Tell Your Boss Takeaways from **"Unlocking Success: The Path to a Better Credentialing Process & Delegation Strategy"**

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Thesis: An effective credentialing program that centralizes like functions related to hospital privileging and payer enrollment has proven to be successful in facilitating rapid network expansion, shortening provider onboarding time frames, and improving quality and data management processes.

Furthermore, such a program positions health systems to negotiate and implement delegated credentialing agreements with contracted payers shortening days to enrollment and significantly enhancing the health of the revenue cycle.

Learning Objective#1: Define the two contexts of credentialing for health systems and the impact of consolidating like procedures.

Key points:

1. Medical Staff Credentialing: Also called Hospital Privileging, is the process of determining scope of practice of licensed independent practitioners, contracted and employed, in a hospital setting - this function is supported by the Medical Staff Office, generally, in collaboration with Physician Services. **2.** Managed Care Enrollment: Also called Provider Enrollment, is the process of applying to contracted managed care payers for network participation to establish member access and secure in-network reimbursement - this function is supported by the Managed Care team in collaboration with Physician Services team(s). **3.** Medical Staff Credentialing is governed by: Internal Bylaws, State and Federal Regulations, and Accrediting Body Standards. **4.** Managed Care Enrollment is governed by: DOI Regulations, Medicaid Regulations,	Medicare Regulations, and Accrediting Body Standards. As a result of the significant overlap in the process and procedures of the credentialing that precedes hospital privileging and payer enrollment, health systems are consolidating otherwise siloed procedures to: 5. Reduce the redundancy that frustrate their providers, **6.** Establish a centralized source of truth for provider data, **7.** Reduce operational cost, and implement a single Credentialing Program to support hospital privileging and delegated enrollment. In so doing, they are able to establish an efficient provider onboarding process and a Credentialing Program that can be leveraged to transition time-consuming enrollment to a more efficient model of delegated enrollment. Please reference White Paper.

Learning Objective#2: Understand delegation eligibility requirements and operational implications.

Key points:

1. Although each health plan is different, there are general guidelines to determine qualification: • Network Size: >150 providers. • Credentialing Program in place for a minimum of 6 months. • At least 90% of Network must have been processed through the Credentialing Program. • Compliance to payer and Federal/State requirements. • Some payers require NCQA Accreditation or Certification, direct or through sub-delegated vendor. • Technology and compliance to CR1C requirements.	**2.** Operational Implications: • Single instance of credentialing to support hospital privileging and delegated credentialing. • All encompassing Credentialing Program that address primary source verifications for hospital privileging and managed care. • Centralize Ongoing Monitoring and Expirables Management - employed and contracted providers • Provider data management manual and policies shared across divisions

Learning Objective#3: Summarize the benefits of delegation to the parties involved with a focus on operational impact, compliance matters, and revenue cycle management.

Key points:

1. The health plan/entity that is delegating: • Quickly Resolve Network and Coverage Adequacy Issues • Maintain Compliance to TAT Requirements • Reduce In-House, Administrative Costs • Accommodate Network Growth Initiatives • Comply with State and Federal Data Requirements	**2.** Delegate: • Faster Provider Enrollment • Faster Reimbursement • Faster Provider Onboarding • Reduce Member Access Issues • Preserve Revenue o Reduce Denials o Increase Cash Flow o Data Integrity and Accuracy • Increase Network Footprint • Increase Contracting Leverage • Enhance Brand Integrity

Delegated Credentialing

The faster, safer, less-stress way to ensure credentialing quality

As part of symplr CVO's ongoing commitment to innovative thinking in healthcare contracting, sourcing, and evidence-based research, this white paper is the latest dedicated to addressing quality management tools in the U.S. health system, specifically credentialing.

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A white paper by:
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Abstract:

Credentialing is one of many quality management tools that healthcare organizations implement to monitor patient safety. While most will agree that it plays a valuable role in establishing and governing high-quality provider networks, very few appreciate its impact on strategic growth opportunities, revenue cycle management, and data integrity.

