Provider News

March 1, 2006

When Is A PPO NOT A PPO?

A few years ago, most of us had pretty clear ideas of what an HMO was … and a PPO. Those categories are a lot less clear today. This will discuss some of the changes and suggest issues you will want to consider in deciding what managed care organizations you work with, and what you expect of them.

HMO's used to be special types of insurance companies that viewed primary care physicians as "care managers" or "gatekeepers". Over time, some insurance companies also offered "gatekeeper" based insurance products, complicating this a bit. In general, both HMOs and insurance companies have found that most employers, or more accurately most employees and dependents, don't really want to work with a gatekeeper, and most primary care physicians also found the role a bit uncomfortable. What this has led to is more "open access" products in which an insured either does not select a principal primary care physician at all, or has one "for the record" but does not need to get approvals for referrals to specialists and may even go to other primary care physicians. These are sometimes called "point of service" plans, but some are just called "preferred provider organizations", our old friend the PPO.

PPOs started from the other end. They were initially developed as networks of healthcare providers that agreed to physician fees or hospital discounts for which the quid pro quo was an expectation that they would be in a preferred position for referrals. These started off as arrangements in which the benefit plan arranged by the employer always included a "benefit preference" for use of preferred providers. The simplest form of this is still around today, one copay or deductible or coinsurance level for care from preferred providers, and a higher copay or deductible or coinsurance level for care from providers that are not in the PPO's provider panel.

Some PPOs stuck with the original business idea, but then "went wrong" (provider perspective) by including every physician and every hospital. Where a network consists of all providers, additional referrals can not be expected, the provider interest in participation almost becomes negative – "I will lose referrals I now get if I don't participate". Other PPOs went wrong by operating as what are called "silent PPOs". Silent PPOs do not necessarily REQUIRE that the benefit plans using their provider panel include a benefit preference in favor of participating providers. The worst of them don't even show their network identification (or logo) on the eligibility cards and just serve as computer-to-computer shopping places for payers to search for discounts.

What all this means is that HMOs and insurance companies now market PPO-based products, and there are also PPOs in the managed care world that want you to be a participating provider. These two "PPO" types have some very important differences to you as a provider. One distinction you may find useful is that an insurer or HMO offering "their own" PPO controls their own behavior and has a fairly direct degree of control over subcontractors such as behavioral services carve out networks. Independent PPOs, more commonly called "rental" PPOs, exercise limited control over the insurance products to which their providers are committed and even less over the ultimate payer's subcontract arrangements. Said more directly, if you are mad at an insurance company, you are talking to someone that CAN usually fix what you are complaining about. If you are mad at a payer using a rental PPO, however, the PPO can almost never fix the problem directly. The PPO has to take your problem to the ultimate payer, the PPOs client, and ask the problem be addressed. Some rental PPOs do this better than others, but rental PPOs are always intermediaries, not principals. You may want to keep distinctions like this in mind in considering the financial terms you accept from a managed care organization.

We will look at some other differences in later articles.

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Payor Updates

SelectNet:United HealthCare

United HealthCare's use of SelectNet for much of United's non-MAMSI business in this area was ended as of February 1, 2006. United's "new" physician panel is composed, as we understand it, of a number of physicians who have signed new United HealthCare participating physician agreements, some who have negotiated amendments to their MAMSI agreements, and some that are being continued as participating providers under letters of agreement, apparently designed as bridge devices while United and the physicians complete negotiation of a new United HealthCare agreement. If you have questions about your standing with United HealthCare please check directly with them, neither MAMSI nor United are Health Partners Network payer relationships. United's Morgantown office telephone number is 304-285-3772.

Certain specific employer groups served by United HealthCare are continuing to use SelectNet. The two groups of which we are aware are Wells Fargo and GE Plastics. Wells Fargo is the parent company of Acordia, itself the owner of SelectNet. It is also our understanding that two additional employer groups in the Ohio area, Cytec and Energizer, will continue to use SelectNet. Please handle this business as you would any other SelectNet business.

Coventry:Carelink:Southern Health:First Health

Coventry, Carelink's parent corporation, has decided to consolidate Carelink's executive, finance, and utilization management responsibilities with the Southern Health management team in Virginia. Carelink will continue to have its own provider contracting, provider relations, and marketing staff based in West Virginia at their current addresses.

Coventry has also confirmed that the "Carelink" provider contracting staff will also handle provider contracting matters for First Health and CCN, both national PPOs owned by Coventry. HPN currently has agreements with Carelink, First Health and CCN and has begun discussions with Carelink's provider contracting staff on how best to transition to either two agreements, one for Carelink and one for Coventry's national PPO business, or a single agreement.

