Provider Enrollment 101 for Medical Staff and Credentialing Professionals

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OBJECTIVES

✓ What is the difference between credentialing and enrollment
✓ Provider Enrollment in the spotlight
✓ Special challenges
✓ Enrollment success tips
✓ Delegated Credentialing
CREDENTIALING

- Healthcare credentialing refers to the process of verifying education, training, and proven skills of healthcare practitioners.
- Can be a very lengthy process.
- A credentialing process is utilized by healthcare facilities as part of its process to allow practitioners to provide services.

WHAT IS PROVIDER ENROLLMENT?

Enrollment is defined as the tasks that support the process of becoming a Participating Provider in a health insurance network.

Enrollment usually includes:

- Commercial insurance networks (Credentialing and Contracting)
- Government programs (Contracting Only)
  - PECOS (Medicare)
  - Medicaid (some paper, some online)
  - TriCare

ENROLLMENT

- Enrollment is the process of applying to health insurance plans/networks for inclusion into provider panels to bill and be paid for services rendered.
- Delegated Credentialing
- Impacts Revenue Cycle
ENROLLMENT

- The provider enrollment process involves:
  - requesting enrollment/contracting with a plan;
  - completing the plans’ application and submitting required documents;
  - signing a contract; and any other steps that may be unique to a carrier.
  - can be a lengthy process.

WHAT’S THE DIFFERENCE?

HealthStream’s research* indicates that healthcare executives are using the terms “credentialing” and “enrollment” interchangeably when it comes to the process of requesting enrollment of a provider in a health insurance network; however, credentialing and enrollment are very different functions.

*Provider Enrollment White Paper, 2015

WHOSE RULES DO WE FOLLOW?

**For Credentialing**
- TJC (Joint Commission) standards
- CMS and State regulations
- Medical Staff Bylaws, Rules and Regulations

**For Enrollment**
- National Committee on Quality Assurance (NCQA) standards or:
- Utilization Review Accreditation Commission (URAC) standards
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Individual health plan requirements
THE CHALLENGE

- Coordinate seemingly different goals
  - Assure qualifications and competence
  - Generate Revenue
  - Care for patients
- Comply concurrently with sometimes conflicting standards and regulations of multiple agencies
- Provider satisfaction

COORDINATION

- Identify similarities and differences in the standards and requirements during the credentialing process. Adopt the stricter standard.
- Revise Policies & Procedures and Bylaws to reflect changes in these stricter standards.

WORK SMARTER. NOT HARDER!

WHEN DOES ENROLLMENT START?

- Depending on the insurance payer, the enrollment processes can take anywhere from 90 – 120 days
- The enrollment process should begin well before the physician has been granted privileges at the healthcare institution.
WHO IS ENROLLED?

Enrollment may be a broader group than those credentialed at a hospital as enrollment includes practitioners who bill for their services. For example:

- Social workers
- Psychologists
- Speech pathologists
- Physical Therapist
- Optometrists

WHY IS ENROLLMENT IN THE SPOTLIGHT?

- Enrollment = Reimbursement
- Reimbursement = Money
- Thus, Enrollment = Money

Timely enrollment is key to reducing write-offs in revenue cycle.

Hospitals, Healthcare Organizations and Medical Groups are actively seeking solutions to improve efficiency and improve their revenue cycle process.
WHY FOCUS ON ENROLLMENT?

- Days in A/R due to pending provider enrollment
- Denial of claims/write-offs due to services rendered prior to enrollment
- Write-offs are lost revenue

Turn Around Time (TAT) assumes days from the initial application until provider is participating (par) with payer.

