Mastering the Mechanics of Managed Care Credentialing and Attaining Delegation

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Presented By

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Objectives

- Describe NCQA and CMS credentialing requirements
- List the required verifications and sources
- Identify methods to achieve and document compliance
- Discuss new standards and regulations for 2022
- Evaluate an organization's eligibility for delegation
- Determine the delegation approach that best fits your organization
- List critical steps to achieve delegation status with payers

NCQA Credentialing Standards

Overview of Credentialing Standards

- CR 1: Credentialing Policies
- CR 2: Credentialing Committee
- CR 3: Credentialing Verification
- CR 4: Recredentialing Cycle Length
- CR 5: Ongoing Monitoring and Interventions
- CR 6: Notification to Authorities and Practitioner Appeal Rights
- CR 7: Assessment of Organizational Providers
- CR 8: Delegation of CR

CR 1: Credentialing Policies

Practitioner Types

- Practitioners who are licensed, certified or registered by state to practice independently; have an independent relationship with the organization; and provide care
- Includes practitioners in individual or group practices, facilities, rental networks and telemedicine
- Includes virtual-only providers (no physical office location)
- Excludes facility-based practitioners (inpatient or facility setting practice only)

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Verification Sources

- Primary source
- Contracted agent of the primary source
- NCQA-accepted source
- Documentation methods:
  - Signed/initialed and dated documents
  - Comprehensive signed checklist
  - Automated credentialing system
  - Web crawlers

Credentialing Criteria and Process

- Criteria for credentialing and recredentialing used to assess practitioner's ability to provide care must be defined
- Decision-making process is described in policies
- Practitioners must be credentialed before providing care to members
  - Provisional credentialing option

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Provisional Credentialing

- Organization 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
  - Current, signed application and attestation
- Approval only valid for 60 calendar days; must complete full credentialing process during this time
- Medical Director and/or Credentialing Committee process applies for decision
- May not be listed in directories until fully credentialed

Clean File Management

- Organization establishes criteria for a clean file
- Credentialing committee can review and make final decision or may grant authority to medical director, or designated equivalent
- Medical director approval is considered final decision date

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Nondiscrimination

- Organization must monitor credentialing decisions to prevent discrimination based on applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes
- Monitoring processes may include:
  - Heterogeneous Credentialing Committee membership with non-discrimination attestation statement
  - Audit files that may suggest discrimination
  - Audit practitioner complaints

Credentialing Discrepancies

- When information obtained during the credentialing process varies substantially between the source and the practitioner
- Organization policy must define process for notification
  - Timeframes for notification and response
  - Consequences for non-response

Decision Notifications

- Committee decisions must be communicated within 60 calendar days
  - All initial credentialing decisions
  - Recredentialing adverse decisions
- Retain copy of letter in credentials file

Medical Director Responsibilities

- Policies describe the medical director's overall responsibility and participating in the credentialing process
- Examples include
  - Review and make recommendations to the Credentialing Committee
  - Approve clean files
  - Review ongoing monitoring findings

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Confidentiality

- Organization must ensure confidentiality of credentialing information
- Processes may include
  - Signed confidentiality statements
  - Appropriate disposal of confidential information
  - Limiting access to credentialing files and database

Directory Data

- Credentialing data displayed in directories and member materials accurately reflects information obtained during credentialing process
- Methods
  - Regular audits, e.g. monthly or quarterly
  - Interfaces or data feeds between systems
  - Produce directories from credentialing database

Practitioner Rights

- Organization notifies practitioner of the following rights:
  - Correct erroneous information
  - Receive status of application upon request
  - Review information submitted
- Notification methods:
  - Application / Letter
  - Website
  - Provider manual

Credentialing System Controls

- Requires processes for:
  - Receipt, dating and storage of verified information
  - Tracking and dating of verified information modified after receipt
  - Identifying staff that can review, modify and delete information and under what circumstances
  - Security controls that prevent unauthorized changes to information
  - Auditing process of system controls

CR 2: Credentialing Committee

- Uses 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 meet in person or virtually, not email

CR 3: Credentialing Verification

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)

