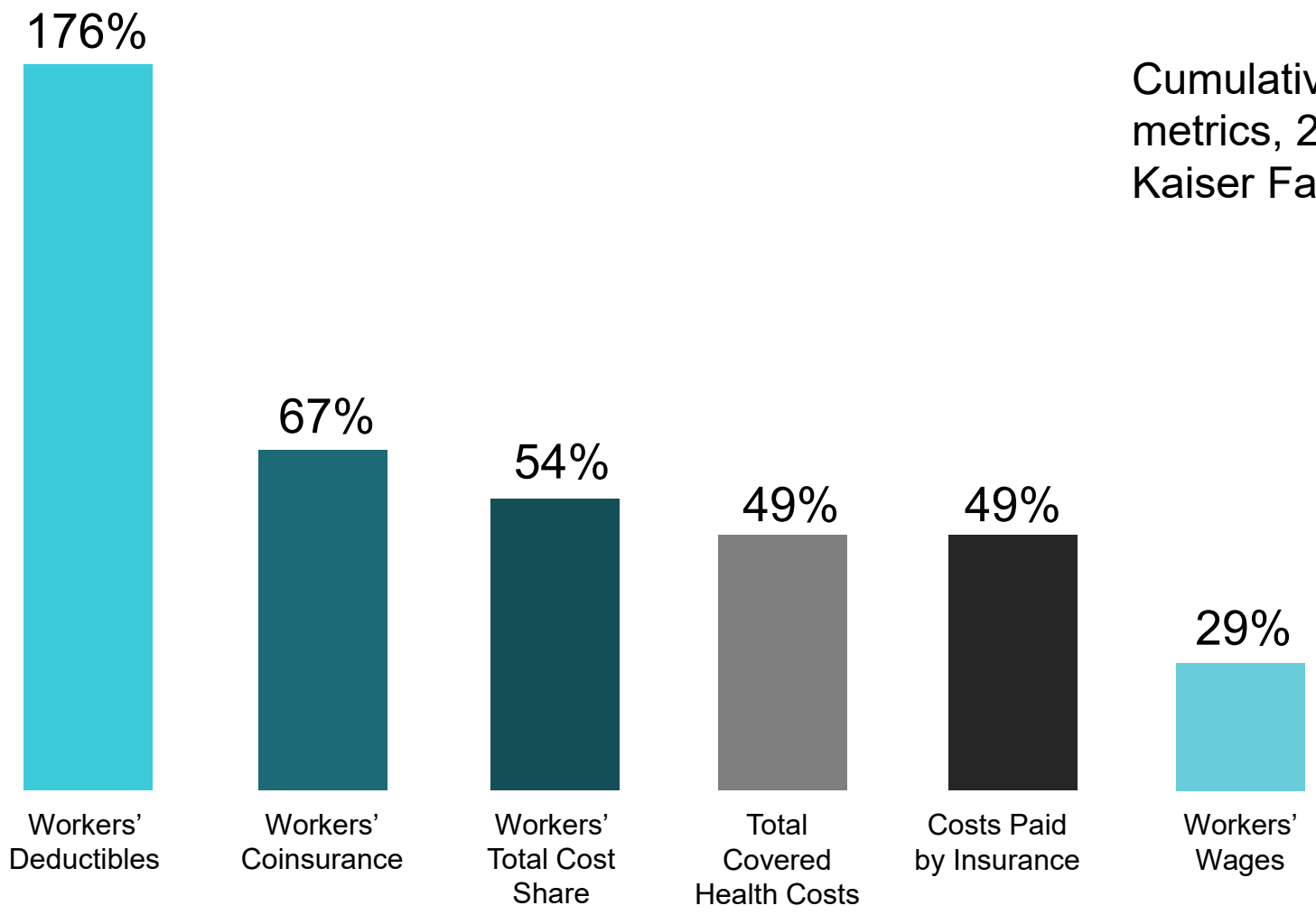
“In 2021, the cost of healthcare for a hypothetical American family of 4 covered by an average employer-sponsored *preferred provider organization (PPO)* plan is $28,256”

According to The Milliman Medical Index (MMI)

https://us.milliman.com/en/insight/2021-Milliman-Medical-Index

The Problem

Household Income is Devastated by Healthcare



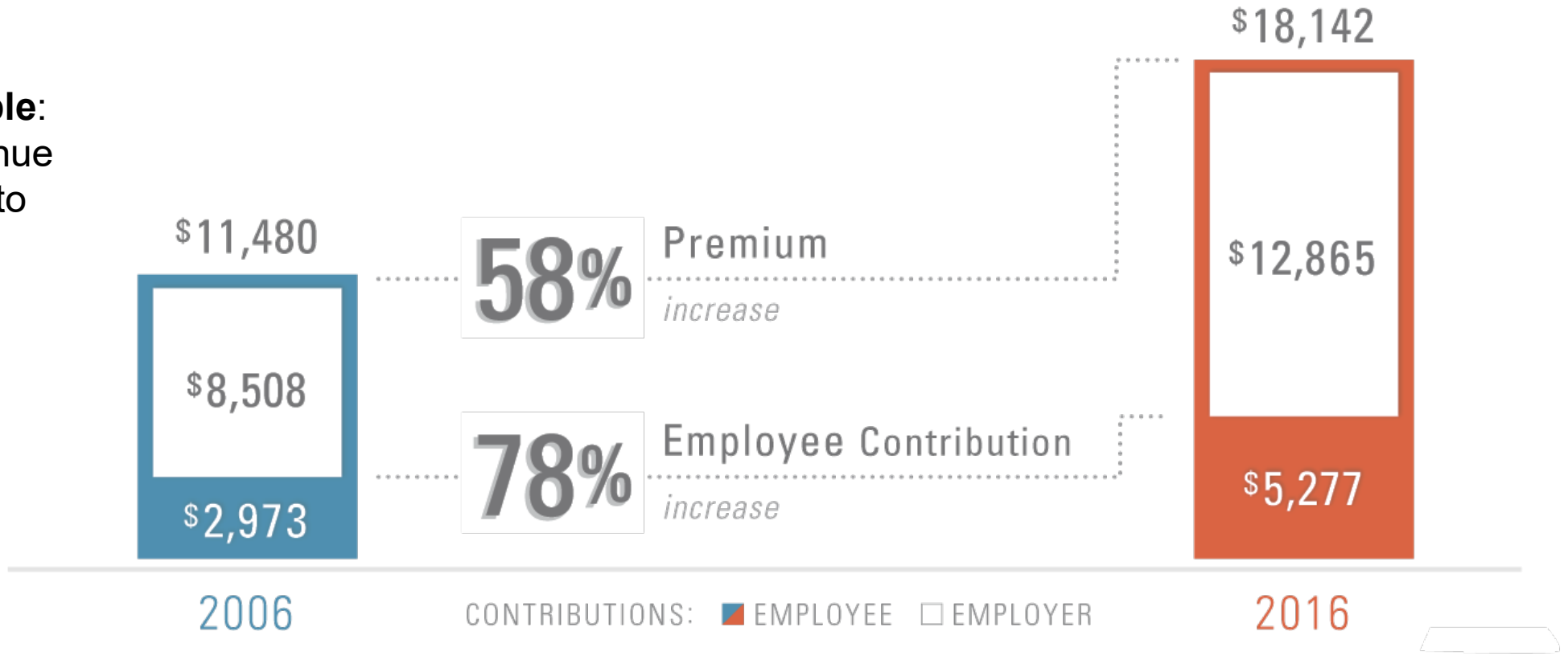
Cumulative growth in select metrics, 2010 to 2020 – Kaiser Family Foundation