TIME IS MONEY WHEN ENROLLING PROVIDERS

$6641 in opportunity costs (what a physician could bill)* per day ($1,560,688 divided by 235 = $6641.23)  
$1500 estimated daily physician cost **

30 new physicians per year
If you save 1 day in time = $194,730
1 day (30 physicians x $6641)= $199,230 – 1 Day x ($1500 x 30 physicians) = $45,000
If you save 15 day on your TAT= $2,920,950
TATs can be shortened with implementation of the best practice recommendations in this presentation

*Source: 2016 Merritt Hawkins Physician Inpatient/Outpatient Revenue Survey
**Source: StaffCare, A Company of AMN Healthcare – based on average locum tenens data/cost

OTHER FACTORS

- Provider Enrollment OnBoarding Delays
  - Onboarding Delays = Lost Revenue
- Provider Enrollment lead time is insufficient
- Provider Delays
- Processing Inefficiencies
- Follow-up with payers is time consuming
Unfortunately, many are unfamiliar with physician credentialing and enrollment

A hospital system in the Southwest experienced this problem with a multispecialty spine practice it acquired in 2011

Administrative staff spent a full year attempting to credential and enroll the physicians and non-physician providers with the hospital’s workers’ compensation contracts

During this period, the system lost approximately $500,000 on under-reimbursed care

2017 Provider Enrollment Survey
Verity, A HealthStream Company

WHAT ARE SOME OF YOUR ORGANIZATION’S BIGGEST CHALLENGES?

<table>
<thead>
<tr>
<th>Opportunity for Improvement</th>
<th>Very Important</th>
<th>Somewhat Important</th>
<th>Not Very Important</th>
<th>Not Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing time to enroll providers</td>
<td>86.2%</td>
<td>13.8%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>streamlining provider identification and enrollment process</td>
<td>82.4%</td>
<td>17.6%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>implementing process efficiencies to improve the financial results related to enrolling physicians under existing practice contracts and related contracts</td>
<td>64.3%</td>
<td>29.9%</td>
<td>4.1%</td>
<td>5.5%</td>
</tr>
<tr>
<td>reducing required resources and administrative costs through automation and provider simplifications</td>
<td>62.2%</td>
<td>30.6%</td>
<td>4.1%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Maintaining an accurate provider directory, provider participation and data located on our website to support patient decision making</td>
<td>57.1%</td>
<td>30.6%</td>
<td>7.1%</td>
<td>5.1%</td>
</tr>
<tr>
<td>tracking metrics, benchmarks, and provider enrollment data to drive efficiency of decision on enrollment and compliance</td>
<td>52.2%</td>
<td>31.6%</td>
<td>6.5%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Automating enrollment with similar payer transaction types such as EDI, STT and ERA</td>
<td>48.4%</td>
<td>35.5%</td>
<td>11.2%</td>
<td>5.0%</td>
</tr>
<tr>
<td>streamlining provider identification and enrollment process available for similar payer transaction types</td>
<td>47.4%</td>
<td>32.4%</td>
<td>13.0%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Resolving disparate credentialing authority with similar health insurance networks</td>
<td>42.3%</td>
<td>29.9%</td>
<td>11.7%</td>
<td>26.6%</td>
</tr>
<tr>
<td>Integrating with EASQ and PECOS systems</td>
<td>40.3%</td>
<td>27.8%</td>
<td>13.1%</td>
<td>28.8%</td>
</tr>
<tr>
<td>Automating enrollment with common payer transaction types such as EDI, STT and ERA</td>
<td>29.6%</td>
<td>36.6%</td>
<td>16.6%</td>
<td>29.9%</td>
</tr>
<tr>
<td>Bringing provider enrollment tasks to resolve outsourcing the service</td>
<td>27.5%</td>
<td>5.6%</td>
<td>9.1%</td>
<td>77.0%</td>
</tr>
</tbody>
</table>
Enrollment with Payers

Verity’s 2017 Provider Enrollment Survey showed that 81% of healthcare organizations feel it is important to reduce time to enroll providers.