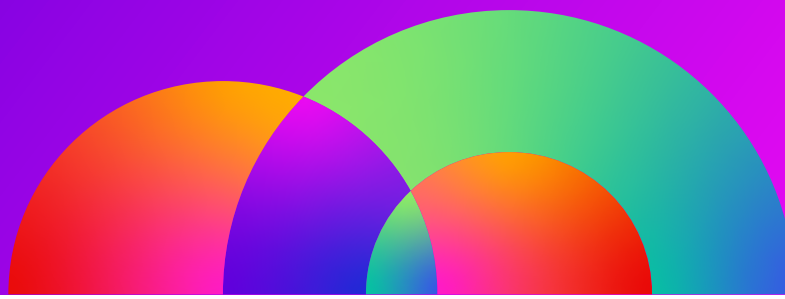
In fact, credentialing is an area of healthcare operations that is often overlooked in enterprise-wide strategic planning. It isn't until delays and backlogs result in serious financial and administrative woes in the form of bad debt or frustrated providers that most organizations will approach the topic. Even then, it's usually with great trepidation and uncertainty.

The truth is that there is significant risk associated with provider credentialing — failures of credentialing have been linked to large malpractice suits, some of which set the legal precedents for the credentialing laws and regulations in place today. And while the fundamental structure of evaluating competency and qualifications remains unchanged across organization types, variations in regulations between state, federal, and accrediting bodies render already complex procedures nearly impossible to absorb.

Why would any health system or provider network want to take this on?

An effective credentialing program has proven to be successful in facilitating rapid network expansion, shortening provider onboarding time frames, improving quality and data management processes, increasing contracting leverage with managed care partners, and significantly enhancing the health of the revenue cycle.

In this white paper, we will establish a common understanding of credentialing, underscore the benefits and risks of delegated credentialing, and provide a road map for organizations interested in expanding into this critical area of healthcare.



Introduction to Credentialing

Credentialing has existed in some form or another since 1000 BC[1] — a testament to its enduring value. In its simplest form, it is the process by which providers are deemed qualified to render patient care. In its truer, more complex form, it is subject to a plethora of standards and regulations that prescribe how and what is to be evaluated. So, what was once an interview before a panel of wise men is now a heavily regulated process that includes verification of specific data elements against primary sources, review of findings against legal and regulatory standards, and approval by a board of peers. Data-driven insights — from malpractice claims history to state and federal sanctions review — inform every step of the credentialing process to ensure a complete and accurate assessment of a provider's capacity to render patient care.

Credentialing Process Overview

Figure 1.

Step 1

Application

- Provider attestation and release
- Provider rights

Step 2

Primary Source Verification of Information, Including:

- Peer references
- Education/training
- State license
- Prescribing authority, e.g., DEA, CDS
- Board certifications
- Current professional liability coverage
- Professional liability
- Claims history
- Hospital affiliations/privileges
- Work history
- OIG – List of Excluded Individuals and Entities (LEIE)
- GSA – System for Award Management (SAM)
- Limited Access Death Master File (LADMF)
- Treasury Department – Office of Foreign Assets Control (OFAC)
- State medicaid exclusions listing
- Medicare opt-out listing
- Medicare exclusion listing
- Medicare preclusion listing

Step 3

Review and Decision by a Peer Review Committee

- Appropriate training and experience?
- Meet state, federal, quality standards?

Step 4

Access to Members

- Provider appropriately privileged
- Provider loaded to directory

Credentialing is the process of obtaining, verifying, and assessing the qualifications of a practitioner or facility to provide care and services to patients. Both the scope and procedures governing this process are different depending on entity type, state, and accrediting body.

Credentialing takes place in multiple contexts in the healthcare industry and is the gate-keeping mechanism for the delivery of safe patient care. There are two primary instances where credentialing occurs: hospital credentialing (also known as medical staff credentialing), which precedes hospital privileging; and managed care credentialing, which precedes health plan enrollment. In the former, the requirements and procedures for credentialing are regulated by the hospital's internal bylaws, a combination of state and federal laws, and accrediting body standards.