The Problem

Average Health Insurance Premiums

Worker Contributions for Family Coverage, 2006 – 2016: 'Status Quo' Approach

Unsustainable: Cannot continue to 'cost shift' to employees.



(Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2016)

The Broken System

Why is Healthcare so Expensive?

- Employees never ask for the price of service, don't shop around
- Hospitals – Create own prices; operating like an unregulated utility (think OPEC)
- Most assume there is no choice and that the BUCAHs act on our behalf
- Physicians – Greater utilization, more income (fee for service)
- Employee/members – Limited interest and resources to make informed financial decisions
- Insurance – Higher the cost, higher the profit (even w/fixed margin – think MLR). System is SET UP TO FAIL the employer/member.

The 'Affordable' Healthcare Act and "MLR"

- MLR, or Medical Loss Ratio, is a prime example of misaligned incentives in the health care supply chain. The Medical Loss Ratio is a provision in the Affordable Care Act that was intended to keep insurance carriers from over charging their customers.

- It requires that carriers spend $.80 of each dollar collected in the small group market, and $.85 of each dollar collected in the large group market, to pay its customers' medical claims and activities that improve the quality of care.

- If health care costs go up, then the carrier is justified in charging higher premiums increasing the value of their 15% or 20%. **With a model like this, carriers benefit when health care costs go *UP*.**

The Broken System

Why is Healthcare so Expensive?

PPO: Formal Definition

A Preferred Provider Organization (or ”PPO” and sometimes referred to as a Participating Provider Organization or Preferred Provider Option) is a managed care organization of medical doctors, hospitals, and other health care providers who have agreed with an insurer or a third-party administrator **to provide health care at REDUCED RATES to the insurer's or administrator's clients.**

PPO: Definition in Practice

A Preferred Provider Organization (or ”PPO” and sometimes referred to as a Participating Provider Organization or Preferred Provider Option) is a Contractual Arrangement, created in secret and considered proprietary, that is made between two entities (insurance carriers and medical providers including hospitals, physicians and ancillary providers) that not only control the cost of care that most employers and employees pay, **BUT IN WHICH EACH OF THOSE ENTITIES BENFEFIT AS THE COSTS GO UP.**

The Broken System

Why is Healthcare so Expensive?

- Healthcare Bills are Paid with little diligence
  - "**No Audit**" Clause
  - Gov't Stats show **90%, 95**%, 97% of Claims found to have errors
  - **98%** of Claims are **Paid off** High Level Summary Bill (**UB-04**)
  - **No Transparency**: PPO's hide *true costs*
- PPO Top-down pricing with NO Benchmarking – **ILLUSIONARY DISCOUNTS**
- **Conflict of Interest**: We assume Carriers/PPO Networks are acting on behalf of client's best interest
- "**Head in the bed**" mentality from the capitalistic provider community. (Dr. Josh Luke, "Health-Wealth". *www.health-wealth.com*)

Why Errors Exist

Care Giving is Primary / Billing is Secondary

Separate Systems

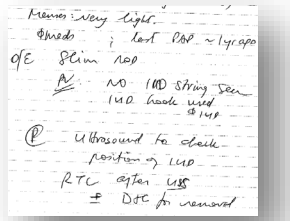
- EMR – Manages Clinical Care
- RevCycle – Manages Billing

