BEST PRACTICES IN SPECIALTY PROVIDER RECRUITMENT AND RETENTION: CHALLENGES AND SOLUTIONS

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ABSTRACT: A health plan's most valuable resource is its provider network, but many organizations struggle in building and maintaining provider relations, and, more specifically, in recruiting and retaining providers. This is particularly true in Medicaid managed care, where historically low reimbursement rates have made recruiting a challenge, particularly for specialty providers. To identify barriers and solutions, the Association for Community Affiliated Plans (ACAP) conducted a study of its member plans in the spring of 2004, selecting four plans for in-depth case studies. The plans stressed the importance of two complementary approaches: sustaining relationships with providers through regular and meaningful communications and introducing technology applications to facilitate process improvement. Specifically, ACAP plan leaders experienced the greatest success in improving provider relations in the following five areas: 1) payment practices, incentives, and financial assistance; 2) utilization management; 3) communications and provider outreach; 4) practices to simplify administrative burdens; and 5) enabling services.

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EXECUTIVE SUMMARY

A health plan's most valuable resource is its provider network, which includes primary care and specialty physicians, institutional providers like hospitals and nursing homes, and ancillary providers like home health agencies and rehabilitation centers. Many organizations, however, struggle in building and maintaining provider relations.

This ongoing challenge to recruit and retain providers puts health plan members at risk for poor access. Medicaid health plans are particularly sensitive to the importance of offering dependable access to specialty services because their patients experience more chronic illness and disabilities, and therefore may require more specialty care, than do patients of commercial health plans.

To identify the barriers to recruiting and retaining providers, the Association for Community Affiliated Plans (ACAP) conducted a study of its member plans in the spring of 2004. Four plans were selected for more in-depth case studies to examine practices that address provider recruitment and retention barriers.

Challenges and Obstacles to Recruiting and Retaining Providers

The top five challenges reported by plan leaders were: 1) low payment rates, 2) preference for private patients, 3) general scarcity of providers, 4) scarcity of providers in rural regions, and 5) frustration with referral and pre-authorization processes.

Certain specialties are more challenging to recruit and retain. One-third of respondents reported that 78 percent of the specialties included in the survey are severely or moderately challenging to recruit. Pediatric specialties of all kinds were considered among the most challenging providers to find. Other hard-to-fill specialties include dermatology, psychiatry, orthopedics, and plastic surgery.

Matching Best Practices to Challenges

The plans repeatedly stressed the importance of sustaining relationships with providers through regular and meaningful communications. Additionally, plans were introducing technology applications as important tools in facilitating process improvement. Medicaid managed care plans looking to improve specialty recruitment and retention may gain as much from the simpler examples of operational change in this report as from the more innovative strategies.

ACAP plan leaders experienced the greatest success in improving provider relations in the following five areas: 1) payment practices, payment incentives, and financial assistance; 2) utilization management practices; 3) communications and provider outreach practices; 4) practices to simplify administrative burdens; and 5) enabling service practices.

Payment Practices, Payment Incentives, and Financial Assistance

The ACAP plans ranked low payment rates as the top frustration of both primary care providers and specialists, with 94 percent of the plans identifying this as a contracting challenge. Medicaid plans have had a limited ability to improve provider reimbursements, which have been linked to their states' historically low Medicaid rates. Instead they have tried to pay providers promptly and have offered financial incentives aligned with high-quality care. Most efforts to improve claims turnaround time concentrated on front-line processes, departmental reorganizations, new technologies, and financial incentive practices.

Utilization Management Practices

Most utilization management practices addressed providers' frustrations with the referral and authorization processes—one of the top three challenges to recruiting and retaining providers. Plans also introduced general improvements in utilization management customer service and used technology tools to facilitate authorizations and referrals.

Communications and Provider Outreach Practices

ACAP plans have invested in building and maintaining solid provider relationships through outreach. In-person meetings, or "face time" are highly valuable—particularly when plan representatives spend time in providers' offices. Regular written communications are also important to inform providers about changes to administrative procedures, clinical breakthroughs, quality measures, and legal updates.

Practices to Simplify Administrative Burdens

Providers spend more office time satisfying health plan and state reporting requirements for Medicaid managed care than they do for commercial or Medicare patients. ACAP plans are sensitive to this administrative burden and look for ways to simplify these requirements. Many of the surveyed plans have simplified eligibility and credentialing processes, and a few plans have taken similar steps to simplify the process for health care encounter data submission.

Enabling Service Practices

Just six of the ACAP plans reported success with using enabling services to improve provider relations. These services, which are aimed at patients who have trouble keeping appointments, address the social barriers that may prevent or interfere with members' ability to receive medical services. Examples include transportation services, child care arrangements, interpreter services, and providing members who lack telephone service with cell phones so case managers can contact them.

Conclusions

The recruitment and retention challenges and opportunities of the ACAP plans offer strategic advice for all health plans, from sophisticated technologies that reduce administrative burdens to the most basic and reliable forms of good communication and outreach. These tactics can help attract new providers, as well as improve quality of care, enhance member satisfaction, and achieve cost savings.

BEST PRACTICES IN SPECIALTY PROVIDER RECRUITMENT AND RETENTION: CHALLENGES AND SOLUTIONS

INTRODUCTION

A health plan's most valuable resource is its provider network, which includes primary care and specialty physicians, institutional providers like hospitals and nursing homes, and ancillary providers like home health agencies and rehabilitation centers. Managed care organizations have improved in their use of tools and practices like utilization management (UM), quality improvement, and claims processing services, but they continue to struggle in building and maintaining provider relations.

This ongoing challenge to recruit and retain providers puts health plan members at risk for poor access, which may include delays in appointment scheduling and in the waiting room, unreasonable travel distances to specialists, and treatment of medical conditions by physicians who do not have the correct expertise or appropriate training. Medicaid health plans are particularly sensitive to the importance of offering dependable access to specialty services because their patients experience more chronic illness and disabilities, and therefore may require more specialty care, than do patients of commercial health plans.[1]

To identify the barriers to recruiting and retaining providers, the Association for Community Affiliated Plans (ACAP) conducted a study of its member plans in the spring of 2004. ACAP represents 18 Medicaid-focused, community affiliated health plans and one integrated service delivery network in 11 states, serving 1.7 million Medicaid and State Child Health Insurance Program (SCHIP) beneficiaries. Plan leaders from 17 of the 18 member plans completed an online survey. Of these, four plans were selected for more in-depth case studies to examine practices that address provider recruitment and retention barriers. Plans selected for a case study met at least two of the following criteria:

- The survey respondent offered thorough responses throughout the survey, particularly in the "best practices" section.
- The health plan demonstrated a "best practices" spirit.
- The plan offered diversity in geography, plan size, plan age, and provider payment arrangements relative to other case study candidates.

While several plans met the selection criteria, only four plans were selected, based on geographical diversity, for case study site visits due to budget constraints (Table 1).

Table 1. ACAP Plans Selected for Case Studies

Health Plan	Location	Enrollment
CareOregon	Portland, Oregon	95,000
Community Health Plan of Washington	Seattle, Washington	202,000
Hudson Health Plan	Tarrytown, New York	46,300
Neighborhood Health Plan of Rhode Island	Providence, Rhode Island	73,300

While the study revealed challenges and opportunities for all providers, including primary care physicians (PCPs), this report emphasizes strategies for specialists, as recruitment and retention challenges are more prevalent with this population. This is the first published study to provide a comprehensive look at health plan practices that address the challenges of maintaining specialty provider networks in Medicaid managed care.

