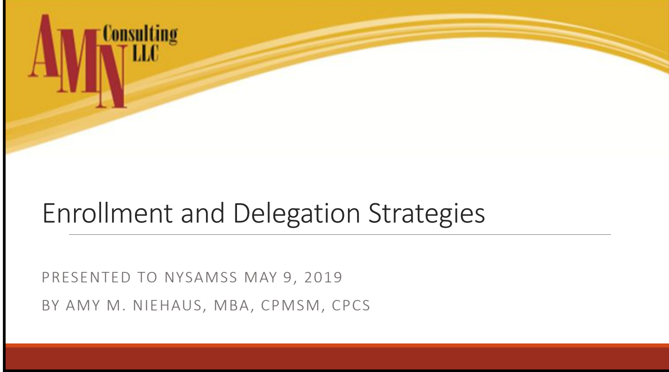

Objectives

- State the difference between enrollment and credentialing
- Discuss the impact of payer credentialing processes on enrollment
- Identify solutions to common enrollment challenges
- Name the benefits of attaining delegation with payers
- Describe NCQA credentialing standards required under delegation
- List critical steps to achieve delegation

Enrollment Nightmares

Manual processes

Claim holds

Denied claims

Incomplete applications

Missed start dates

Write-offs

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Payer Credentialing vs Enrollment

What are Payers?

- Healthcare entities other than the patient that finance or reimburse the cost of health services
  - Commercial: Health Plans/Managed Care Organizations
  - Federal/State: Medicare/Medicaid/TRICARE/TriWest
  - Health Plan Sponsors (employers or unions)

What is Credentialing?

- The process of documenting evidence of professional licensure, education, certification or other qualifications required to perform certain health care roles

- National Committee for Quality Assurance (NCQA)

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Why do Payers Credential?

- Ensure practitioner has legal authority and relevant training and experience to provide quality care
- Accreditation/Regulatory Requirements
  - NCQA, URAC, CMS, DOI
- Legal Precedent
- Internal Policies and Procedures

What is Enrollment?

- Submitting required documentation to third party payers to gain approval into payer networks and allow provider to bill for services
- Also referred to as Payer/Provider Enrollment

Why do Providers Enroll?

- Be considered "in-network" with payers and be listed in directories
- Receive direct reimbursement for healthcare services provided
- Drive patient contacts

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Enrollment Challenges

- Volume
- Payer requirements
- Provider information
- Timeliness
- Communication
- Resources
- Internal structure

What is the biggest enrollment challenge?

Delayed or lost reimbursement

Understanding Payer Processes and Requirements

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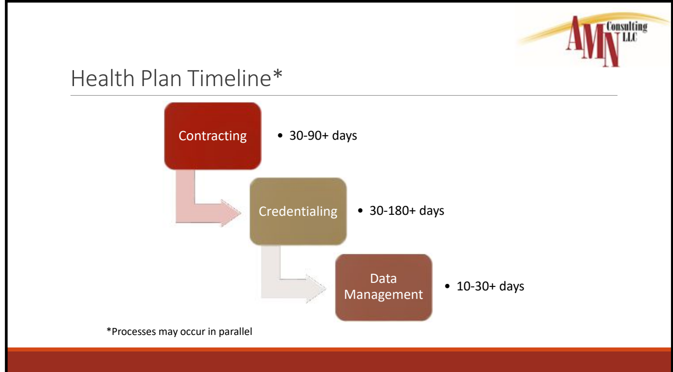

