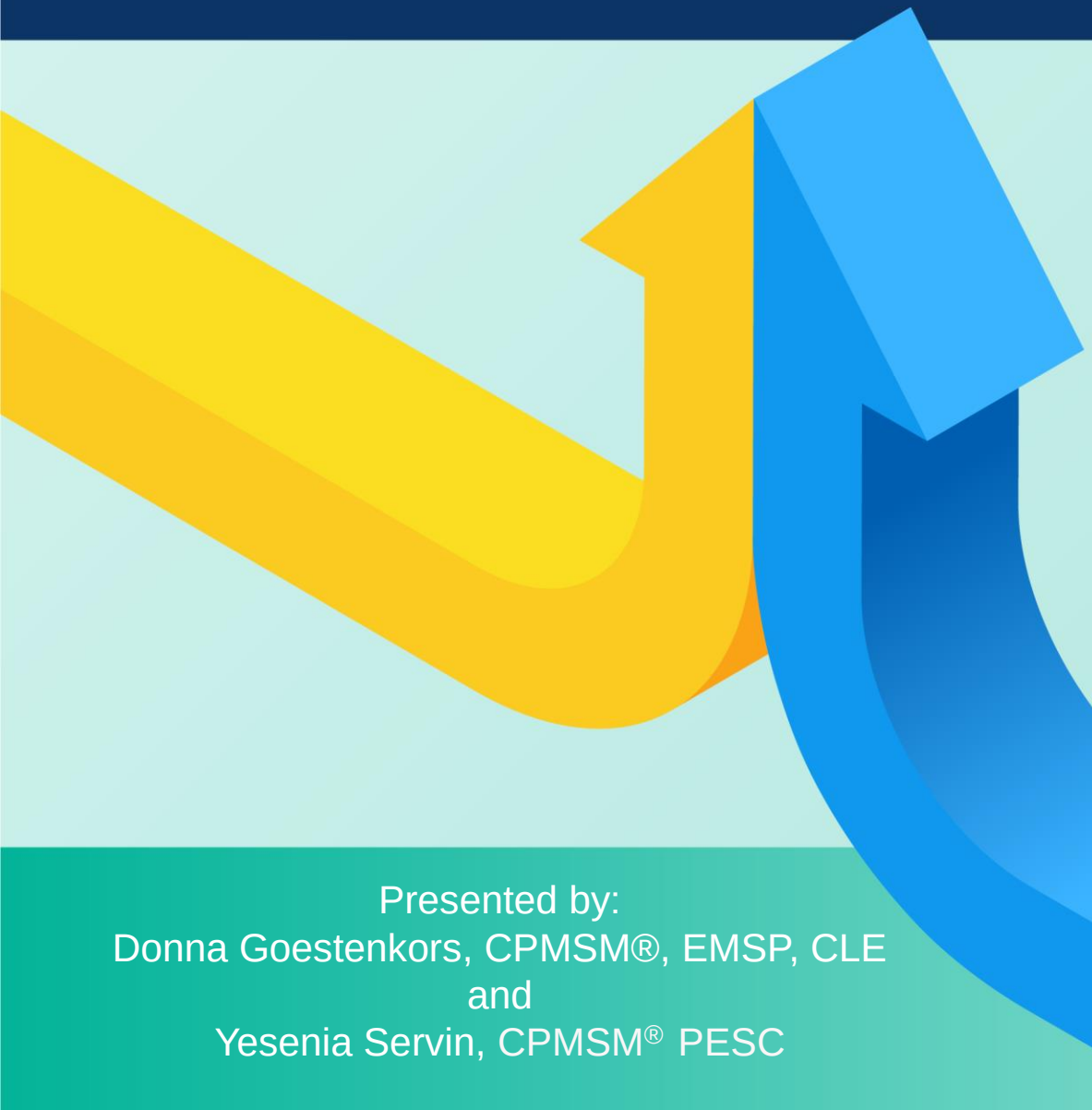
2024 ANNUAL EDUCATION CONFERENCE

April 24, 2024 • 2:15 p.m.



STRATEGIES FOR SUCCESS:

Streamlining Provider Enrollment

Presented by:
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and
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Meet Your Presenters

Donna Goestenkors, CPMSM®, EMSP, CLE
Team Med Global-President

Yesenia Servin, CPMSM®, PESC
YS Credentialing

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Objectives

1. Explain the different types of information required by Payers.
2. Identify the key elements of the Payer Enrollment package.
3. Describe the research needed for a successful Payer Enrollment process.

