

Managed Care Standards Update & Efficiency Tools

Rachelle L. Silva, BBM, CPMSM, CPCS
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Objectives

- Identify the regulatory and accrediting bodies in the managed care environment
- Define and discuss the development of required managed care credentialing documents
- Define the required structure, verification elements, time-frames, and approved sources to ensure compliance.
- Utilize effective managed care tools that will assist in making the credentialing process more efficient

Regulatory Agency/Legislation

- Department of Health and Human Services
 - Centers for Medicare and Medicaid Services (CMS)
 - ❖ Medicare CoPs - Managed Care Manual (Chapter 6)
- Health Insurance Portability and Accountability Act (HIPAA)

Accrediting Bodies

- National Committee for Quality Assurance (NCQA)
- NCQA Credentials Verification Organization (CVO)
- URAC (was originally Utilization Review Accreditation Commission)
- Accreditation Association of Ambulatory Health Care (AAAHC)

Types Of Health Plans

- Health Plans administered by CMS
 - Medicare/Medicaid
 - State Children's Insurance Programs (SCHIP)
 - Federal Employee Health Benefit Plan (FEHB)
 - Tricare (Military)
- Commercial Health Plans (e.g. United, Blue Cross)
- Third Party Administrator Health Plans (e.g. self insured)
- Commercial Medicare Advantage Supplemental Health Plans

Credentialing Environments

- Health Plan
- Physician Hospital Organization (PHO)
- Independent Physician Organization (IPA)
- Single Specialty/Multispecialty Clinic
- Provider Group
- Hospital
- CVO

Terminology

- Practitioner
- Provider
- Network (Par & Non-Par)
- Member

Governing Documents

- Credentialing Plan, OR
- Credentialing Policies and Procedures

Scope Of Practice

- Who needs to be credentialed
 - Licensed independent practitioners
 - Practitioners with an independent relationship with the organization
 - Practitioners who provide care to members
 - Telemedicine – practitioner route or provider route

Scope Of Practice (Cont.)

- Who does not need to be credentialed
 - Hospital based practitioners
 - ❖ Emergency Medicine
 - ❖ Pathology
 - ❖ Radiology
 - ❖ Neonatology
 - ❖ Anesthesiology

Committee Structure

- Medical Director or other designated physician
- Credentialing Committee
 - Peer review body
 - Range of practitioners participating in the network
 - May have separate review bodies for each practitioner type

Committee Review

- **All** files are reviewed against minimum credentialing criteria
 - Thoughtful review and discussion
 - Review practitioners who do not meet criteria
 - Acceptable meeting format
- Meeting minutes
- Mechanisms for approval
 - All files reviewed by the Credentials Committee; OR
 - Medical Director approves Clean files

Non-discrimination

Credentialing decisions will not be made based on a practitioner's race, ethnic/national identify, gender, age, sexual orientation or patient type (i.e. Medicaid) in which the practitioner specializes.

- Required mechanisms implemented
 - Prevention – proactive steps to avoid discrimination
 - ❖ Heterogeneous Credentials Committee
 - ❖ Redacted identifiers
 - Monitoring
 - ❖ At least annually audit the credentialing process for discrimination

Timeliness

- Assessment of timeliness
 - Credentials Committee or Medical Director decision date utilized to assess timeliness of required timeframes

Notifications

- Practitioner notification of Credential Committee decisions
 - Initial Approval and Denials
 - ❖ CMS/NCQA – 60 calendar days
 - ❖ URAC – 10 calendar days
 - Recredential Denials
 - ❖ CMS/NCQA – 60 calendar days
 - ❖ URAC – 10 calendar days

Application

- Types of Applications
 - Organization specific
 - State standardized; voluntary or mandated
 - CAQH

Application Attestations

- Disclosures
 - Reasons for the inability to perform the essential functions of the position
 - 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 and signed attestation confirming the correctness and completeness of the application
 - ❖ (URAC – complete and accurate)

Application Attestations (Cont.)

- Current Malpractice insurance coverage
 - Source:
 - ❑ CMS – application attestation, malpractice carrier, or face sheet
 - ❑ NCQA – application attestation to include amount of coverage even if \$0 and the expiration date, may obtain face sheet in lieu of attestation
 - ❑ URAC – face sheet
- Work history
 - Gaps
- Admitting Privileges

Verification Sources

- Primary source
- A contracted agent of the primary source
 - Requires additional documentation of the contract between the primary source and the agent
- An accepted source listed for the credential by the regulatory/accrediting body

Required Verifications

- Licensure
 - Covid – CMS 1135 waiver for state licensure (3/1/20 – 10/31/21)
- DEA or CDS
 - Pending attestation
- Education and training
 - Highest Level of training
 1. Board Certification
 2. Residency
 3. Medical School
 - Advanced Practice Professionals
 1. Professional/Graduate School
 2. Board certification, if applicable

Required Verifications (Cont.)

- History of professional liability settlement or judgments
 - Past 5 years
- Sanctions –License and Medicare/Medicaid
 - Most recent 5 years

Verification Timeframes (Calendar Days)

	CMS	NCQA	NCQA CVO	URAC	AAAHHC
Attestation	180	365	305	180	180
Licensure	180	180	120	180	180
DEA or CDS	180	Prior to decision	Prior to decision	Prior to decision	180
Education/ Training	180	Prior to decision	Prior to decision	Prior to decision	180
Board Certification	180	180	120	180	180
Work History	180	365	305	180	180
Claims History	180	180	120	180	180
Sanctions	180	180	120	180	180

Audience Poll

Why the stricter timeframes for processing an application with a CVO?