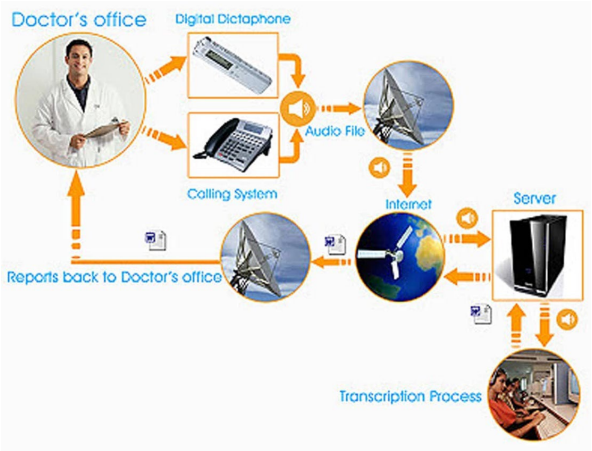
Medical Transcription

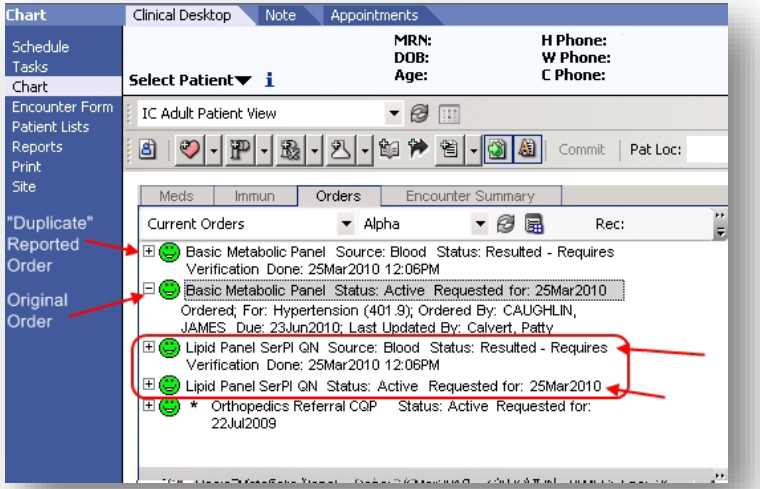
- Offsite/Offshore
- Manual Data Entry
- Sloppy Handwritten Orders/Documentation

Clinical Workflow

- Booked When Ordered (not when rendered)
- Standard ”Order Sets” Bundle Services
- PRN prescriptions ('pro re nata’) taken as needed
- Anesthesia not documenting Start/Stop Time
- PCP and RN order the same treatment







Why Errors Exist

How to Maximizing Revenue: Upcoding & Unbundling

Upcoding

- RN procedure coded as by MD Specialist
- Simple, single-view X-ray coded as complex with different viewing angles
- Sedation billed as anesthesia
- ED minor treatment (antibiotics and basic wound care) coded as high-complex care
- NICU Severity Level 4 coded for full stay
- Add History of Cancer Diagnosis Code, upgrades to more costly DRG case rate
- Change primary Diagnosis Code to adjacent code, upgrades to more costly DRG case rate

Unbundling

- Operating Theater billed in conjunction with bundled Surgery CPT (all Surgery CPTs are bundles)
- Supplies billed separate from Surgery CPT
- Same X-Ray or MRI used twice (head used for neck too)
- Blood draw, separate from lab (Arterial Puncture, Venipuncture Routine)
- IV Treatment, separate from R&B (IV Therapy EA AD HR, Concurrent IV Ther)
- Diabetes Treatment, separate from R&B (Glu Home Use Diagnos, Glucose Quant, Insulin 1 Unt Inj)

Sample Descriptions

Facility Billing Practices

Universal Bill

- Summary charges
- 1-3 pages
- Generally utilized for immediate payment

Itemized Bill

- Complete description of charges
- Varies in length

Medical Chart

- Complete Records
- Combination of physician/nurse notes and test results
- Often 500+ pages
- Key Data

- *The U.S. General Accounting Office has estimated that there are overcharges on 99% of all hospital bills!*
- *A review of 40,000 hospital bills in a national study by Equifax Services found errors on over 97% of bills!*

The Solution

Physician-Led Medical Bill Review

Over 90%

of hospital bills contain errors to the detriment of the payer

Studies by U.S. Government and Equifax

DAILY

Unbundling Data Entry Errors

Human Error

Hoteling Days

Early Admission

Duplicate Billing, Replacement Orders, Services Not Rendered

Common - booked when ordered, not when rendered
Supplies ordered but not used

Inaccurate Time Charges

ICU, OR, excessive time or mismatch;
Observation vs. Clinical Days;

MONTHLY

Adverse Clinical Occurrences

Never events / MedMal

Miscellaneous

Overlapping / conflicting protocols; Quarterly updates to Clinical Access; Providers & Emergency Department to In-Patient conversion

Did you know...

The Physician Panel:

- Performs a line-by-line review
- Corrects any mistakes
- Ensures accurate and reasonable pricing