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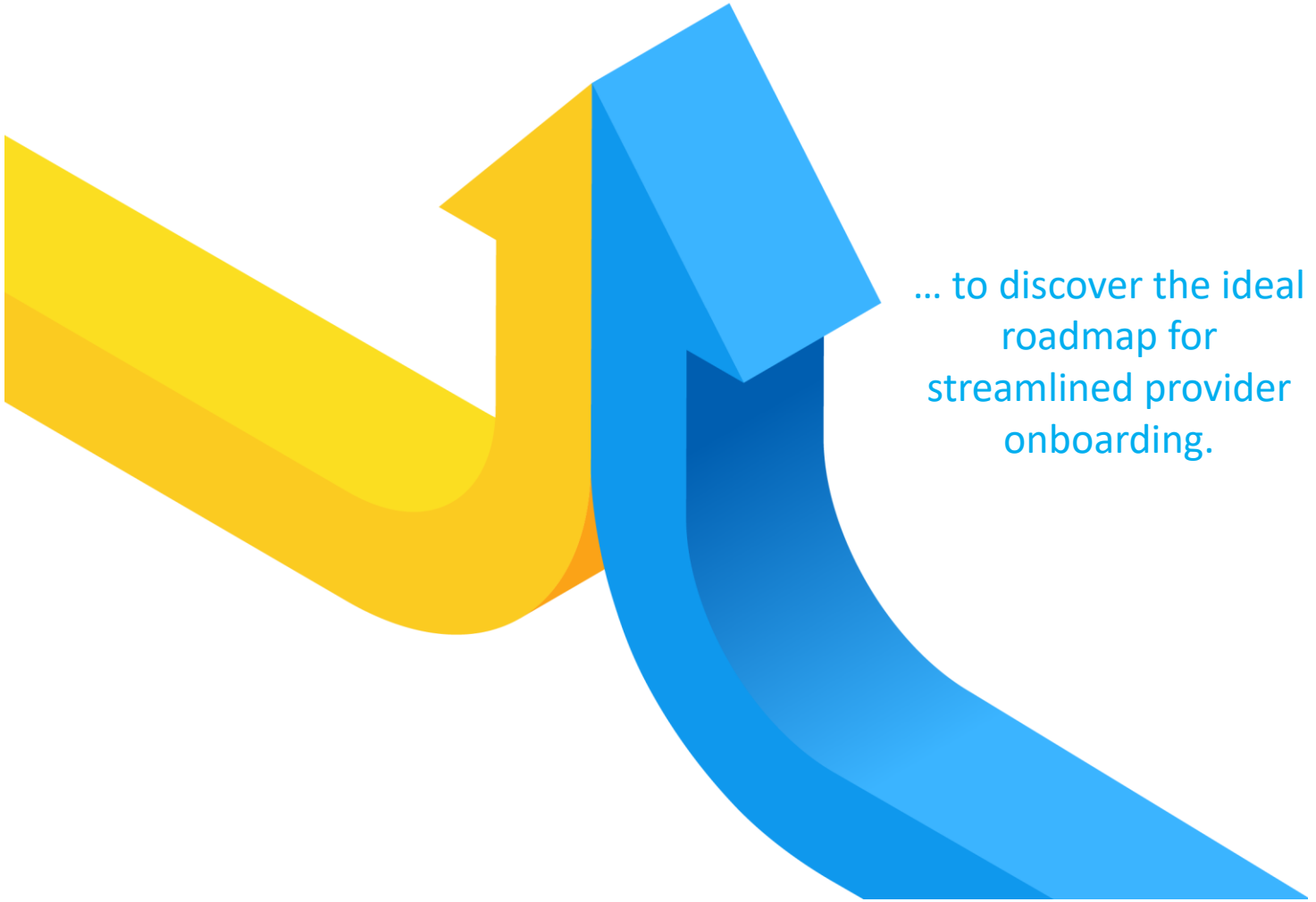
Prepare Yourself



… to discover the ideal roadmap for streamlined provider onboarding.