CHALLENGES AND OBSTACLES TO RECRUITING AND RETAINING PROVIDERS

Survey participants were asked to select among 12 challenges in recruiting and retaining PCPs and specialists, such as dissatisfaction with low payment rates, frustration with claims turnaround delays, high no-show rates, and patient non-adherence to treatment plans.[2] The top five challenges reported were: 1) low payment rates, 2) preference for private patients, 3) general scarcity of providers, 4) scarcity of providers in rural regions, and 5) frustration with referral and pre-authorization processes.

Additional challenges included: concerns with payment accuracy; the risk of members being retroactively disenrolled by the state, leading to denied payments for services previously authorized; the high turnover rate of Medicaid enrollees; and greater reporting needs for Medicaid patients than for commercial patients. In all, 19 challenges were identified and ACAP plan representatives reported practices to fully or partially address 15 of these 19 barriers.

Certain specialties are more challenging to recruit and retain. One-third of respondents reported that 78 percent of the specialties included in the survey are severely or moderately challenging to recruit. Pediatric specialties of all kinds were considered among the most challenging providers to find. This finding is particularly troubling, as most of the plans' beneficiaries are families with children. Other hard-to-fill specialties include dermatology, psychiatry, orthopedics, and plastic surgery.

The kinds of challenges varied by specialty. For instance, cardiologists may limit their Medicaid cases to control the reimbursement mix, and dermatologists often treat a high volume of cosmetic cases that offer higher reimbursement levels. Orthopedists are reluctant to care for Medicaid plan members because the high no-show rates result in financial losses for reserved operating room time. Many otolaryngologists are not in locations that are convenient for Medicaid members.

MATCHING BEST PRACTICES TO CHALLENGES

ACAP plans reported an abundance of strategies implemented to support, directly or indirectly, specialty network recruitment and retention. The majority of practices are not necessarily the "best," but are good business practices made better. These practices represent the managed care industry's ongoing efforts toward continuous quality improvement. The plans have similar overall strategies, with operational differences that may provide useful to all plans.

The plans repeatedly stressed the importance of sustaining relationships with providers through regular and meaningful communications. Additionally, plans were introducing technology applications as important tools in facilitating process improvement. These two approaches complement each other by combining fundamental and basic needs (i.e., communication) with an increased level of sophistication (i.e. technology tools). Medicaid managed care plans looking to improve specialty recruitment and retention may gain as much from the simpler examples of operational change in this report as from the more innovative strategies.

ACAP plan leaders experienced the greatest success in improving provider relations in the following five areas: 1) payment practices, payment incentives, and financial assistance; 2) UM practices; 3) communications and provider outreach practices; 4) practices to simplify administrative burdens; and 5) enabling service practices.

PAYMENT PRACTICES, PAYMENT INCENTIVES, AND FINANCIAL ASSISTANCE

The ACAP plans ranked low payment rates as the top frustration of both PCPs and specialists, with 94 percent of the plans identifying this as a contracting challenge. Medicaid plans have had a limited ability to improve provider reimbursements, which have been linked to their states' historically low Medicaid rates. Instead they have tried to pay providers promptly and have offered financial incentives aligned with high-quality care.

Most efforts to improve claims turnaround time concentrated on frontline processes, departmental reorganizations, new technologies, and financial incentive practices. One plan gave providers cash advances and an apology if the plan owed claims that were stuck in the system. Other plans have set departmental rules to enter all claims within two weeks of the received date, a policy that was linked to claims processor's performance standards. Some plans have reorganized by creating claims processing teams that specialize in handling claims from either institutions or providers, and others who manage electronic claims. Others have transferred the responsibility of claims research from the claims department to the provider relations department. Lastly, several plans have outsourced paper claims or have hired more claims processing staff members to meet industry standards.

Technology enhancements have also helped to improve claims turnaround through online claims inquiry capabilities for administrative staff. This is a tool that allows doctors and their staff to go online to check the status of a claim, much like tracking the status of a package en route. In addition, Web-based desktop analysis tools can help monitor claims by tracking the following variables: time claim submitted, time claim inputted, internal processing time, and post time.

To improve provider relations, some plans are also using financial incentives. For instance, CareOregon has developed a Care Support and System Innovation grants program to encourage system improvements and develop plan/provider partnerships in improving quality. (See the CareOregon case study for more information about this program.) Other strategies include paying bonuses to PCPs to improve child immunization rates and paying higher rates for providers in rural and frontier regions.

UTILIZATION MANAGEMENT PRACTICES

Most UM practices addressed providers' frustrations with the referral and authorization processes—one of the top three challenges to recruiting and retaining providers. Plans also introduced general improvements in UM customer service and used technology tools to facilitate authorizations and referrals.

Improvements in Referral Practices

To determine specialties for which referrals are appropriate, the plans researched PCP referral histories. In doing so, they discovered certain specialties for which secondary referrals were uncommon and, in some cases, discontinued their use. These specialties included audiology, obstetrics, physical therapy, plastic surgery, and podiatry. In addition, some plans allowed specialists to send members for ancillary tests without sending them

back to their PCPs for referrals. One plan asked PCPs to send referral forms to the plan office, which handled data entry and created a corresponding referral number. This process eliminated the need for members to bring referral forms from the PCP office to the specialist. It reduced the unnecessary claims denial rate by 75 percent and pleased specialists by decreasing their administrative workload.

Improvements in Authorization Practices

Improvement strategies in this area include discontinuing authorization requirements for office-based services of in-network specialists and emergency room services, and authorizations that specialists are required to obtain from PCPs. Some plans replaced authorizations set by dollar thresholds with more meaningful categories like indications that may signal the presence of a significant or complex medical condition; high-cost conditions; conditions with a history of overutilization or inappropriate utilization; and conditions with corresponding legal requirements (e.g., hysterectomies and sterilizations). Lastly, some plans have begun to provide Web-based search engines so that providers can search by diagnosis code for conditions that require authorization.

Improvements in Customer Service

Plans have increased the hours of UM staff members who handle authorization requests by outsourcing this task to off-site vendors. Other strategies include adding more fax lines, 24-hour confidential voice mail lines, and toll-free numbers for pre-certifications.

COMMUNICATIONS AND PROVIDER OUTREACH PRACTICES

ACAP plans have invested in building and maintaining solid provider relationships through outreach. In-person meetings, or "face time" are highly valuable—particularly when plan representatives spend time in providers' offices. Regular written communications are also important to inform providers about changes to administrative procedures, clinical breakthroughs, quality measures, and legal updates.

The Value of "Face Time" and Written Communications

To improve communications and outreach, plans have shifted more provider relations interactions from the telephone to in-person meetings at provider offices. This can be achieved through routine provider site visits, with the frequency of such visits depending on member volume. For example, sites with 500 or more members have monthly visits; while sites with fewer members may have visits every six weeks or once per quarter. One plan reported that, in place of written or online surveys, it sends pairs of representatives to visit providers and determine their levels of satisfaction. The plan felt this approach—interviewing the provider and taking notes—generates richer feedback and helps providers

feel that the representatives are really listening to them. Another plan placed provider relations representatives in the communities that it serves. Providers and office staff often relate better to representatives who live in and understand their communities. Finally, one plan gave providers the CEO's direct telephone number. This strategy promoted good will between the plan and its providers. The CEO received an initial flurry of phone calls, but then the volume subsided.