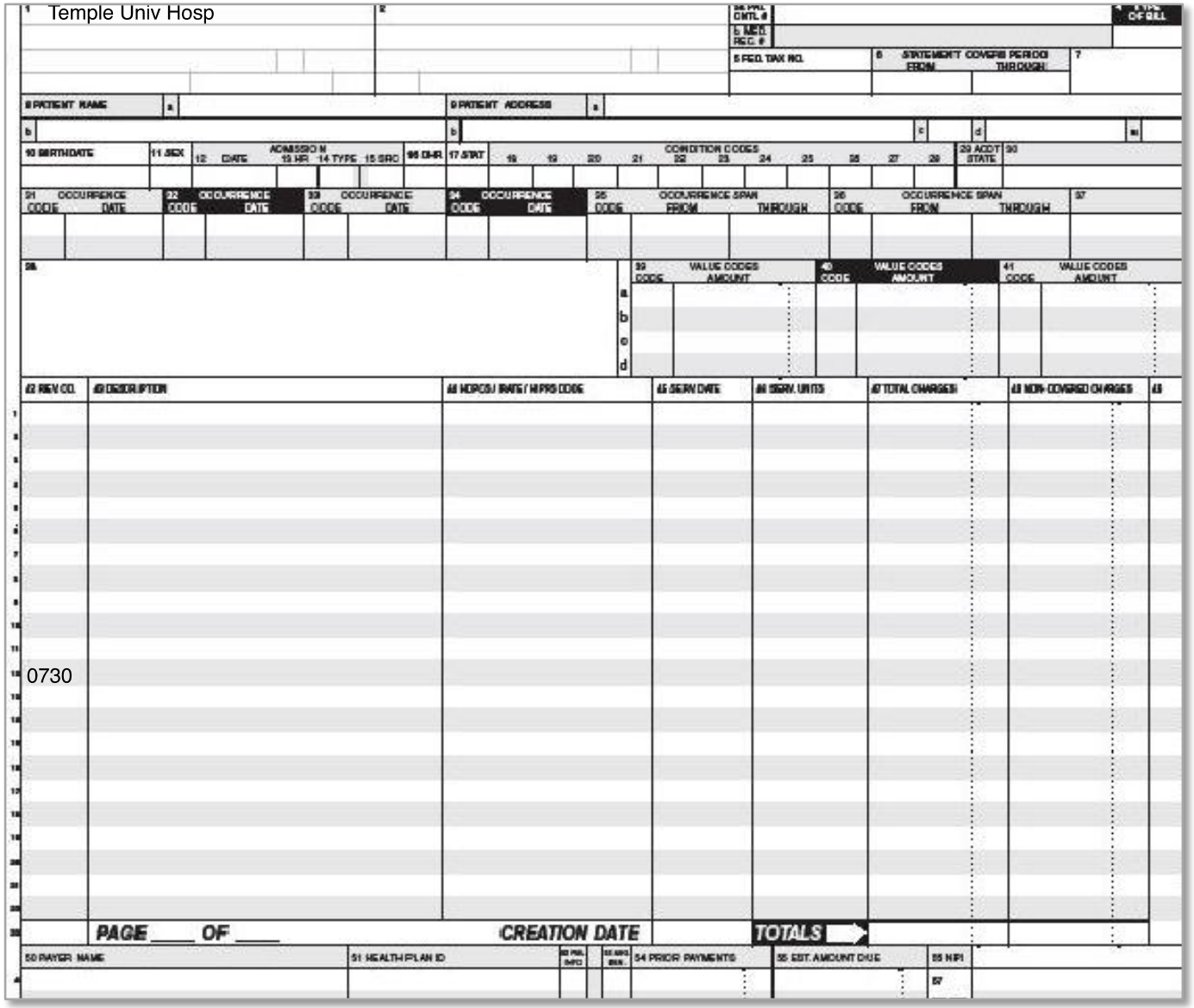
>8%

Savings from errors alone

Physician Led Medical Bill Review

UB-04 Invoice Used to Pay Hospital Bills

***7% to 10% of charges include errors but can't be seen on this invoice**



Physician Led Medical Bill Review

MUST Have the Itemized Bill

***7% to 10% of charges are in error but can't be seen on this invoice**

041X	Respiratory Services	**Rev Code Total**	**$956.62**
	PCO17: 320: Excessive charge		$956.62
042X	Physical Therapy	**Rev Code Total**	**$1,497.45**
	PCO17: 320: Excessive charge		$1,497.45
043X	Occupational Therapy	**Rev Code Total**	**$771.56**
	PCO17: 320: Excessive charge		$771.56
045X	Emergency Room	**Rev Code Total**	**$2,299.99**
	PCO05: 93055: Service - Integral		$788.70
	PCO17: 320: Excessive charge		$1,511.29
046X	Pulmonary Function	**Rev Code Total**	**$1,097.80**
	PCO05: 93055: Service - Integral		$1,097.80
063X	Pharmacy - Extension of 025X	**Rev Code Total**	**$3,671.97**
	PCO05: 93097: Drug - Integral		$164.49
	PCO05: 93099: Supply - Integral		$50.00
	PCO17: 320: Excessive charge		$2,069.04
	PCO17: 323: Excessive charge		$1,388.44
071X	Recovery Room	**Rev Code Total**	**$2,635.68**
	PCO17: 323: Excessive charge		$2,635.68
073X	EKG/ECG (Electrocardiogram)	**Rev Code Total**	**$704.84**
	PCO17: 320: Excessive charge		$704.84
		Grand Total by Rev Code:	**$129,291.76**

Detail

Date	Billed	Excluded	Allowed	PCO	Reason	Rev.	Description
05/26/2012	$1,460.00	$992.80	$467.20	PCO17	623: Excessive charge	121	ROOM 210 S
05/27/2012	$102.30	$102.30	$0.00	PCO05	93011: Equipment - Integra	272	ET TUBE ANY SIZE
05/27/2012	$114.40	$114.40	$0.00	PCO05	93011: Equipment - Integra	272	STYLET INTUBATING 14MM DISP
05/27/2012	$261.80	$261.80	$0.00	PCO05	93055: Service - Integral	450	INFOSION/HYDRATION- EA ADDL HOUR
05/27/2012	$261.80	$261.80	$0.00	PCO05	93055: Service - Integral	450	IV PUSH EA ADDL SEQ NEW SUB
05/27/2012	$28.60	$28.60	$0.00	PCO05	93055: Service - Integral	300	SPECIMEN COLLECTION - CHRG ONLY
05/27/2012	$265.10	$265.10	$0.00	PCO05	93055: Service - Integral	450	IV PUSH INITIAL
05/27/2012	$386.10	$386.10	$0.00	PCO05	93097: Drug - Integral	301	ACETAMINOPHEN
05/27/2012	$21.05	$21.05	$0.00	PCO05	93099: Supply - Integral	250	SODIUM CHLORIDE 0.9% INJECT. 10ML
05/27/2012	$48.00	$48.00	$0.00	PCO05	93099: Supply - Integral	250	LIDOCAINE 2% 5ML LIFESHIELD INJ

FIRST PHP Claim Sent to AMPS - $517,126 in ERRORS

Common Tactic: NICU Severity Upcoding / MBR INN Claim - Regional Health Plan

Scenario

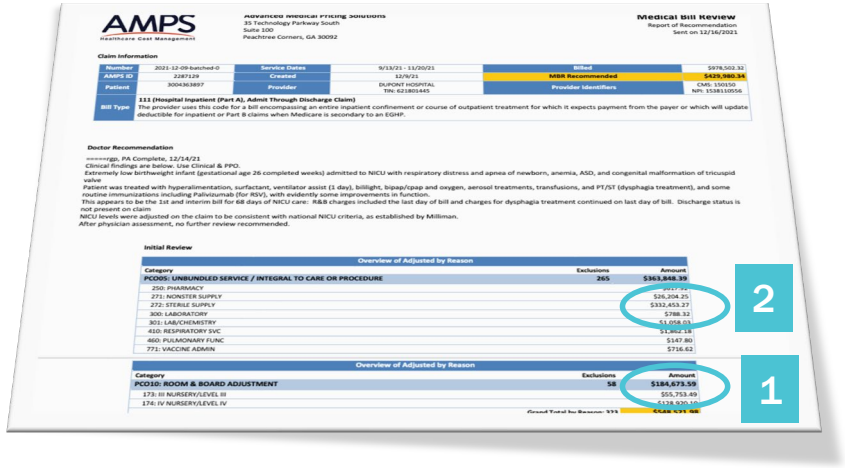
- MBR performed on INN Claim
- Large & complex NICU Claim
- First 68 days of Interim Bill