CVO has no review or approval authority. File needs to be released for the client to review/approve within the 365/180 calendar timeframes.

Appropriate Documentation

- Credentialing verifications signed and dated
- Signed and dated checklist
- Automated credentialing system
- Acceptable signatures

Provisional Credentialing

- One time granting only at initial credentialing
- Required verifications
 - Licensure
 - Malpractice claims history
 - Current and signed application and attestation
- Same review and approval process
- Granted no longer than 60 calendar days
 - Covid extension – 180 calendar days (3/1/20 – 6/30/21)
- ❖ Ineligible – practitioners credentialed under a delegated credentialing agreement

Recredentialing

- Same criteria and policy requirements
- Same verification requirements with the exception of static information
- Recredentialing cycle length – at least every three years to the month not to the date
 - Counted Credentials Committee decision date to Credentials Committee decision date
 - AAAHC – as defined by state law and organization policy to exceed three years

Recredentialing (Cont.)

- Extending recredentialing cycle length
 - Documentation practitioner is on leave for: active military service, maternity leave, sabbatical
 - Must recredential within 60 calendar days of return to practice
- Covid Extension (3/1/20 - 6/30/21)
 - Recredentialing cycle extended 2 months to 38 months

Reinstatement

- Administrative termination/reinstatement (e.g. practitioner did not return application)
 - If reinstated within 30 calendar days - recredentialing process
 - If reinstatement is more than 30 calendar days - initial process

Ongoing Monitoring

- Monitoring conducted between credentialing cycles
 - License Sanctions
 - Medicare/Medicaid Sanctions
- Timeframes
 - Within 30 days of publishing
 - Every 6 months If information not published – document no set publish date
 - Individual query every 12-18 months if entity does not release sanction information

Ongoing Monitoring (Cont.)

- Complaints
 - Investigate practitioner specific member complaints
 - Evaluate the history of complaints for all practitioners
 - Implement interventions if evidence of poor quality that could affect the health and safety of its members
- Timeframe – at least every six (6) months

Confidentiality

- Policies regarding confidentiality
- Practitioner authorization to release information
- Mechanisms implemented to protect confidential information (e.g. access to paper and electronic)
- Employee education/Confidentiality statements
- Disposal of confidential documents

Credentialing System Controls

New Standard Effective 7/1/2020

- How PSV is received, dated, and stored
- Tracking modifications (when, how, who, and why)
- Authorization to modify credentials information
 - Staff level authorized to access, modify and delete
 - Circumstances for allowable modifications or deletion
- Risk assessment audits
 - Audit methodology (credential files and security protocols)
 - Staff involved in the audit process
 - Audit frequency

Credentialing System Controls (Cont.)

- Security controls

- Need to know database access

- Password protections

1. Strong passwords.

2. Do not write down passwords

3. Use different passwords for different accounts.

4. Scheduled intermittent password changes

- Changing or withdrawal of passwords

1. Alerting appropriate staff in charge of computer security

2. Disable or remove access to employees who change departments or leave the organization

Practitioner's Rights

- Review of non-peer review protected information submitted in support of the credentialing application
- Notification of information obtained that varies substantially from the application and the process for the practitioner to correct the information
- Obtain the status of the application upon request
- Notification of these rights

Appropriate Interventions

- Range of issues that would require intervention
 - Patient complaints
 - Quality concerns
 - Inappropriate advertising
 - Mismanagement of billing/claims management
- Process for investigation of the issue
 - Collegial intervention
 - Suspension
 - Termination
- Required reporting – State Medical Board and/or NPDB

Appeals Process

- Written notification to the practitioner to include:
 1. Reasons for the action; and
 2. Summary of the appeal rights and process
- Request a hearing within 30 calendar days after notification
- Practitioner rights to be represented by an attorney or another person of their choice
- Appointment of a hearing officer or a panel of individuals to review the appeal
- Written notification of the appeal decision

Delegation

- Written mutually agreed upon contract
- Details responsibility of credentialing activities
- Semiannual reporting
- Annual review of the delegates policies and credential files
- Organization retains the right to approve, suspend, and terminate
- Corrective action plan processes for deficiencies

Organizational Providers

- Verified compliance with state licensing requirements and federal regulations
- Evidence of review and approval by an accrediting body
- Conducts on-site quality assessment if provider is not accredited
 - ❖ Assessment performed prior to initial approval and every 36 months thereafter

Departmental Best Practices

- Internal monitoring and auditing practices
 - Data accuracy
 - File auditing – completeness, accuracy, timeliness
 - Performance improvement

Efficiency Tools

- Checklist
- DEA/CDS explanation/waiver form
- Admit/Coverage arrangement form

Efficiency Tools (Cont.)

- Verbal verification forms
 - Degree Program
 - Post Graduate Training Program
 - Board Certification
 - Licensure
 - Hospital Privileges
 - Professional Liability Insurance

Questions and Answers



THANK YOU!

Contact Information:
Rachelle Silva, BBM, CPMSM, CPCS
Southern Belles and Beau, LLC
Email: southernbellesandbeau@gmail.com