Most health systems adhere to the accreditation standards of one of the following bodies:

- The Joint Commission (TJC)
- Accreditation Association for Ambulatory
- Health Care (AAAHC)
- Det Norske Veritas Healthcare (DNV)
- Healthcare Facilities Accreditation Program (HFAP)

An appropriately qualified, licensed independent practitioner (LIP) must apply for hospital privileges, comply with medical staff credentialing requirements, and be approved by a series of peer review and governing boards prior to being granted privileges to admit, consult, or treat patients in an in-patient hospital setting.

In the latter instance of credentialing, namely managed care credentialing, health plans comply with state and federal laws and accrediting body standards prior to approving providers as "in-network" to see patients. In contrast to medical staff credentialing, health plans typically adhere to the standards of one of the following accrediting bodies:

- National Committee for Quality Assurance (NCQA)
- Utilization Review Accreditation Commission (URAC)

Similar to medical staff credentialing, providers — a classification that includes both practitioners and organizational providers such as home healthcare facilities, skilled nursing facilities, etc. — must complete an application, provide supporting documents, and comply with health plan-specific credentialing requirements to access members and be reimbursed for their services — a process known as managed care enrollment.

The general standards of credentialing specify at a minimum what information and supporting documents are required as part of the hospital privileging or managed care enrollment process, what elements must be primary-source verified, what procedures must be employed by the hospital or health plan to complete primary-source verifications, and the maximum amount of time that can elapse before a provider must go through the process again.

Step 1	Step 2	Step 3
Application and Supporting Documents, including	**Submit to Hospital or Payer**	**Member Access**
• Provider attestation and release • Provider rights	• Credentialing (see figure 1.) • Full execution of contract or add to existing group contract • Approved providers loaded in downstream systems and directories	• Provider has appropriate privileges • Provider loaded to director • Reimburse per terms of contract

Regardless of context, the mission of a credentialing program is to ensure that every provider[2] has both the legal authority and relevant training to deliver healthcare services prior to gaining access to members.[3] Ultimately, the responsibility — by virtue of ostensible agency — is on the hospital or health plan to ensure that providers are appropriately vetted, approved, and monitored on a regular basis. In doing so, they establish a quality governance infrastructure that effectively mitigates risks associated with patient care.

As powerful a tool as credentialing is, if it is not properly implemented and managed, it can pose serious risk to the health plan or hospital in the form of inadequate network and care coverage, non-compliance with state and accrediting body standards, operational and financial strains, and impediments to strategic growth initiatives.

These pains are felt even more strongly by health systems or provider networks that face costly delays in new provider onboarding, highly manual and time-consuming application processes, frustrated providers, and significant issues in revenue cycle management.

Manually enrolling a single provider in a health plan can take anywhere from 3 months to 12 months. Delays in managed care enrollment are extremely costly. Every month enrollment is delayed, physician practice groups and health systems lose an average of $100,000 for a single primary care provider. For specialty care, the losses can be even more staggering at $300,000 per physician per month.

Source: Industry norms and symplr's experience with customers

Enter delegation.

Delegated Credentialing

Credentialing delegation has evolved to become a collaborative effort between health plans, health systems, and provider networks to offset these risks and ensure that high-quality care is available to members. Credentialing delegation is a regulated process by which one healthcare entity grants another healthcare entity the authority to perform a contractually defined set of credentialing functions on its behalf while maintaining oversight of the proper execution of these functions. The decision to delegate is not easy to come to, primarily because of ostensible agency — accountability for the proper execution of the delegated functions resides with the entity delegating the function, namely, the hospital or health plan.

Credentialing delegation in managed care is a regulated process by which the health plan grants a health system or provider organization the authority to perform a contractually defined set of credentialing functions on its behalf while maintaining oversight of the proper execution of these functions.

Organizations must comply with strict policies and procedures when exploring delegation opportunities to safeguard themselves from the risks associated with entrusting another organization with such a critical process. As an example, health plans have minimum requirements regarding network size, experience, accreditation status, and operational infrastructure of a prospective delegate. Assuming the prospect meets the initial requirements, a formal pre-delegation assessment is conducted to ensure the prospective delegate has the capacity to take on and properly execute the delegated functions.