Findings

1. **$184,673 Savings** - NICU Levels adjusted to be consistent with national NICU criteria established by Milliman
2. **$332,453 Savings** - Unbundled Services from Med Surg Supplies removed Applied PPO Discount & AMPS Adjustments

	Billed	Allowed	Savings %
Before AMPS	$ 978,502	$ 391,401	60%
After AMPS	$ 978,502	$ 171,992	82%

1. $184,673 – NICU Severity Level Correction
2. $332,453 – Med Surg Unbundled Supplies



Charged $138,071 for a Service that was NEVER performed

Services Booked When Ordered / Expertise Required to Identify Non-Rendered Services

Scenario

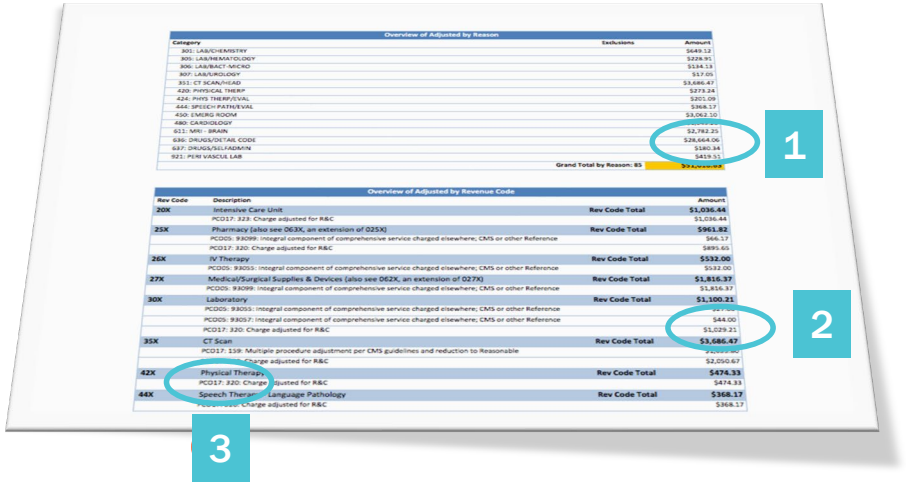
- Emergency Room visit, chest pains
- Stress Test ordered, but not rendered
- MBR Full performed on OON claim
- AMPS Medical Director review of sequence of events and notes identified, previous HIDA scan showed biliary calculus deposits. Therefore, Stress Test (Adenosine) not performed.

Findings

1. **$118,630 Savings** – Denied all charges associated with Adenosine Stress Test
   - Dr. Duke - The notes stated an adenosine stress test would be considered *but this test was never performed* most likely because the results of a previous HIDA scan showed biliary calculus deposits. The patient's pain was attributed to this as all of his cardiac markers had remained unchanged including serial EKG's. …the (adenosine) test was never performed and the MAR shows no administration of this medication and there is no adenosine stress test report included. Deny the entire charge for Adenosine.
2. **$4,922 Savings** – Denied outpatient encounter line-items, not applicable since converted to in-patient encounter
3. **$9,894 Savings** – Adjusted to R&C prices

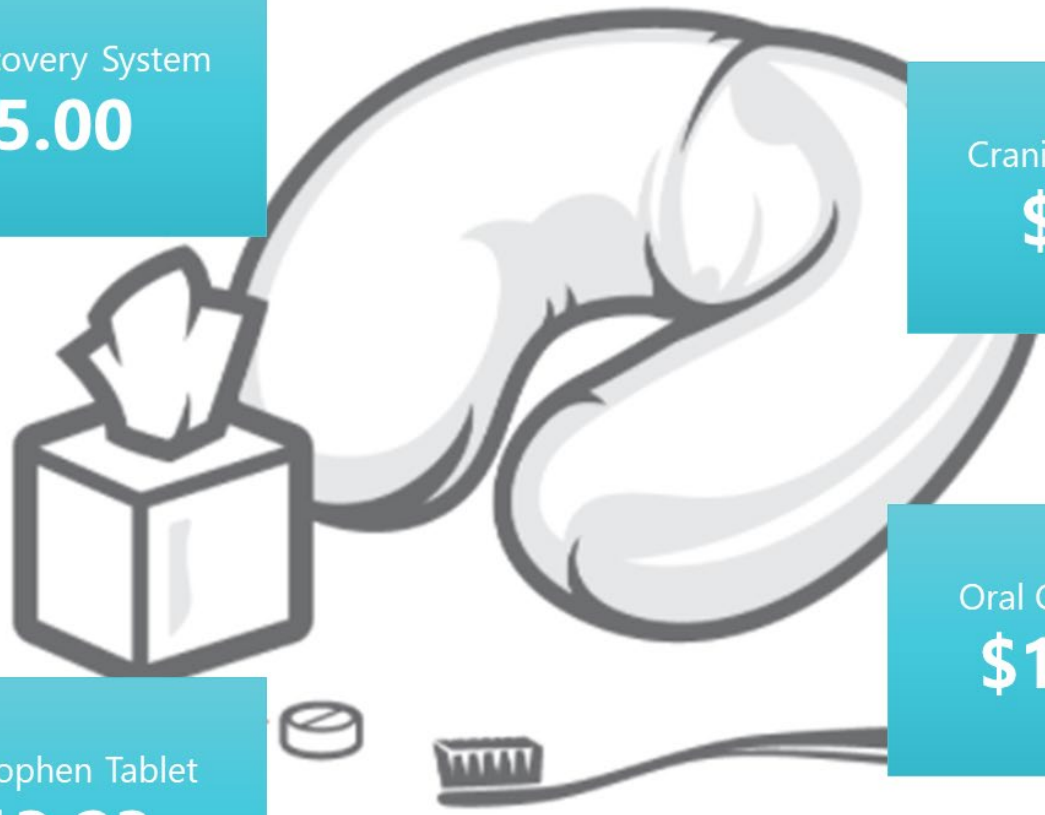
	Billed	Allowed	Savings %
Before AMPS	$ 138,071	$ 133,929	3%
After AMPS	$ 138,071	$ 4,625	97%