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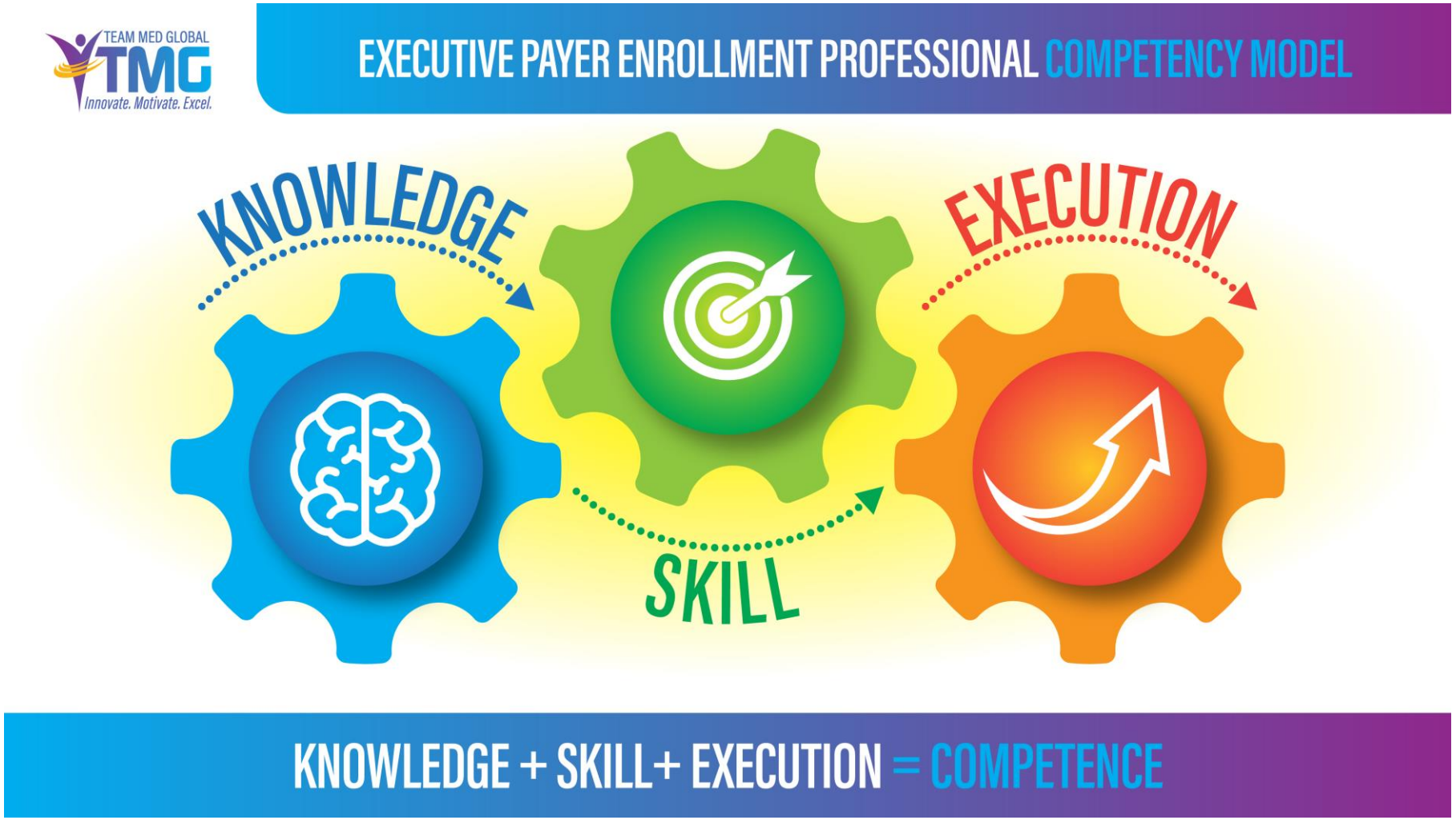
Starts With…



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Payer Enrollment vs. Credentialing

- Payer Enrollment is defined as:
  - The process of applying to health insurance plans/networks for inclusion into provider panels to enable the provider to bill for services rendered.
- Credentialing is defined as:
  - The process of verifying the credentials of a healthcare practitioner's identity, education, training, experience and competence to perform the clinical privileges they are requesting and that they are physically able and competent to perform those privileges.

