13 Network Structure and Management

Objectives

After completing this module, you will be able to:

- identify the main considerations in a market analysis for a health plan network;
- list the factors in deciding the number, types, and locations of providers in a network;
- describe the main steps of the provider recruitment and selection process;
- describe provider credentialing; and
- identify the most important provisions of the provider contract.

As you have previously learned, health plans arrange for the delivery of high-quality, cost-effective healthcare services to plan members. This is accomplished by the development and management of the plan’s provider network. Since the plan’s members interact with the organization primarily through its providers, the steps the plan takes to design, assemble, monitor, and maintain its network are critical to the success of the plan.

In this module we begin our discussion of network management by describing factors that influence network design. Next we address some standard considerations in network structure, such as size and composition. We then discuss some of the issues health plans address when selecting, credentialing, negotiating with, and contracting with providers. We finish the module with an overview of the activities that are necessary to maintain the network and cultivate provider satisfaction.

Market Analysis

To establish a provider network, a health plan must understand the characteristics of its proposed service area, the needs of its proposed members, and its proposed products and focus. A market analysis is the tool used by plans to gather and analyze information on characteristics of the market, providers, competitors, employers, service area, general population, and the health plan itself. Market analysis also includes an analysis of current economic conditions.

The Market

One purpose of analyzing the market is to understand the level of health plan activity in a market—referred to as market maturity. The level of maturity in the market often indicates how knowledgeable providers and consumers are about health plans, how receptive providers and consumers are likely to be to health plans, and how active competition is among health plans in the service area. Markets at different levels of maturity require different network management approaches and strategies. For example, in a market with little health plan activity, consumers and purchasers are likely to be
more receptive to loosely managed plans (such as PPOs) than to tightly managed plans (HMOs).

The Provider Community

The purpose of analyzing the provider community is to understand the types, numbers, and locations of healthcare providers in the proposed service area, as well as utilization patterns and healthcare costs. Providers include physicians, hospitals (the services they provide and the number of beds), and other practitioners and facilities. Analysis of the provider community also includes understanding the locations of the providers, including distances between provider locations and members’ homes and workplaces as well as any geographic barriers that may affect access.

It is critical for the health plan to also understand existing referral patterns and established provider relationships in the service area, as well as hospital admitting/procedural privileges. Many physicians have established relationships with particular healthcare professionals in their community. In some communities groups of physicians may be affiliated with one entity, such as a hospital, a physician group or organization, or a physician/hospital-type organization. Understanding the existing referral patterns and the relationships of the providers in the proposed service area allows the plan to utilize network approaches and techniques reflective of these relationships. For example, if many of the physicians in the service area are affiliated with a single entity, the plan will most likely need to contract with that entity, while if most physicians are not affiliated with a single entity, the plan has more contracting options.

The Competition

Analysis of the competition includes understanding and assessing other health plans in the market. This assessment should include the following types of information for each competitor plan in the proposed service area:

- competitor product types and premiums;
- competitor network characteristics, including provider numbers, types, and locations and physician-to-member ratios;
- cost-containment strategies used by competitors; and
- provider satisfaction with competitors.

Employers

Analysis of the employers in the area includes understanding the size of employers. Large employers (more than 1,000 employees) tend to adopt health plans more quickly and are more likely to offer a choice of health plans than small companies. Small companies (less than 100 employees) may have less experience with health plans and lack the financial and administrative resources necessary to offer multiple health plan options.
The Service Area

Analysis of the proposed service area includes understanding whether it is primarily rural, suburban, or urban.

- Rural communities typically have limited numbers and types of providers and facilities, including few hospitals. This makes it difficult for health plans to build a comprehensive network that satisfies member demand for a complete range of healthcare services. Also, in rural areas with few providers the health plan may have little or no choice about which facilities to include in its network.

- Urban areas (population greater than 500,000) have larger numbers of physicians and facilities. The characteristics of urban areas offer health plans more flexibility in provider contracting. However, with more providers there is also increased pressure on the plan to offer larger networks. This in turn can complicate the plan’s management of costs, quality, and satisfaction levels.

