2016 Annual Conference

Credentialing Standards

Presenters:
Mei Ling Christopher
Veronica Harris – Royal
Agenda

- Definitions
- 2016 vs. 2017 Regulatory Updates
- Understanding the Standards
- SB 137 – Provider Directories
- Reminders
- Questions and Answers
Definitions

- **Annual Audit**: A health plan must conduct an audit at least every 12 months; 2-month grace period allowed (14 months).

- **Adverse Event**: An injury that occurs in the course of a member receiving health care services from a practitioner also known as Sentinel Event.

- **Delegation**: A formal process by which the organization gives another entity the authority to perform certain functions on its behalf.
Definitions

- **Documented Process**: Policies and procedures, process flow charts, protocols and other mechanisms that describe the methodology used to complete a task.

- **Structural Requirement**: Essential program, process and procedural components of the NCQA's standards that the organization is required to meet. (must have your own policy and procedures) e.g. CR 1 and CR 6
Definitions

- **Element**: The scored component of a standard that provides details about performance expectations. NCQA evaluates each element to determine the degree to which the organization meets the standard’s requirements.

- **Factor**: A scored item in an element. For example, an element may require the organization to demonstrate that its policies and procedures include four specific items; each item is a factor.

*Example: CR 9 Element A, Factor 1*
Definitions

• **Independent Relationship:** An organization directs its members to see a specific practitioner or group of practitioners, including all practitioners that members may select as primary care practitioners. Not synonymous with independent contract.

• **Policies and Procedures:** A documented process that describes the course of actions taken and the method in which the action will be carried out by the organization’s staff to achieve objectives.
Acronyms

- California Department of Insurance (CDI)
- Centers for Medicare & Medicaid Services (CMS)
- Department of Health Care Services (DHCS) Medi-Cal
- Department of Managed Health Care (DMHC)
- National Committee for Quality Assurance (NCQA)
- Organizational Providers (OPs) aka Health Delivery Organization (HDOs)
NCQA Updates 2016-2017

- NCQA eliminated Practitioner Office Site Quality (CR 5), causing all other standards to be renumbered.

- NCQA eliminated CR 7B - Reporting to Appropriate Authorities and CR 7C – Practitioner Appeal Process.

- Minor rewording that did not change the intent of the requirement.
DO YOU UNDERSTAND?

YES!
I CAN EXPLAIN IT.

I MIGHT NEED
MORE HELP.
Understanding the Standards

- CR 1: Credentialing Policies
- CR 2: Credentialing Committee
- CR 5: Ongoing Monitoring and Interventions
- CR 6: Notification to Authorities and Practitioner Appeal Rights
- CR 7: Assessment of Organizational Providers
- CR 8: Delegation
CR 1 Element A
Credentialing Policies

- **Factor 1:** Policies should list the types of practitioners you credential
  - MDs, DOs, DDS, Podiatrists, NPs, PAs, etc.

- **Factor 2:** Verification sources used for each file element (examples)
  - State Medical License via the State Medical Board
  - DEA via a copy of the DEA or NTIS
  - Education/Training via the AMA, AOA, Residency Program
  - Board certification verified via the AMA or the ABMS
CR 1 Element A
Credentialing Policies

- **Factor 3:** Criteria for credentialing and recredentialing
  - Define the criteria it requires to reach a credentialing decision
    - Criteria designed to assess a practitioner’s ability to deliver care

- **Factor 4:** The process for making credentialing and recredentialing decisions
  - Determine which practitioners may participate in its network
CR 1 Element A
Credentialing Policies

• **Factor 5:** Managing files that meet the criteria
  ◦ Describe the process used to determine and approve clean files. May present to CC or MD

• **Factor 6:** The process for delegating credentialing and recredentialing
  ◦ Describes what activities may be delegated
  ◦ How the organization decides to delegate
  ◦ Provide a statement indicating that the organization does or does not delegates credentialing activities
CR 1 Element A
Credentialing Policies

- **Factor 7:** The process for ensuring nondiscriminatory credentialing
  - The policy must state that credentialing decisions are not based on an applicant’s race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes.
  - The policy must include a procedure for Preventing and Monitoring discrimination.
CR 1 Element A
Credentialing Policies

• Prevention examples:
  ◦ Maintaining a heterogeneous credentialing committee and requiring signed statements affirming they do not discriminate.

• Monitoring examples:
  ◦ Periodic audits of credentialing files that suggest potential discriminatory practice in selection.
  ◦ Annual audits of practitioner complaints

• Factor 8: Discrepancies in credentialing information
  ◦ How are practitioners notified if information from other sources varies?
CR 1 Element A
Credentialing Policies

- **Factor 9:** Notification of decisions
  - Policies must specify the timeframe for notifying applicants of initial credentialing decisions and recredentialing denials within 60 days.