DEA/CDS

- Verify DEA or CDS in states where practitioner will treat members, if applicable to scope of practice
- Plan must have a documented process for credentialing practitioners with pending DEAs
- Sources include:
  - DEA/CDS agency
  - AMA Physician Profile
  - Certificate copy

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 include:
  - School/training facility
  - AMA/AOA Profile

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 include:
  - Specialty board
  - AMA/AOA Profile
  - ABMS display agent

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

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

License Sanctions

- Verify past 5-year history of sanctions
- State sanctions, restrictions on licensure or limitations on scope of practice
- Sources include:
  - Licensing board
  - NPDB

Medicare/Medicaid Sanctions

- Verify past 5-year history of sanctions
- Sources include:
  - OIG LEIE
  - NPDB
  - AMA Profile
  - State Medicaid agency

Application and Attestation

- Completed for initial credentialing and recredentialing and 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

Application and Attestation, cont.

- Acceptable signature types
  - Faxed
  - Digital
  - Electronic
  - Scanned
  - Photocopied
- Signature stamps are acceptable only if physical impairment or disability documented

Verification Timeframes

- Compliance measured based on date of final decision
- Example:
  - Decision made on 10/22/2021
  - Verifications must be dated no earlier than 4/25/2021 (180 days) or 10/21/2020 (365 days)
- Reverify aging elements to ensure compliance

Verification Elements and Timeframes

Credentialing Element	Frequency	Timeframe
License	Initial and Recred	180 days
DEA/CDS	Initial and Recred	Prior to decision
Education/Training	Initial Only	Prior to decision
Board Certification	Initial and Recred	180 days
Work History	Initial Only	365/180 days*
Malpractice History	Initial and Recred	180 days
License Sanctions	Initial and Recred	180 days
Medicare/Medicaid Sanctions	Initial and Recred	180 days
Application/Attestation	Initial and Recred	365/180 days*

*CMS

CR 4: Recredentialing Cycle Length

- Required at least every 3 years
- Similar process to initial credentialing
- Compliance measured from month/year to month/year
  - Example: 10/15/2016 through 10/31/2019
- Consider a 34- or 35-month cycle to ensure compliance

CR 5: Ongoing Monitoring and Interventions

Ongoing Monitoring

- In between recredentialing cycles, must monitor for, collect, review and take appropriate action in cases of poor quality regarding the following:
  - License sanctions
  - Medicare/Medicaid sanctions
  - Complaints
  - Adverse events

License Sanctions

- Must review sanction reports for all active licenses within 30 calendar days of data release, or
- Query at least every 6 months if reports not regularly published, or
- Query 12-18 months after last credentialing cycle if no reports published
- Sources include:
  - Licensing board
  - NPDB Continuous Query
  - Federation of State Medical Boards (FSMB)

Medicare/Medicaid Sanctions

- Must review sanction reports for Medicare and Medicaid within 30 calendar days of data release
- Sources include:
  - OIG LEIE
  - NPDB Continuous Query
  - FSMB
  - AMA Physician Profile / Continuous Monitoring Service
  - State Medicaid agency

Complaints

- Must monitor for complaints received from its members regarding network practitioners and investigate upon receipt as appropriate, along with practitioner's history
- Evaluate history all practitioner complaints at least every 6 months
- Sources:
  - Patients/members
  - Medical staff/healthcare practitioners
  - Organization staff
  - Public
  - Media

Adverse Events

- An injury that occurs while a patient/member is receiving health care services from a practitioner
- Must monitor at least every 6 months; may limit to primary care/high-volume behavioral health practitioners
- Sources:
  - Quality/outcomes data
  - Complaints

CR 6: Notification to Authorities and Practitioner Appeal Rights

- Actions taken against a practitioner for quality reasons must be reported to appropriate authorities and organization must offer an appeal process
- Policy must define range of actions available to improve performance before termination
- Appeal process is made known to practitioner
- Follow HCQIA and any state regulations

CR 7: Assessment of Organizational Providers

- 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

CR 8: Delegation of Credentialing

- Delegation Agreement
- Pre-delegation Evaluation
- Review of Delegate's Credentialing Activities
- Opportunities for Improvement