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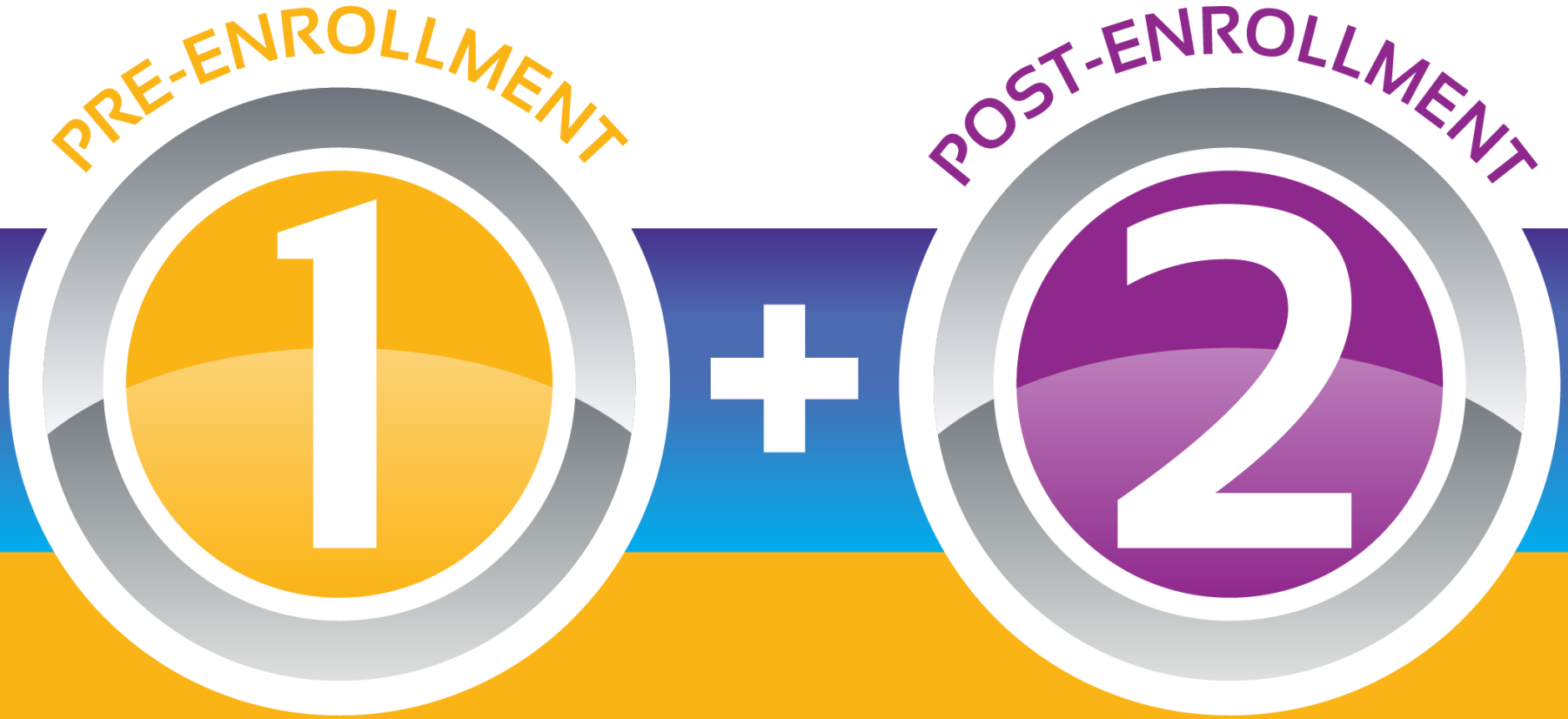
Provider Enrollment Model

PROVIDER ENROLLMENT

Provider Enrollment

Enrollment = Two Steps



Provider Enrollment

What is the process?

PRE-ENROLLMENT

1. Determine which plans to enroll
2. Contact payer/ ask questions
3. Collect provider information and documents
4. Obtain and complete applications

Provider Enrollment

What is the process?

PRE-ENROLLMENT

Prepare letter of interest

Submit enrollment packet to payer

Follow up until decision is made

Network denials– what next?

Provider Enrollment

What is the process?

