



“WC Networks: What Options Do We Really Have?”

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Questions to Ask When Looking at a WC HCN

General Questions & Considerations

- What should you get with a WC network?
 - Better providers?
 - Avoidance of over-treating providers?
 - More control of medical services?
 - Better coordination with Utilization Management and Claims Management?
 - Improved return-to-work?
 - ...will you actually get that with the network?

- Are there **real** savings (net of access costs)?
 - What are the access costs?
 - What is the charge basis?
Examples:
 - % of savings (may not be the best alternative)
 - Per claim file
 - Per claim file + add on for multiple years
 - Per medical bill
 - Are the access costs predictable?
 - What are the *projected* hard savings? (*i.e.*, savings below TX fee schedule)
 - What should be the soft savings? And will you get them...
 - Less time off work
 - Improved return-to-work efforts, including light duty
 - Improved quality of care

- Fewer physical therapy visits
 - Reduced over utilization (treatment guidelines)
 - No unnecessary surgeries
- ...can you put a number to that savings? Any track record?

- Are the access costs reasonable?
 - What are your current medical costs running?
 - What are the projected savings (below fee schedules)/additional provider costs (provider fees above the TX fee schedule) with the network?
 - When checking savings, ask for:
 - For a Voluntary Discount network – The savings for that portion *below* the TX fee schedule as a percentage of bills that were reduced below the TX fee schedule
 - For both an HCN and Voluntary Discount Network – The savings for that portion *below* the TX fee schedule as a percentage of *ALL* bills at fee schedule (whether reduced or not) (this is important given that some will actually be above fee schedule)
 - For an HCN – The savings from reduced utilization and improved return to work as well as savings resulting from application of treatment guidelines
 - What is the network access fees as a percentage of total medical costs paid?
 - What is the network access fees as a percentage of savings?

Prospective Network Questions

- Do you plan to develop a network that will cover the entire State of Texas?
 - If is yes, please explain how you plan to handle rural Texas.
 - If no, please list the medical service regions where you plan to focus your network development efforts.
If this involves a staged development over time, please define the timeline for your network development and expansion.
 - Is any portion of your network leased or was it developed internally? If any portion is leased, who will be conducting the credentialing (delegated or internally)?
 - How do you plan to handle rural Texas? Are there any regions you do not plan to serve at all?
 - Please provide a map showing, by County, the medical service regions for the entire State of Texas that you plan to use in your network development efforts.
- Will you limit the number of providers in each area, or is your goal to have as broad of network at possible? Explain.
- Criteria for provider participation



- What was initial screening process?
 - Describe the factors you will use to choose your providers and rank them in order of preference. Provide a brief explanation of each of the factors.
- Did all or a portion of the network convert from a “voluntary” network focused on discounts or was it built from scratch? Explain.
- If all or a portion of the network converted from a “voluntary” network, have providers subsequently notified you of the desire to terminate the relationship? Please provide details.
- How many providers have cancelled or terminated contracts with the HCN over the past 12 months? Explain the reasons given for termination.
- For the entity:
 - Based on your experience with claims, are there providers in the network you especially want?
 - And more importantly, are there providers you don't want?
 - Need to work with your adjusters to find out who the *difficult* providers are in your area
 - Need to get the good guys in the network
 - Are they there?
 - At what fee schedule? (not just average, but actual fee amounts...some accept fee schedule for office visits, then upcharge for the high cost procedures...ask for the details)
- What is your target fee schedule for payments to providers?
 - Will you base your fee schedule on Medicare?
 - If yes, what percentage and how will the percentages vary by specialty?
 - If no, then please describe your proposed alternative and how it varies by specialty.
- What are the fee schedules for specific providers, specifically in your area? Proprietary? (Network should disclose...Who pays the bills?)
- Are the important facilities in the network? (Hospitals have not been eager to sign up)
- Please provide a specimen copy of the network agreement between the network and the carrier/payor that you propose to use.
- Please provide a specimen copy of the provider agreement between the network and the healthcare provider.
- Do you have online access to copies of actual provider contracts with specific providers for payors to review?
- Please describe how your network contract will address treatment plans as a component of managing the cost of claims.