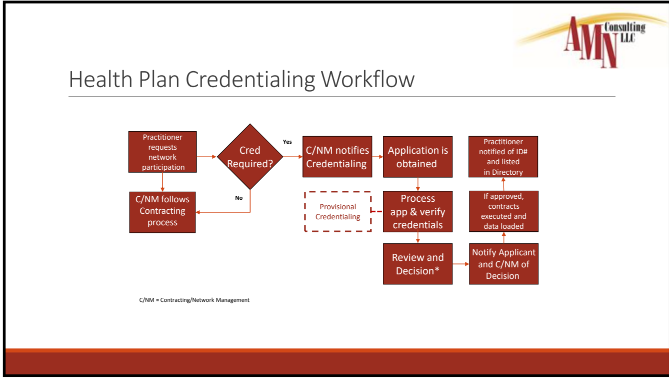

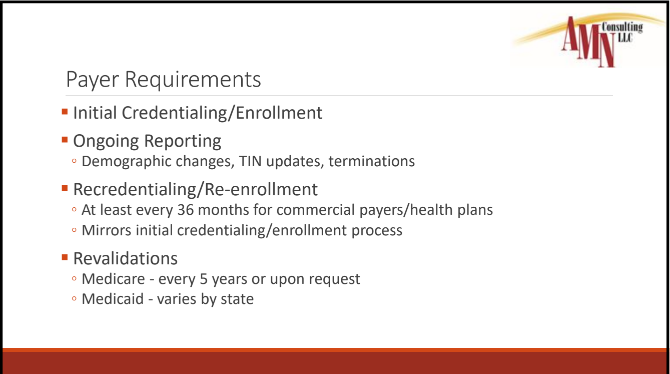

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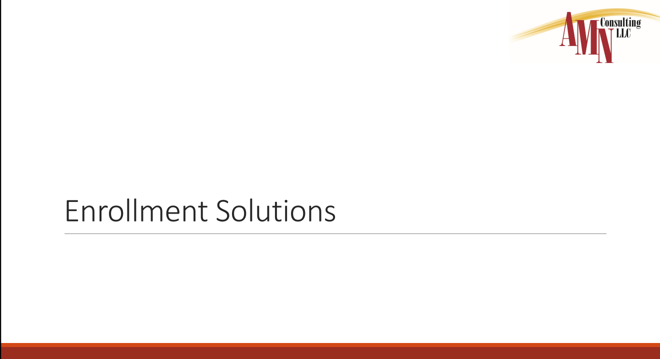
Payer Requirements, con't.

- Type of application
- Specific forms
- Required documents
- Method of submission
- Submission timeframe
- Reporting frequency
- Method of communication
- Copies of documents



Sample Payer Repository

Payer Name	Contract Date	Contact Information	Preferred Mailing Address	Average TAT	Method of Submission	Earliest Submission	Accreditor/ Regulator	Plan-specific Requirements	Reporting Requirements
ABC Health	1/1/2014	Mary Jones, CPCS mjones@abchealth.org (618) 259-1030	118 Skyway Ct # C, East Alton, IL 62024	95 days	CAQH only	90 days	NCQA URAC	* Verification of all current and prior state licenses held * Does not accept copy of DEA certificate	Monthly
My Plan	7/1/2011	Jane Smith jane.smith@myplan.org (999) 555-1234	One Union Avenue St. Louis, MO 63118	75 days	CAQH or paper	90 days	NCQA	* Hospital admitting arrangements accepted * Requires copies of licenses	Semi-annually
Medicare	3/1/2011	MAC: Palmetto GBA (803) 735-1034	17 Technology Circle Columbia, SC 29203	45/60 days	PECOS or paper	30 days	CMS	* Original signatures required	As needed
Medicaid	5/1/2011	Provider Services: (855) 237-6178	Molina Healthcare PO Box 40309 N Charleston, SC 29423	130 days	CAQH or paper	N/A	CMS	* Molina Attestation and Release Form required	As needed

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Application Submission

- Commercial
  - Earliest submission: varies by payer
- Medicare
  - Early submission: 60 days prior to effective date if compliant at that date
  - Late submission: effective up to 30 days prior to submission date
- Medicaid
  - Earliest submission: varies by state

Application Completeness

- Application/Attestation
  - Current signature date
- Work history
  - Month/Year
  - Explanation of gaps
- Malpractice history
  - NPDB
- Disclosure questions
  - Explanations

Technology – Commercial Payers

- CAQH ProView®
  - Used by over 900 healthcare organizations
  - Practice Manager module
- Commercial software
  - Enrollment and other functions
  - Online collection of provider data
  - Application pre-population
  - Potential integration with CAQH and PECOS
  - https://www.capterra.com/credentialing-software/

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Technology - CMS

- PECOS for Medicare
  - Initial enrollment averages 45 days vs 60 days for paper
  - Status, changes and revalidations
  - Identity & Access Management System
    - Surrogate Registration
- Revalidations
  - Download report and track https://data.cms.gov/revalidation
  - Use PECOS to manage