- **Factor 10:** Medical Director participation
  - Policies must describe the Medical Director or physician’s overall responsibility for credentialing.
CR 1 Element A
Credentialing Policies

- **Factor 11**: Ensuring Confidentiality
  - Policy must clearly state that information obtained is confidential and how it is protected. (Locked files, securing information, signed confidentiality statements)

- **Factor 12**: Practitioner directories and member materials *(Not Scored for Delegation Oversight)*
  - Policies describe the process for insuring that the information provided in member materials and directories is consistent with info obtained during the credentialing process
CR 1 Element B
Practitioner Rights

• **Factor 1:** Review information submitted to support their credentialing application

• **Factor 2:** Correct erroneous information
  ◦ The time frame
  ◦ The format
  ◦ Where to submit corrections
  ◦ How practitioners are notified of their right

• **Factor 3:** Check the status of their application
CR 2 Element A
Credentialing Committee

- **Factor 1:** Uses participating practitioners for credentialing decisions
- **Factor 2:** Review credentials for practitioners who do not meet the established criteria/thresholds
- **Factor 3:** Ensures that files that meet established criteria are reviewed and approved by a medical director or designated physician
CR 5 Element A
Ongoing Monitoring

Collect and reviewing:

- **Factor 1:** Medicare and Medicaid Sanctions
  - NPDB, FSMB, State Medicaid Agency, List of Excluded Individual and Entities (OIG), Medicare exclusion database, AMA Physician Mastery file and FEHB Program department record.
  - For delegates contracted with CMS must use OIG

- **Factor 2:** Sanctions or limitations on licensure
  - Appropriate state agencies, State licensing boards, NPDB, FSMB)
CR 5 Element A
Ongoing Monitoring

- Information must be reviewed within 30 calendar days of the release from the reporting entity.
- If no sanction reports are available must conduct individual queries every 12-18 months on credentialed providers.
- If reports are not published on a set schedule must document and query at least every 6 months.
- Can use Continuous Query, however must show evidence of monthly reports.
Factor 3: Collecting and review complaints
- Investigating Complaints upon receipt
- Evaluating the history of complaints at least every six months

Factor 4: Collecting and reviewing information from identified adverse events
- Monitoring for adverse events (Minimum PCP and High-Volume Behavioral Healthcare providers)
- Monitoring at least every six months

Factor 5: Implementing appropriate interventions
CR 6 Element A
Notification to Authorities

- **Factor 1:** Specify the range of actions that may be taken to improve performance prior to termination
  - e.g. Profiling, Corrective Actions, Monitoring, Medical Record Audit

- **Factor 2:** Reporting to Authorities
  - NPDB, State Agencies – California Medical Board (805 and 805.1 Reports)
    - Specific Incidents that are reportable
    - How and when to report
    - To whom incidents are reported
    - Reporting responsibilities
CR 6 Element A
Practitioner Appeal Rights

- **Factor 3:** Appeal Process
  - Written notification of a review action
  - Allowing a request for a hearing
  - Allowing at least 30 calendar dates to request
  - Allowing representation by an attorney or another person of their choice. CA Regulation does not allow the group attorney representation unless the practitioner also has representation.
  - Appointing a hearing officer or appeal panel
  - Written notification of the decision

- **Factor 4:** Making the appeal process known
CR 7 Element A
Organizational Providers

- **Factor 1:** Provider in good standing with state and federal regulatory bodies
  - Specify Sources

- **Factor 2:** Approval by an accrediting body
  - Specify Sources

- **Factor 3:** Conduct an onsite quality assessment if the provider is not accredited
  - Need assessment criteria for each type
  - Process to ensure providers credential practitioners
  - CMS or State Reviews – no older than 3 years old
CR 7 Element B
Medical Providers

- Hospital
- Home Health Agencies
- Skilled Nursing Facilities
- Free-standing surgical Centers
CMS Medical Providers

- Hospital
- Home Health Agencies
- Skilled Nursing Facilities
- Free-standing surgical Centers
- Clinical Labs
- Comprehensive Outpatient Rehabilitation Facilities
- Outpatient Physical Therapy Providers
CMS Medical Providers

- Outpatient Speech Pathology Providers
- End-Stage Renal Services Providers
- Outpatient Diabetics Self-Management Training Providers
- Portable X-Ray Supplier
- Rural Health Clinics
- Federally Qualified Health Centers
CR 7 Element C
Behavioral Healthcare Providers