The Population

Analysis of the population includes understanding key demographic characteristics. Characteristics of the population in the proposed market often influence the mix of providers and facilities included in the network. Some important population characteristics are ages, income levels, ethnicities, and religions. For example, health plan networks that serve the elderly (Medicare) often need to include post-acute care facilities (rehabilitation centers and skilled nursing facilities) in their networks. Plans that serve populations with large ethnic, racial, or religious groups should have networks that accommodate diverse language, cultural, and medical needs.

The Health Plan

The characteristics of the health plan affect the requirements for its network. Some of the characteristics of a plan that affect network requirements are:

- products offered by the health plan (number and types),
- geographic scope and market focus,
- particular population, and
- plan type.

Health plans that offer more than one type of plan may choose to develop separate networks for each plan type. Another option is to coordinate provider networks through a system of interrelated networks, sometimes referred to as nested, customized, or sub-networks. Typically plans that offer only one type of health plan establish a single network designed around a unique set of goals and strategies.

Economic Conditions

Network design and management can be influenced by the level of growth or decline in an economy. A growing economy typically leads to increases in employment, population
growth, and eventually growth in the medical community such as more hospitals, physicians, and other providers. On the other hand, a declining economy would likely have the opposite effect.

**Regulatory Requirements and Accreditation Guidelines**

In addition to understanding the characteristics of the proposed market, a health plan must understand and comply with the wide range of federal and state laws and regulations. And if the plan is or plans to be accredited, it must meet the standards set by accrediting agencies that are applicable to its network.

**Laws and Regulations**

Laws and regulations affecting health plans will be discussed in more detail in a later module, but at this point it is important to understand that some are applicable to a plan’s provider network, including those that address issues such as network adequacy, patient access to healthcare services, quality of care, mandated benefits, and providers’ right to contract. In this section we will summarize some of these laws.

The HMO Act of 1973 requires federally qualified HMOs to provide:

- geographic accessibility to primary care and most specialty providers with “reasonable promptness” and “within generally accepted norms for meeting projected enrollment needs,”
- access to medically necessary emergency services 24 hours a day, seven days a week; and
- a detailed description of service areas and provider locations.

The Federal Employees Health Benefits (FEHB) program requires health plans serving federal employees and their dependents to provide:

- immediate access to emergency services,
- urgent appointments within 24 hours,
- routine appointments within one month, and
- average office waiting times of no more than 30 minutes.

The NAIC Managed Care Plan Network Adequacy Model Act, adopted in 1996, offers guidelines for states to use in measuring network adequacy. **Network adequacy** is the extent to which a network offers the appropriate types and numbers of providers in the appropriate geographic distribution according to the needs of the plan’s members. The Model Act includes standards for:

- provider-enrollee ratios,
- geographic accessibility,
- appointment waiting times,
- hours of operation, and
• volume of technical and specialty services available in the service area.

Under the Model Act health plans are required to file an access plan showing how specific standards will be met.

State any willing provider laws require health plans to allow any provider who is willing to accept the terms and conditions of the plan’s provider contract to participate in the plan’s network. A plan’s ability to include economic criteria (such as average cost per case or per member) as a term or condition of the contract depends on particular state laws. In some cases any willing provider laws apply to PPOs but not HMOs and similar plans.

State mandated benefit laws typically require health plans to:

• include in the plan’s benefit design specific benefits (such as chiropractics, hospice, home healthcare, and hospitalization for maternity care of a specified length);

• include in the network specified providers or provider classes (such as behavioral healthcare professionals); and

• grant direct access without referral by the primary care physician to specified provider classes (such as dermatologists, obstetricians/gynecologists, and pediatricians).

As of 2014, the Patient Protection and Affordable Care Act (PPACA) of 2010 (commonly known as healthcare reform) will require most health plans to cover a comprehensive set of healthcare services, including preventive and wellness care, prescription drugs, mental healthcare, emergency care and ambulance services, and others, as stipulated by the Secretary of Health and Human Services (HHS). The Secretary will also have the responsibility of developing regulations to ensure a sufficient choice of providers by plan members as well as network adequacy and access.

Guidelines of Accrediting Agencies

Standards established by independent accrediting organizations also influence network design and management. The National Committee for Quality Assurance (NCQA) and URAC are two of the best known accrediting agencies. You will learn more about health plan accreditation in a later module.