Onboarding Team

- Provide status updates
- Educate stakeholders
- Eliminate duplication
- Avoid team conflict
- Improve communication
- Increase satisfaction

Revenue Monitoring

- Track claim holds and write-offs
- Track reasons for denials
- Identify average turnaround times for enrollment
- Prioritize and modify enrollment processes

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Contract Management

- Send application packet with contract and require both be returned together
- Require receipt of all payer application data 60-90 days prior to start date
- Establish starts dates based on enrollment status
  - Medicare, at a minimum
  - Top 'n' commercial payers accounting for 'n'% of revenue
- Monitor and avoid scheduling patients with non-par payers until enrolled

Credentialing & Enrollment Integration

Non-Integrated Credentialing and Enrollment Environment

- Separate departments
- Different leadership
- Various databases
- Siloed processes
- Misaligned goals

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Credentialing and Enrollment Similarities

- Collect applications, forms, and signatures
- Follow-up with practitioners
- Track application processes
- Manage practitioner data
- Monitor expirables
- Verify credentials*

Case Study

- Health system with 4 hospitals and 400 member employed medical group
- MSSD and Provider Enrollment are separate departments reporting to different leaders
- Each department has own database with conflicting information
- Delays in practitioner start dates
- Experiencing lengthy enrollment TAT with payers resulting in A/R write-offs and claim holds
- High leadership and practitioner dissatisfaction

Alignment/Integration Options

- Option A: enrollment department reports to Credentialing/MSSD director (or vice versa)
- Option B: enrollment activities shared with credentialing staff
- Option C: enrollment and credentialing fully integrated into one department

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Benefits of Alignment/Integration

- Leverage existing staff and skillsets
- One practitioner database as "source of truth"
- Eliminate duplication of processes
- Reduce enrollment turnaround time
- Increase revenue timeliness
- Increase satisfaction

Delegation

What is Delegation?

- Merriam Webster Dictionary: to give (control, responsibility, authority, etc.) to someone: to trust someone with (a job, duty, etc.)
- NCQA: delegation occurs when an organization gives another entity the authority to carry out a function that it would otherwise perform

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What Entities Can Be Delegated To?

- Health plans can delegate credentialing activities to a variety of entities, including
  - IPAs
  - PHOs
  - CVOs
  - Hospitals
  - Medical groups
  - Other health plans

Benefits of Delegated Credentialing

- Decreases paperwork for practitioners and staff
- Reduces turnaround time for enrollment
- Enhances revenues through timelier reimbursement
- Increases satisfaction – administration, staff & practitioners
- May eliminate CAQH ProView® data management

Delegation Requirements

- Compliant credentialing policies and procedures
- Sufficient resources
- Minimum provider volume*
- NCQA accreditation or certification*

*varies by payer

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NCQA Credentialing Standards

Policies & Procedures

- Define credentialing and recredentialing criteria and process
- Demonstrate compliance with accreditation standards and regulatory requirements
- Outline Who, What, Where, When, How

Application and Attestation

- Completed for initial credentialing and recredentialing, that includes the following:
  - Reasons for inability to perform essential duties*
  - Lack of present illegal drug use*
  - History of loss of license and felony convictions
  - History of loss or limitation of privileges or disciplinary actions
  - Current malpractice insurance coverage
  - Current and signed attestation confirming correctness and completeness of application

*ADA compliant

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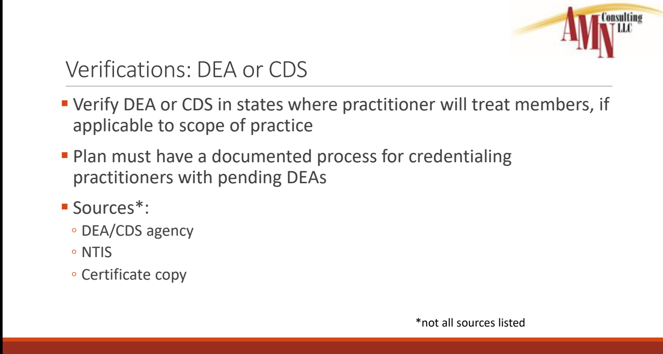
Application and Attestation

