

**The Professional Provider-Health Plan Work Group
Subcommittee to the Health Insurance Advisory Council
Progress Report
June 1, 2008**

The Healthcare Reform Act of 2004 § 42-14.5-3 (d) required the creation of a subcommittee to the Health Care Advisory Council known as the Professional Provider-Health Plan Workgroup (“Workgroup”) to address specifically identified areas for administrative improvement.

This subcommittee has been charged with developing a plan to implement the following activities:

(vii) By December 1, 2007, a report to the legislature on the temporary credentialing of providers seeking to participate in the plan's network and the impact of said activity on health plan accreditation;

(viii) By February 1, 2008, a report to the legislature on the feasibility of occasional contract renegotiations between plans and the providers in their networks.

(ix) By May 1, 2008, a report to the legislature reviewing impact of silent PPOs on physician practices.

The Professional Provider Health Plan Workgroup is comprised of professional provider representatives, billing agents, physician group leaders and the three major Rhode Island Health Plans: UnitedHealthcare of New England, Blue Cross and Blue Shield of Rhode Island and Neighborhood Health Plan of Rhode Island. The members for this initiative are: Steve DeToy- Rhode Island Medical Society; Christopher Dooley- Women & Infants PHO; Lorraine Roberts- Lighthouse MD; Paul Carey-RI Urological Specialties; Joel Kaufman M.D.- Lifespan/Physicians PSO; Charlene Denton-Lifespan PSO. Health Plan representatives are Robert Cambio- BCBS; Beverly Jane Perry- UnitedHealthcare of New England; Maureen Brousseau- Neighborhood Health Plan of Rhode Island.

In March 2006 and March 2007 the OHIC presented a progress reports detailing the workgroups efforts on prior activities. This report summarizes the remaining activities defined above. A copy of the Workgroup’s Charter is attached, as are the final reports for each of the items identified.

(vii) Temporary Credentialing

The concern behind this legislation is the timeframe between when the provider submits his/her application to a health plan and when they are approved and made effective as part of the network and are paid at an in-network rate. [B1] The group explored the possibility of reducing that time by allowing plans to temporarily credential providers.

The health plans are, in limited cases, able to temporarily or provisionally credential providers under both NCQA standards and CMS guidelines. However, the three local health plans do not currently allow for temporary or provisional credentialing of providers due primarily to the administrative burden.[B2]

(viii) Occasional Contract Negotiations

The Workgroup discussed the current managed care contract negotiation process and the general dissatisfaction the provider community has with the ability to negotiate with health plans. Providers, especially individual practitioners, believe they do not have the “leverage” that the larger provider groups have when dealing with the local payers.

The health plans have to have some uniformity in the network for ease of administration and those operational changes need to be uniform.

The Workgroup concurred with the recommendation that the Office of the Health Insurance Commissioner or the Department of Health Office of Managed Care Regulation establish more specific regulations with which to measure the impact of proposed contract modifications prior to implementation. These regulations would include guidelines to monitor the impact of the modification on patient safety, the administrative burden to the practice and impact of change on health care system as a whole.

(ix) Impact of Silent PPOs

In silent PPO arrangements, access to providers contracted rates are “rented” or “leased” to payers who are not party to the original contract. This is very confusing to the physician’s office, as they often do not know that these contracted rates are being applied until after the claim has been processed.

The health plan networks selling their contracted provider rates are primarily located outside the state of Rhode Island. Some of the companies that sell or rent their networks have contracted discounted fee for service arrangements with the providers and the providers generally find this reimbursement acceptable.

The Rhode Island Medical Society agreed to look into statutes passed in other states on this issue and will evaluate introducing legislation in Rhode Island as appropriate.

CONCLUSION

The Professional Provider Health Plan workgroup has completed the tasks as outlined in the Lewiss Gallo statute. It has proven to be a promising forum to address some problematic administrative interactions between professional providers and health plans. The group is interested in continuing to meet to identify and address provider issues.

Health Insurance Advisory Council Subcommittee
Professional Provider-Health Plan Work Group
Charter
October 2007 Revised

Purpose Statement

The Professional Provider-Health plan Work Group a subcommittee of the Health Insurance Advisory Council, exists to develop a plan to implement the specific activities as outlined in 42-14.5-3.