E-mail newsletters have slowly started to supplement or replace direct mailings. Instead of sending newsletters as downloadable files, which creates more work for recipients, plans prefer to send either a link that takes the user to the desired information or a newsletter that resides in the body of an e-mail message. Finally, a few plans have conducted annual provider satisfaction surveys and shared the survey results with the providers, along with corrective actions they plan to take.

Provider Recognition Practices

One plan had a successful, low-budget marketing campaign called "Thanks Doc." Under this program, the plan thanked network participants who provided uncompensated care to the uninsured, in addition to the care provided to plan members. They leased a billboard, sent personal letters from the medical director, and secured public radio and television spots to thank the providers. Some plans present a quality award—a trophy and gift—to the most outstanding provider in each county at an annual provider dinner. Another plan highlighted provider best practices in office administration, clinical practices, and quality measures in its provider newsletter and public forums. One plan sent flowers and candy to providers for outstanding scores on Early and Periodic Screening, Diagnosis, and Treatment Program services and on Health Plan Employer Data and Information Set (HEDIS) or other quality initiatives.

Provider Outreach Practices

To encourage specialists to join the network, plans have tracked claims submitted by nonparticipating specialists to identify those that submit claims frequently and may be potential recruits. They have also asked their contracted PCPs in rural communities to identify which specialists accepted their referrals based on informal collegial relations. One plan found members were getting care in neighboring states, so it began recruiting providers across state lines.

PRACTICES TO SIMPLIFY ADMINISTRATIVE BURDENS

Providers spend more office time satisfying health plan and state reporting requirements for Medicaid managed care than they do for commercial or Medicare patients. ACAP

plans are sensitive to this administrative burden and look for ways to simplify these requirements. Many of the surveyed plans have simplified eligibility and credentialing processes, and a few plans have taken similar steps to simplify the process for health care encounter data submission.

Simplifying the Eligibility Verification Process

Plan providers verify member eligibility of Medicaid enrollees before each scheduled appointment because eligibility status changes frequently for these members. If the provider treats a patient on a day when he or she is not eligible, the health plan will not pay for the services. Contracting providers, therefore, rely on the plans for simple and dependable access to member eligibility status.

Several plans implemented an online lookup system through a secure Web application or through an interactive voice response (IVR) option that verifies eligibility by telephone. The IVR strategy is particularly useful for providers who do not have Internet access or when an Internet connection is temporarily out of service. Another option, mainly used by high-volume practices, is a card swipe system to verify eligibility. To help providers deal with the changing nature of eligibility status among Medicaid beneficiaries, one plan honored claims payment of retroactively terminated members if the provider established member eligibility on the date of service by printing out an eligibility screen, using an online application. This plan maintained that the good will this action generated was worth the cost incurred.

Simplifying the Credentialing Process

Health plans set their own credentialing standards, which providers must satisfy to participate in the networks. Plans research and verify the credentials of every provider and re-credential their qualifications every few years. This process is an administrative burden to providers because: 1) they participate in several health plan provider networks, and have to complete different credentialing applications on different schedules for each plan, and 2) some re-credentialing requests may duplicate the original credentialing process and may be conducted more frequently than some providers believe are necessary.

ACAP plans are taking steps to improve the credentialing process by reducing the amount of documentation that providers must submit, enabling electronic submissions, and extending re-credentialing from every two to every three years. One plan contracted with a central clearinghouse to manage an online uniform credentialing system, and eliminated the need for its providers to submit credentialing documents to more than one health plan. For instance, the Medicaid plans in New York City have signed up with the

Council for Quality Affordable Health Care to manage online uniform credentialing, thereby eliminating the need for providers to submit credentialing documents to more than one health plan.

Simplifying the Health Care Encounter Data Submission Process

One plan contracted with a central clearinghouse, (e.g., WebMD) for providers to submit encounter data, thereby avoiding multiple submissions of the same data to different entities. Another plan improved encounter data accuracy by offering providers a coach to review current coding methods and teach strategies that could improve reimbursement levels.

ENABLING SERVICE PRACTICES

Just six of the ACAP plans reported success with using enabling services to improve provider relations. These services, which are aimed at patients who have trouble keeping appointments, address the social barriers that may prevent or interfere with members' ability to receive medical services. Health plans typically engage in enabling services to improve access to care and health outcomes. These activities can be costly and are usually not reimbursed by the state. Examples include transportation services, child care arrangements, interpreter services, and providing members who lack telephone service with cell phones so case managers can contact them.

CONCLUSIONS

Managed care is a highly complex business—and is even more so when serving Medicaid beneficiaries. Experts have focused on the success of health plans in technical terms, for example, by reviewing a plan's accreditation status, immunization rates, HEDIS scores, and financial reserves. Yet the ability of plans to meet the challenges of building and maintaining a provider network with practices that engender good community relations may be the strongest indicator of a healthy plan.[3]

The recruitment and retention challenges and opportunities of the ACAP plans offer strategic advice for all health plans, from sophisticated technologies that reduce administrative burdens to the most basic and reliable forms of good communication and outreach. These tactics can help attract new providers, as well as improve quality of care, enhance member satisfaction, and achieve cost savings.

To ensure good access to care, plans must not only periodically assess their practices and strategies, but review how they measure success. Most ACAP plans, however, were unable to sufficiently answer the question: "How do you know when a

strategy has been successful?" Frequently, this answer involved tracking provider and member complaint levels. But by tracking progress and measuring success before complaints are filed, plans may gain better focus and efficiency in their provider management practices. For example, plans that arrange transportation for members in order to reduce no-show rates should survey providers to determine if this strategy has proven successful. Plans that introduce Web-based eligibility lookup tools should follow up with primary care providers to ascertain whether these providers experienced a reduction in the provision of uncovered services. There are many ways to track the success of provider relations process improvements. Plans must select indicator measures that will represent the outcomes of their best efforts.

Finally, all the surveyed plans had a readily identifiable staff member responsible for provider relations and the recruitment process. However, the nature of provider relations under managed care has become more specialized and some internal leaders could only speak to a part of the process before turning to another staff member for more information. Plans may benefit from empowering one plan leader with the appropriate expertise to oversee and monitor the entire realm of provider recruitment and retention and its accompanying processes. In doing this, and in continuing to meet challenges and engage in best practices, the plans can work to fulfill their missions of creating sustainable improvements in building and maintaining provider networks.

NOTES

[1] A. Weil, "There's Something About Medicaid," *Health Affairs* 22 (January/February 2003): 13–30.

[2] A complete list of challenges researched for this study can be found on the ACAP Web site at http://www.communityplans.net/publications/Working%20Papers/ChallengesandActions.pdf.

[3] B. Smith, "Customer Satisfaction Is the Wrong Measure," *Gallup Management Journal* (April 14, 2005), http://gmj.gallup.com/content/default.asp?ci=15850.

APPENDIX 1. CASE STUDIES

CAREOREGON

PLAN PROFILE

CareOregon is a 95,000-member plan serving residents throughout Oregon. The plan was founded in 1994 by the Multnomah County Health Department, Oregon Primary Care Association, and Oregon Health Sciences University. Currently, 84 percent of its members reside in the three-county area surrounding the city of Portland, with the remaining members in more rural regions. Roughly one-half of the members are mothers and children who qualify for coverage under Temporary Assistance for Needy Families (TANF). The remaining members are covered under the state's Medicaid expansion program or the State Children's Health Insurance Program (SCHIP) and include many adults with chronic care needs.