- Signature may be faxed, digital, electronic, scanned or photocopied
- Signature stamps are acceptable only if physical impairment/disability documented

Verifications: License

- Valid, current and in effect at time of decision
- Verify license in state(s) where practitioner will treat members
- Source:
  - State licensing board (PSV required)



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Verifications: Education/Training

- Plan must verify the highest level:
  - Medical/Professional School
  - Residency
  - Board Certification, if applicable
- Only required at initial credentialing, unless new training identified at recredentialing
- Sources*:
  - School/training facility
  - AMA/AOA

*not all sources listed

Verifications: Board Certification

- Verify if listed on application
- Document expiration date or lifetime certification
- If board does not provide expiration date, document board certification current at time of verification
- Sources*: specialty board, AMA/AOA, ABMS or official display agent

*not all sources listed

Verifications: Work History

- Obtain a minimum of 5 years of relevant work history or from time of initial licensure
- Month/year required for start/end dates if less than 5 years
- Gaps exceeding 6 months require verbal explanation; 1 year requires written explanation
- Only required at initial credentialing
- Not verified, but review must be documented
- Sources:
  - Application
  - Curriculum vitae

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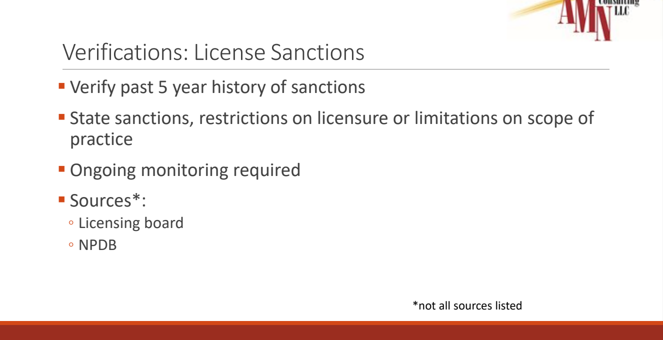
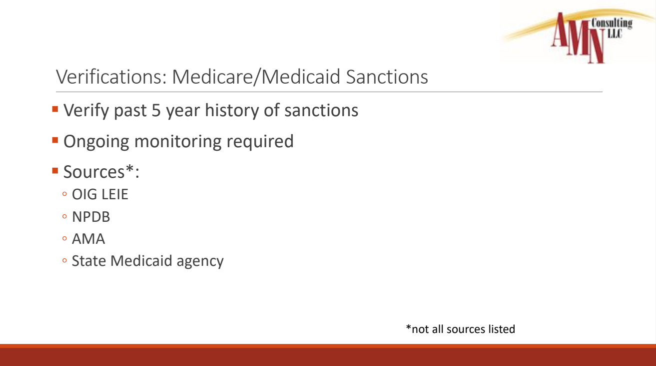
Verifications: Malpractice History

- Confirm past 5 years of malpractice settlements
- If training occurred during those 5 years, do not need to confirm with hospital insurance carrier
- Sources:
  - NPDB
  - Malpractice carrier





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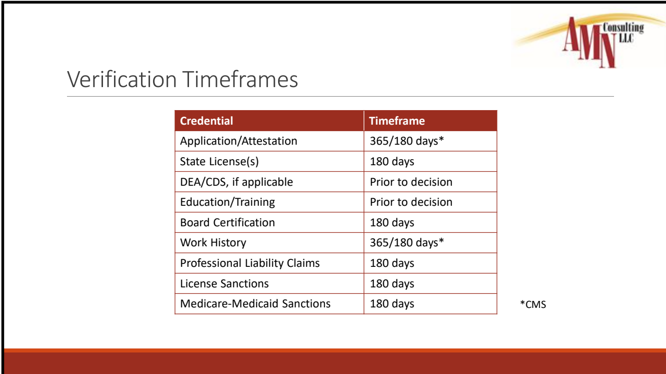
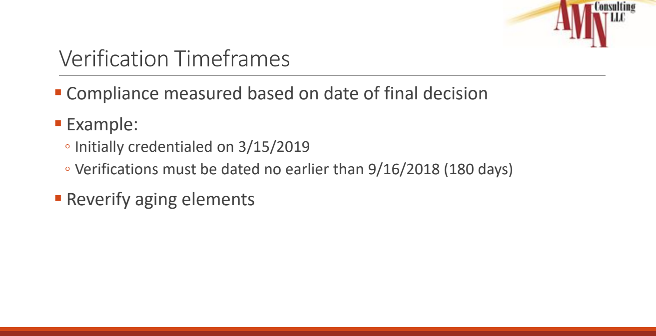