POST-ENROLLMENT

Obtain proof of enrollment

Implement with billing department

Record/load new contract in database

Maintenance for continued enrollment

SonomaCredentialingServices

DIFFERENT TYPES OF INFORMATION REQUIRED BY PAYERS

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Information Asked for by Payers

Provider Info & MSP knowledge required for Enrollment varies greatly by Payer:

- Medicare – typically asks for the most information from Providers:
  - Medicare is the Gold Standard – the strictest of payers, requires the highest level of provider examination
    - Provider screenings, background checks, program integrity audits, application fee, etc.
  - MACs, Jurisdictions
    - Administer enrollments, claims, reimbursement, EHR, compliance/audits
  - Providers are required to adhere to clear and firm:
    - Conditions of Participation
    - Provider Standards of Compliance and Standards of Care
    - Protections in place for Medicare beneficiaries
  - Enrollment applications & processes are relatively straight forward & uniformed
  - But require in-depth information Provider information

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Information Asked for by Payers

Provider Info & MSP knowledge required for Enrollment varies greatly by Payer:

- State Medicaid (Medi-Cal in CA) – information required varies the most
  - Most states follow Medicare guidelines/policies; some state Medicaids require Medicare in order to enroll
  - Enrollment and Provider information requirements vary greatly by state
  - Larger states/higher population are typically stricter than others in their Enrollment requirements & processes:
    - California
    - Texas
    - Florida
    - New York
  - Typically, comparatively longer/more in-depth Enrollment applications
  - Typically, comparatively longer processing times due to lengthy state reviews
  - Revalidation requirements vary by state, provider type and if the provider is located in-state or out-of-state

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Information Asked for by Payers

Provider Info & MSP knowledge required for Enrollment varies greatly by Payer:

- Commercial/Private Payers – Information requirements vary due to network status
  - Larger Payers mostly follow Medicare guidelines, information-wise
    - Especially if the Payer offers Medicare replacement products (Medicare Advantage)
    - May have extra requirements if the payer offers Medicaid MCO products or Dual Eligible (Medi/Medi)
    - Can be equally examining (as CMS) of provider information (screenings etc.)
  - If Provider is entering a state Medicaid MCO network, that states Medicaid is a typically required
  - Can have long processing times, more red tape, more strict policies on network participation
  - Networks may not always be “open” for certain provider types and geographic areas
    - MSPs may have to request or apply for Enrollment or a contract
    - Letters of Interest can sometimes be required by commercial/private payers for certain provider types
  - Some of the smaller, more localized private payers may not require as much information as the larger payers

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KEY ELEMENTS OF THE PAYER ENROLLMENT PACKAGE

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Key Elements of an Enrollment Package

What is a **“Clean”** Payer Enrollment Package?

- Clean is defined as being complete and error free.
- All required documentation is included and not missing.
- Credentialing documents are not expired.
- Legal business name of the organization matches to the application, and to the IRS and NPI documents.
- Provider name and address on licensure matches the application, if applicable.
- All required fields are complete or marked with N/A if not applicable.

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Key Elements of an Enrollment Package

What is a **“Clean”** Payer Enrollment Package? (cont.)

- Application is legible, if hand-written (for paper applications)
- Application is signed and dated, by the appropriate person. (for paper applications)
- Application is submitted to the required, appropriate department, person etc. within the Payer.
- Application is submitted via the Payer’s preferred method
- A “clean” enrollment package is one that can be processed without the Payer having to come back and ask for additional information or clarification.
- Submitting a “clean” application can reduce processing time by Payers.

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Key Elements of an Enrollment Package

What is typically included in a **Payer Enrollment Package?**

- Instructions
  - No brainer but can be a great resource for many questions!
- Enrollment Application
  - Depending on the Payer and their processes, the application can be short or extensive in length.
- Provider Agreement
  - Spells out responsibilities of each party, rates, policy on claims submission, reimbursement, etc.
- Ownership Disclosure
  - Asks for information on who owns the entity, percentages, personal addresses
  - If they have ownership in any other entities that bill for services
- Attestation Questions
  - Questions addressing any adverse legal actions, exclusions, sanctions, fraud, etc.
- Checklist of Attachments
  - Supporting documentation as required by Payer

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Elements of the Enrollment Application

The Payer Enrollment Application – What information is typically asked?

