Managed Care Credentialing: Compliance Strategies for Health Plans, CVOs, and Delegated Entities

Amy M. Niehaus, MBA, CPMSM, CPCS

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Amy M. Niehaus, MBA, CPMSM, CPCS, Author
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About the Author

Amy M. Niehaus, MBA, CPMSM, CPCS

Amy M. Niehaus, MBA, CPMSM, CPCS, is a credentialing and medical staff services consultant with over 25 years' experience in the industry. She advises clients in the areas of accreditation, regulatory compliance, credentialing, privileging, process simplification/redesign, credentialing technology, CVO development and certification, enrollment, and delegation.

Niehaus has been a member of the National Association Medical Staff Services (NAMSS) since 1991 and is dual-certified as a Certified Professional Medical Services Management (CPMSM) and a Certified Provider Credentialing Specialist (CPCS). She has served as a NAMSS Instructor from 2010-2021, presenting CPCS and CPMSM certification programs and developing new content for NAMSS education programs. She has served in other NAMSS roles, including chair of its MCO Task Force, chair and member of the Education Committee, and independent study program editor. She was awarded the Joan Covell-Carpenter award in 2003 for her *Synergy* article entitled "Physician Credentialing Guide." She is also a former president of the Missouri Association Medical Staff Services and the Greater St. Louis Area Chapter.

Niehaus has been a speaker and educator since 2000. She has developed and presented various programs to state and national audiences on credentialing and privileging processes; The Joint Commission, NCQA, and URAC accreditation standards and survey preparation; CVO certification; provider enrollment; and delegation. She has authored and contributed to a variety of industry-related publications, including NAMSS *Synergy*, The Greeley Company, Credentialing Resource Center, AHLA MedStaff News, and *Becker's Hospital Review*.

Niehaus has worked in multiple environments throughout her career, including acute care hospitals, CVOs, and managed care organizations, which have provided her with unique and diverse insight into all facets of the medical staff services and credentialing profession. She has held numerous management roles culminating as a director of credentialing for a national health benefits organization. Since 2014, she has utilized her knowledge and experience as a consultant to support numerous clients within the healthcare industry. She holds a Bachelor of Science degree from the University of Missouri and a Master of Business Administration from Maryville University in St. Louis.

Introduction

The world of credentialing has expanded dramatically over the past few decades. Initially, medical services professionals (MSP) primarily worked in standalone hospitals and didn't need to know about the credentialing activities in other organizations, such as managed care organizations (MCO) and health plans, because, for the most part, those activities did not impact their roles and responsibilities. The same held true for MCOs, which focused on developing products and networks to provide covered healthcare services to its members. Each organization worked within its own silo and performed its credentialing activities in accordance with its own accrediting and regulatory requirements.

But then the healthcare environment started to change. Many hospitals became part of larger healthcare systems, patient care services extended outside of the hospital to outpatient clinics and surgery centers, physician/hospital organizations (PHO) and independent practice associations (IPA) were created to form alliances and gain contracting leverage in the marketplace, and hospitals began employing practitioners and assuming responsibility for enrolling them with third-party payers.

Today, we have the perfect storm: Hospital credentialing, managed care credentialing, and delegated credentialing are all coming together onto the same stage. As healthcare systems and hospitals are looking for ways to integrate more fully and achieve greater efficiencies, many hospital medical staff services departments are taking on the additional responsibilities of enrolling employed practitioners and attaining delegated credentialing from commercial payers to improve their organization's revenue cycle.

Now more than ever before, MSPs, credentialing specialists, and enrollment specialists in all healthcare environments need to know more about MCOs and the regulations and standards that drive their credentialing processes. This book was developed to support those MSPs and specialists by providing the information, tools, and techniques they need to succeed in this ever-changing industry. Whether you are a seasoned hospital MSP who is now tasked with integrating provider enrollment or taking on delegated credentialing or someone who needs to learn how to perform credentialing in a health plan, this book was created with you in mind.

This manual will provide readers with the following information:

- An overview of the managed care environment
- An interpretation of the accreditation standards and regulatory requirements that drive the MCO credentialing process
- An understanding of a health plan's credentialing process
- Insight into what delegated credentialing entails for both parties
- The role of credentials verification organizations in delegated credentialing

- Understanding of the various NCQA accreditation programs and survey process
- Opportunities to test knowledge through quizzes and other learning activities
- Industry resources and tools

In addition, readers will benefit from the knowledge and experience of industry professionals, who have provided their own tips, tools, and leading practices to support health plans and MCOs in achieving compliance or to support health systems, hospitals, and provider groups in developing or improving provider enrollment practices or achieving delegated credentialing.

Disclaimer

Please note that this guide is not intended to be the sole source of information for an organization or individual desiring to learn more about the credentialing requirements for MCOs and health plans. It is intended to supplement the applicable accrediting body's standards manual with the experience, perspectives, and knowledge from those working within the industry.

Sources Used for Credentialing Regulations and Accreditation Standards

National Committee for Quality Assurance (NCQA) Health Plan Standards effective 7/1/2022
www.ncqa.org

URAC Health Plan Standards v7.3
www.urac.org

Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

Title 42: Public Health
PART 455—PROGRAM INTEGRITY: MEDICAID
Subpart E—Provider Screening and Enrollment
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455#subpart-E

Chapter 1

Overview of the Managed Care Environment

Before we get into the details of how and why insurers credential, let's start with a little background on the managed care environment. First, let's talk about the name. There are many terms used to describe these types of organizations. *Managed care organization* (MCO) has been used throughout the healthcare industry to describe companies that provide healthcare insurance and benefits. Examples include national organizations such as Aetna, Blue Cross Blue Shield, and United Healthcare, as well as regional and local insurers. These organizations are also known as *health plans, health insurers, healthcare benefit companies, third-party payers,* and *commercial payers*. These terms tend to be used somewhat interchangeably within the industry, but throughout this book, the most commonly used terms will be *health plan, MCO,* and *payer*.