Statutory expectations:

(i) By January 1, 2006, a method whereby health plans shall disclose to contracted providers the fee schedules used to provide payment to those providers for services rendered to covered patients;

(ii) By April 1, 2006, a standardized provider application and credentials verification process, for the purpose of verifying professional qualifications of participating health care providers;

(iii) By September 1, 2006, a uniform health plan claim form to be utilized by participating providers;

(iv) By March 15, 2007 a report to the legislature on proposed methods for health maintenance organizations, non-profit hospital or medical service corporations to make facility specific data and other medical service-specific data available in reasonably consistent formats to patients regarding quality and costs. This information would help would help consumers make informed choices regarding the facilities and/or clinicians or physician practices at which to seek care. Among the items considered would be the unique health services and other public goods provided by facilities and/or clinician or physician practices in establishing the most appropriate cost comparisons.

(v) By December 1, 2006, contractual disclosure to participating providers of the mechanisms for resolving health plan/provider disputes; and

(vi) By February 1, 2007, a uniform process for confirming in real time patient insurance enrollment status, benefits coverage, including co-pays and deductibles. (vii) By December 1, 2007, a report to the legislature on the temporary credentialing of providers seeking to participate in the plan's network and the impact of said activity on health plan accreditation;

(viii) By February 1, 2008, a report to the legislature on the feasibility of occasional contract renegotiations between plans and the providers in their networks.

(ix) By May 1, 2008, a report to the legislature reviewing impact of silent PPOs on physician practices.

A report on the work of the subcommittee shall be submitted by the health insurance commissioner to the joint legislative committee on healthcare oversight on March 1, 2006 and March 1, 2007 and March 2008.

Membership

Health care providers, billing office managers, and Rhode Island licensed health plans. Advisory Council members may recommend Workgroup participants based on their background and expertise. Final decisions are made by the Office of the HIC, with the goal of having knowledgeable, committed members representing a cross section of interested parties committed to the group's success. Membership may vary when subject matter expertise is required based on statutory deliverables.

Leadership

The Work Group shall be staffed and chaired by the Provider Liaison of the Health Insurance Commissioners office.

Conduct of meetings

- All meetings will be open to the public.
- Meetings will be conducted in open, participatory style, inclusive of all members.
- Meetings will be held as needed to obtain consensus and develop recommendations within the specified timeframes.
- Minutes will be taken and posted.

Agenda and Deliverables

The agenda for its work will be based on deliverables. The primary deliverable will consist of a recommended plan for meeting each of the statutory objectives within the timeframes outlined above. Such recommendation shall include specific criteria, timetable and mechanisms for ensuring health plan and provider compliance. Recommended plans shall be submitted to the Health Insurance Commissioner and full Health Insurance Advisory Council for review and comment. The Workgroup will also monitor implementation of the plan(s). Disputes or areas where no consensus can be reached will be adjudicated by the Health Insurance Commissioner.

Expectations of Members

Attend meetings on time
Provide best input to help group meet common goal
Do work in between meetings, to include seeking input and building consensus.
Bring disputes or concerns to attention of chair and other members.

OFFICE OF THE HEALTH INSURANCE COMMISSIONER
PROFESSIONAL PROVIDER HEALTH PLAN WORKGROUP
TEMPORARY CREDENTIALING
DECEMBER 1, 2007

Statutory expectations §42-14.5-3

“To establish and provide guidance and assistance to a subcommittee (“The Professional Provider-Health Plan Work Group”) of the advisory council created pursuant to subsection (c) above, composed of health care providers and Rhode Island licensed Health Plans. This subcommittee shall develop a plan to implement the following activities:

(vii) By December 1, 2007, a report to the legislature on the temporary credentialing of providers seeking to participate in the plan's network and the impact of said activity on health plan accreditation;

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A report on the work of the subcommittee shall be submitted by the health insurance commissioner to the joint legislative committee on health care oversight on March 1, 2006 and, March 1, 2007, and March 1, 2008.

Overview

The Professional Provider Health Plan Workgroup composition for this task included: Chris Dooley- W&I and Kent PHOs, Paul Carey- RI Urological, Lorraine Roberts-Lighthouse Medical Billing, Charlene Denton-Lifespan/PSO, Steve DeToy-RIMS, Fernanda da Costa-DOH, Donna Valletta- DOH, Robert Cambio-BCBSRI, Holly Vota-BCBSRI, BJ Perry- UHC, Danielle Denis-NHPRI, Maureen Brousseau-NHPRI.

The Workgroup met in September 2007 to discuss the intent of the statute language that was added to the workgroup responsibility in the 2007 legislative session.