A copy of Coventry's announcement and Q&A material is included as an insert to this Newsletter.

Upcoming HPN Meetings

In addition to our standard governance sessions, HPN will be conducting "all interested physician" meetings in a variety of locations this spring. Information concerning the Health Plan transition as well as contracting updates and review of government programs activity such as Medicare Managed Care, Workers Comp, etc. will be reviewed and discussed. Please plan on joining us for the session in your area.

All Interested Physicians

March 17
Parkersburg
11:30 -12:30 (Lunch Provided)
CCMH Auditoriums 1,2,&3
Practice Managers Invited

Davis Memorial Medical Staff

March 21
Elkins
6:00 - 7:30 pm
Davis Inn

HPN Update

HPN Fee Analyses and Opt In Material

HPN has long used a Fee Analyzer model to evaluate payer physician fee offers and create objective and consistent measures of the "average $/RVU" as part of our opt in material. We update the Fee Analyzer every year with new RVUs, any payer fee changes, and new frequency of services information. For 2006 we have made several other changes that should make our opt in material easier to read and give you additional information that may be helpful in considering payer offers. The major changes are 1) addition of selected immunization codes and 2) use of both facility and nonfacility fees, for services with site of service fee differences.

We have reevaluated all of our active payer fee schedules with the new Fee Analyzer and will be sending you an updated version for your records. This would be an excellent opportunity for you to make certain that you are comfortable with your "opt in" decisions. As a messenger model network, HPN must forward payer offers whether or not we suspect that fee levels being offered will be acceptable to most area physicians. In some cases, a payer may not have modified their fees but, as RVUs change over time, their fees look either better or worse, relative to those of other similar payers, than they did several years ago. You should periodically review the fee offers of HPN payers to assure yourself that you are comfortable continuing to participate in those you do, and comfortable continuing to not participate in those you elected to reject.

Don't ever hesitate to give HPN staff a call to get additional fee information beyond that available in the opt in material. We have full electronic fee schedules for all of our payer relationships. Many of you already use the Fee Engine that carries most CPTs and was designed to make it easier to determine whether or not you are being paid properly.

HPN Dues

The HPN dues process is again in full swing for the period January through June 2006. HPN was pleased to be able to both leave the base levels of HPN dues unchanged for another period as well as to refund a portion of your 2005 dues amount through a credit on this billing period.

As a reminder, HPN is funded 100% from the participation dues of our members.

HPN Participation Summaries

HPN has begun distributing summaries of your HPN participation status. The summaries include a list of contracts you currently participate in through HPN, a list of providers affiliated with your tax ID, and a variety of administrative measures reflecting our records of your practice.

Please take a few moments to review, update and return this summary to HPN. We want to make certain your records and ours are in "synch". This helps make certain we are best able to represent you and your practice effectively and professionally with our payer organizations.

HPN 2006 Fee Engine

It is that time again. Shortly you will be receiving an updated HPN fee engine. This update will include the 2006 changes to the RBRVS values and their effects on our payor reimbursements. There have also been updates to the PEIA and Medicaid fee schedules as well as Medicare.

HPN Staff Changes

Brad Minton has decided to leave HPN and become a Health Plan employee. He will be based in Health Plan's Morgantown office and he will be directing Health Plan operations through this transition period including all provider relations, contracting and public relations in our service area. Brad was a part of the development process that brought Health Plan into this region and his involvement should assure a smooth transition.

HPN has appreciated Brad's contributions over the last eight years and we will miss him.

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Health Plan/IPN

Integrated Provider Network:Health Plan Transition

IPN and Health Plan have decided to end their almost 12 year old network and insurance risk sharing relationship. As a part of this transition, IPN will be assigning its various provider participation agreements to Health Plan as of the termination effective date, probably July 1, 2006. IPN will continue to serve its network management role until that date as well.

For providers that have direct agreements with IPN, your point of contact will shift from IPN to Health Plan, usually at their Morgantown office. For providers in the Elkins and Parkersburg areas that participate in Health Plan through Health Partners Network, your point of contact will continue to be HPN.

IPN's owners, West Virginia University Hospitals (WVUH) and University Health Associates (UHA), will continue as participating providers with Health Plan. They have also recently signed three year agreements under which their employee benefit plans will continue to be served by Health Plan's unit that handles self funded employers. Their decision to end IPN's network management and insurance risk sharing activities is not a reflection of their view of Health Plan as an insurer, but just an acknowledgement that serving as an insurer (through risk sharing) does not fit with their view of their core missions in the future.

IPN's owners and Health Plan look forward to a smooth transition that should be nearly transparent to their participating providers and will not affect the way or manner services are provided for Health Plan members including reimbursement levels, policies and procedures, etc.