Another nuance of the terminology used within the industry is the distinction between *provider* and *practitioner*. The industry tends to use the term *provider* to describe both practitioners and facilities, as it includes all aspects of healthcare delivery, which is relevant to the discussion of health plans. Throughout this manual, *practitioner* will refer to an individual working in healthcare, such as a physician, chiropractor, nurse practitioner, or social worker. The term *provider* will mean healthcare facilities, such as hospitals, surgery centers, pharmacies, durable medical equipment companies, etc., in addition to practitioners.

So, what is *managed care*? According to the U.S. National Library of Medicine, managed care describes "programs intended to reduce unnecessary health care costs through a variety of mechanisms, including:

- Economic incentives to select less costly forms of care by both physicians and patients,
- Reviewing medical necessity of services,
- Increased beneficiary cost sharing,
- Controls on inpatient admissions and lengths of stay,
- Selective contracting with health care providers, and
- Intensive management of high-cost cases"

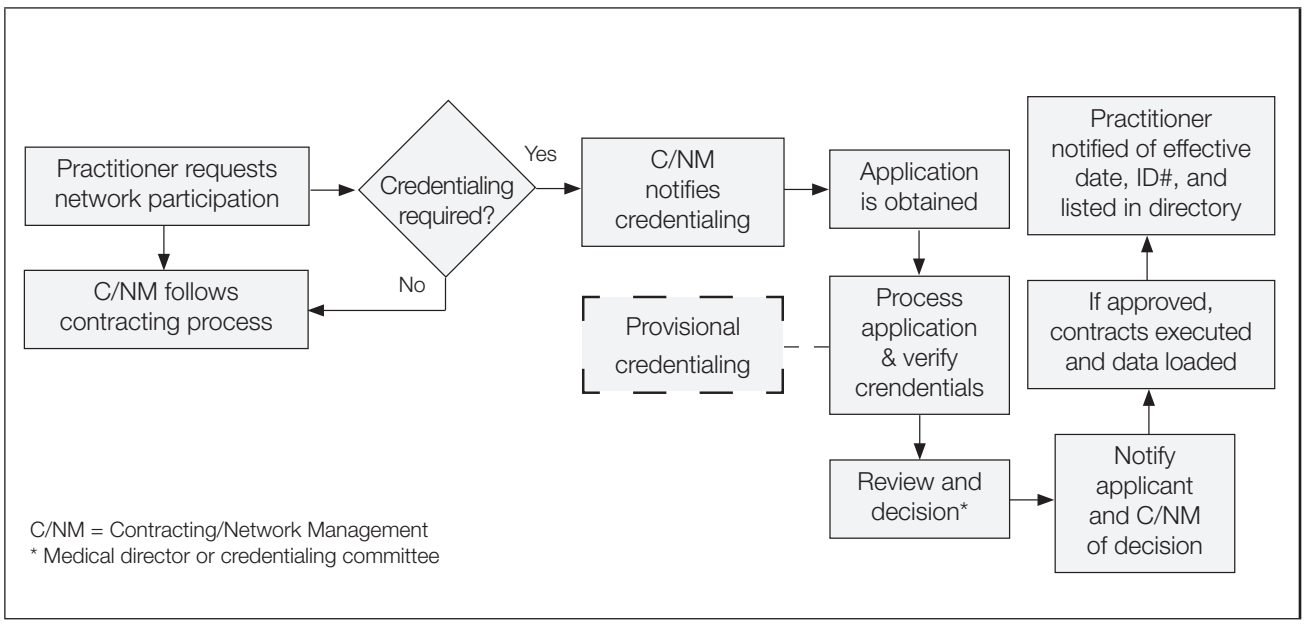
3. Review and make decision (approve/deny/pend)
   - Performed by medical director if granted authority by credentialing committee to approve complete, "clean" applications that meet all criteria
   - Performed by credentialing committee for files that do not meet criteria for clean designation or if medical director decision-making is not granted
4. Notify applicant and internal departments of final decision

In an MCO, the credentialing process may be initiated within the contracting or network management area. If the decision is made to contract with a provider, the MCO determines whether credentialing is required. (Under National Committee for Quality Assurance [NCQA] and URAC accreditation standards, not all contracted providers are required to be credentialed; more details are provided in Chapter 2.) The credentialing department is notified of the provider contract, and the application is obtained and processed.

Once the credentialing process is completed, the final decision is communicated to the applicant and network management. If approved, the contract is finalized, and provider demographics, fee schedules, etc., are loaded into the plan's provider database/claims system so that the practitioner or facility can be recognized as participating and be listed in the member directories. A provider identification number is assigned for submitting claims for healthcare services provided.

Figure 1.1 illustrates at a high level the process by which a practitioner may be credentialed and contracted within a health plan. Please note that this example does not necessarily apply to all health plans but rather is intended to provide the reader with a general overview of the process.

Figure 1.1 Example of High-Level Credentialing Workflow in a Health Plan



Chapter 2

Accreditation and Regulatory Requirements

Accreditation and regulatory standards for managed care credentialing establish a minimum standard that health plans use to identify appropriately qualified individuals and organizations to participate in their networks and to provide quality care to their members. Many organizations choose to exceed these standards based on their culture, experience, market competition, and member expectations.

This chapter will focus primarily on the credentialing requirements under the National Committee for Quality Assurance (NCQA) health plan standards. It will also include references to URAC health plan standards and to Centers for Medicare & Medicaid Services (CMS) regulations for Medicare Advantage. In many cases, URAC and CMS requirements align with NCQA's, but, where applicable, significant differences are identified. State-specific Medicaid requirements may vary and will not be addressed in this book unless requirements are standard across all states. Readers should consult their specific state regulations to ensure compliance with any additional requirements.