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
  - right of the plan to make the final decision
  - remedies for non-compliance

Pre-Delegation Evaluation

- 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 and procedures, application forms, committee roster
    - Provider roster
  - May include
    - File review
    - Staffing levels
    - Performance records

Annual Review of Delegate's Credentialing Activities

- Ensure continued compliance
- Similar to pre-delegation review process
  - Policies and procedures
  - File review using one of the following NCQA audit process methods ***required***
    - 5% of network or 50 files, minimum of 10 initial and 10 recred files
    - May use 8/30 methodology
- Semi-annual review of reports

Annual Review of Delegate's Credentialing Activities, cont.

- 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

Improvement Opportunities

- Organization identifies and follows up on improvement opportunities, if applicable, at least once every 2 years
  - Pre-delegation evaluation
  - Ongoing reports
  - Annual review
- Applies to delegation arrangement in effect for more than 12 months
- NCQA determines appropriateness if no opportunities identified

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CMS Credentialing Regulations for Medicare Advantage (MA)

OIG LEIE

- Must check each new list, i.e., monthly
- Other sources are not recognized

Medicare Opt-Out

- Provider's voluntary status to not accept federal reimbursement
- Valid for two years; automatically renews unless provider withdraws
- Currently 25,000+ practitioners on list
- Must check on a regular basis, e.g., monthly
- Sources:
  - CMS website: https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits
  - CMS Medicare Administrative Contractors (MAC): https://www.cms.gov/MAC-info

Hospital Admitting Privileges

- Must verify clinical privileges at hospital designated as primary admitting facility, if applicable
- Sources:
  - Hospital roster
  - Application with attestation

Preclusion List

- List of providers and prescribers who are precluded from receiving payment for MA items and services or Part D drugs furnished or prescribed to Medicare beneficiaries
- Must check within 30 days of monthly release
- List only available to CMS approved MA health plans
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Preclusion-List

Site Visit Policy

- Must establish policy for conducting site visits
- Not required to conduct site visits, but at a minimum, should consider performing initial credentialing site visits for primary care physicians, OB/GYNs and other high-volume providers
- Organization determines frequency and criteria
- Many organizations continue following NCQA's prior standard

Complaints / Grievances

- Must develop and implement policies that address the ongoing monitoring of grievances filed against health care professionals

Adverse Events

- Must have an ongoing quality improvement (QI) program
- Purpose of a QI program is to ensure that organization has the necessary infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis

CMS Credentialing Regulations for Managed Medicaid

OIG LEIE

- Must check the LEIE no less frequently than monthly
- State Medicaid Agencies may require monitoring of state sanction lists

National Provider Identifier (NPI)

- Unique 10-digit identification number issued to health care providers by CMS
- Replaced the Unique Physician Identification Number (UPIN)
- Required identifier for Medicare services as part of the Administrative Simplifications portion of the Health Insurance Portability and Accountability Act (HIPAA)
- Source: https://npiregistry.cms.hhs.gov/

System for Award Management (SAM)

- Formerly Excluded Parties List System
- Must check no less frequently than monthly
- Source: www.sam.gov

Social Security Death Master File (SSDMF)

- Used to match records and prevent identity fraud
- Contains over 85 million records of deaths reported to the Social Security Administration since 1936
- Maintained by SSA and made available through the National Technical Information Service (NTIS)
- Must be certified to access the Limited Access Death Master File or contract with a certified vendor
- https://ladmf.ntis.gov/

Site Visits

- Must conduct pre-enrollment and post-enrollment site visits for moderate or high categorical risk providers
  - High risk providers have 5% or more direct or indirect ownership interest in a provider
- Purpose is to verify the information submitted is accurate and to determine compliance with federal and state enrollment requirements

Criminal Background Check

- Must obtain consent to conduct background checks, which may include fingerprinting, based on Fraud, Waste and Abuse (FWA) screening criteria or if required by state law
- Must establish categorical risk levels for providers who pose an increased financial risk of FWA
- Must perform background checks for high risk providers
- High risk providers must submit set of fingerprints within 30 days of request

Complaints / Grievances

- Must use data collected from its monitoring activities to improve the performance of its managed care program, including complaints and grievances

Adverse Events

- Must have in effect a monitoring system for all managed care programs
- Must address performance of the organization regarding quality improvement

What's New for 2022?