The concern behind this legislation, as identified by Steve Detoy of the Rhode Island Medical Society, is the timeframe between when the provider submits his/her application to a health plan and when they are approved and made effective as part of the network and are paid at an in-network rate. [B3]The provider community is frustrated that they are not able to see the health plans’ patients during the time when their application is being reviewed. If they do see patients during this time, they are paid at a non-network rate, which could mean no payment for some insurance products.[B4] This group explored the

possibility of further reducing that time by allowing plans to temporarily credential providers.

“Temporary” or “provisional” credentialing is a mechanism whereby providers’ health plan applications can be “approved” in advance of full credentialing committee approval in order to allow them to treat patients at an earlier date. National Committee on Quality Assurance (NCQA) and Medicare allow for “provisional” credentialing for select situations only. The group discussed the implications of “temporary” or “provisional” credentialing on health plans’ accreditation and operations.

It is of note that there is companion legislation also passed in the 2007 session that requires health plans to reimburse the health care provider for covered services rendered to a member the first day following the credentialing committees approval (See 27-20.9-2).

Discussion

The group discussed the concept of temporary credentialing within the National Committee on Quality Assurance (NCQA) standards. NCQA is a certifying body for health plans. NCQA only allows for “provisional” credentialing for providers who are applying to the network for the first time. They allow that the plan may make physicians available prior to the completion of the initial credentialing process as long as the following elements are satisfied;

- Primary-source verification of a current, valid license to practice (*CR 3, Element A*)
- Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query (*CR 3, Element B, factor 4*)
- A current and signed application with attestation (*CR 4, Element A, factors 1-6*)

In this case, only a subset of the full application is verified and approved by the Plan Medical Director prior to the application being full verified and reviewed by the health plan credentialing committee. The provider then may become effective on the date of the Medical Directors approval. NCQA limits provisional status to a 60- day period, during which time the providers’ complete application must be fully reviewed and approved by the Plan credentials committee.

The Centers for Medicare and Medicaid (CMS) has a similar policy whereby newly trained providers may begin to provide care at an earlier date. CMS also limits their “provisional” credentialing. Only newly trained providers who have completed their training within the last 12 months may be permitted up to 60 days of provisional status. Just as with NCQA, the complete application must be reviewed and approved within the 60 day period. Provisional status is not permitted for providers who completed their training earlier than the last 12 months.

All plans reported that although they are permitted from an accreditation standpoint to do so, they do not currently allow for provisional or temporary credentialing for several reasons.[B5]

- 1) Is only applicable to newly trained providers or those not providers previously credentialed by the plan.
- 2) It adds administrative burden since the process for approving the provider temporarily requires collection and verification of certain data elements and a review by a Medical Director, which is addition to completing the full credentialing and approval process for the provider.
- 3) Most applications are processed in under 60 days, so the window of time between temporary approval and complete approval is minimal.
- 4) Providers in group practices may arrange for claims to be submitted under a participating supervisory arrangement for the few weeks it takes to be credentialed.
- 5) Although NCQA and CMS allow for temporary credentialing for the products they review/oversee, the plans do not see the business case to allow for temporary credentialing across all products. Having multiple effective dates for different lines of business would be confusing.

The three local plans reported the following application turnaround times.

Neighborhood Health Plan of Rhode Island
98.5% in 60 days

United Healthcare
Average national turnaround is 34 days; UHC is unable to provide Rhode Island specific turnaround time reports

BCBSRI
89% completed in less than 30 days
97% completed in less than 45 days

Conclusion

In answer to the statutory question, the health plans are, in limited cases, able to temporarily or provisionally credential providers under both NCQA standards and CMS guidelines. However, the three local health plans do not currently allow for temporary or provisional credentialing of providers due primarily to the administrative burden.[B6]

It was discussed that most providers in group practices are able to address the payment issue by submitting claims under a participating supervising physician arrangement (incident to billing) during the credentialing timeframe.

It was agreed that it is important for the health plans to turnaround provider applications as quickly as possible in order to limit the time the providers claims are processed as non-participating. The group identified that the provider community needs better education on how to accurately complete, update and maintain the mandated Council for Affordable Quality Health Care (CAQH) application. A subgroup will be meeting on how to best assist the providers in this regard.

OFFICE OF THE HEALTH INSURANCE COMMISSIONER
PROFESSIONAL PROVIDER HEALTH PLAN WORKGROUP
Occasional Contract renegotiations and Impact of Silent PPOs
June 2008

Statutory expectations §42-14.5-3

“To establish and provide guidance and assistance to a subcommittee (“The Professional Provider-Health Plan Work Group”) of the advisory council created pursuant to subsection (c) above, composed of health care providers and Rhode Island licensed Health Plans. This subcommittee shall develop a plan to implement the following activities:

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Overview

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The Workgroup met in April 2008 to discuss the final two items identified in the statute; the ability of providers to renegotiate and the impact of silent PPOs on physician practices in Rhode Island.