This chapter aims to provide readers with a general knowledge and understanding of credentialing requirements for managed care organizations (MCO) and health plans. It is not designed to replace the actual standards manuals from the various accreditors but rather to provide readers with supplemental information and insight to develop a fully compliant credentialing program. It is highly recommended that organizations obtain the applicable accreditors' standards as well to gain access to additional information regarding accreditation requirements. Understanding such standards will facilitate development of a comprehensive and compliant credentialing program within a health plan. It also helps hospitals, health systems, and provider groups perform enrollment for their employed practitioners (look for various enrollment tips and tools incorporated throughout the book) and the opportunity to secure delegated credentialing agreements with commercial third-party payers, which will be described in Chapter 5.

Policies and Procedures: The Credentialing Program Foundation

All accrediting and regulatory bodies require policies and procedures that describe the credentialing program of an MCO or health plan. Policies and procedures provide the framework under which MSPs and credentialing specialists perform their work. They also define the credentialing and recredentialing criteria, enabling health plans to objectively evaluate and select network practitioners to provide care and meet their goals for provider access and availability. Additionally, accreditors and regulators look at an organization's policies and procedures as the first step in determining compliance with standards. To ensure they stay up to date and meet these needs, policies and procedures should be reviewed and updated at least annually.

There are very specific elements that must be included in the health plan's policies and procedures. The following are questions organizations should consider when developing its credentialing program:

- **Practitioner types:** Who will be credentialed?
- **Criteria:** What credentialing requirements do applicants have to meet in order to participate in the plan?
- **Verification:** What sources will be accepted to verify credentials?
- **Review and decision process:** How does the plan evaluate and make decisions on applicants?
- **Files:** How are practitioner files managed within the credentialing process?
- **Nondiscriminatory practices:** Is the credentialing process performed in a manner that does not discriminate against applicants?
- **Practitioner notifications:** Under what circumstances and time frames does the plan communicate with its practitioners?
- **Medical director:** How does this role fit into the credentialing program?
- **Confidentiality:** What processes are in place to maintain the confidentiality of practitioner information?
- **Directories:** How is practitioner credentialing data that is displayed to members maintained in an accurate and timely manner?

Each of these elements will be explored in detail, along with other accreditation standards, as we move through this chapter.

Figure 2.1 Credentialing Scope Summary

	NCQA	URAC	CMS
Included	• Licensed independent practitioners • Behavioral healthcare practitioners • Hospitals • Surgery centers • Home health agencies • Skilled nursing facilities • Behavioral health facilities	• Licensed independent practitioners • Behavioral healthcare practitioners • Hospitals • Surgery centers • Home health agencies • Skilled nursing facilities • Behavioral health facilities • Speech therapy • Occupational therapy • Physical therapy • Alternative medicine providers	• Physicians • Licensed independent practitioners
Excluded	• Hospital-based practitioners • Dental network dentists • Consultants • Locum tenens • Pharmacists in utilization management-delegated	• Hospital-based practitioners	• Hospital-based practitioners • Medical students • Residents • Fellows

Credentialing criteria

In its policies, a health plan must describe its criteria for credentialing and recredentialing of practitioners within its scope. Such criteria include licensure, Drug Enforcement Administration (and/or state Controlled Dangerous Substances) certification, malpractice insurance, education, training, and board certification. Accreditors do not require specific criteria or define how the health plan must apply its criteria; the organization makes those decisions. For example, what does the health plan want to require to ensure a quality network for its members? Is board certification mandated or optional? What makes sense, based on geographical differences, for malpractice insurance limits or claims history?

A health plan that has a large rural member base may have different requirements when it comes to board certification or malpractice insurance limits, as it may be more difficult to attract and retain practitioners in those areas. At a minimum, health plans must require current licensure in the state in which the practitioner will treat members. We will explore additional criteria later in this chapter.

Chapter 3

Verification Requirements

The purpose of the verification process is to ensure that the information provided by the applicant is accurate and to determine whether the applicant's credentials meet the organization's criteria, as outlined in its policies. Verifications are performed during both initial credentialing and recredentialing, although only those elements subject to change (e.g., licensure) are required to be reverified at recredentialing. Figure 3.1 summarizes the various credentialing elements that must be verified through an appropriate source (either primary or secondary source accepted) and the associated time frames required by the regulatory and accreditation bodies impacting managed care credentialing. More details about each of these elements will be provided throughout this chapter.

Verification Time Frames

Establishing specific time frames for obtaining verifications ensures that decisions are based on current information. Compliance with National Committee for Quality Assurance (NCQA) health plan verification time frames is measured by counting backward from the date of the medical director's or credentialing committee's decision. For example, if the health plan made its decision on July 14, 2022, the license, board certification, claims history, license sanctions, and Medicare/Medicaid sanctions must have been verified no earlier than January 15, 2022. For the application, attestation, and work history, the information must have been received no earlier than July 14, 2021. URAC measures its six-month time frame from month/year to month/year. For example, a verification obtained any time in January 2022 is current through July 31, 2022.

These time frame requirements are often misinterpreted to mean that the entire credentialing process has to be completed within 180 days, but that is not the case. If a verification date goes beyond 180 (or 365) days and a decision has not yet been made, then the organization must simply reverify that credentialing element prior to making a final decision. With most verification data available through the Internet, the credentialing process typically takes much less time to complete than the accreditors' verification time frames allow.