1. $118,630 - Adenosine Stress Test Never Administered
2. $9,894 - Excessive charges adjusted
3. $4,922 - Unbundling & ER to Inpatient w/ ER left on bill



Actual Hospital Charges
From Audited Claims

Mucus Recovery System
$75.00



Cranial Support System
$450.00

Oral Cleansing Device
$1050.00

Acetaminophen Tablet
$513.23

Hospital Mark-Up

How much does a Computed Tomography (CT) Scan cost?

	Average Billed	Average Cost	Average Medicare Payment	50% PPO Discount	MC+ 150%
Hospital A	$1,506	$134	$175	$753	$263
Hospital B	$1,516	$112	$195	$758	$293
Hospital C	$2,268	$232	$193	$1,134	$290
Hospital D	$1,547	$212	$207	$773	$311
Hospital E	$3,042	$76	$213	$1,521	$320
Hospital F	$1,492	$141	$181	$746	$272

What is "Open Access"?

It is a Self-Funded Plan Design that involves the removal of the middle-man (the PPO Network), and as such, ALLOWS for Medical Bill Review as well as ensuring the plan does not overpay

- **To determine what a fair market reimbursement is to the provider for a particular service, 'reference points' are used when repricing claims**
  - **Cost: Self-Reported provider Costs are submitted to Medicare every year. This data is utilized in determining a FAIR payment**
  - **Medicare Allowed Rates: Also public data that is used in making a determination of FAIR**
- **Mainly, claims are repriced to the Average of 150% of Medicare & 135% of the provider's Cost, or benchmarked back to Medicare, ~148%**

The Solution

Open Access Claim Example

XYZ Medical Procedure Using a traditional 'Top Down' PPO Discount Model

- Medicare Allowed Rate = $1,000
  - COST to provider ~$920.00
- Provider's Billed Charge = $7,000 (7x's Medicare)
- PPO Network 'discount' = $3,200
- PAID AMOUNT BY PLAN = $3,800 (3.8x's the Medicare Rate)

XYZ Medical Procedure Using a traditional "Cost-Plus" Reference Based Reimbursement Model

- Medicare Allowed + ~50% = $1,500
- SAVINGS TO PLAN = $3,800 - $1,500 = $2,300 or 39%

The Solution

Savings Estimates – Raw Data Sample

Indiana Based Employer (84 Employees on the Plan)

Estimated Savings moving from PPO to RBR		
XYZ Corp	**PPO Performance**	**AMPS RBR Estimate**
Billed Charges	$ 2,743,160	$ 2,743,160
Discount*	$ 1,208,670	$ 1,930,029
AMPS PPL: Avg of Medicare +50 / Cost +35	44.1%	70.4%
Allowable Amount	$ 1,534,490	$ 813,132
Plan Paid	$ 1,304,317	$ 691,162
Patient Responsibility	$ 230,174	$ 121,970
Fees (Healthlink, $8 PEPM)	$ 1,152	$ 274,316
Fees (FirstHealth, $5.15 PEPM)	$ 309	
Fees (CIGNA, $16.75 PEPM)	$ 13,467	
PPO Network Access Fee Per Employee (Total EE: 84) AMPS 10% GBC		
Total Spend	**$ 1,549,418**	**$ 1,087,448**
Total Savings		**$ 461,971**
Total Savings %		**29.8%**

You can take control over your plan and its costs!....

What's Easier?? Increasing revenue by 40% OR cutting healthcare costs by 20%?

.....No contest!

Employer with ~$50M in top line revenue, spends ~$5M on healthcare costs (typical for a company with ~500 employees). They make ~$2.5M in profits last year (5% margin). Through a refined health benefits approach, they can recognize a conservative 20% cost reduction (on the high end, we can see as much as 30-40%). In doing so, their EBITDA grew by $1M which is a 40% increase. To create the same EBITDA impact, they'd have to grow top line revenue by ~$20MM!

Imagine the increased wages, year-end bonuses, profit-sharing, additional hiring, expansion plans, etc. that could be achieved

All In One SOLUTION

Fiduciary Protection *Ensures prudent execution of Plan Document terms*

Intelligent Pricing *Fair Pricing built on expertise and smart software*

Member Advocacy *Standing ready to help Members*

Care Navigation *Connecting Members with friendly Providers*

Provider Relations *Fostering local relationships*

Data Visibility *On-demand data visibility – anytime, anywhere*

Member Advocacy

Education From The Start

- ***Direct line of communication with Members*** by attending open enrollment and educating Members on their new healthcare plan
- Available ***12 hours each weekday*** from AMPS multi-lingual Member Services Centers in Atlanta, GA and Phoenix, AZ
- ***Tailored training and marketing materials*** on how to identify a balance bill and engage their Member Advocate