Verification Timeframes

Credential	Timeframe
Application/Attestation	365/180 days*
State License(s)	180 days
DEA/CDS, if applicable	Prior to decision
Education/Training	Prior to decision
Board Certification	180 days
Work History	365/180 days*
Professional Liability Claims	180 days
License Sanctions	180 days
Medicare-Medicaid Sanctions	180 days

*CMS



Medical Director Review

- Plan establishes criteria for a "clean" file
- Medical director, or designated equivalent, can be granted authority to approve "clean" files
- Final approval date on application
- Medical Director authority can be limited to review and make recommendations to Credentialing Committee

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Credentialing Committee

- Use a peer review process to make credentialing and recredentialing decisions
- Participating practitioners representing range of specialties provide expertise and advice
- Reviews all files or only those that do not meet "clean" criteria
- No size requirement
- May be in person or virtual, not email

Provisional Credentialing

- May conduct process one-time for initial applicants
- Required Elements:
  - PSV of current, valid license in state(s) where treating patients
  - PSV of past 5 years malpractice history from carrier or NPDB
  - Current, signed application and attestation
- Approval only valid for 60 calendar days; must complete full credentialing process during this time
- Same verification timelines apply
- Medical Director and/or Credentialing Committee process applies for decision

Practitioner Notifications

- When information obtained during the credentialing process varies substantially between the source and the practitioner
- Committee decisions must be communicated within 60 calendar days
  - All initial credentialing decisions
  - Recredentialing adverse decisions
- Notification of the following rights:
  - Right to correct erroneous information
  - Receive status of application upon request
  - Right to review information submitted

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Office Site Quality

- NCQA retired this standard in 2017; but some payers may still require
- Ensure that practitioner offices meet office-site standard criteria:
  - Physical accessibility
  - Physical appearance
  - Adequacy of waiting/examining room space
  - Adequacy of medical/treatment record keeping
- Implement appropriate interventions when criteria are not met
- Perform site visit within 60 days of member complaint that meets threshold criteria
- Evaluate at least every 6 months until deficiencies cleared

Recredentialing

- Required at least every 3 years
- Similar process to initial credentialing
- Compliance measured from month/year to month/year
  - Example: 3/15/2016 through 3/31/2019
- Consider a 34 or 35 month cycle to ensure compliance

Ongoing Monitoring

- In between recredentialing cycles, must monitor for, collect, review and take appropriate action in cases of poor quality regarding the following:
  - License and Medicare/Medicaid sanctions
    - Must review within 30 calendar days of data release; query at least every 6 months
  - Complaints
    - Investigate upon receipt; evaluate history at least every 6 months
  - Adverse events
    - Monitor at least every 6 months; may limit to PCPs and HVBH

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Appeal Process

- Plan must offer a formal appeal process when taking any actions for quality reasons
- At a minimum, should meet the requirements of the Health Care Quality Improvement Act (HCQIA) of 1986
- State regulations may vary

Organizational Providers

- Not typically included in delegation agreements
- Assess specific facilities
  - Hospitals
  - Home health agencies
  - Skilled nursing facilities
  - Free-standing surgical center
  - Behavioral healthcare (inpatient, residential, ambulatory)
- Must initially confirm and reconfirm at least every 3 years
  - Status with state and federal regulatory bodies; and
  - Accreditation status; or
  - Conduct onsite quality assessment, if not accredited
- No required timeframe for gathering data, e.g. 180 days