Figure 3.1 Verification Summary of NCQA, URAC, and CMS (Medicare Advantage)

Verification element	Credentialing cycle	Time frame (Days are measured in calendar days)		
		NCQA	URAC	Medicare Advantage
License (current)	Initial credentialing Recredentialing	180 days	6 months	6 months
DEA or CDS (current)	Initial credentialing Recredentialing	Prior to decision	6 months	6 months
Education and training	Initial credentialing	Prior to decision	6 months	6 months
Board certification, if applicable	Initial credentialing Recredentialing	180 days	6 months	6 months
Primary facility admitting privileges	Initial credentialing Recredentialing	N/A	N/A	6 months
Work history	Initial credentialing	365 days	180 days	6 months
Malpractice insurance	Initial credentialing Recredentialing	365 days (via application/ attestation)	6 months	6 months
Malpractice liability claims	Initial credentialing Recredentialing	180 days	6 months	6 months
License sanctions	Initial credentialing Recredentialing Ongoing	180 days	6 months	6 months
Medicare/Medicaid sanctions	Initial credentialing Recredentialing Ongoing	180 days	6 months	6 months
Medicare opt-out	Initial credentialing Recredentialing Ongoing	N/A	N/A	6 months
Application/Attestation	Initial credentialing Recredentialing	365 days	180 days	6 months
Authorization	Initial credentialing Recredentialing	N/A	180 days	N/A
Preclusion list	Initialing credentialing Ongoing	N/A	N/A	30 days

Chapter 4

The Credentialing Process

Once a managed care organization (MCO) or health plan has defined its credentialing program or plan through its policies and procedures, it can implement the process of credentialing a network of healthcare practitioners to provide services to its members. Within a health plan, a credentialing department is designated to perform the various processes to support the plan's credentialing program. Within the organizational structure, the credentialing department may be a standalone unit, or it may be incorporated into the network management or quality department. Although the titles of credentialing staff vary greatly within the industry, typical positions include credentialing director/manager, credentialing team lead, and credentialing specialist. Depending on the size of the organization, there may also be designated auditors and delegation coordinators. This chapter will describe initial credentialing and recredentialing processes that may be encountered while working within a commercial health plan under National Committee for Quality Assurance (NCQA) accreditation standards, although it is noted that each organization may have unique differences. These processes would also apply to organizations seeking to obtain delegation status with health plans.

Application Process

Credentialing typically begins upon receipt of an application. There are many forms available for health plans to use to obtain the information that regulators and accreditors require, as well as the information the health plans need to appropriately evaluate and determine whether an applicant meets their criteria for credentialing and network participation.

State-mandated forms

Because many types of healthcare organizations have requirements for how to perform credentialing, practitioners are frequently asked to fill out different application forms for each hospital, health plan, ambulatory surgery center, and other healthcare entity in order to gain membership, privileges, or network participation. This duplication of effort requires significant resources from the practitioner and his or her office staff, taking away from the actual practice of medicine. As a result, many states have initiated legislation to require the use of a standardized application form for credentialing to

Differences From Hospital Credentialing

The operational process of credentialing a practitioner to participate in a health plan's network has some similarities to a hospital's credentialing processes; however, there are also important distinctions. Figure 4.2 highlights some of the key differences between health plan credentialing and hospital credentialing, using NCQA and Joint Commission standards, respectively.

Figure 4.2 Differences Between Health Plan Credentialing and Hospital Credentialing

	NCQA (health plan)	The Joint Commission (hospital)
Element		
Education and training	Highest level of education or training is verified, unless board certified	All relevant education and training are verified
Peer references	Not required	Required at initial appointment/ granting of privileges
Malpractice history	Verify minimum of past 5 years	As defined in bylaws or policy
Time limits	Applicable for verifications and notification to applicant of final decision	As defined in bylaws or policy
Privileging	Not applicable	As applicable
Final decision-making authority	Credentialing committee (or designated medical director)	Governing body
Recredentialing/reappointment cycle	At least every 3 years	Not to exceed 2 years

Chapter 5

Delegated Credentialing

Delegate (verb)

To entrust to another; to assign responsibility or authority.

—Merriam-Webster, *www.merriam-webster.com/dictionary/delegate*

In managed care credentialing, *delegation* is defined as a formal process by which an organization gives another entity the authority and responsibility to perform certain functions on its behalf through a contractual arrangement. This chapter will focus on the processes of delegated credentialing based on accreditation requirements and outline the benefits and challenges of delegation from the perspectives of both the health plan and the delegated entity. Delegation can provide many benefits to both organizations, but there are also risks involved. We have all heard the expression "If you want something done right, you have to do it yourself," but effective delegation can prove that old adage wrong. It is up to both the health plan and delegated entity to evaluate the potential relationship and determine whether delegation is appropriate for them and can support their goals.

Benefits to the Health Plan

For a health plan, the benefits of delegating some or all of its credentialing processes to a third party can be significant, as the following examples illustrate:

- **Helps manage the workload.** The volume of practitioners who must be credentialed and recredentialed can exceed tens or even hundreds of thousands based on the size of the plan and its geographic coverage. Delegating credentialing activities to qualified business partners is often a viable option for managing the process.
- **Improves turnaround time for network participation.** Delegation reduces or eliminates the health plan's internal credentialing process and accepts that of a delegated entity, which often allows newly contracted practitioners to provide healthcare services to a health plan's members much more quickly.

Tip

Many health plans make their policies, procedures, or requirements for delegated credentialing available to potential delegated entities to review in advance of undergoing the preassessment process.

In addition, a file review is typically performed to validate that the credentials files are processed in accordance with the entity's policies and procedures and are compliant with applicable accreditation standards. URAC requires a file audit during the preassessment review. NCQA standards do not specifically require a file audit during the preassessment review, but most health plans perform one to validate a potential delegate's compliance with standards. If the health plan does conduct such an audit, then it will typically follow the requirements used for file audits during annual oversight. For comparison, both accrediting body requirements are listed in Figure 5.1.