CR 1.C Credentialing System Controls - Changes

- Processes required for:
  - Receipt, dating and storage of PSV information
  - Tracking and dating of PSV information modified after receipt
  - Identifying ~~staff~~ ***roles or titles of staff*** that can review, modify and delete information and under what circumstances
  - Security controls that prevent unauthorized changes to information
  - Annual auditing process of system controls ***and actions taken when appropriate***
- **MUST PASS for ALL 5 factors!**

CR 1.D Credentialing System Controls - *NEW*

- Monitor CR system controls at least annually by
  - Identifying all modifications to credentialing information that did not meet organization's policies and procedures for modifications
  - Analyzing all instances of such modifications that did not meet policy, both qualitative and quantitative
  - Acting on all findings and implementing a quarterly monitoring process until improvement demonstrated over three consecutive quarters (F3)
- **MUST PASS for ALL 3 factors!**
- **Factor 3 is N/A if all modifications met policy**

Audit Sampling is ALLOWED!

- Organizations that use auditing as the monitoring method in CR 1, Elements C and D may use the 5% or 50 files audit process
  - At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.
- Cannot apply the 8/30 rule!
- FAQ: https://ncqa.secure.force.com/faq/FaqArticleDetail?id=ka02M000000eyyIQAQ&product=HP

Audit Sampling is ALLOWED!, cont.

- Must determine the sample size of 5% or 50 files (whichever is less) based on ALL files in the file universe
- File universe includes all files WITH OR WITHOUT modifications
- Sample that will be audited must include ONLY files with modifications (i.e., modifications that meet and do not meet the organization's policies and procedures)
- Analysis report must include the number or percentage of files that do not meet the organization's policies and procedures

Key Takeaways – Element C Policy

- Make sure policy is clear on methodologies, who is doing the changes, who is overseeing, what happens if inappropriate changes are found
- Focus on credentialing modifications only
- Describe all possible authorized modifications; adjust based on findings

Key Takeaways – Element D Process

- Have a robust tracking system
- Audit the sample against policy
  - Were changes authorized per policy?
  - Were changes made by authorized staff?
- Document findings
- Implement corrective action plans for unauthorized changes and audit for 3 consecutive quarters

CR 8.A 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 **(including credentialing system controls)**
  - right of the plan to make the final decision
  - remedies for non-compliance

CR 8.A Delegation Agreement, Factor 4 Explanation - NEW

- If the organization contracts with delegates that store, create, modify or use credentialing data on the organization's behalf, the delegation agreement describes:
  - The delegate's CR system security controls in place to protect data from unauthorized modification as outlined in CR 1, Element C (Credentialing System Controls), factor 4.
  - How the delegate monitors its credentialing system security controls at least annually, as required in CR 8, Element C, factor 5.
  - How the organization monitors the delegate's credentialing system security controls at least annually, as required in CR 8, Element C, factor 5.

CR 8.A Delegation Agreement, cont.

- Agreements dated 1/1/2022 and later must include description of delegate's system controls
- Prior agreements have until 7/1/2024 to incorporate new language
- May provide updated delegation agreement OR copy of delegate's system control policies through 7/1/2024
- FAQ: https://ncqa.secure.force.com/faq/FaqArticleDetail?id=ka02M000000eycCQAQ&product=HP

CR 8.C Annual Review of Delegate's Credentialing Activities

- Review delegate's credentialing policies and procedures
- Audit delegate's credentials files
  - File review using one of the following NCQA audit process methods ***required***
    - 5% of network or 50 files, minimum of 10 initial and 10 recred files
    - May use 8/30 methodology
- Evaluate delegate's performance against NCQA standards
- Review delegate reports at least semi-annually
- **Monitor delegate's credentialing system controls**
- **Act on findings and perform quarterly monitoring, if needed**

No Surprises Act – Provider Directories

- Effective 1/1/2022 for health plans
- Verification policy and procedure must be established
  - Verify and update provider directories at least every 90 days, or update directory within two (2) business days of receiving provider change
  - Respond to inquiries regarding provider participation status within one (1) business day of receipt and maintain record of inquiry for two (2) years
  - Remove or suppress unverified providers from directories
- Supports existing CMS and NCQA directory accuracy requirements

No Surprises Act – Provider Directories, cont.