PAYMENT AND CONTRACTING PRACTICES

The plan pays all primary care physicians (PCPs) and specialists on a fee-for-service (FFS) basis, except for a capitated eye vision vendor. PCPs were previously capitated, but a financial analysis revealed that FFS equivalency was less costly to the plan. Additional analysis showed that capitation was not improving access to care or having an impact on service utilization. Furthermore, many of the community health centers (CHCs) that CareOregon works with qualify for additional federal funding to achieve cost-based reimbursement. These considerations led to the decision to discontinue capitating primary care to maximize other governmental funding sources, which did not risk limiting cash flow on a member per month basis as did capitation.

The plan has 950 PCPs in the network and 3,000 specialists. While less than 10 percent of the PCPs are based at the CHCs, up to 60 percent of the members receive primary care in these settings. Ninety percent of the plan's PCPs are in private group practices. These practitioners serve about 40 percent of the plan's members. Private group PCPs have a much easier time making referrals to specialists than do the CHC-based PCPs.

To date, CareOregon has not offered provider incentives, although it rolled out a Care Support and System Innovation Program (described more fully in the Practices to Improve Provider Recruitment and Retention section) in October 2004 to facilitate quality improvement at the system level.

RECRUITMENT AND RETENTION CHALLENGES

CareOregon has faced serious challenges in recruiting and retaining specialty providers. Contracting PCPs identified orthopedics, dermatology, allergy, neurology, and neurosurgery as the top five specialties that pose access problems for members.

Plan leaders provided various explanations for these recruiting issues. Providers, both PCPs and specialists, have been dissatisfied with low payment rates. Oregon offers lower salaries compared with other states, which has made recruitment particularly difficult. In addition, PCPs and specialists have been frustrated with high no-show rates by Medicaid beneficiaries and have expressed a preference for private sector patients. This has been complicated by the frequency with which members lose and regain Medicaid eligibility, which interferes with continuity of care. Providers also have been frustrated with the plan's referral and preauthorization process.

Plan leaders also believed providers feared greater malpractice exposure with Medicaid patients. In addition, providers have been concerned about managing a higher-cost case mix under Medicaid. This is compounded by their concern that Medicaid enrollees have been less likely to adhere to treatment recommendations. Because Medicaid enrollees tend to have more chronic illnesses, they have more serious consequences when they do not follow treatment recommendations.

PRACTICES TO IMPROVE PROVIDER RECRUITMENT AND RETENTION

CareOregon focused on practices to improve access to particular specialties and on those that could streamline the referral and authorization processes. Additional practices will be implemented in the next few years, including an incentive framework to improve quality of and access to care and a central triage and referral unit to systematize and distribute PCP referrals across the network to improve access to specialty services.

Encouraging Specialty Physician Extenders

One specialty provider group employs an orthopedic physician's assistant to extend its ability to serve a high volume of patients. The physician's assistant has triaged surgical cases and provided some non-surgical treatment. This arrangement has had a significant positive impact on the practice's ability to serve patients, many of whom are CareOregon members. Because of this success, CareOregon plans to explore how other specialty groups can similarly improve access to care.

Utilization Management

To simplify referral and authorization processes, the plan conducted an analysis of all specialty categories and medical services requiring a referral or authorization to determine

the percentage that were approved. In many cases, referrals and authorizations were approved 95 percent or more of the time. Based on this finding, the plan decided to stop requiring referrals for many specialty categories (Table A-1) and authorizations.

Table A-1. CareOregon Contracted Specialists Not Requiring Referrals

1. Cardiologist	7. Oncologist
2. Cardiopulmonary surgeon	8. Pulmonologist
3. Gastroenterologist	9. Radiation oncologist
4. Hematologist	10. Surgical oncologist
5. Nephrologist	11. Thoracic surgeon
6. Neurologist	

For a list of procedures that no longer require an authorization, see Appendix 2.

After these changes were implemented, the plan conducted its first provider satisfaction survey in the spring of 2004 and found that providers reported a 70 percent satisfaction rate regarding the referral and authorization process, the plan's turnaround time, and the overall process. The survey asked providers to assess the plan's performance in the areas of: response time and service; provider tools (e.g., online systems such as claims inquiry, eligibility verification, and authorization submissions); referrals and authorizations; and claims. It will re-administer the survey each spring to monitor provider satisfaction.

In addition to the changes in the referral and authorization process, CareOregon is contemplating redesigning the way members are referred to specialists. Currently, PCPs refer patients directly to specialists. Private-practice PCPs have little difficulty referring members to specialists but PCPs at the CHCs struggle to find specialists willing to see their patients. This causes recurring challenges in access to care and delays in service, as up to 60 percent of CareOregon members are served by the CHC-based PCPs. CareOregon leaders envision designing a triage referral center that would accept PCP referrals and route them to contracted specialists—a concept which has been used by medical societies to obtain specialty care for the uninsured. This would effectively mask the member's CHC connection and avoid the access problems. Members would be distributed across the specialty network to ensure a balanced use of the network and faster access.

The plan would also like to begin paying providers for telephone consultations with patients, using the available, albeit underused, Current Procedural Terminology (CPT) codes. To implement a payment strategy, CareOregon plans to develop per member per month benchmarks. CareOregon hopes this practice will increase provider satisfaction; improve access to care for members, particularly those with chronic diseases

who may have difficulty getting to medical offices; and increase the number of patients a provider can serve per day.

Care Support and System Innovation Program

CareOregon developed a Care Support and System Innovation Program to engage providers in its community in a way that encourages system change, improves provider satisfaction, and increases access to care. The program, which began in October 2004, offers annual funding above current reimbursement levels. The program is divided into two parts: the care support program and the system innovation program.

Care support program. PCPs with more than 300 CareOregon members have been encouraged to initiate programs that complement and enhance current efforts in the following areas: complex care management, chronic care management, reducing health disparities, improving access to care and office efficiencies, and increasing patient safety. Qualifying PCP practices can apply online for a grant from CareOregon. A set of grants will be awarded each year.

System innovation program. Specialists, hospitals and ancillary providers with annual CareOregon payments of over $50,000 can qualify for grants of up to 20 percent of their total annual payments. The grants will fund programs that focus on implementing or expanding evidence-based practices, demonstrating compliance with national practice standards, or furthering CareOregon's mission.

CareOregon believes improvements in the health system will improve overall provider satisfaction. By focusing on system change, rather than incentives for individual providers, the plan believes it can improve quality and enhance provider relationships.

SUMMARY OF PROVIDER RECRUITMENT AND RETENTION PRACTICES

- Added specialty physician extenders to the provider network
- Studied and simplified the referral and authorization requirements
- Developed a provider-driven, system-based incentive program for grants
- Currently redesigning how members are referred to specialists by establishing a centralized triage referral center
- Conducts ongoing annual provider satisfaction survey
- Reimburses providers for conducting medical consultations by telephone

COMMUNITY HEALTH PLAN OF WASHINGTON

PLAN PROFILE

Community Health Plan of Washington (CHPW) serves 202,000 members in 33 of the state's 39 counties. More than one-half its members (126,580) are enrolled in Healthy Options, the state's Medicaid program for mothers and children. Another 64,000 are Medicaid expansion members in the state's Basic Health Plan. In addition, the plan serves 2,200 SCHIP members and 9,000 state employees. CHPW was established in 1992 by a network of community and migrant health centers across the state. Roughly one-half of its members live in three urban/suburban counties: King County (Seattle), Pierce County (Tacoma), and Snohomish County (Everett). The remaining members live in rural communities in eastern Washington and in the city of Spokane.