Figure 5.1 File Audit Sample Size

NCQA	URAC
5% or 50 of the entity's credentials files, whichever is less; minimum of 10 credentialing and 10 recredentialing files	10% of entity's credentials files; minimum of 10 files and maximum of 30 files

Following NCQA processes, a health plan can utilize the 8/30 rule during a file review. This means that if the first eight files reviewed are in compliance for a given element, then no additional file review is required for that element. If the first eight files are perfect, then no other files are reviewed. Please review NCQA's publication in the Appendix for more information on the use of 8/30 methodology. If the delegated entity is NCQA accredited or certified, then even less review is needed, as elements already validated by NCQA do not require review by the health plan. Refer to Chapter 7 for more information on becoming NCQA accredited or certified.

Tip

If fewer than 10 files were processed by the delegated entity in the previous year, then all files should be audited.

There are other elements that a health plan may want to evaluate as part of its delegation preassessment process to ensure the entity has the capacity to perform the work, such as:

- Staffing: Does the organization have sufficient staff to process the volume of work, or are additional staff being hired to manage the increase?
- Performance: How has the organization performed for other clients? What were the recent results of clients' accreditation audits related to credentialing?

Chapter 6

Credentials Verification Organizations

As mentioned in Chapter 5, health plans can delegate to many different types of organizations, including credentials verification organizations (CVO). CVOs are entities that perform a set of credentialing activities on behalf of clients pursuant to an agreement. A CVO can usually verify practitioner credentials in a manner that is more efficient and cost-effective than the client can perform itself. This is due to the CVO's ability to leverage the volume of practitioner verifications it performs and its use of this information on behalf of multiple clients, which therefore reduces duplication of effort.

CVOs may also be known by other names, such as *credentials verification service* or *centralized credentialing department,* but this chapter will use the industry-recognized acronym *CVO*. There are three types of CVOs that will be referenced within this chapter:

1. External: Independent, for-profit organization that provides services to a variety of external clients
2. Internal: Nonprofit organization that provides services exclusively within its own organization, such as a health system or national health plan
3. Hybrid: Organization that provides services to clients both internally (nonprofit) and externally (for-profit)

History of CVOs

Prior to the 1980s, credentialing was primarily performed within hospitals, each separately performing similar processes of collecting applications and verifying information on physicians who were applying for medical staff membership/clinical privileges. Due to the duplication and administrative burden this placed on physicians as well as the resources it required of hospitals, various medical societies and hospital associations responded by developing centralized credentialing services to support physicians who held membership and privileges at multiple hospitals. The 1990s saw an increase in practitioner credentialing by managed care organizations (MCO) and health plans due to the requirements of the National Committee for Quality Assurance (NCQA), through which they were seeking accreditation, resulting in a large number of external CVOs entering the market. As healthcare

Figure 6.2 CVO and Health Plan Verification Time Frames

Verification element	NCQA verification time frames	
	Health plan (based on final decision date)	CVO (based on date reported to client)
License (current)	180 days	120 days
DEA or CDS (current)	Prior to decision	Prior to reporting to client
Education and training	Prior to decision	Prior to reporting to client
Board certification, if applicable	180 days	120 days
Work history	365 days	305 days
Malpractice history	180 days	120 days
License sanctions	180 days	120 days
Medicare/Medicaid sanctions	180 days	120 days
Application/attestation processing	365 days	305 days
Application/attestation content	N/A	No time limit
Ongoing sanction monitoring*	N/A	Defined by policy/ delegation agreement

*See Chapter 2 for required time frames for reviewing sanction sources.

URAC CVO accreditation

URAC offers a CVO accreditation program to entities that offer credentialing services to healthcare organizations, including health plans. URAC CVO accreditation is valid for three years and evaluates a comprehensive set of core standards, including the following:

- Organizational structure
- Policies and procedures
- Regulatory compliance
- Interdepartmental coordination
- Oversight of delegated functions
- Marketing and sales communications
- Business relationships
- Information management
- Quality management
- Staff qualifications
- Staff management
- Clinical staff credentialing and oversight role
- Healthcare system coordination
- Consumer protection and empowerment

Chapter 7

NCQA Accreditation

As covered in Chapter 6, credentials verification organization (CVO) certification or accreditation can identify organizations that meet industry standards for application management and verification of credentialing elements. The National Committee for Quality Assurance (NCQA) offers more comprehensive recognition programs related to credentialing, including Health Plan (HP), Credentialing (CR), and Provider Network (PN) accreditation. Though all of these programs are directly related to credentialing, each has its own distinct set of requirements, standards, and benefits. Determining which NCQA status to pursue greatly depends on the type of entity involved and the type of credentialing activities performed.

Health Plan (HP) Accreditation

As the name indicates, HP accreditation is for health plans and other managed care organizations (MCO) that provide a comprehensive healthcare benefits package to members. Other eligibility requirements include:

- Is licensed as a health maintenance organization (HMO), point-of-service (POS) plan, preferred provider organization (PPO), or exclusive provider organization (EPO)
- Contracts with members or employers to provide services through an organized delivery system, including ambulatory and inpatient sites
- Performs functions as outlined in standards
- Complies with applicable federal, state, and local laws and regulations, including any requirements for licensure
- Does not discriminate on the basis of gender, sexual orientation, race, creed, or national origin
- Has processes to monitor, evaluate, and improve the safety and quality of care provided to members
- Reports Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results