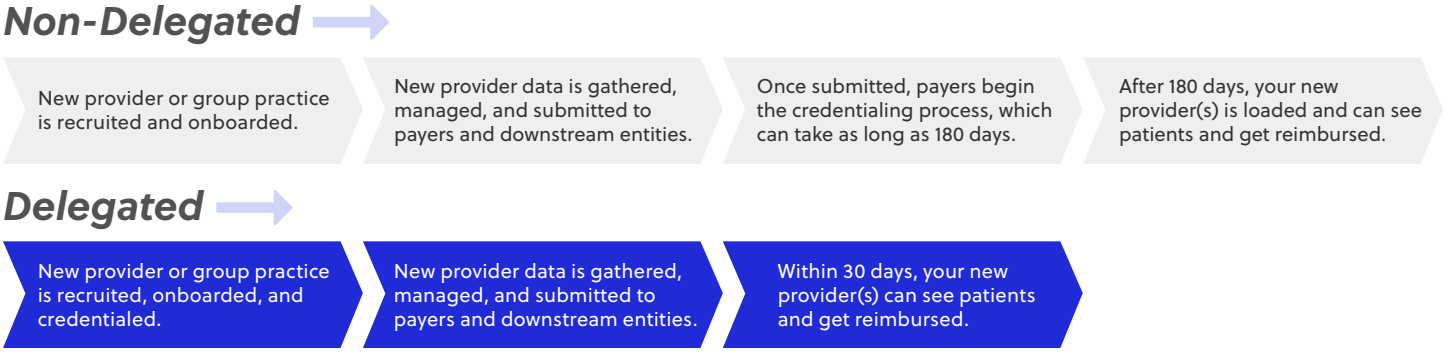
This assessment includes a thorough evaluation of an organization's credentialing infrastructure:

- **Credentialing Program** – Policies and procedures
- **Quality Program** – Monitoring of processes and personnel
- **Experience and Expertise** – Accreditation status, e.g., National Committee for Quality Assurance (NCQA)
- **File Review** – Evidence of compliance to policies and procedures
- **Ongoing and Performance Monitoring** – Sanctions, adverse actions, and member complaints review process
- **Peer Review Committee** – Composition and charter
- **Reporting Capabilities** – Software and business intelligence tools
- **Vendor Management** – Evidence of oversight of any outsourced functions

Upon the successful completion of the pre-delegation assessment, a formal contract that defines the delegated functions is executed by both parties. The contract itself is also held to the same rigorous standards that permeate the entire process.

- Delegated functions and responsible parties
- Quality improvement procedures
- Oversight of delegated functions
- Terms for corrective action and revocation

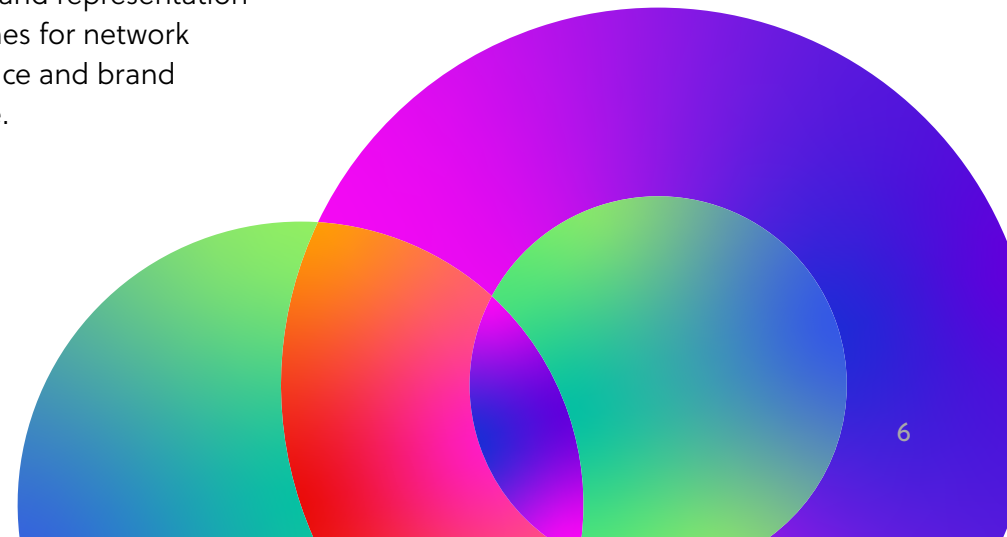
Once the contract is executed by both parties, the enrollment landscape shifts from a non-delegated credentialing model to a delegated credentialing model. With the proper due diligence in place, the risk of delegation gives way to a synergistic partnership.



