



National Provider Identifier (NPI)

One of the provisions of the 1996 HIPAA law that actually may benefit health care providers is finally coming close to reality. This is the creation of a single identifying number for a provider that must be used by all payers. Not particularly creatively, this is called the "National Provider Identifier" or NPI.

NPI's, once assigned, remain the identifier for a provider whether they change practice locations, employers or locations.

You may get your NPI now but you must do so by the end of May 2007. CMS recommends that NPI's be obtained early to give plenty of time for both the paperwork and the effort required to include the new NPI in your claim system and get it recognized by your clearinghouse, payers, vendors and other providers.

Health care providers who participate in a group practice, or are organizational providers, should coordinate with their organization to determine the appropriate time for NPI application.

Health care providers can apply for an NPI by filling out a paper NPI Application/Update form and mailing it to the processing company or by using the web-based process available at <https://nppes.cms.hhs.gov>. We have used this process and found it very straightforward.

Discount Cards Make a Reappearance

Recently, it has come to our attention that a new generation of discount cards has surfaced in some physician offices. We are aware of discount cards affiliated with Private Health Care Systems (PHCS). PHCS seems to have numerous arrangements with medical discount programs that have an agreement with Careington International, a Third Party Administrator (TPA), who arranges for access to PHCS' network.

The medical discount programs are not health insurance, but are marketed as 'membership associations' or 'affordable alternatives' to health insurance. Members pay an initial fee and then make set monthly payments depending on the plan they purchase. Through these discount arrangements, members receive PHCS' contracted rates.

Additionally, members must pay the contracted rate at the time of service or no discount applies. If providers know the contracted rate, they can collect the fees at the time of services or they have the alternative to bill 70% of charges, resubmit the bill to Careington for repricing, and then subsequently bill the patient the difference between the 70% and the contracted rate.

The cards that we have seen all have PHCS stickers, but are under such names as Prudent Choice Affordable Healthcare Solutions, Consumer Health Benefits Association, Heartland Alliance of America, and First Access Quick Pay Program. HPN providers can opt-out of these arrangements. We are looking for feedback from HPN providers as to whether or not these types of arrangements are acceptable. Please contact us if you have any questions or comments regarding discount cards.

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Payor Updates

Humana ChoiceCare Medicare Advantage PPO: Existing Payor, New Product

The Humana ChoiceCare Medicare Advantage PPO (MA) product has successfully met HPN's minimum participation thresholds. Humana's MA product will be added as an Amendment to the existing HPN:Humana ChoiceCare PPO contract which became effective in 2004. A provider is not required to participate in both the PPO product and the Medicare Advantage PPO product, but can opt to participate in just one or both products. The HPN:Humana ChoiceCare Medicare Advantage PPO amendment will become effective July 15, 2006.

Humana has partnered with Wal-Mart, Sam's Club, and State Farm to maintain high visibility to Medicare enrollees. Humana has been very responsive to HPN's messengered requests and is very anxious to begin this new relationship. We anticipate a surge in the number of MA enrollees in West Virginia as Humana continues to build its network.

Human follows Medicare preauthorization policies and procedures, therefore, bariatric surgery may be the only service requiring preauthorization. A copy of the agreement and provider reference guide is available upon request.

Humana's Private Fee For Service (PFFS) Product: No Contract Required

Humana's Medicare Advantage PPO product is not to be confused with Humana's Private Fee For Service (PFFS) product that is also being marketed in West Virginia under the name Humana *Gold Choice*. The PFFS product does not require a contract and is not part of this amendment. A provider is deemed a participating PFFS provider if:

- A provider has knowledge that a patient is enrolled as a Member in a PFFS product.
- A provider has a reasonable opportunity to obtain the terms and conditions for participation, and A provider renders care to a PFFS member.

Humana Gold Choice members have already been seen by some HPN providers. Please pay close attention to the member identification cards as they are very similar for both the Medicare Advantage PPO and PFFS products. As always, if you have any questions, please give us a call.

Carelink

Carelink, First Health and CCN are all part of the Coventry group. HPN now has separate provider agreements with each of these three, a situation that we generally try to avoid. We are pleased to report that Coventry's decision to give their locally-based subsidiary, Carelink, lead responsibility for provider network issues with other Coventry units has allowed HPN to begin to make progress in resolving this situation.

Carelink and HPN have agreed to begin work on a replacement agreement that will replace the three existing HPN agreements. This will probably not be completed until late this year or early next, but at least gives us a path. In the meantime, HPN is working with Carelink/Coventry to make certain that the First Health and CCN provider network information matches what is shown in HPN's records. This was done, we thought, as recently as mid last year, but some recent First Health claims problems have made it clear that the reconciliation process needs to be redone.

Please give us a call if you have issues with Carelink, First Health or CCN.

Medicare

Medicare Isn't Just "Medicare" Anymore

Some provider offices are experiencing difficulty distinguishing between the various Medicare plans, and it is even more confusing for the Medicare enrollee. In many cases it is unclear to the enrollee as to which Medicare plan they have selected.

One suggestion is that you routinely ask your "Medicare" patients something like – "Have you decided to participate in Medicare with one of the commercial insurers?" This is to draw out that they MAY have made a change.

A related suggestion is to begin asking "Medicare" patients to give you a copy of their latest Medicare insurance eligibility card. Some offices do this routinely, and this sounds like a commercial patient process, but Medicare now has so many options that verification of eligibility should be standard office policy at each visit for all Medicare enrollees.