Figure 7.1 Comparison of NCQA Eligibility Requirements

CR accreditation	CVO certification
• Performs credentialing functions directly or through contractual agreement	• Performs credentials verification of practitioners for its clients according to NCQA standards
	• Processed at least 75 credentialing files 3-6 months prior to its survey submission date
• Performs credentialing activities for at least 50% of its practitioner network	• Directly performs credentials verification activities for at least 50% of its contracted practitioners
• Maintains the necessary policies and procedures	• Maintains the necessary credentialing information, policies, and procedures
• Does not discriminate on the basis of gender, sexual orientation, race, creed, or national origin	• Operates without discrimination with regard to sex, race, creed, or national origin
• Complies with applicable federal, state and local laws and regulations, including any requirements for licensure	• Complies with applicable federal, state and local laws and regulations, including requirements for licensure or registration
• Must not be licensed as an HMO, POS, PPO, or EPO	• Obtains errors and omissions insurance for $1 million–$2 million
• Must not be eligible for NCQA accreditation as a health plan or a managed behavioral health organization	
PN accreditation	
• All of the CR accreditation requirements listed above, plus: - Performs provider network functions directly or through a contractual arrangement - Performs provider network activities directly for at least 50 percent of the provider network	

Comparison of NCQA Credentialing Standards

Similar to CVO certification, the CR and PN accreditation programs have core standards that will be assessed against all organizations, with several "must-pass" elements within those standards. All core standards must be met even if the organization does not have any clients. This ensures that all accredited organizations meet the requirements outlined by NCQA to maintain a high-quality network to provide services to its current and future contracted clients. (Please note that for HP accreditation, the core standard designation does not apply.) Figure 7.2 summarizes the credentialing standards for HP, CR, and PN accreditation. While some of the elements for a particular standard may differ between the programs, the overall intent of the standard is the same. The CVO certification standards are also provided for a full comparison.

Chapter 8

Test Your Knowledge

This chapter is dedicated to testing your knowledge of credentialing for managed care through quizzes, case studies, and other learning activities.

Chapter 1: Overview of the Managed Care Environment

- Quiz

Chapter 2: Accreditation and Regulatory Requirements

- Quiz
- Match game

Chapter 3: Verification Requirements

- Quiz
- Case study 1

Chapter 4: The Credentialing Process

- Quiz
- Case study 1

Chapter 5: Delegated Credentialing

- Quiz
- Case study 1
- Case study 2
- Case study 3
- Delegated credentialing agreement review activity
- File audit activity

Chapter 6: Credentials Verification Organizations

- Quiz

Chapter 7: NCQA Accreditation

- Quiz

Appendix

Appendix 1 NCQA Credentialing Verification Table

The following information is based on minimum requirements for NCQA health plan credentialing. Users should customize this grid to ensure that the sources are applicable to their organization and that the time frames are appropriate based on their organization type. Organizations may follow credentialing standards under Health Plan (HP), Credentialing (CR), or CVO standards.

Element	Verification requirements	Frequency	Time frame	Source(s)
State license	Current and valid at time of decision Verify all states in which the practitioner will provide care to members	Initial credentialing Recredentialing	HP/CR: within 180 days of credentialing decision CVO: within 120 days of reporting to client	State licensing or certification agency
DEA or CDS (if applicable)	Current and valid at time of decision Must verify all states in which the practitioner will provide care to members Option: If allowed by organization's policies, applicants with a pending DEA may submit documentation of another participating practitioner with valid DEA/CDS to write prescriptions on their behalf.	Initial credentialing Recredentialing	HP/CR: prior to credentialing decision CVO: prior to reporting to client	DEA or CDS Agency Copy of DEA or CDS certificate Visual inspection of the original DEA or CDS certificate (documented in file) AMA Physician Masterfile (DEA only) AOIA Physician Profile Report (DEA only) State pharmaceutical licensing agency, where applicable
Education and training	Highest level must be verified (if not board certified) • Residency • Graduation from medical/professional school	Initial credentialing	HP/CR: Prior to credentialing decision CVO: Prior to reporting to client	Residency: Training program • State licensing agency, specialty board, or registry • Review of sealed transcript • AMA Physician Masterfile (MD/DO only) • AOIA Physician Profile Report (DO only) • FCVS for closed residency programs Medical/professional school • State licensing agency, specialty board, or registry • Review of sealed transcript • AMA Physician Masterfile (MD/DO only) • AOIA Physician Profile Report (MD/DO only) • Education Commission for Foreign Medical Graduates (ECFMG)

Appendix 5 Form for S I Opt Out SAM Review

SAM/Medi-Cal Suspended and Ineligible Provider List/Medicare Opt-Out Listing

Provider Name: _____

Provider Found: _____NO _____YES If YES, specify which report: _____

SAM: Date Run: _____

https://www.sam.gov/ SAM/

Suspended and Ineligible Provider Listing: Date Run: _____

http://files.medi-cal.ca.gov/pubsdoco/SandlLanding.asp

Medicare Opt Out:

https://med.noridianmedicare.com/web/jeb/enrollment/opt-out/opt-out-listing;jsessionid=30AE8549DE55FEC2ED355B379AD886B3

Northern California Published Date: _____

Southern California Published Date: _____

According to section 4507 of the Balanced Budget Act of 1997, certain Medicare physicians and practitioners are permitted to "opt out" of Medicare for two years for all covered items and services that he or she furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician or practitioner and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

Information Verified by: _____

Verification date: _____

Source: Anonymous. Reprinted with permission.

Appendix 9 Office Site Visit Tool

When conducting a site visit, written verification of criteria is not required unless specifically stated. Reviewers deviating from criteria should indicate rationale in comments section. The initial reviewer is responsible for conducting corrective action plan (CAP) follow-up if indicated. This form may be used for all CAP follow-up activities. Please note deficiency-specific comments on CAP section of this tool and indicate follow-up dates (see last page of this form).