Benefits of Delegated Credentialing

Benefits for Hospitals	• Streamline credentialing operations across facilities • Reduce administrative and financial burden associated with credentialing in-house • Enhance provider experience • Shorten privileging time frames • Quickly resolve care coverage issues
Benefits for Health Plans	• Quickly resolve network adequacy issues • Reduce turnaround time for network participation • Accommodate network growth • Reduce costs associated with credentialing in-house • Reduce administrative and financial burden associated with credentialing in-house • Support contracting efforts • Enhance physician/provider/member experience • Focus resources on quality improvement measures and delegation oversight audit efforts
Benefits for Health Systems and Provider Networks	• Eliminate the 180+ day delay in managed care enrollment process • Establish control over provider data in health plan systems and directories • Reduce member access issues • Improve revenue cycles • Increase contracting leverage • Enhance physician/provider experience
Benefits for Providers	• Faster access to members • Lower administrative burden • Fewer credentialing-related denials
Benefits for Patients	• Adequate care coverage • Reduction in surprise billing

In assuming the delegated functions, health systems and provider organizations realize unparalleled improvements in the processes that govern the growth and representation of their network, shorten turnaround times for network participation, enhance provider experience and brand integrity, and expedite access to revenue.



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Faster enrollment and reimbursement.

Delegated credentialing reduces managed care enrollment time frames, directly impacting member access and reimbursements.

More efficient enrollment process.

Delegated credentialing reduces the administrative burden of submitting hundreds of provider applications individually. Instead, all providers can be added to a single roster and submitted to the health plan at one time. Tracking and reconciliation processes are also easier with delegated credentialing.

More control over provider data.

Delegated credentialing allows organizations to have more control over how the network is reflected in health plan directories. Demographic updates and network participation changes are efficiently handled through rosters, ensuring provider data accuracy.

Greater provider and patient satisfaction.

Faster onboarding means that providers can start doing what they love to do — taking care of patients — several weeks sooner. And patients benefit from receiving that care without surprise billing.

Longstanding Effects

Decrease / Reduce	*Increase*
• Decrease enrollment processing time: → 60-90 days to 30-45 days through a delegated contract • Mitigate Risks • Reduce member access issues • Lower administrative costs • Avoid costs associated with delayed enrollment: → $100,000/primary care provider/month → $300,000/specialty care provider/month	• Quality control over provider data • Increase contracting leverage • Faster access to revenue • Improve provider satisfaction

Source: Industry norms and symplr's experience with customers

Roadmap to Delegation

Organizations must demonstrate operational competency and expertise in credentialing to qualify for delegation. To this end, a credentialing program must align state and federal requirements with accreditation standards in the following areas:

- Credentialing policies and procedures
  - Credentialing and recredentialing time lines and procedures
  - Assessment of organizational providers
  - Ongoing monitoring
  - Practitioner rights
- Data security and management of credentialing information
- Quality oversight and continuous monitoring
- Credentialing committee and peer review

To mitigate the operational impact of varying standards and regulations, organizations must:

- Evaluate network distribution to determine state-specific regulations
- Evaluate managed care contracts to determine health plan- and CMS-specific regulations
- Evaluate what accreditation body governs their organization or their managed care partner

An effective and consistent credentialing program should comply with the standards while accounting for costs. As an example, in the State of New York, managed care credentialing requirements include primary source verification of practitioners against the Limited Access Death Master File; the State of Illinois does not have this requirement. Although consistency in the process enables scale and automation, and decreases the likelihood of errors and omissions, organizations should evaluate the financial impact associated with streamlining procedures against the strictest standards.