PAYMENT AND CONTRACTING PRACTICES

Nineteen CHCs contract with CHPW, with 78 clinic sites throughout the state. The plan pays full capitation to 95 percent of the CHCs, which amounts to 600 of the 1,300 primary care providers (PCP) in the network. The remaining 700 PCPs are with private practices, the majority of which are paid on an FFS basis.

In comparison, 90 percent of the plan's specialists are in private practice and are paid on an FFS basis. Another 5 percent of specialists are employed by the CHCs, who work in internal medicine, obstetrics and gynecology, and behavioral health. The remaining 5 percent of specialists are hospital-based. The plan delegates specialty care to a few alternative medicine subcontractors including those that provide acupuncture, chiropractics, and naturopathic care.

CHPW's number of PCPs has increased over time, as a result of the Medicaid managed care market shrinking from 20 plans to four plans and CHPW absorbing other plans' memberships. In contrast, the specialty network was reduced by 30 percent, from 10,000 to 7,000 providers. The plan studied claims reports to identify the participating specialists who had sufficient claims volume to justify remaining in the network and reduced the network accordingly. This reduction focused on specialists that did not pose a recruitment challenge.

The plan offers PCPs incentive payments that are linked to a set of annual performance metrics. In addition, all CHCs and high-volume private PCP practices qualify for incentives of up to $1.00 per member per month depending on their performance in three areas: clinical quality, based on select HEDIS measures; service

quality, based on results from the Consumer Assessment of Health Plans (CAHPS)* tool; and data capture, based on a set of CHPW specifications that began in 2004.

Most providers are pleased with the program, which has been in place for five years. CHPW attributes the use of the performance metrics to a 31 percent increase in immunization rates for children under age 2. This raised the immunization rate to 71 percent, for which the plan received formal recognition from the state Medicaid agency. In response to this recognition, the plan sent a special mailing to its PCPs to thank them for improving patient care.

RECRUITMENT AND RETENTION CHALLENGES

CHPW faces serious challenges in recruiting and retaining specialty providers. Specialists in short supply include endocrinologists, neurologists, psychiatrists, and urologists. Gastroenterologists are scarce and in high demand since the Medicare program began covering colonoscopies.

Specialists are generally dissatisfied with the plan's payment rates, even though many share CHPW's mission to serve vulnerable populations and are willing to provide care on a case-by-case basis rather than under contract. Specialists are also frustrated with high no-show rates for medical appointments; with the uncertainty that CHPW members may be retroactively disenrolled from the Medicaid program, resulting in unpaid claims; and by Medicaid patients who do not adhere to the treatment plans.

Additional, yet more moderate recruiting challenges, include providers' frustration with the pre-authorization and referral processes and general preference for private sector patients.

PRACTICES TO IMPROVE PROVIDER RECRUITMENT AND RETENTION

The plan is taking a two-pronged approach to ease the administrative burdens on its provider network, which it expects will improve satisfaction and overall provider relations. One approach relies on technology to simplify claims submission, referrals, and credentialing and the other provides an on-site administrative coach to bolster medical practice efficiencies. The plan is also investing in its long-standing relationships with providers. With routine on-site orientation and informational office visits.

* CAHPS is a survey and reporting tool that provides information to help consumers and purchasers assess and choose among health plans. As the recognized standard for obtaining consumers' assessment of their health plans, it is used widely throughout the United States. CAHPS was developed in 1995 through a series of research grants made by the Agency for Healthcare Research and Quality (AHRQ).

Technology Enhancements

A consortium of the state's health plans and hospitals, known as the Washington Healthcare Forum, created an online portal for claims entry called OneHealthPort. The consortium aims to standardize the claims submission process and ease the administrative burdens on the managed care provider community. CHPW is a member of OneHealthPort and pays an annual fee to participate in the program. In the future, OneHealthPort will be used to standardize and simplify the referral form and credentialing requirements. It is too soon to report on feedback from the provider community.

Four years ago, the plan introduced Adaptis Connect, a program that allows providers to look up information online, including eligibility, claims status, PCP assignment, and referral entries. To date, response has been weak, with just one-third of the PCP practices using Adaptis Connect. The plan believes the poor response reflects providers' lack of online access.

Administrative Practices

After conducting an audit that compared patient records to health care encounter forms, the plan identified numerous process errors that led to incomplete and inaccurate data submissions. These errors were made by CHPW, its third-party administrator, and provider practices. The plan corrected its errors and those of the third-party administrator and will launch a project to coach contracted CHCs on troubleshooting their encounter data practices.

The CHCs have an incentive to improve encounter data accuracy; inaccurate coding and the omission of some diagnosis codes prevents them from receiving higher reimbursements for patients with complex medical conditions. A Health Risk Adjustment Factor has been introduced by the state Medicaid agency to increase payments for patients who require chronic medical care, thereby adding incentive to attend to these administrative efficiencies.

CHPW will bring a coding coach to each CHC, train staff members on coding and documentation practices, and track reimbursement and administrative improvements resulting from the training. The coach will provide each CHC with a plan for process improvement. In 2005, CHPW will host a provider practice forum, with CHC clinic personnel who use best practices serving as faculty. A toolkit of these best practices will be distributed to participants.

Provider Outreach

Provider relations coordinators travel monthly to visit with high-volume PCP practices throughout the state. In addition, the plan holds annual meetings in four locations throughout the state with all PCPs and high-volume specialists to address legislative changes and updates, provider recruitment updates, medical management news, benefit changes, and best practices in the field.

The plan produces a quarterly electronic provider newsletter, although distribution has been challenging as some providers do not have Internet access and e-mail addresses are not always readily available. To assess provider satisfaction, CHPW sent out its first provider survey. The survey queries providers about their satisfaction with CHPW overall, case management, prior authorization process, referrals and network issues, access to specialty services, and other issues. The results will allow CHPW to be more strategic in addressing recruitment and retention challenges.

SUMMARY OF PROVIDER RECRUITMENT AND RETENTION PRACTICES

- Joined a community consortium to offer providers an online portal (OneHealthPort) to submit electronic claims in a standardized format, standardize and simplify referrals with an online form, and standardize credentialing requirements with an online application and renewal form
- Coaches CHCs on improved coding practices to increase reimbursement opportunities and improve the quality of encounter data
- Provides ongoing monthly guidance with visits by provider relations coordinators to high-volume PCP offices
- Holds annual meetings for PCPs and high-volume specialists to address important issues in the field
- Distributes a quarterly electronic newsletter
- Conducts provider satisfaction surveys

HUDSON HEALTH PLAN

PLAN PROFILE

Hudson Health Plan (HHP) is a 46,300 member plan serving New York residents in the Hudson Valley enrolled in Medicaid managed care, Child Health Plus, and Family Health Plus (a Medicaid expansion program). Established in the mid-1980s, HHP was formed by a group of CHCs and serves a diverse membership in urban, suburban, and rural regions of New York. Sixty-five percent of its members live in urban settings, 32 percent live in suburban regions, and the remainder live in rural areas.

PAYMENT AND CONTRACTING PRACTICES

The plan pays capitation to most of its PCPs and also pays a small amount of "bill aboves" (a designated set of CPT codes paid on a FFS basis) to these PCPs. Specialty care is reimbursed on an FFS basis at a rate roughly equivalent to Medicare reimbursement fees, which are higher than New York State's Medicaid fee schedule. Providers are generally satisfied with these arrangements.