Network Structure, Composition, and Size

Structure

Health plans typically structure their networks in one of two ways, either as a closed panel or an open panel.

• In a closed panel plan, providers see only health plan members and generally operate out of health plan facilities and offices. Providers are either employed directly by the plan (staff model) or belong to a group of providers that hold contracts with the health plan (group model).
In an open panel plan, independent physicians or providers who meet the health plan’s standards of care may be eligible to contract with the plan. Providers see both plan members and nonmembers and typically serve members out of their own facilities and offices.

Whether a plan structures its network as a closed or open panel network depends on the structure and characteristics of the health plan.

**Composition**

As we learned previously, a health plan ensures that its members have convenient access to healthcare services. To provide good access, health plans must see that their network includes:

- the appropriate types of providers,
- the appropriate number of providers, and
- providers in the appropriate locations.

Regulations and standards require that networks be adequate. Guidelines have been established and are used to develop and maintain networks that are adequate in structure, composition, and size to meet the needs of plan members. The composition of a plan’s network is important to the health plan for many reasons, including marketing and product differentiation, member satisfaction and retention, and compliance with laws and standards specific to network adequacy.

**Types of Providers**

A health plan’s provider network typically includes a mix of the following types of providers:

- **Primary care providers (PCPs).** In most cases primary care providers are general practitioners, family practitioners, internists, or pediatricians. Some plans classify obstetricians/gynecologists (OB/GYNs) as primary care providers, while others consider them specialists. Some plans also include nurse practitioners (NPs) and physician assistants (PAs) in their primary care panels, but NPs and PAs typically work under the supervision of a physician, and their ability to provide services independently may be limited by state law.

- **Specialists.** A specialist is a healthcare professional whose practice is limited to a certain branch of medicine, based on specific services or procedures (such as anesthesia), specific body systems (neurology), certain types of diseases (oncology), or an age group (pediatrics or gerontology). Ideally, all specialty categories will be represented in a provider network.

- **Hospitalists.** A hospitalist is a physician who exclusively manages inpatient hospital care. Hospitalists may be employed by a hospital or be in a medical group. Hospitalists allow other physicians to focus on the outpatient care of their patients.
• **Healthcare facilities.** Health plans contract with a variety of facilities including hospitals, ambulatory surgery facilities, ambulatory diagnostic and treatment centers, retail health clinics, sub-acute care facilities, and skilled nursing facilities.

• **Ancillary service providers.** Ancillary services is an umbrella term for a variety of healthcare services that are an adjunct to primary, specialty, and facility-based care. Ancillary services include diagnostic services (such as laboratories and radiology), therapeutic services (including home healthcare), physical and occupational therapist, pharmacists, and durable medical equipment and supply companies.

**Number and Locations of Providers**

Factors such as health plan characteristics, provider access, population characteristics, purchaser and consumer preferences, and health plan goals influence network design. We will now review how these factors specifically influence the number and locations of healthcare practitioners, hospitals, and facilities needed by the health plan.

**Practitioners**

• **Plan characteristics.**
  
  o *Level of managed care.* In general, more highly managed plans (plans that practice more managed care techniques and concepts) need fewer providers than more loosely managed plans. For instance, an HMO, which is highly managed, requires fewer providers than does a PPO or POS product with the same number of members.

  o *Size of plan.* Large plans typically need fewer providers per 1,000 members than do small plans because large plans can benefit from economies of scale and other efficiencies. However, if the membership in a large plan is geographically widespread, the plan will likely need a broader panel to provide adequate access to care and services.

• **Provider access.**

  o A *provider-to-member ratio* is a ratio of the number of providers available to plan members to the number of members (usually number of providers per 1,000 members). Ratios can be used for both PCPs and specialists.

  o *Geographic distribution* is based on the number of providers within a certain number of miles and/or a certain number of minutes of driving time. Software is used to measure the accessibility of healthcare networks and evaluate geographic distribution for specific provider types. For example, to maximize access a plan may require that its network have at least two PCPs within a three-mile radius of each ZIP code in the service area. Or a network might include at least two PCPs within a given radius of members’ homes (such as an eight-mile radius for urban areas or a 20-mile radius for rural areas). **Drive time** refers to how long members must drive to reach a provider. Drive time is typically set at 15 minutes for urban areas and up to 30 minutes for rural areas. In some
states, health plan licensure bodies (such as the Department of Insurance) have established requirements for access based on time or distance.