Credentialing policies and procedures.

The policies and procedures serve as the foundation for the operational structure of the credentialing program. The policies must define:

- Provider types that are within the scope and authority of the credentialing program
- Application source and supporting documents that are required from each provider
- Elements that will be verified and the sources that will be used for primary source verification
- Timeliness standards regarding credentialing, recredentialing, and provider notifications
- Ongoing monitoring of providers on a monthly or semiannual basis against state licensing boards for actions, and state and federal sanctions lists
- Provider rights as it pertains to appealing credentialing decisions or being granted

Data security and management of credentialing information.

Credentialing is the entry point of a large amount of data that must be appropriately stored and managed. The policies must define the parameters that allow for the secure and confidential exchange of provider data internally and externally with third parties as required to complete the credentialing process. There must be evidence in the form of training certificates and confidentiality statements indicating that personnel were, and will continue to be, trained in proper handling procedures.

Quality oversight and continuous monitoring.

Governing the entire credentialing program must be a quality improvement infrastructure that not only monitors personnel performance, but measures compliance to accuracy thresholds. The appropriate checks and balances — in the form of file audits, productivity reports, and annual policy review — ensure that providers are being processed accurately and efficiently and demonstrate the quality of the credentialing program to regulatory agencies and network partners.

Credentialing committee and peer review.

Not unlike what transpired in 1000 BC, today a committee of the provider's peers is required to evaluate the information gathered during the credentialing process and assess whether the provider is qualified and capable of performing duties as defined within the scope of their practice and specialty. As such, a critical component of a credentialing program is the establishment of a Peer Review Committee. In the broadest sense, the purpose of the Peer Review Committee is to provide organizational oversight and decision-making about credentialing and recredentialing of providers wishing to participate in the network. This is accomplished through the regular examination of programmatic and administrative performance measures. In concert with this, the committee identifies programmatic and administrative opportunities for improvement, recommends programmatic and policy changes based upon industry best practice, and partners with all departments to design, implement, and evaluate improvement initiatives.

Objectives of the Peer Review Committee
• Ensure the overall integrity of the network of providers • Act as the organization's advisory body for credentialing-related topics • Define and maintain credentialing program criteria for credentialing providers, including criteria related to sanctions, termination, and reinstatement

Duties and Responsibilities of the Peer Review Committee
• Approve all credentialing program-related policies and procedures • Review and adopt all credentialing program documents, plans, and reports • Oversee programmatic and performance indicators as required by organizational, industry, and accrediting bodies and others, recommending corrective action when necessary • Determine the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas of focusight audit efforts

The roadmap to delegation can be very difficult to navigate — the stakes are high, and the process is complex. But to reiterate: an effective credentialing program will facilitate rapid network expansion, shorten provider onboarding time frames, improve quality and data management processes, increase contracting leverage with health plans, and significantly enhance the health of the revenue cycle.

Conclusion

Delegation is the faster, safer, less-stress way to ensure credentialing quality.

Enforced standards of credentialing establish and govern quality and accountability in healthcare. Today, there is a prevalence of delegation in the market as organizations are realizing the benefits of this collaboration. As healthcare organizations expand their geographic footprint, the emerging web of regulations can seem impossible to navigate, making the establishment of a delegated credentialing program daunting, to say the least. Daunting, but certainly not impossible — getting there will require a partner with a proven knowledge of state and federal regulations and the industry standards that govern credentialing. While that might sound like a lot to ask, if a healthcare organization is to succeed in the constantly evolving landscape of credentialing, it's essential.

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Notes:

1 In ancient Persia, tradition required verification of a physician's qualifications prior to allowing the practice of medicine.

2 A practitioner, e.g., MD/DO, NP, PA, etc., or facility, e.g., hospital, skilled nursing facility, home health agency, etc., that contracts with a health plan to provide patient care.

3 A member is any individual who receives care through insurance, federal, or state coverage.

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