The plan uses several incentive payment methods with PCPs, focusing on quality improvement. While the incentive payment methods were not designed to improve provider recruitment and retention, but rather to improve quality, they have provided a collateral benefit in overall relations with providers. The plan began to pay PCPs a quality bonus in 1999 to reward them for meeting the state's Department of Health Quality Assurance Reporting Requirements (QARR) Scores, a HEDIS equivalent. PCPs receive a percentage of $1.00 per member per month depending on their performance on QARR. PCP administrative compliance practices, such as good medical record keeping practices and claims data accuracy, have improved since inception, as network providers sought to maximize the quality bonus payment.

HHP also pays an immunization bonus to PCPs to improve child immunization rates. PCPs are eligible for this bonus for each child enrolled on his or her second birthday. PCPs receive $100 for each child fully immunized, and $200 for each child fully immunized in a timely manner.

Eighty-seven percent of the plan's PCPs are in private practice and care for about 60 percent of the enrollees. The remaining PCPs are CHC-based and care for 40 percent of the membership. Ninety-nine percent of contracted specialists are in private practice. The plan relies on numerous efforts to establish and maintain good relationships with these private-practice providers.

RECRUITMENT AND RETENTION CHALLENGES

HHP faced barriers typical of Medicaid health plans in its efforts to recruit and retain providers. It has found specialists to be in short supply, particularly pediatric specialists. Specialists have not wanted to risk payment losses for patients who could be retroactively disenrolled and have been dissatisfied with the plan's payment rates compared to commercial reimbursement levels. In general, specialists have expressed a preference for private sector patients.

PRACTICES TO IMPROVE PROVIDER RECRUITMENT AND RETENTION

The plan has depended on building good relationships with providers to overcome recruitment and retention barriers and has also introduced new technologies to ease administrative burdens.

Provider Outreach

The provider relations department has been persistent in developing relationships with the provider community. One method has been through quarterly site visits to PCPs and high-volume specialists. These visits have served to educate providers and administrative staff about health plan procedures, introduce new administrative practices, review quality improvement initiatives, and troubleshoot provider complaints. The department has held two provider dinners per year with nationally recognized speakers. More than 200 providers and their guests attended the most recent provider dinner. The plan has also held a successful and popular party for medical office staff.

Utilization Management Improvements

The plan has considered discontinuing the use of paper referrals and prior authorization requirements for most specialty care. This change is common across the ACAP plans, many of which have experienced positive feedback from providers and members.

Claims Improvements

Three years ago, HHP introduced an electronic data interface (EDI) to facilitate electronic billing. This program reduced claims turnaround time for the 45 percent of the provider practices that currently use it. In the past, some providers had left the network due to their dissatisfaction with claims delays. To address this issue, the plan moved the responsibility of research for pending claims from the claims department to provider relations, which allowed it to be more responsive to providers. Since this move, providers expressed greater satisfaction with claims turnaround and with overall communications about problem claims. To further assist providers, provider relations representatives have

reviewed monthly claims denial reports to be prepared to answer providers' questions about particular denials.

Lastly, provider relations staff have tracked claims submitted by non-participating specialists. When representatives identified non-participating providers who have submitted claims to the plan with some frequency, they have reached out to those specialists to join the provider network. This has proven to be a useful strategy.

Technology Enhancements

HHP recently implemented a provider portal that gave providers Web-based access to verify member eligibility at the point-of-service. In addition, the provider portal soon will allow providers to research the status of claims and member history, and will remind them of certain HEDIS requirements, such as immunizations. Another eligibility verification tool launched by HHP is an interactive voice response system, which allows providers to call a toll-free number to verify eligibility through an automated system. Before these tools were implemented, providers relied on a bimonthly eligibility printout or called the plan's call center to verify member eligibility.

Special Provider Recognition

More than half of the surveyed ACAP plans have not engaged in special recognition for providers. HHP, however, has pursued many initiatives in this area. It presents a quality award to the most outstanding provider in each county at its annual provider dinner. It also awards gifts based on performance, like a Palm Pilot to providers who exceeded the state's QARR score. It also distributes a QARR bonus payment and immunization bonus each year.

SUMMARY OF PROVIDER RECRUITMENT AND RETENTION PRACTICES

- Relocated claims research for pending claims from the claims department to provider relations
- Conducts quarterly site visits with PCPs and high volume specialists
- Holds annual dinners to honor PCPs and obstetricians and provide high-profile medical education
- Presents annual quality awards to providers with outstanding Quality Assurance Reporting Requirements (QARR) performance
- Makes annual QARR bonus payments to reward good administrative practices

- Makes regular immunization bonus payments to providers who meet immunization targets and maintain good records
- Currently considering discontinuing paper referrals and prior authorization requirements
- Testing a provider portal to verify member eligibility at the point-of-service and research outstanding claims
- Identifying non-participating specialists who submit claims with frequency to potentially recruit them for the provider network
- Launching an interactive voice response system to enable providers to call a toll-free number to verify eligibility through an automated system

NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND

PLAN PROFILE

The Neighborhood Health Plan of Rhode Island (NHPRI) is a 73,300 member plan serving Rhode Island residents enrolled in RIte Care (the state's Medicaid managed care program); the state's program for children with special health care needs; and Substitute Care (a program for foster children). NHPRI also runs a small commercial product that covers some health plan employees and employees of several of the plan's contracting CHCs. Established in 1994, NHPRI was formed by the state's 14 CHCs to improve access to care for RIte Care enrollees. Sixty-nine percent of its members reside in the cities of Central Falls, Newport, Pawtucket, Providence, and Woonsocket. NHPRI defines its members as the "poorest of the poor."

PAYMENT AND CONTRACTING PRACTICES

There are about 700 PCPs in NHPRI's provider network. Eighty-five percent of the plan's PCPs are CHC-based, with the rest in solo or group practices. The number of contracted PCPs started to increase in 2001, as a result of one health plan leaving the market. In 2003, there was additional growth when the plan began serving children with special needs and it reached out to PCPs not in the plan's provider network. Just 12 percent of the PCP offices receive capitation for primary care, but this segment represents at least one-half of the PCPs in the network and serves about 70 percent of the membership. The remaining PCP sites are paid on an FFS basis. Some CHCs provide both prenatal care and deliveries, which are paid FFS. If a member loses eligibility during pregnancy, these CHCs are reimbursed according to the number of visits or on a per-trimester basis.

The plan has about 1,200 contracted specialists, most of which are in solo or group practices. About 4 percent of the specialists are employed by the CHCs; most are obstetricians. Other represented specialties include allergists and dermatologists. All specialists are reimbursed for services on an FFS basis. As noted earlier, the plan increased its number of specialists in 2003 to include those serving children with special needs. The plan had little difficulty recruiting these specialists. It attributes success to the commitment of providers to remain with special needs children in treatment, to the competitive reimbursement rates offered by NHPRI, and to good relationships that developed between the primary care providers and specialists.

The plan uses subcontractors for behavioral health and pharmacy services, with positive results. The behavioral health vendor, Beacon Health Strategies, maintains a site at NHPRI headquarters, which contributes to good care coordination.