Copays are another area of sensitivity. You will definitely want to collect your copay at time of service from any patient in a Medicare managed care plan.

Please let your patients know which, if any, Medicare managed care plans you participate in. You may want to consider posting them together.

The CMS website offers plan information related to our area. A payer offering Medicare Advantage may offer several plan variations. The CMS website shows the following: Humana/ChoiceCare offers 2, Mountain State Blue Cross offers 4, The Health Plan offers 2, and Carelink Advantage offers 1. Make sure your employees all know which plans you cur-

HPN Dues

You may have received your dues billing for the last half of 2006. We thought this would be a good time to review HPN's basic dues policies.

HPN's annual dues are \$600 for a primary care physician and \$800 for a specialist. HPN has long followed a policy of charging a lower dues level in geographic areas where HPN is new or our provider agreements may not have as much volume as in some other areas. The dues levels are 25%, 50%, 75% and 100% of the standard dues. HPN's Board reconsiders every six months the dues level for geographic areas that are not at the full standard dues level.

Physician dues are matched by participating HPN hospitals. Where a physician practices at two or more hospitals, HPN charges a portion of the hospital-match dues to each hospital at which the physician is active.

Dues are billed in six month increments and West Virginia sales tax is charged on a portion of HPN's dues. HPN's dues are owed when billed, and we have to follow Board-set rules where providers do not pay their dues on a timely basis.

HPN's dues are set to cover its expenses and produce a very very small targeted net income. Where HPN's financial results are better than expected, as in 2004 and 2005, the Board may declare a partial dues rebate that is credited to providers that were HPN members in the year with the favorable results, but the rebate is credited on their first dues for the next calendar year.

HPN does not currently charge dues for physician assistants, nurse practitioners, nurse midwives or nurse anesthetists. This policy is reviewed periodically.

HPN works hard to keep its dues level as low as possible and believes its dues are lower than those of other networks in this region.

Please let us know if you have any questions about your dues billing.

So – What is a CVO?

Health Partners Network has begun the process of converting its "credentialing" function from one that makes privileges decisions to one that operates as a Credentialing Verification Organization, or CVO. HPN is hopeful that this change will have little impact on both how HPN interacts with you to maintain current credentials information on file and with payers. The payer reactions to this change are not yet known as HPN is just beginning discussions with them.

Why the change? All of HPN's agreements with delegated credentialing authority leave the payer with the right to accept or reject HPN's credentialing decisions. Although HPN's credentials decisions have not been challenged often, this means that HPN accepts the legal responsibility for credentialing decisions but does not have the authority to make its credentialing decisions "stick" with payers. The payers who maintain accreditation from either URAC or NCQA actually must retain the final credentialing decision authority. What has been disappointing to HPN is that some payers have not honored the credentials effective dates of HPN's credentialing decisions. In practical terms, this costs time in getting providers registered with payers, and this time costs providers money.

Much of what HPN does now with you and payers is expected to continue with HPN operating as a CVO. HPN will continue to maintain a credentials information data base, work with you to keep it current, and provide payers requested information from that data base as needed by them for either initial credentialing or recredentialing. HPN's database already maintains all information required for the West Virginia standard application and all HPN-payer supplements/attestation pages. HPN has also been scanning and storing images of some of the related support material, such as DEA and State licenses. We are completing a conversion to a more powerful version of this software package that should make it easier for us to give payers whatever they need, ranging from the full State app and all related material to something like the summary we now provide.

HPN has also begun the process of accreditation as a CVO. HPN has given an initial application to URAC, a national accreditation agency, and is hopeful that the full review process by URAC can be completed later this year.

One change that HPN will probably have to make is to bring forward the process of getting updated information so that it can be provided to the payers with which you participate in time to allow the payer credentialing decision process to operate. HPN has been VERY flexible with some providers that have been slow in getting update information to us and we will not be able to be quite as flexible operating as a CVO.

We will give you updates as we work through details with specific payers. In the mean time, please give us a call if you have any questions.

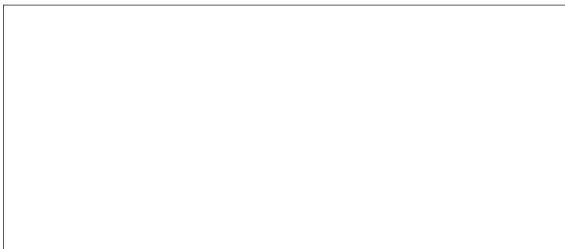


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Making Managed Care Work

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hpns.net*



Health Plan/IPN

Health Plan – Elkins and Parkersburg Areas

Health Plan has advised HPN that they will begin approaching Elkins and Parkersburg area providers sometime after July 1st about shifting from HPN's current agreement to "direct" provider agreements. This change is related to the termination of the Integrated Provider Network (IPN) and Health Plan risk agreement that ends July 1st.

HPN has NOT been told what terms Health Plan will offer providers under direct provider agreements. Health Plan also has not made clear whether conversion to direct provider agreements will be optional or they will force this issue by terminating the HPN subcontract with IPN that is being assigned to Health Plan effective July 1st as part of the IPN:Health Plan risk agreement termination.

HPN wishes that Health Plan was not converting to direct provider agreements but will cooperate with Health Plan's decision. Please keep in mind that HPN staff are not permitted to advise you about any aspect of Health Plan's direct provider agreements.

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