- How will network deal with removal of providers?
- How does the coverage of the network match up with the entity's employee population? By county or portions there of...
- How will you deal with out-of-network providers
 - Where there is network coverage?
 - Where entity has employees with no HCN coverage?
 - Is there a voluntary discount network option? Describe how this works and where it fits into the process
- Who will handle and how will 2nd requests for changes in treating provider be handled?
- What about requests for referrals to specialists?
- Are there necessary specialists not included in network? How will you handle? (Ex: oral surgeons, anesthesiologists) Provide details on your access plan.
- Are there any specialty sub-network carve outs? Can there be? (Ex: dialysis, pain management)
- How will you deal with Required Medical Examinations (RME's) and Designated Doctors (DD's)?
 - Doctors must be out of HCN
- What service capacity do you plan to develop internally within your network? Please list all that apply:
 - Utilization review
 - Bill review and repricing
 - Case management
 - Others?
- Does the network require that other services are performed by affiliated companies?
 - Bill Review and repricing
 - Pre-Auths/UM
 - Large Case Management
 - Field Case Management
- Will you sell your network services on both a bundled and unbundled basis? If you will agree to unbundle your services, please describe your approach.
- Please describe your approach to preauthorization. Will your network contract maintain the list set forth in the statute/rule or will you modify the utilization review requirements as allowed by HB 7?
- A lengthy list of preauthorization may become a cost driver to users of a network. What steps did the network take to maximize the benefit between the use of



treatment guidelines and preauthorization without an unnecessary increase in preauthorization costs?

- If the entity currently contracts with a preferred vendor for preauthorization, medical bill review, and case management, will you honor that existing relationship?
- What sort of ongoing quality management will you be doing?
 - What are the Quality Measures for Providers?
 - How will you report the results of the quality management process to clients?
 - Will the report be provided to clients regularly, or is the information reported upon request?
 - Are Ad Hoc reports available? If so, is there a charge?
- What are the success metrics for the network performance? Truly measurable?
- How will feedback get to network providers based on services and outcomes
 - Complaints
 - Over utilization
 - UM feedback
 - Adjuster feedback
 - ...
- Please describe the HCN's dispute resolution process. Has the Network received any disputes to date? How is the resolution communicated to the parties?
- Please describe your approach to treatment guidelines.
 - Will you develop your own or use commercially available guidelines?
 - What do you recommend?
 - If you will use an existing set of Evidence-based Treatment Guidelines have been/will be adopted?
- Please describe your solution to provide access to a list of providers in the network
 - Online look-up—by provider—by area?
 - PDF Directories by area?
- Credentialing
 - How do you plan to address credentialing for the network?
 - Will you charge a fee to the providers for credentialing?
 - What level of credentialing?
 - How often recredentialed?
 - Will any portion of the credentialing be delegated?
 - Who will perform the required on-site visits to the selected providers?



- Systems
 - How do you propose to handle EDI?
 - With TDI/DWC?
 - With clearinghouses?
 - With providers?
 - Online lookup – by area, by specialty
 - Database of providers, fee schedules, contract details
MUST BE DATE SENSITIVE
 - Online management of contracts
 - Fee schedule uploads to bill review systems
 - Credentialing management
 - Provider recruitment management
- What payors/carriers are you working with in the network development process?
- Who are you partnering with for development of your network? Are you combining forces with other vendors in the industry?
- How will you be paid for your network services?
 - Will you retain a portion of the contracted fee schedule or will you charge a fixed amount per life/claim/bill etc.?
- How will you be paid for other related services (UM, Bill Review...)?
- Have there been any complaints filed with TDI regarding your network? What was the resolution of these complaints? Were the complaints justified?