NHPRI negotiates a single primary care contract each year with the Rhode Island Health Center Association, which represents the interests of the CHCs. The CHCs are paid using capitation payment that includes per month per member dollars based on age and sex categories. In addition to the monthly capitation payment, there are incentive payments available. The incentive payments are determined according to performance in several categories, including quality improvement, patient access, patient satisfaction, disease management, capital improvements, and administrative processes

The plan administers a separate annual incentive pool and the Rhode Island Health Center Association determines how to distribute these dollars across all CHC sites. The Association considers patient volume, service utilization, and cost performance in making these allocations.

NHPRI also has arrangements with practices that serve a high volume of its members and that follow the same mission as NHPRI. These practices are capitated and receive incentive payments similar to those offered to the CHCs.

RECRUITMENT AND RETENTION CHALLENGES

The plan experiences severe to moderate challenges in recruiting most specialists. It attributes these difficulties to the high volume of patients these providers already serve, providers' dissatisfaction with the plan's level of reimbursement, and the perception that NHPRI members are harder to manage and have a higher no-show rate for medical appointments than do commercial enrollees. In 2003, a provider satisfaction survey reported that providers were less satisfied with claims accuracy and related customer service. In addition, providers are frustrated with the referral and authorization process. Plan leaders believe most non-CHC providers prefer private sector patients and that some PCPs are concerned about the adequacy of the specialist network for patient referrals.

PRACTICES TO IMPROVE PROVIDER RECRUITMENT AND RETENTION

NHPRI has strengthened many internal business practices to improve its overall operations and relations with its provider network. The improved practices center on UM, claims, provider relations, and enabling services.

Utilization Management Improvements

The plan discontinued its emergency room authorization requirement and attributes this change to a 4 percent increase in provider satisfaction between 2002 and 2003. This change also led to improvements in claims turnaround time. One unfortunate result of this

change is that the plan no longer has timely data on members' emergency room visits, which has delayed its ability to offer these members care management assessments.

NHPRI also stopped requiring referrals for most specialty services, with the exception of: audiology, obstetrics, physical therapy, plastic surgery, and podiatry.

The plan has also added eight new case management programs to its UM program. Initially designed to improve member satisfaction and control utilization, NHPRI has also noticed a positive shift in its providers' perception of UM.

Claims Improvements

Over the last four years, the plan introduced several changes to its claims department, which reduced the average claims turnaround from 42 days to 20 days. In addition, the percentage of clean claims★ paid within 30 days increased by 47 percent, from 52 percent in 2000 to 99 percent in 2004. NHPRI attributes these improvements to:

- Reorganization of the claims department into institutional vs. professional claims. The previous organization, which had representatives handling claims from particular facilities, had proved to be inefficient.
- Adding claims processing staff to meet industry standards. Previously, the department operated at staffing levels below industry standards.
- Eliminating the emergency room authorization and most specialist referrals. This reduced the number of delayed claims.
- Changing the claims system's payment rule, which previously imposed unnecessary holds on sending out claims denial statements to providers.
- Setting and enforcing a departmental rule to enter all claims within two weeks of receipt.
- Introducing an electronic data interface (EDI) to enable provider sites to submit claims electronically. Forty percent of all provider practices have switched to EDI for claims submission.
- Reviewing EDI-generated reports of claims submission errors with high-volume provider sites.

★ A clean claim or "error-free" claim is a medical claim that contains all of the information necessary to process the claim for approval or denial and if approved, for payment.

Provider Relations Outreach

In the last few years, the plan streamlined the credentialing application process by verifying information electronically, simplifying the recredentialing process, and extending recredentialing from every two to every three years. These changes have eased the administrative burden associated with credentialing for both the plan and providers.

NHPRI's provider relations representatives conduct monthly visits to the CHCs, to contracted primary care sites with over 500 members, and to the hospital-based primary care sites. It holds quarterly group meetings with all the CHCs and three other primary care sites and hospital based primary care sites to review and discuss financial and clinical information, disease management program issues and HEDIS measures. These efforts maintain communications between the plan and its primary care network. To serve specialists and low-volume PCPs, the plan installed a dedicated customer service telephone line in the provider relations department.

In an annual provider satisfaction survey, NHPRI asks providers about their level of satisfaction with: care management, pharmacy services, claims processing, behavioral health services, customer service, the interactive voice response system, interpreter services, provider relations representatives, provider resources (e.g., newsletter, Web site, etc.), continuity of care, and access to specialty care.

Enabling Services

The plan offers a few enabling services to improve members' access to care. Some of these services provide tangential benefits to providers in that they may reduce the number of missed appointments and enhance members' ability to understand and follow treatment plans. These services include:

- A transportation benefit paid by the state. NHPRI helps members arrange for transportation to and from their medical appointments.
- Outreach by case managers to members discharged from the hospital to ensure they keep their follow-up medical appointments within 21 days of discharge. The plan will help members schedule or reschedule an appointment, as necessary.
- Coordination of interpreter services with an outside agency.

SUMMARY OF PROVIDER RECRUITMENT AND RETENTION PRACTICES

- Discontinued the emergency room authorization requirement
- Stopped requiring referrals for most specialty services

- Added eight new case management programs to UM
- Reorganized the claims department, and added claims processing staff to meet industry standards
- Set a departmental rule to enter all claims within two weeks of the received date
- Introduced an electronic data interface to enable provider sites to submit claims electronically
- Streamlined the credentialing application process
- Installed a dedicated customer service telephone line for specialists and low-volume PCPs
- Conducts ongoing monthly visits to the CHCs and contracted primary care sites
- Holds quarterly group meetings with all CHCs and other primary care sites
- Seeks provider feedback using an annual satisfaction survey
- Offers enabling services, including transportation, case management, and interpreter services

APPENDIX 2. CAREOREGON CPT CODES

Day Stay/Day Surgery/Surgical Center/Treatment Center Procedures Not Requiring an Authorization for Contracted Providers

Effective January 1, 2004

Cardiology	
Angiography	75635-75790
Angioplasty (transluminal balloon)	5470-35476
Aortography	75600-75630
Cardioversion	92960, 92961
Cardiac catheterization	93501-93572
Ear, Nose, and Throat	
Laryngoscopy	31505-31579
Nasopharyngoscopy w/endoscope	92511
Removal foreign body (ear)	69200-69222
Gastroenterology	
Endoscopic gastro tube placement	43246
ERCP	43260-43272
Flexible sigmoidoscopy	45330-45345
Liver biopsy	47000
Paracentesis	49080, 49081
Proctosigmoidoscopy	45300-45327
Upper endoscopy procedures	43200-43272
General Surgical Procedures	
Breast biopsy	19100-19103
Fine needle aspiration	10021, 10022
Gastrostomy tube placement	43750, 43760, 43761
Incision and drainage; abscesses and cellulites:	
Skin and subcutaneous tissue	10060-10061, 11042
Wound infection, skin	10180
Lymph node biopsy	38500-38530
Pilonidal cyst with abscess	10080-10081, 11770-11772
Central venous device procedures for hemodialysis, hyperalimentation, chemotherapy	36555-36597, 36800-36870
Gynecology	
Colposcopy of cervix	57420-57461
Conization of cervix	57520, 57522
D & C (except for infertility treatment)	58120, 59812, 59820-59830
Laparoscopy (ovary/fallopian tube)	58600-58673

Note: OregonCare does not cover procedures that are done for the purpose of establishing or re-establishing fertility. Additionally, for sterilization procedures, providers must have appropriate consent form signed within Office of Medical Assistance Programs timelines in to receive payment.