- Other considerations. Provider capacity to accept patients and the clinical skills of various providers are other factors that can also impact staffing needs.

- Population characteristics. Demographic characteristics of plan membership such as age, sex, income, ethnicity, and education level influence both the numbers and types of providers in the network. For example, networks of plans with large numbers of women and children typically include large numbers of OB/GYNs and pediatricians. Plan networks serving Medicare beneficiaries typically have larger numbers of providers and a broader mix of specialists than networks serving similarly sized younger populations.

- Purchaser and consumer preferences. Primary factors that influence customers’ selections among health plans are perceptions of quality, access to care, and costs.

  - Perceived quality. If perceived quality is the dominant consideration, then the actual composition of the network and provider selection criteria are key elements of the network development.

  - Access. If access is the major issue for customers, a large, very inclusive network is desirable.

    - PCPs. For purchasers and members the primary care panel is typically the largest and most important component of the provider network. Larger PCP panels tend to result in higher market share and high levels of member acceptance and satisfaction, but they can result in higher plan costs. Limiting the size of the PCP panel can reduce costs for administration and network management, but these reductions are generally outweighed by customer preferences for larger PCP panels.

    - Specialists. The size of the specialist panel is typically less important to customers that the size of the PCP panel. Therefore, health plans can often limit specialist panels to include only providers who offer the highest-quality, most cost-effective care in the service area.

**Hospitals and Other Facilities**

The goal of a health plan is to include enough facilities in its network to effectively serve the plan’s membership. Therefore, the network needs the appropriate number of hospitals and facilities of the appropriate types and in the appropriate locations. Many of the factors that affect the number of practitioners needed in a network also affect the number and locations of hospitals and other facilities. Considerations include:

- access by plan members,
• service capacity,
• types and quality of services offered,
• accreditation status,
• reputation within the service area,
• cost and use of resources,
• level of participation in health plans, and
• willingness to agree to contract terms acceptable to the health plan.

Member preference may also affect the number of facilities included in a network if preferences are strongly divided among facilities. Also, if a plan wants to contract with a hospital that is part of a multi-hospital entity, the plan may also have to contract with the other hospitals that belong to the entity.

Provider Recruitment and Selection

Recruitment

During a health plan’s analysis of the market, discussed earlier in this module, the plan gathers, analyzes, and understands important information about the provider community in the service area, including the number and locations of providers. The following sources provide additional information about providers and may be used in the recruitment process:

• Purchasers, plan members, plan personnel, and other providers. Recommendations from purchasers and enrollees are very valuable to the plan. Inclusion of providers recommended by purchasers and enrollees can give the health plan a competitive advantage when negotiating with purchasers and can also help sell the plan to potential members.

• Local, state, and national medical societies

• Directories and lists

• Provider directories from competing plans

During the recruitment phase of the network development process, a health plan typically sends a mass mailing to the providers in the service area. This mailing introduces the health plan and gives information about it. It usually describes the plan’s credentialing process and may include a copy of the plan’s fee schedule and a provider contract.

Selection

To be selected by a health plan for its network, a provider must demonstrate to the plan that she is able to meet the needs of the plan and its members. Major components of provider selection process are:

• application,
Network Structure and Management

- credentialing, and
- recredentialing.

These are discussed below.

**Application**

The selection process begins with the submission of an application by the provider. Although application forms vary, most include questions on the following:

- basic demographic information
- office information (location, phone numbers, limitations)
- education and training
- work history
- professional licenses
- certifications (specialty, DEA)
- specialty care certification or eligibility
- hospital affiliations
- malpractice insurance information
- malpractice claims history
- references

**Credentialing**

Once a health plan receives the provider application, it begins the credentialing process. This includes reviewing and verifying the information submitted on the application form, determining the provider's current clinical competence, and verifying that the provider meets the health plan’s preestablished criteria for participation in the network.