Practitioner Info:	**Total Number of On-Site Staff:**				**Reviewer Information:**
PCP (or) Specialty					Name
Name	Physician		NP		Organization
Address	RN		PA		
	LVN		MA		
Phone Fax	Clerical		CNM		
Medical Group/IPA	Other				Date of Site Visit
Names of additional practitioners (or attach roster)	**Visit Purpose**				**Corrective Action Plan**
	Complaint Regarding:				Scores below ___ % require a CAP.
	___ Physical Accesibility				**CAP INFORMATION**
	___ Physical Appearance				CAP follow-up visits must occur within six months of deficiency.
	___ Adequacy of Waiting/Exam Room Space				Next Follow-up Date: _____
	___ Adequacy of Equipment				Next Follow-up Date: _____
	___ CAP Follow-up				Next Follow-up Date: _____
Name of office contact:	___ Other_____				Next Follow-up Date: _____

Site Point Summary			**Site Score Summary**		**Medical Recordkeeping Score**
Enter total earned (yes) points and total available (yes + no) points for each section.			Calculate the percentage score for each section (earned/available). Calculate site score (total earned/total available).		Scores below ___ % require a CAP
	Earned	Available	Section Score	Site Score	Earned _____ Available _____
A. Physical Accesibility	___	___	_____ %	Earned _____	
B. Physical Appearance	___	___	_____ %	Available _____	Medical Record Keeping Score _____ %
C. Adequacy of Room Space	___	___	_____ %		
D. Adequacy of Equipment	___	___	_____ %	Total Score	
E. Availability of Appts	___	___	_____ %	_____ %	

A. Physical Accessibility*	**Yes**	**No**	**N/A**	**Comments**
1. Access to building is adequate, evidenced by reasonable parking and/or feasible public transportation within walking distance.				
2. Accommodations for persons with disabilities are available, evidenced by designated parking, loading zone, and/or public transportation within close proximity to the building. This includes the following:				
a. External ramp (if applicable)				
b. Automatic entry option or alternative access method				
c. Elevator for public use (if applicable)				
d. Restroom equipped with large stall and safety bars or other reasonable accommodation				
Inside Office				
1. Emergency medications (injectable epinephrine, Benadryl) are available on-site.				
2. There is a procedure for the management of nonmedical emergencies (i.e., earthquakes).				
3. There is a procedure for handling medical emergencies appropriate to the patient population.				

Appendix 9 Office Site Visit Tool (cont.)

B. Physical Appearance/Safety*	Yes	No	N/A	Comments
1. Inside exit signs are clearly visible.				
2. Evacuation plan is posted, inside building, in a visible location.				
C. Adequacy of Waiting and Examining Room Space*	**Yes**	**No**	**N/A**	**Comments**
1. Waiting room seating capacity is adequate.				
2. The number of exam rooms per practitioner is adequate.				
D. Adequacy of Equipment**	**Yes**	**No**	**N/A**	**Comments**
1. Fire protection equipment is up to date, accessible, and in working order.				
2. Refrigerator thermometer temperature is maintained and documented daily at 35°– 46° F.				
3. Medications are not accessible to patients and stored in a separate refrigerator from food, drinks, and personal items.				
4. Radiology technologists licenses are current.				
5. Radiology equipment maintenance documentation is current.				
6. Routine maintenance of autoclave is documented.				
7. Cold chemical sterilization containers are dated. List chemicals being used: _____				
E. Availability of Appointments* (Title 28, 1300.67.2.2.)**	**Yes**	**No**	**N/A**	**Comments**
1. Nonurgent appointments are scheduled within calendar days				
2. Nonurgent appointments are scheduled within calendar days				
3. Nonurgent appointments are scheduled within calendar days				
F. Medical Recordkeeping * *(Note to reviewer: This is not a chart audit. There is no minimum requirement for number of charts. A model chart or blinded chart may be used.)*	**Yes**	**No**	**N/A**	**Comments**
1. Patient medical records have a secure/confidential filing system.				
2. Patient medical records have legible file markers.				
3. Forms and methodology for filing within a chart is consistent.				
4. Patient medical records can be easily located.				
5. Refusal of interpretation services is documented in the chart, if applicable (*California Health & Safety Code).****				
6. Medical record documentation is signed with practitioner credentials (CMS).** Note: Handwritten signature or initials; signature stamp or authenticated electronic signature on the medical record AND credentials either next to the provider's signature or preprinted with the provider's name on the group practice's stationery. If the provider of service is not listed on stationery, then the credentials must be part of the signature for that provider.				

** Category required by NCQA.*

*** Category required by CMS.*

****Question required by DMHC.*

Appendix 17 Provider Confidentiality Policy

This policy is applicable to the following sites: Priority Health
Applicability limited to: Priority Health
Reference #: 3237
Version #: 2
Effective date: 03/11/2014
Functional area: Provider enrollment and life cycle

1. Purpose

To protect the confidentiality of all information obtained during the credentialing process and to maintain confidentiality of all practitioner/provider-specific information.

2. Policy

Priority Health will treat information it receives and maintains as part of its credentialing and recredentialing activities as confidential in order to maintain protection under Michigan and Federal Peer Review Protection Laws. Priority Health will not disclose information to individuals who are not members of the credentialing committee, the quality integration committee, or the board of directors, except as permitted or required by supporting credentialing policies/procedures or as required by state or federal statutes, regulations, or judicial order. Priority Health will maintain all quality integration committee and credentialing committee documents in a secure manner in Priority Health's credentialing department.

Priority Health will exercise due care with practitioner/provider-specific information by keeping all practitioner/provider files locked and in a secure area. Priority Health staff will not disclose practitioner/provider confidential or protected information to parties outside of the organization unless required by law, in which case Priority Health legal counsel will be involved. Direct access to practitioner/provider files is limited to credentialing and provider information management team members. Other Priority Health personnel who are members of the credentialing committee, Priority Health legal counsel, and credentialing committee members will have access to practitioner/provider files via a credentialing team member.

All Priority Health employees sign a confidentiality statement upon employment. In addition, all credentialing committee members are required to sign a confidentiality agreement.