<table>
<thead>
<tr>
<th>Opportunity for Improvement</th>
<th>Very</th>
<th>Somewhat</th>
<th>Not Very</th>
<th>Don’t Know</th>
<th>Don’t Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing time to enroll providers</td>
<td>67.5%</td>
<td>17.3%</td>
<td>7.1%</td>
<td>5.9%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Implementing process efficiencies to improve the health plan’s ability to enroll providers in an efficient manner</td>
<td>63.8%</td>
<td>26.6%</td>
<td>4.8%</td>
<td>5.9%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Providing education on enrollment processes</td>
<td>64.5%</td>
<td>18.8%</td>
<td>8.7%</td>
<td>5.6%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Maintaining accurate provider directory</td>
<td>63.4%</td>
<td>28.3%</td>
<td>4.9%</td>
<td>5.9%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Tracking metrics, benchmarks, and provider enrollment data to drive efficiency and decrease processing time</td>
<td>55.9%</td>
<td>34.6%</td>
<td>6.6%</td>
<td>5.9%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Standardizing provider data sets across your enterprise</td>
<td>49.4%</td>
<td>28.9%</td>
<td>11.5%</td>
<td>13.0%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Integrating your enrollment platform with other internal systems to reduce manual data entry and provider enrollment processing</td>
<td>47.9%</td>
<td>25.8%</td>
<td>13.3%</td>
<td>14.0%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Receiving delegated authority from healthcare insurance networks</td>
<td>42.8%</td>
<td>25.8%</td>
<td>13.3%</td>
<td>20.4%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Adding a high volume RAC system</td>
<td>41.9%</td>
<td>27.9%</td>
<td>13.3%</td>
<td>16.0%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Adding long and complex transaction types such as EDI</td>
<td>28.8%</td>
<td>26.9%</td>
<td>16.9%</td>
<td>29.9%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Bringing provider enrollment-house</td>
<td>13.0%</td>
<td>5.9%</td>
<td>9.1%</td>
<td>67.5%</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

STATISTICS OF ENROLLMENT

Respondents were asked how many providers they enroll. Two thirds indicated 100 or more.

- Don’t Know: 10.8%
- 100: 24.2%
- 51-100: 25.4%
- 26-50: 11.7%
- 11-25: 16.2%
- 10-9: 8.7%
- 1: 0.2%

Statistics of Enrollment

The typical organization handles a variety of enrollment activities for more than 100 providers who each participate in 10-29 health plans.

- 30+: 19.3%
- 20-29: 23.9%
- 10-19: 37.8%
- 0-9: 19.3%
Health Plans and Networks have their own applications and requirements.

Health Plans require regular updates, usually monthly, when provider information changes such as addresses, tax ids, license expirations, etc.

Identical data doesn’t always mean the same thing between hospitals and health plans.

**What Are Other Challenges?**

- Not a linear process
- Checklists sometimes fail
- Lack of communication to key stakeholders

**Strategies to Align Credentialing and Enrollment**

- Understand the challenges of all involved
- Collect ALL data once and only once
- Work through data issues (address, specialty, etc.)
- Centralize the status reports
STRATEGIES TO ALIGN

- Give providers one message or contact
- Interdepartmental committee
- Enable providers to see where they are in the process
- Automate and enhance communication

STRATEGIES TO ALIGN

- Assign one liaison to serve as the facilitator and project manager
- Consider a concierge approach
- Measure timeframes between activities
- Ask Providers, their staff for feedback
- Analyze

ENROLLMENT SUCCESS POINTS

- Begin enrollment process immediately
- Start collecting provider’s information and documents
- Automate the credentialing and enrollment process
  - Software
  - Web portals
  - Electronic Submissions
  - Minimize the use of paper forms
ENROLLMENT SUCCESS POINTS
✓ Communicate, Communicate, Communicate
✓ Document, Document, Document

PROVIDER ENROLLMENT, CHAIN, AND OWNERSHIP SYSTEM (PECOS) - MEDICARE
Benefits
✓ Internet-based
✓ Updates/Changes
✓ View/Check Status
✓ Quicker Enrollments
✓ Surrogacy program
✓ E-Sign
✓ Upload Documents
✓ Smart Technology determines which forms are needed