- Inpatient
- Residential
- Ambulatory

- Examples of BH Providers
  - Psychiatric Hospitals and Clinics
  - Addiction disorder facilities
  - Residential Treatment Centers for Psychiatric and addiction disorders
CR 7 Element D & E
Assessing Providers

- Maintaining a process that shows that it confirms:
  1. That the provider is in good standing with state and federal regulatory bodies
  2. Accreditation with an approved accrediting body or
  3. Conducted a quality assessment
## Organizational Providers

### 2016 Annual Conference

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<th>Facility Name</th>
<th>Facility Type</th>
<th>Prior License Verification Date</th>
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<th>Prior Accreditation Expiration Date/Status</th>
<th>Prior Site Visit Date/Status</th>
<th>Prior Review/Approval Date</th>
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Organizational Provider Summary Review

Initial Contracting Assessment □ Reassessment □ Prior Approval Date: __/__/____

Name of Facility: _______________________ Medicare Contract: Yes □ No □

Type of Facility: ________________________

Certified by Medicare: Yes □ No □ Medicare Certification Number: _______________

NPI: _________________________________

License Verification:
Licensing Agency: _______________________
Validation/Verification Date: __/__/____ License Expires: __/__/____ Status: ________

Accreditation Status:
Is The Facility Accredited? Yes □ No □ Accrediting Body: _______________________
Validation/Verification Date: __/__/____ Accreditation Expires: __/__/____ Status: ______

Onsite Quality Assessment/Site Audit conducted by ____________________________(CMS, DHCS, Other)

Audit Date & Score/Compliance: __/__/____ Score: ________Compliant? Yes □ No □

Federal Standing Verification:
Medicare/Medicaid Sanction Review (OIG) Verification Date: __/__/____ Status: ______

Additional Requirements:
Malpractice Insurance Expires: __/__/____ Verification Date: __/__/____

Review/Approval Date: __/__/____ Reviewed by: _________________________________
Committee Review/Approval Date: __/__/____ (if applicable)
Decision: Approve □ Deny/Terminate □ Pend □

This document is for informational purposes only
delegation.
### CR 8 Element A
Delegation Agreements

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<th>Type</th>
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<th>Delegation Agreement Effective Date</th>
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Always complete the above box when a PO delegates any part of the credentialing process.
CR 8 Element A
Delegation Agreements

- **Factor 1:** Mutually Agreed upon – Signed by both parties

- **Factor 2:** Describes the delegated activities and the responsibilities

- **Factor 3:** Requires at least semiannual reporting. (Required quarterly for Med-Cal)

- **Factor 4:** Describes the process by which the organization evaluates the delegated entity's performance
CR 8 Element A
Delegation Agreements

- **Factor 5:** Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.

- **Factor 6:** Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.
If the delegation arrangement includes the use of protected health information by the delegate. The delegation document must include the following:

- **Factor 1:** Allowed uses of PHI
- **Factor 2:** A description of safeguards to protect information
- **Factor 3:** Ensures that the delegate has similar safeguards
CR 8 Element B
Provisions of PHI

- **Factor 4:** Stipulates that the delegate provides individuals with access to their PHI
- **Factor 5:** Stipulates that the delegate informs the organization if inappropriate uses of information occurs
- **Factor 6:** Ensures that PHI is returned, destroyed or protected if the delegation arrangement ends
CR 8 Element C
Predelegation Evaluation

- Evaluating a potential delegates capacity to meet NCQA and other regulatory bodies requirements prior to implementing delegation.

- Evaluation must be conducted within 12 months prior to implementing delegation.

- If the delegation agreement is amended to include additional activities, they must be evaluated prior to implementation.
CR 8 Element D
Review of Delegate’s Activities

- **Factor 1:** Annually reviews credentialing policy and procedures
- **Factor 2:** Annually audits cred and recred files
- **Factor 3:** Annual evaluates performance
- **Factor 4:** Evaluates regular reports semiannually, as specified in the agreement
CR 8 Element E
Opportunities for Improvement

- For Agreements that have been in effect for more than 12 months, the organization identified and followed up on opportunities for improvements, if applicable.
Reminders

- HIV AIDS specialists must be screened annually and send to the referral department within 30 days of the annual screening process.
- Must have a DEA for each state that they practice.
- **SB 137** Provider Directories
- **CPPA** California Participating Practitioner Application
Reminders

- Appropriate Documentation:
  - Source Used
  - Date of the Verification
  - Report date if applicable
  - Signature/Initial of the person verifying the information

- FAQs on the ICE Website:

- All Plan Letter – Medi-Cal – more to come
  - Social Security Death Master File
  - NPPES query for NPI
Questions and Answers