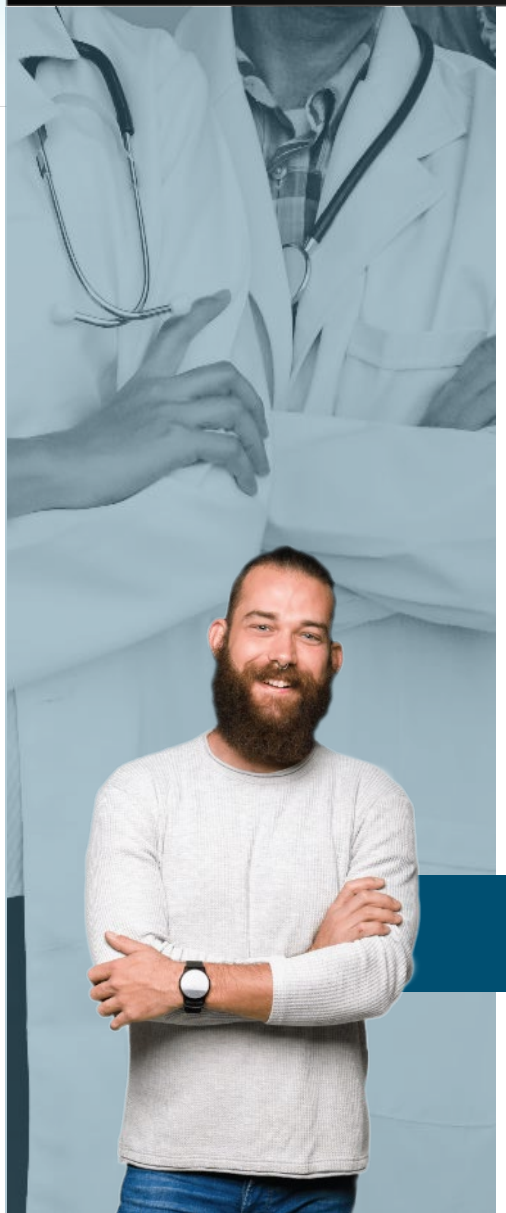
A Proactive Approach

- AMPS Member Advocacy Team proactively contacts the Member with a reminder to call their AMPS Member Advocate

Human Resources

All In One provides Human Resources with educational material to distribute to Members in order answer common questions

Care Navigation



Find.

- AMPS Provider Finder and Pricing Tools are used by AMPS Navigation Team and utilization management partners to find a “friendly” Provider when needing medical care, based on cost, quality, location, and prior utilization.

Steer.

- Steer Members to contracted Providers in AMPS “direct-to-employer” programs.
- Plan designs that offer savings for both the Plan and the Members when utilizing the AMPS direct contacted Providers for medical care.

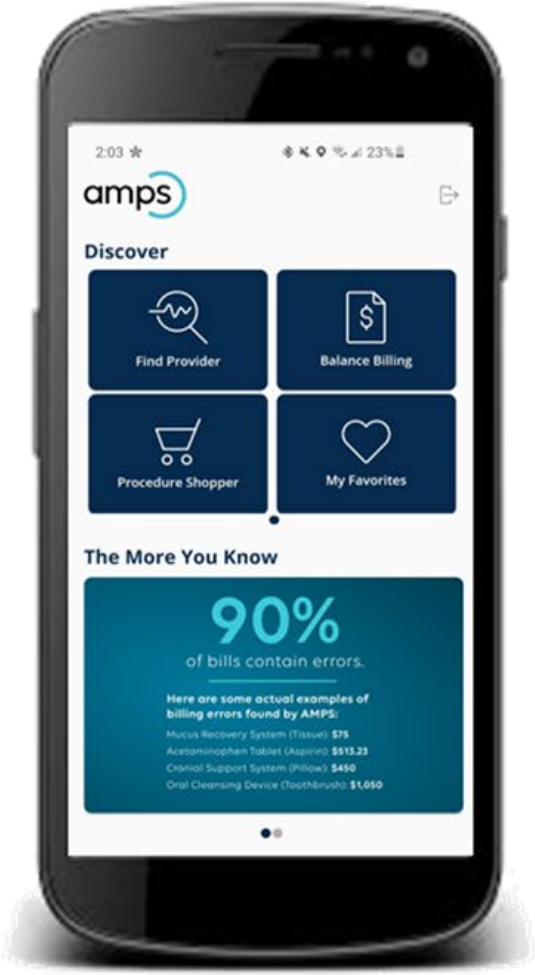
Schedule.

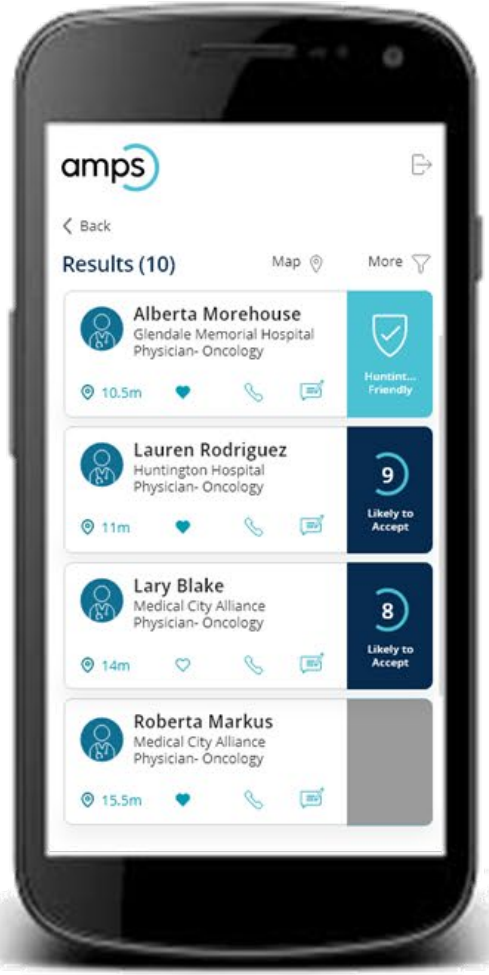
- Transparent, bundled pricing on planned elective medical procedures
- Additional savings at **Ambulatory Surgery Centers,** independent **Imaging Facilities** and GI Centers as opposed to a hospital.