*The Importance of Credentialing*

The goal of health plans is to offer members a delivery network that includes high-quality providers. Specifically, credentialing addresses these objectives:

- evaluating providers and determining which are the most qualified,
- minimizing the liability and other legal risks associated with medical practice by eliminating providers whose histories and practice patterns indicate that they might pose a legal risk for the plan, and
- meeting the requirements of accrediting bodies and regulators for accreditation or licensure.

Because credentialing is such an important part of the selection process, we will examine credentialing in detail, review who typically performs credentialing, describe
how the credentialing process works, and discuss standards used in the credentialing process.

_Credentialing—Who Does It?

The responsibility for credentialing varies from plan to plan. In some plans credentialing is handled by a committee or department, while in others it is performed by an individual. In still other plans, credentialing is contracted to external entities called _credentialing verification organizations (CVOs)._ Practitioners are usually included in the credentialing committee or serve on the review body; they provide technical knowledge and peer perspectives in the credentialing process.

_The Credentialing Process_

As mentioned, the credentialing process begins with the provider’s submission to the health plan of a completed application (and required supporting documentation). The next steps in the process are completed by the health plan and include:

- review of the application,
- verification of the documentation and information,
- determination of the need for additional documentation or follow-up, and
- request for any information required to verify credentials.

The health plan may also perform site inspections of the provider’s offices and may inspect and evaluate medical records on site. Note that the credentialing process typically is completed before the health plan contracts with the provider.

_Standards Used in Credentialing—Guidelines, Policies, Procedures, and Criteria_

Health plans establish and utilize plan-specific guidelines for credentialing, with each plan’s guidelines reflecting the unique characteristics of the plan. Written policies define the requirements for participation in the network and identify the specific documentation that will be used to verify requirements. Procedures describe how the process is performed. Criteria are used to assess a practitioner’s ability to deliver necessary care to health plan members and typically include licensure, relevant training and/or experience, and disclosure of any issues that may affect care delivered (such as health issues).

_Verification_

As noted, during credentialing the plan verifies the information submitted by the provider on the application form and validates that the provider meets the health plan’s preestablished criteria for participation in its network. To ensure that credentialing decisions are based on accurate and current information, health plans are required to obtain documents directly from educational institutions and agencies (primary sources). Health plans typically delegate primary source verification activities to third-party CVOs.

Many of the standards and criteria used by health plans in credentialing verification are based on existing standards established by accrediting agencies such as URAC. In
addition, a health plan is required to obtain information relating to malpractice, licensure, actions taken related to professional reviews, actions taken by the Drug Enforcement Agency (DEA), and Medicare/Medicaid exclusions. The National Practitioner Data Bank (NPDB) is a repository for information relating to malpractice, licensure, and actions taken related to professional reviews.

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<th>The National Practitioner Data Bank (NPDB)¹</th>
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<td>The legislation that led to the creation of the NPDB was enacted because the U.S. Congress believed that the increasing occurrence of medical malpractice litigation and the need to improve the quality of medical care had become nationwide problems that warranted greater efforts than any individual state could undertake. The intent is to improve the quality of healthcare by encouraging state licensing boards, hospitals, and other healthcare entities and professional societies to identify and discipline those who engage in unprofessional behavior, and to restrict the ability of incompetent physicians, dentists, and other healthcare practitioners to move from state to state without disclosure or discovery of previous medical malpractice payment and adverse action history. Adverse actions can involve licensure, clinical privileges, professional society membership, and exclusions from Medicare and Medicaid.</td>
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The NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of healthcare practitioners’ professional credentials. The information contained in the NPDB is intended to direct discrete inquiry into, and scrutiny of, specific areas of a practitioner’s licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges. The information contained in the NPDB should be considered together with other relevant data in evaluating a practitioner’s credentials; it is intended to augment, not replace, traditional forms of credentials review.

Credentialing—Organizational Providers

During the credentialing process, health plans are required to evaluate the quality of organizations such as hospitals, nursing homes, and home health agencies. Health plans must verify that these organizations are in good standing with regulatory bodies and accredited by the appropriate accrediting body.