Discussion-Contract renegotiations

The Workgroup discussed the current managed care contract negotiation process and the general dissatisfaction the provider community has with the ability to negotiate with health plans. Providers, especially individual practitioners, believe they do not have the “leverage” that the larger provider groups have when dealing with the local payers.

Providers do not like being in what they feel is a “take it or leave it” contracting position. The provider’s concerns regarding their contracts go beyond their inability to negotiate fees. The physicians want to discuss in advance the plans’ administrative changes like increased utilization review requirements, specialty pharmacy rules and high deductible plans. These administrative changes have significant impact on provider’s offices that they believe is overlooked by the plans.

The health plans explained that they have to have some uniformity in the network for ease of administration and that these operational changes need to be uniform. BJ Perry and Bob Cambio representing the plans indicated that their provider contracts do allow for a provider to express their desire to re-negotiate the provider contract at any time. The contracts also allow for the plans to make administrative changes with notice.

The ability of providers to negotiate with health plans has been a topic that this office recently addressed as part of the mandated Special Legislative Commission to develop recommendations for strengthening the role of the state's primary care physicians. This Commission also considered enacting legislation to empower primary care providers to jointly negotiate with health insurers. The OHIC chaired this special commission last fall and delivered its findings to the legislature earlier this year. This Workgroup discussed the Commission’s report.

Conclusions and Findings

The Workgroup understands that despite the provider’s frustrations, individual contract rate negotiations are up to the discretion of the health plans. Additionally, they understand that antitrust laws prohibit the ability of providers to join together to negotiate with health plans.

However, the Workgroup concurred with the recommendation of the Special Commission that it may be appropriate to have more input from the provider community prior to implementation of material contract modifications or significant administrative changes to the network. Ideally, the physician community wants meaningful bilateral dialogue with the health plans prior to implementation of any material contract change.

The Workgroup concurred with the recommendation that the Office of the Health Insurance Commissioner or the Department of Health Office of Managed Care Regulation establish more specific regulations with which to measure the impact of proposed contract modifications prior to implementation. These regulations would include guidelines to monitor the impact of the modification on patient safety, the administrative burden to the practice and impact of change on health care system as a whole.

Discussion – Silent PPOs

The Workgroup also addressed the impact of Silent PPOs on the physician's practices. Physicians agree to participate in a health plans network and accept that health plans members at the fees in their contracts. In silent PPO arrangements, access to these contracted rates are "rented" or "leased" to payers who are not party to the original contract. This is very confusing to the physician's office as they often do not know that these contracted rates are being applied until after the claim has been processed and it is indicated on the explanation of benefits. There is often no indication on the patient's ID card that they are members of the network.

Ideally providers need to know to whom these contracted rates apply in advance. They need more clear communication from the contracted plans if they are marketing their networks to others. The providers often are put in a position of agreeing to payment policies of these contracted entities and of which they have no prior knowledge.

Conclusions and Findings

Silent PPOs are problematic to the provider community. These arrangements are an administrative burden the provider's offices. The patients are not properly identified at the time of service. The explanation of benefits indicates that the discount has been taken. The payment and utilization rules vary and the provider has no direct contract with this entity and has little or no recourse.

It was stated that the health plan networks selling their contracted provider rates are primarily located outside the state of Rhode Island. Some of the companies that sell or rent their networks have contracted discounted fee for service arrangements with the providers and the providers generally find this reimbursement acceptable.

Steve Deto of the Rhode Island Medical Society will look into statutes passed in other states on this issue and will evaluate introducing legislation in Rhode Island as appropriate.

[B1]The key word here is “effective” BCBSRI process is that the provider is effective the date following approval by the credentialing committee. As you will see below – for BCBSRI – that means 90% of our providers are effective in less than 30 days for submission of their complete application.

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[B4]Pat – BCBSRI does not reimburse out of network providers directly as a general rule. Payment is made to the member at the out of network rate which you accurately state is sometimes, no payment.

[B5]This is not entirely true. Although we (BCBSRI) would prefer not to expand our existing process of offering provisional status for non BlueCHIP, we do currently have a process in place for Provisionals

[B6]BCBSRI does