Additional CMS Requirements

MEDICARE ADVANTAGE

- Medicare Opt-out
- Hospital admitting privileges
- GSA/EPLS/SAM

STATE MEDICAID AGENCY

- NPPES/NPI
- Social Security Death Master File
- Criminal background check

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Steps To Achieve Delegation

Delegation Steps

- Pre-delegation assessment
- Delegation agreement
- Annual oversight audit

Sub-delegation

- Sub-delegation occurs when a delegated entity contracts with a third party to perform a delegated function
- Examples:
  - Payer to PHO to Hospital
  - PHO to Hospital to CVO
- Must follow same standards as the health plan
- Health plan must receive results of delegated entity's oversight assessment or perform the oversight assessment directly
- Pre-approval may be required

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Pre-Delegation Assessment

- Evaluation of the potential delegate's ability to perform required PRIOR to signing an agreement
  - Written review of delegate's understanding of standards and delegated tasks
    - Policies & procedures, application forms, committee roster; provider roster
  - May include:
    - File review
    - Staffing levels
    - Performance records
- Onsite visit not required
- NCQA Accreditation or Certification a plus!

Delegation Agreement

- Must include the following elements:
  - mutually agreed upon
  - responsibilities of each party/activities being delegated
  - reporting frequency, at least semiannually
  - performance evaluation process
  - use of Protected Health Information (PHI)
  - remedies for non-compliance
  - right of the plan to make the final decision

Delegation Agreement Considerations

- Responsibilities
- Effective date
- Loading turnaround time
- Communication
- Reporting
- Audits

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Annual Assessment

- Annual reviews to ensure continued compliance
- Similar to pre-delegation review process
  - Policies and procedures
  - NCQA standards and Plan's own requirements
  - File Review: NCQA audit process required
    - 5% of network or 50 files, minimum of 10 initial and 10 recred files, OR
    - 8/30 methodology
- Onsite visit not required
- Semi-annual review of reports

Annual Assessment

- Performance improvement opportunities identified and followed up on, if applicable
- Corrective actions required if issues identified
  - Education
  - Corrective Action Plan
  - Terminate agreement if non-compliant
- NCQA Accreditation or Certification a plus!

Termination of Delegation

- Recredentialing must still occur at least every 36 months
- Organization may obtain files from the delegate and continue with established timeframes; OR
- Perform initial credentialing within 6 months of termination

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Case Study

Case Study

Your health system has a 400 member employed medical group that continues to grow each year. Your CFO has asked you to investigate obtaining delegated credentialing status with your top 10 commercial payers to streamline the provider enrollment process and improve timeliness of reimbursement.

What steps do you need to take to evaluate your eligibility and readiness for delegation status?

S U C C E S S

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Steps to Delegation Success

- Complete cost/benefit analysis
  - Current payer mix
  - Volume of claim holds
  - A/R write-offs
  - Organizational costs
- Request information from payers
- Evaluate eligibility against requirements
- Develop project plan
- Obtain leadership support/project champion

Steps to Delegation Success

- Review own P&Ps against payer requirements, NCQA/other standards
- Audit credentials files to identify any gaps or issues
- Put action plans in place, if needed
- Notify payers to initiate delegation process

Result

Efficiency &/or Delegation

=

Faster Enrollment

=

Timelier Revenue

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Acronyms

- ABMS (American Board of Medical Specialties)
- AMA (American Medical Association)
- AOA (American Osteopathic Association)
- A/R (Accounts Receivable)
- CAQH (formerly Council for Affordable Quality Healthcare)
- CDS (Controlled Dangerous Substances)
- CVO (Chief Financial Officer)
- CMS (Center for Medicare & Medicaid Services)
- DEA (Drug Enforcement Agency)
- DOI (Department of Insurance)
- EPLS (Excluded Parties List System)
- GSA (General Services Administration)
- HCQIA (Health Care Quality Improvement Act)
- MCO (Managed Care Organization)
- MSSD (Medical Staff Services Department)
- NCQA (National Committee for Quality Assurance)
- NPDB (National Practitioner Data Bank)
- NPPES (National Plan and Provider Enumeration System)
- NPI (National Provider Identifier)
- OIG LEIE (Office of Inspector General List of Excluded Individuals and Entities)
- PECOS (Provider Enrollment, Chain & Ownership System)
- PSV (Primary Source Verification)
- RCM (Revenue Cycle Manager)
- SAM (System for Award Management)
- SSDMF (Social Security Death Master File)
- URAC (formerly Utilization Review Accreditation Commission)

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