Priority Health credentialing department will maintain the complete file of all providers for a minimum of 20 years following termination from Priority Health. Terminated provider files will be maintained on-site at Priority Health in the credentialing department for the first two (2) years following termination. Files of providers who have not been with Priority Health for over two (2) years will be sent to Kent Records for confidential storage with a destroy date of twenty (20) years.

3. Revisions

12/98 annual review; 5/99 revisions; 8/99 revisions; 11/99 revisions and annual review; 12/00 revision and annual review; 9/02 annual review; 10/02 annual review; 10/03 annual review; 10/04 revisions and annual review; 11/07 biennial review; 7/09 CMS revisions; 12-7-11.

Priority Health reserves the right to alter, amend, modify, or eliminate this policy at any time without prior written notice.

Policies superseded and replaced: Formerly part of Policy #2/0030/R3 — Practitioner Credentialing, Recredentialing, and Hearing Policy & Procedure.

4. References

NCQA Standard CR 1, Priority Health Confidentiality of Medical Information, Confidentiality Agreement with Third Parties, *Medicare Managed Care Manual* (Chapter 11)

Credentialing Overview Policy 160007R0

Appendix 18 MUCH File Audit List

	[Delegate Name]		Audit List for [year]			
	CRED	**First Name**	**Middle**	**Last Name**		**SPECIALTY**
1	CRED					
2	CRED					
3	CRED					
4	CRED					
5	CRED					
6	CRED					
7	CRED					
8	CRED					
9	CRED					
10	CRED					
11	CRED					
12	CRED					
13	CRED					
14	CRED					
15	CRED					
16	CRED					
17	CRED					
18	CRED					
19	CRED					
20	CRED					
21	CRED					
22	CRED					
23	CRED					
24	CRED					
25	CRED					
26	CRED					
27	CRED					
28	CRED					
29	CRED					
30	CRED					

Appendix 19 MUCH File Audit Worksheets Template

Initial Credentialing Delegated Audit
Delegated Entity:
Date:

MCO Name

Reason: Pre-Assessment___ Annual Review **X** Follow-Up Review___ Reviewers Name:

Code as follows:

Y - Element Compliant | **P** - Present

N - Element Not Present | **C** - Current

NA - Element Not Required

Number	Practitioner Identification	Specialty	CR 3A.1: License to Practice	CR 3A.2: DEA	CR 3A.3: Education, Training	CR 3A.4: Board Certification	CR 3A.5: Work History	CR 3A.6: Malpractice History	Hospital Affiliation	CR 3C.1: Reasons for Inability to Perform	CR 3C.2: Lack of Drug Use	CR 3C.3: Loss of License/Felony Convictions	CR 3C.4: Limitations of Privileges	CR 3C.6: Correctness and completion of the application	CR 3C.5: Malpractice Coverage	CR 3C.6: Attestation	CR 3B.1: Sanctions or Limitations on Licensure	CR 3B.2: Medicare/Medicaid Sanctions	NPDB Query	CMS: Medicare Opt Out	OIG Exclusions	Social Security Death Master	MDHHS Sanction Query	SAM	NPI	Decision Date	Physician notified within 60 days	Notes
P C			P C	C	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P		
1																												
		Date																										
	Compliance																											
2																												
		Date																										
	Compliance																											
3																												
		Date																										
	Compliance																											
4																												
		Date																										
	Compliance																											
5																												
		Date																										
	Compliance																											

Appendix 20 MUCH Policy Review Template

Delegate Name:	Date of Review:		
Reason: Pre-Assessment ☐ Annual Review ☐ Follow-Up Review ☐		BCBS Reviewer Name:	
SECTION 1: POLICY/PROCEDURE REVIEW:	**Score**	**Compliance (F, P, N)**	**Comments**
CR 1: Credentialing Policies			
Element A1: The types of practitioners it credentials and recredentials	1.0	F	
Element A2: The verification sources it uses (primary source)	1.0	F	
Element A3: The criteria for credentialing and recredentialing	1.0	F	
Element A4: The process for making credentialing and recredentialing decisions	1.0	F	
Element A5: The process for managing credentialing files that meet the organization's established criteria	1.0	F	
Element A6: The process for requiring that credentialing and recredentialing are conducted in a non-discriminatory manner	1.0	F	
Element A7: The process for notifying practitioners if information obtained during the credentialing process varies substantially from the information they provided to the organization	1.0	F	
Element A8: The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee's decision	1.0	F	
Element A9: The medical director or other designated physician's direct responsibility and participation in the credentialing program	1.0	F	
Element A10: The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law	1.0	F	
Element A11: The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty	1.0	F	
Element B1: The right of practitioners to review information submitted to support their credentialing application	1.0	F	
Element B2: The right of practitioners to correct erroneous information	1.0	F	
Element B3: The right of practitioners to receive the status of their credentialing or recredentialing application, upon request	1.0	F	
Element C1: How primary source verification information is received, dated, and stored.	1.0	F	
Element C2: How modified information is tracked and dated from its initial verification.	1.0	F	
Element C3: Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate.	1.0	F	
Element C4: The security controls in place to protect the information from anauthorized modification.	1.0	F	
Element C5: How the organization monitors its compliance with the policies and procedures in factor 1-4 at lease annually and takes appropriate action when applicable.	1.0	F	
Element D1: At least annually, the organization demonstrates that it monitors compliance with its CR controls, as described in Element C, factor 5 by: Identifying all modifications to credentialing and recredentialing information that did not meet the organization's policies and procedures for modifications.	1.0	F	
Element D2: At least annually, the organization demonstrates that it monitors compliance with its CR controls, as described in Element C, factor 5 by: Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications.	1.0	F	
Element D3: At least annually, the organization demonstrates that it monitors compliance with its CR controls, as described in Element C, factor 5 by: Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.	1.0	F	
Policy dated and approved	1.0	F	