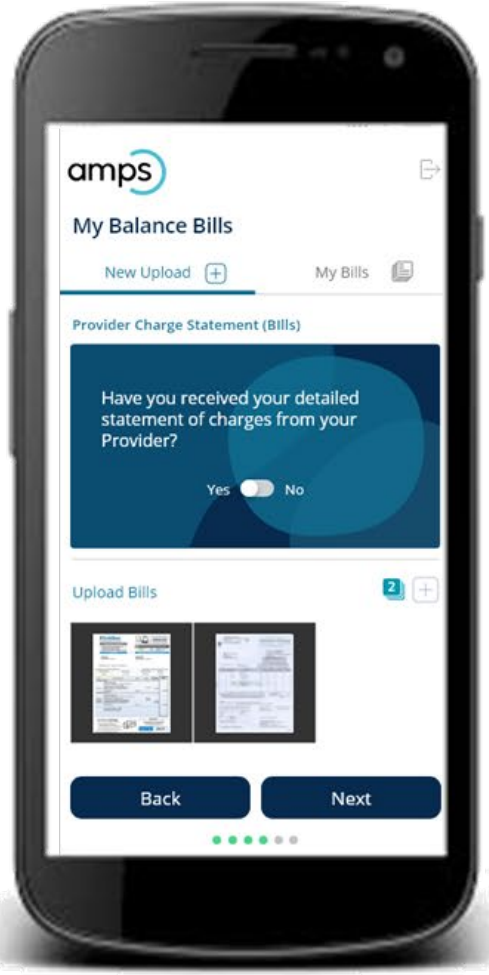
Members

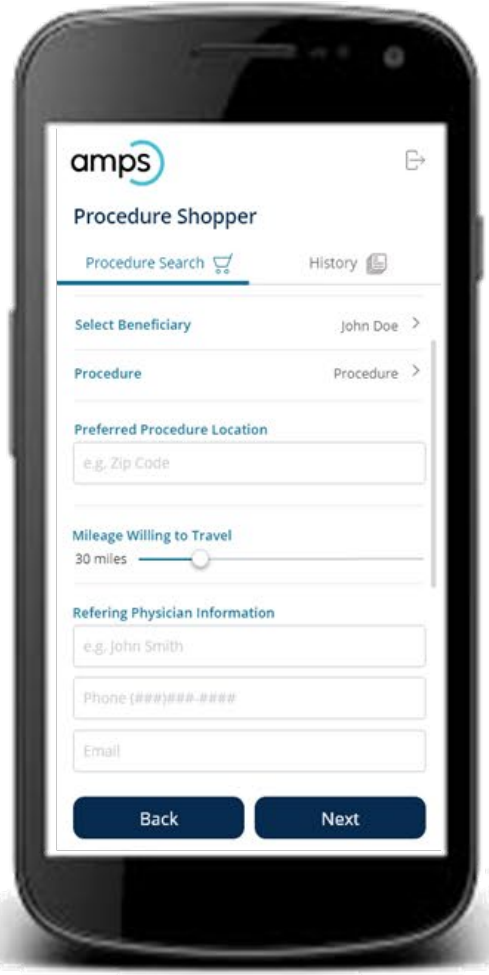
All In One provides members with access to providers offering the best value, lowering the employee's out of pocket costs.

AMPS Connect









Data Visibility

On-demand data visibility – anytime, anywhere

A Trusted Source for Your Data

- On-demand visibility into Plan performance, with noteworthy metrics, easy-to-understand dashboards, messaging alerts, and tailored reports via secure email.

Analytics & Reporting

- 24/7 Access through AMPS Portal
- Transparency
- Email Notifications

CFOs / Consultants / HR

AMPS online portal allows CFOs to monitor the overall medical spend of the company real time with 24/7 access.

Optional Strategies Using an Open Access Model

FULL OPEN ACCESS

Eliminate PPO in its entirety. Replace with RBP for all claims with balance bill protection. No Networks. Max Savings.

HYBRID OPEN ACCESS

Use Professional ONLY Network and all other claims run through AMPS' Open Access Solution

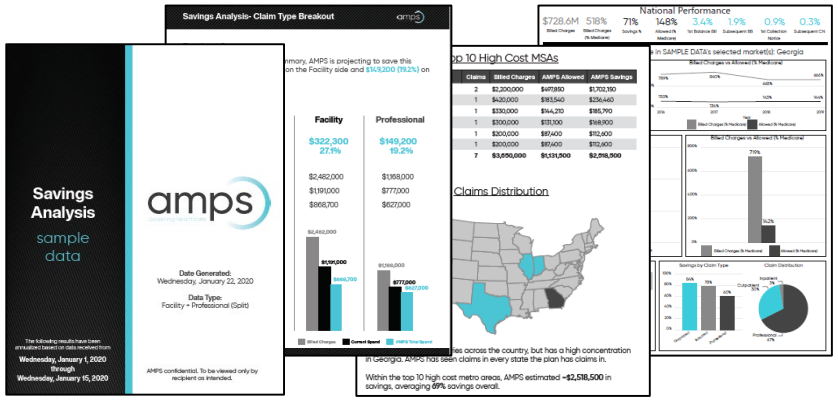
DUAL OPTION

Offer traditional PPO and alternative Open Access solution. Member Choice.

Complimentary Savings Analysis – Proof of Concept

In order to obtain a Savings Analysis from AMPS, we need the data from Option 1 or Option 2 shown. The more comprehensive the data we receive, the more we can drill down into the following areas:

- Savings Summary
- Savings by Claim Type
- Costly Hospitals / Providers
- Claim Insights
- Statistics by Location
- Market Analysis



OPTION 1

AMPS will create a high-level savings analysis based on several assumptions.

Requirements:

1.) Plan Financial Data

- Total Billed Charges
- Total Allowed

2.) Census

OPTION 2

AMPS will create an in-depth savings analysis that provides insight on plan spend, high-cost claims, provider acceptance, etc.

Requirements:

1.) Claim Data – ANSI 837 or Flat File

2.) Census

2.) 3 Largest Claims Paid (UB, IB, EOB)

Thank You!

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