RE-VALIDATIONS
✓ CMS encourages revalidation submission for Medicare through PECOS system.
✓ Required for:
  ➢ All enrolled practitioners
✓ Re-Validation due:
  ➢ Medicare – every 5 years or upon request
  ➢ Medicaid – varies by state
✓ Cycle 2 Revalidation began March 2016
  ➢ Unlike Cycle 1 Revalidation, failure to respond to revalidation notices could result in a hold on your Medicare payments and possible deactivation of your provider’s Medicare billing privileges.
  ➢ Medicare has a tool to check for revalidation dates [https://data.cms.gov/revalidation](https://data.cms.gov/revalidation)
COMMERCIAL ENROLLMENT

✓ Relationships are key!
✓ Know requirements and expectations of each payer
  ➢ Non-delegated credentialing & contracting
  ➢ Delegated credentialing
✓ Confirm if the plan uses CAQH
  ➢ Re-attestation every 120 days
  ➢ Keep documents current
✓ Establish a tracking system to check on status of application

COMMERCIAL ENROLLMENT

✓ Document everything
✓ Remember to ask what the providers “recredentialing cycle” is
  ➢ If new to the plan it could be 36 months
  ➢ If already credentialing and just “flipping” a TIN the cycle could be any time.
✓ Demographic changes
✓ Terminations

BENEFITS OF DELEGATED CREDENTIALING?

What are the value-added benefits to obtaining delegated payor credentialing for your organization?

✓ Streamline credentialing processes
✓ Impacting provider enrollment timeframes
✓ Improving revenue stream
BENEFITS OF DELEGATED CREDENTIALING?

- Providers credentialed quicker, boosting revenue and clinical bandwidth
- Information collected once and used throughout process
- Recredentialing is simplified

HOW DO WE CREATE A DELEGATED PROGRAM?

Develop Shared Project Plan

- Target Dates
- Accountability
- Document
- Tasks
- Communication

KEY PROCESSES TO IMPLEMENTING PROGRAM

- Adopting Credentialing Standards
- Establish Review Process
- On-Going Monitoring
- Create Agreements with Payers
- Re-Credentialing
DELEGATED CREDENTIALING

✓ Adopting Credentialing Standards — The National Committee for Quality Assurance (NCQA) has established standards for payers, as has the Joint Commission for providers. Standards from both organizations should be adopted, as well as any specific standards from regional payers.

✓ Establish a Review Process — Create a committee to define processes and review provider credentialing.

DELEGATED CREDENTIALING

✓ Conduct Ongoing Monitoring — Develop processes to continually monitor work quality.

✓ Re-Credentialing — Create processes to easily re-credential providers on an ongoing basis.

✓ Create Agreements with Payers — Delegated credentialing agreements need to be established, clearly stating structure and metrics, including:

  - Outlining the responsibilities of the payer and delegated entity.
  - Detailing metrics of how the payer can define and assess performance.
  - Developing ongoing oversight processes.
  - Acceptance of the committee date as the start date.

DELEGATION: QUALITY, REPORTING & TIMEFRAME REQUIREMENTS

✓ Reporting: Practitioner Additions, Changes and Terminations
  - Including the Effective date, NPI, Tax ID, etc.

✓ Timeframe: Credentialing and Recredentialing
  - Recredential every 3 years; Notify initial credential decision – 60 days

✓ Verification Timeframes
  - Licensure, Malpractice History recent five years– 180 days

✓ Quality Management & Improvement Plan or Policy/Procedure
  - Tracking Log for complaint reporting and resolution

✓ Ongoing Monitoring
DON'T BE AN OVERACHIEVER!

- Stick to the NCQA Guidelines
- Clearly document your processes
- Align processes with Bylaws and Credentialing P&Ps
- Document, track and review everything
- Protect your providers, protect their data
- Document the presence, review and discussion of Red flags in Practitioner Records

RESOURCES

- http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html
- http://www.tmhp.com/Pages/default.aspx
- www.cms.gov/medicare
- www.cms.gov/MedicareProviderSupEnroll/
- https://NPPES.cms.gov
- http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Medicare_Prot
- Questions?