The Selection Decision

The health plan’s decision to either select or not select a provider for its network is based on the needs of the health plan and the provider’s qualifications. Selection decisions cannot be based solely on the provider’s membership in another organization such as a hospital or medical group. Health plans must apply standards consistently and fairly. Applying standards consistency and fairly and adhering to the plan’s written policies and procedures reduce issues that can result in legal actions by providers.

Recredentialing

As noted, the credentialing process begins before the provider receives a final contract. Once a plan contracts with a provider, it begins an ongoing process of periodically reviewing the qualifications of the provider and verifying that the provider still meets the
standards for participation in the network. This process is known as recredentialing and is typically performed every two to three years.

During recredentialing the health plan verifies the information in the provider’s credentialing data file that is subject to change over time. Examples include licensure, sanctions, certifications, competence, or health status that might affect the provider’s ability to perform services defined in the health plan contract. Many plans also consider results from its quality management and utilization management programs as well as member satisfaction surveys and any member complaints.

Contracting

Once a health plan has selected a provider for its network, the plan presents to the provider an initial contract that specifies the terms of their agreement. The health plan and provider may negotiate and agree to change some of the terms of the contract. When both parties have reached final agreement on the terms, they each sign the contract and it takes effect.

A properly executed contract serves the following important purposes:

- ensuring that both parties understand and consent to their responsibilities to each other,

- providing a reference for clarification of responsibilities in case there is a misunderstanding or disagreement between the parties, and

- serving as evidence in a legal action by the aggrieved party if either party feels that the other has failed to live up to its responsibilities.

Contract Provisions

Health plan provider contracts generally include many provisions. Provisions may be included in the body of the contract, included in exhibits attached to the contract, or incorporated by reference in the contract. Incorporation by reference occurs when a document is made a part of the contract by being referred to in the body of the contract. For instance, a health plan’s provider manual is often incorporate by reference into provider contracts.

Since provider contracts are based on the characteristics of the health plan, contracts and contract provisions vary from contract to contract. Important provisions that are typically found in provider contracts are discussed below.

The Provider Manual

A provider manual is a document that contains information about a provider’s rights and responsibilities as a part of a health plan’s network. Provider manuals are usually incorporated by reference into the contract or are included as exhibits, as these documents tend to change frequently. By including the provider manual as an exhibit or incorporating it by reference, the manual can be changed without necessitating a change to the entire contract.
Provider Responsibilities

The contract defines the responsibilities of both the provider and the health plan. The following are some provider responsibilities commonly found in provider contracts:

- **Provider services.** The contract typically includes a general description of the healthcare services that the provider agrees to furnish and a more detailed and specific description of how the services will be provided.

- **Administrative policies.** The contract generally defines the health plan’s administrative policies and procedures that the provider agrees to follow. These policies are typically related to billing, including the required type of claim form and coding and requirements for timely filing of claims.

- **Credentialing and recredentialing.** Contracts normally require that the provider cooperate with the health plan’s credentialing and recredentialing processes.

- **Utilization management and quality management.** The contract generally requires providers to cooperate with the plan’s utilization management and quality management programs.

- **Medical records.** The contract typically requires providers to maintain complete and accurate medical records and allow health plan staff to access them when needed. Health plans need access to medical records for a variety of purposes such as quality management, utilization management, accreditation, audits and other types of reviews.

- **Payment in full.** Most contracts include a **no balance billing provision**, which requires the provider to accept the amount that the plan pays for medical services as payment in full and to agree not to bill the plan member for additional amounts except for copayments, coinsurance, and deductibles. Most contracts also include a **hold harmless provision**, which forbids providers from seeking compensation from patients if the health plan fails to compensate them because of insolvency or for any other reason.

Health Plan Responsibilities

The following are some health plan responsibilities commonly found in provider contracts:

- **Payment.** The contract specifies how the plan will compensate the provider. Since this changes frequently, it is typically included as an exhibit attached to the contract rather than in the body of the contract.

- **Timely payment.** The contract specifies the time period within which the health plan will provide payment to the provider for services rendered.

- **Risk-sharing and incentive programs.** The contract describes any incentive or risk-sharing plans such as withhold arrangements.
- Eligibility information. The contract affirms the health plan’s responsibility to provide information on member eligibility and benefit levels. This information helps providers identify members and services covered by the plan. The contract also specifies how the health plan will provide this information (telephone, VRU, electronically, real time or batch, etc.).