- Providers must submit directory information, at a minimum
  - At the beginning of the network agreement
  - At the time of termination
  - When there are material changes to the provider directory information
  - ***Upon request by the payer***
  - At any other time determined appropriate by the provider or HHS

The Roadmap to Delegation

Benefits of Delegation

- Decreased paperwork for practitioners and staff
- Decreased enrollment turnaround time
- Earlier and consistent effective dates
- Enhanced revenues through timelier reimbursement
- Better use of resources
- Potential contracting leverage
- Increased satisfaction of administration, staff & practitioners

Delegation Requirements

- Compliant managed care credentialing program
  - NCQA Health Plan Standards
  - URAC Health Plan/Network Standards
  - CMS Medicare Advantage
  - CMS Managed Medicaid
  - Payer requirements*
- Minimum practitioner volume*
- NCQA recognition*
  - Credentialing (CR) Accreditation
  - CVO Certification

*varies by payer

Implementation Options

- Establish approach based on organizational structure; not "one size fits all"
- Leverage existing policies and procedure if possible
- Create sharing agreements between entities if corporate family
- Establish sub-delegation agreements if outside entities utilized

Policies and Procedures

- Create compliant set of credentialing policies and procedures
  - Develop from scratch
  - Enhance existing policies
  - Supplement medical staff bylaws
- Payer may require separate set of policies

Credentialing Process

- Process internally from start to finish
- Utilize CVO for verifications
  - Certification would reduce or eliminate required oversight
- Subdelegate entire process to another entity
  - Internal, e.g. hospital or centralized credentialing department within system
    - Service level agreement
  - External, e.g., third party administrator
    - Accreditation recommended to reduce or eliminate required oversight

Steps to Delegation Success

- Complete cost/benefit analysis
- Obtain leadership support
- Develop project plan
- Request information from payers and evaluate eligibility status
- Identify target payers for delegation
- Consider CR accreditation or CVO certification, if eligible

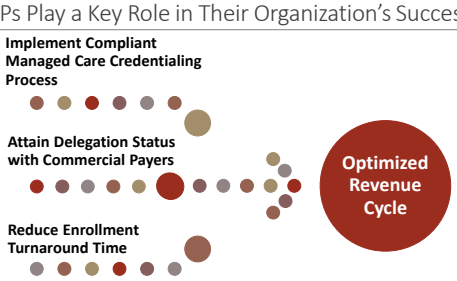
Steps to Delegation Success, cont.

- Review own policies and procedures against standards
- Implement compliant credentialing process
- Audit credentials files to identify any gaps or issues
- Put action plans in place, if needed
- Notify payers to initiate delegation process

Additional Delegation Considerations

- Does not fully eliminate provider enrollment activities
  - Medicare
  - Medicaid
  - Ineligible commercial payers
  - Ineligible practitioners
- Additional responsibilities based on payer requirements
  - Required verifications
  - Scope of practitioners
- Desired delegation timeframe
- Resources

MSPs Play a Key Role in Their Organization's Success!



Resources

- NCQA Corrections, Clarifications and Policy Changes
  - https://www.ncqa.org/programs/health-plans/policy-accreditation-and-certification/policy-updates/
- NCQA FAQs: https://ncqa.secure.force.com/faq/
- Facebook Groups
  - Accreditation and Managed Care Workgroup
  - Credentialing Collaboration Group
  - NAMSS Group

Resources, cont.

- CMS Medicare Managed Care Manual
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c06.pdf
- CMS Medicaid Program Integrity, Subpart E: Provider Screening and Enrollment
  - https://ecfr.io/Title-42/Part-455/Subpart-E
- No Surprises Act
  - https://www.aha.org/system/files/media/file/2021/01/detailed-summary-of-no-surprises-act-advisory-1-14-21.pdf