Hematology/Oncology	
Bone marrow aspiration/biopsy	38220, 38221
Nephrology	
Hemodialysis	90935, 90937
Hemodialysis access, intravenous cannulation for extracorporeal circulation, or shunt insertion	36800-36870
Orthopedics/Plastic Surgery	
Arthroscopy:	
Ankle	29894-29899
Knee	29870-29887
Shoulder	29805-29827
Implant removal (wire, pin, rod)	20670, 20680
Myelogram	72240, 72255, 72265, 72270
Nerve decompression:	
Carpal tunnel	29848, 64721
Ulnar	64718, 64719
Ophthalmology	
Cataract surgery	66820-66825, 66830-66986
Retinopathy surgery procedures	67220-67228
Iridotomy/Iridectomy	66761, 66762
Strabismus surgery	67311-67340
Vitreous procedures	67005-67040
Pulmonology	
Bronchoscopy	31622-31656
Urology	
Lithotripsy	50590, 52353
Orchiectomy	54520-54535
Orchiopexy	54640, 54650
Prostate biopsy	55700, 55705
Renal biopsy	50200
Transurethral surgery	52204-52318
VCUG under sedation	74450
Other	
Blood transfusions	36430
Chemotherapy	96400-96545
Diagnostic procedures under sedation:	
CT scan	70450-70488, 71250-71275, 72125-72133, 72192-72194, 73200-73206, 73700-73706, 74150-74175
MRI	70540-70553, 71550-71555, 72141-72159, 72195-72198, 73218-73225, 73718-73725, 74181-74185
Injections: antibiotics	90788
Sleep studies	95805-95811
Wound care: debridement, wet-to-moist dressings, wound assessment	11040-11044, 15000, 15342, 15343, 15350, 15400, 97601, 97602

APPENDIX 3. ACAP HEALTH PLAN CONTACTS

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RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.cmwf.org.

Eliminating Disparities in Treatment and the Struggle to End Segregation (August 2005). David Barton Smith, Fox School of Business and Management, Temple University. Current efforts to eliminate racial and ethnic disparities in health care fail to address the role that segregation plays, according to the author. By reviewing the history of civil rights era efforts to integrate health care and assessing its accomplishments, he offers lessons to inform current efforts to eliminate treatment disparities.

Equity Measures and Systems Reform as Tools for Reducing Racial and Ethnic Disparities in Health Care (August 2005). Sidney D. Watson, Center for Health Law Studies, Saint Louis University School of Law. Although Quality Assessment and Performance Improvement (QAPI) initiatives are becoming more widespread in federal programs, QAPI requirements do not stipulate that plans or providers must measure racial and ethnic disparities in their care. But performance measurements that do not track data by race and ethnicity, the author says, miss inequities and likely overlook promising techniques for reaching particular groups of patients.

Limited English Proficiency, Primary Language at Home, and Disparities in Children's Health Care: How Language Barriers Are Measured Matters (July/August 2005). Glenn Flores, Milagros Abreu, and Sandra C. Tomany-Korman. *Public Health Reports,* vol. 120, no. 4. In this article, the authors' analysis shows that, even when factoring in multiple variables, parents with limited English proficiency are three times more likely than parents who report speaking English very well to have a child in fair or poor health.

Caring for Patients with Diabetes in Safety Net Hospitals and Health Systems (June 2005). Marsha Regenstein, Jennifer Huang, Linda Cummings, Daniel Lessler, Brendan Reilly, and Dean Schillinger. According to this report's authors, "safety net hospitals," those public institutions that care for a large volume of underserved Americans, provide care to patients with diabetes that is generally as good as the national average.

Impact of the Medicare Prescription Drug Benefit on Home- and Community-Based Services Waiver Programs (April 2005). Charles J. Milligan, Jr., University of Maryland, Baltimore County. With home- and community-based services waiver programs, many low-income, elderly, and disabled adults enrolled in both Medicare and Medicaid can avoid institutionalization and remain in the community. The author of this issue brief says the impending transfer of prescription drug coverage from Medicaid to Medicare may place many "dual eligibles" in jeopardy.

Providing Language Services in Small Health Care Provider Settings: Examples from the Field (April 2005). Mara Youdelman and Jane Perkins, National Health Law Program. Community health centers and small physician practices can have a particularly difficult time effectively serving patients with limited English proficiency. The authors show how a number of solo practitioners, small group practices, and clinics around the country have found creative methods for meeting the needs of these patients.

Cultural Competence and Health Care Disparities: Key Perspectives and Trends (March/April 2005). Joseph R. Betancourt, Alexander R. Green, J. Emilio Carrillo, and Elyse R. Park. *Health Affairs,* vol. 24, no. 2 (*In the Literature* summary). The authors report that culturally competent health

care—broadly defined as services that are respectful of and responsive to the cultural and linguistic needs of patients—is gaining attention not only as a strategy to reduce racial and ethnic disparities, but as a means of improving health care quality. Cultural competence initiatives may even help control costs by making care more efficient and effective.

Creating a State Minority Health Policy Report Card (March/April 2005). Amal Trivedi et al. *Health Affairs,* vol. 24, no. 2 (*In the Literature* summary). In the first "report card" to evaluate all 50 states on their progress in addressing disparities in minority health care, the authors found region of the country to be a significant predictor of performance, with high- and low-performing states tending to cluster geographically.

Quality Report Cards, Selection of Cardiac Surgeons, and Racial Disparities: A Study of the Publication of the New York State Cardiac Surgery Reports (Winter 2004–05). Dana Mukamel et al. *Inquiry,* vol. 41, no. 4 (*In the Literature* summary). According to the authors, quality report cards can work to level the playing field for minorities by improving their ability to see high-quality health providers, in addition to helping consumers make informed health care choices.

Addressing Unequal Treatment: Disparities in Health Care (November 2004). Gillian K. SteelFisher. Prepared for the 2004 Commonwealth Fund/John F. Kennedy School of Government Bipartisan Congressional Health Policy Conference, this issue brief reports that health care services in the U.S. have been improving for decades, but in many instances, racial and ethnic minorities receive fewer health care services, lower quality services, and services later in the progression of illness.

Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care (September/October 2004). Anne C. Beal. *Health Affairs,* vol. 23, no. 5 (*In the Literature* summary). The author argues that while a variety of public and private sector programs are taking on the issue of disparities in health care, better coordination and monitoring at the federal level is needed to maximize their effectiveness.

R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and Its Impact on Care (September 2004). Janice Blanchard and Nicole Lurie. *Journal of Family Practice,* vol. 53, no. 9 (*In the Literature* summary). The authors find that minorities are significantly more likely than whites to report being treated with disrespect or being looked down upon in patient–provider relationships.

A Review of the Quality of Health Care for American Indians and Alaska Natives (September 2004). Yvette Roubideaux. The author documents health care disparities for American Indians and Alaska Natives (AIANs) and reports on progress made in the last five years to reduce or eliminate gaps in care. In examining the demographics of this group, she notes in particular a substantial urban AIAN population that is both understudied and which may be underserved by the traditional AIAN health care infrastructure.

Child Health Disparities: Framing a Research Agenda (July/August 2004). Ivor B. Horn and Anne C. Beal. *Ambulatory Pediatrics,* vol. 4, no. 4 (*In the Literature* summary). In this article, the authors set forth a research framework for identifying racial disparities in children's health, determining their root causes, and developing effective interventions. They emphasize preventive care, culture, and language, and the social determinants of health, including housing, nutrition, and stress factors prevalent in low-income communities.