Termination Provisions

Termination provisions, which are applicable to both the health plan and provider, stipulate how and under what circumstances the parties may end the contract. Generally, the provider and the health plan have the same rights to terminate the contract. Contracts generally can be terminated with cause or without cause, and health plans use different procedures for each.

- Termination with cause is permitted by all standard contracts. A termination with cause occurs when one party does not live up to its contractual obligations or breaches the contract. For example, a provider fails to provide the services required by the contract, or a plan fails to compensate the provider. Contracts generally include a cure provision, which gives the party that breaches the contract a specified time period (usually 60 or 90 days) to remedy the problem and avoid termination. Also, most contracts include a due process clause, which gives a provider that has been terminated with cause the right to appeal.

- Termination without cause may or may not be allowed by a contract; some states do not permit it. A termination without cause occurs when the plan or provider terminates the contract without providing a reason or offering an appeals process. The terminating party is often required to give at least a 90-day notice. Generally health plans terminate providers without cause for business reasons rather than reasons related to the provider’s performance.

The Tone of the Contract

In addition to describing the responsibilities of the parties, the contract gives both parties an opportunity to establish the tone and objectives of the relationship. The contract can define the working relationship between the health plan and the provider as either detailed and formal or open-ended and informal. The contract can also either allow for substantial independent authority or include multiple checks and balances.

The tone and structure of the contract also provide an opportunity for the health plan to influence the nature of the business relationship with the provider. For example, the provider contract can be used by the plan to establish a collaborative relationship with the provider—one in which the provider is included in decisions regarding policies that affect her, such as quality management or utilization management. These types of relationships tend to result in increased provider cooperation with health plan initiatives.

Network Maintenance and Provider Services

Following provider recruitment, selection, and contracting, the health plan focuses on activities essential to maintaining and managing the network. In this section we discuss three important network management functions: provider orientation, peer review, and provider services.
Provider Orientation

The health plan provides orientations to introduce itself to new providers and acquaint them with its systems and operations. Also during orientation the plan provides training in various systems such as utilization review, authorization systems, quality control, and others, as well as in processes and information relevant to the provider’s specific contract and services.

The plan provides a written manual of its policies and procedures relevant to the participating provider. The purpose of this manual is to ensure that the provider understands the various aspects of participation and the procedures to follow. Health plans typically review the manual with the provider during the orientation meeting.

During orientation the health plan informs the provider of its system of regular communications between the health plan and the providers. Health plans provide updates such as new or revised clinical guidelines, benefit changes and claims/coding information, and other information necessary to keep providers informed of changes and updates. Updates are provided through various mechanisms including meetings, newsletters, and/or bulletins.

Peer Review

Another important network management function is peer review. Peer review is the evaluation of a provider’s performance by a peer—usually another provider in the same medical specialty and geographic area. Peer review programs and processes will be discussed in detail in the following module.

Provider Services

The goal of health plan provider services is to maintain communications with providers. Provider services staff typically visit provider offices or clinics to distribute, share, and explain information. Provider services staff also give support, provide training to the provider office staff, and in some cases offer on-site problem-solving to providers who are experiencing administrative difficulties.

The provider services area and staff are also responsible for designing and implementing the health plan’s strategies for ensuring provider satisfaction with the health plan. Strategies used by some plans to increase provider satisfaction include conducting surveys of provider satisfaction and needs; communicating through meetings, newsletters, and office visits; and including providers in decisions and programs that affect them, such as quality and utilization management.

Conclusion

In developing and maintaining a provider network, a health plan must consider a large number of factors. In setting up its network, it must look at the existing market, including providers, competitors, employers, population, service area, and economy. The plan must take into account its own characteristics (plan type, products, etc.), as well as applicable laws, regulations, and accreditation standards. The plan must ensure that its network meets the needs of its members in terms of provider types, the number of providers, and their locations. Doing so involves a variety of activities, such as provider
recruitment, selection, credentialing, and contracting, as well as ongoing activities needed to maintain the network, such as recredentialing, peer review, and provider services.

Note