- Practice Information
  - Practice, Mailing/Correspondence, Billing, Credentialing addresses, phone, email, and contact information
  - Provider Type, Description of Services
  - How the provider plans to bill the Payer and for which codes or taxonomy
  - Group information/ Individual provider information
- Provider Identifying & Competency Information
  - Provider Licensure, Certifications, Education, Training, Qualifications
  - Provider References, Work History, Affiliations, Privileges

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Elements of the Enrollment Application

The Payer Enrollment Application – What information is typically asked?

- Provider Malpractice/Liability Insurance information
  - Coverages and claims history (Payers can require up to 5-10 years of history)
  - Adverse event reporting
- Contact information for the application
  - Name, title, mailing address, phone, email for the person who is completing the application

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Enrollment Application Attachments

Attachments to a Payer Enrollment Application – What can be required?

- Depending on the Payer, Providers can be asked for (as applicable):
  - All applicable Professional, Medical, Federal, State, and Local licensure, certifications, registrations
  - Professional degree, fellowship, residency, CEUs, driver license, Photo ID
  - NPI enumeration confirmation letter/document
  - IRS-issued CP-575, Letter 147C stating the tax ID/EIN number and legal business name of the entity
  - Signed/dated IRS W-9
  - Entity formation documents - Articles of Incorporation, Partnership Agreement, etc.

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Enrollment Application Attachments

Attachments to a Payer Enrollment Application – What can be required?

- Depending on the Payer, Providers can be asked for (as applicable):
  - Professional, Malpractice, General liability insurance, sometimes workers comp insurance coverage
  - Copy of Medicare and/or State Medicaid enrollment
  - Roster of individual providers rendering services
  - Copy of voided check (for Electronic Funds Transfer agreement)
  - Copy of the lease agreement for the practice location
  - Application/Enrollment fee

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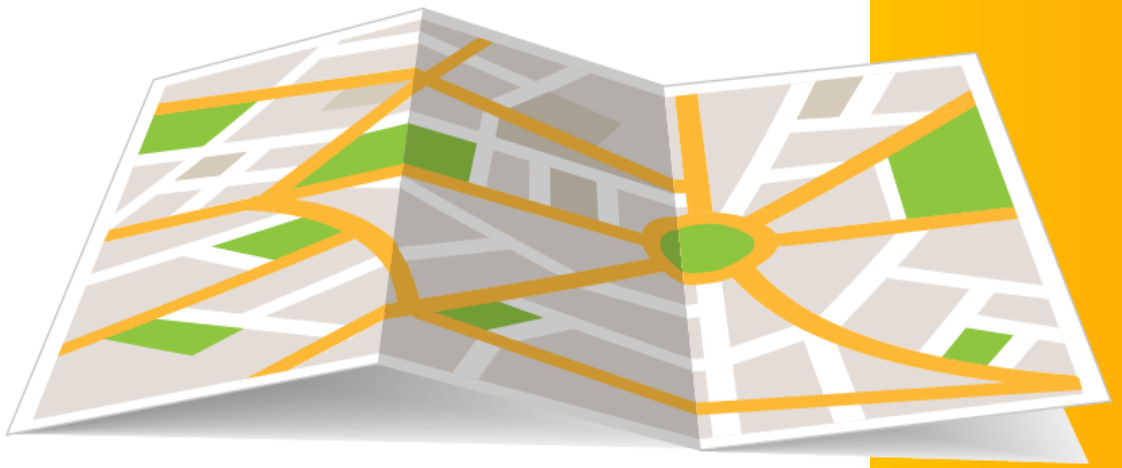

RESEARCH NEEDED FOR A SUCCESSFUL PAYER ENROLLMENT PROCESS

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Research Needed - What Varies by Payer?

- Enrollment Processes vary greatly by Payer.
- Requirements for Enrollment vary greatly by Payer.
- Submission methods vary greatly by Payer.
- Processing timeframes vary greatly by Payer.

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How Enrollment Processes Vary by Payer

Payers have their own **processes** for Enrollment.

- Some Payers contract first, then enroll. Some enroll first, then contract.
- Sometimes Payer networks might not be “open” or guaranteed enrollment. (like Medicare, some Medicaids)
- Sometimes Payer networks might be limited or narrow. (meaning they only allow a certain # of Providers)

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How Enrollment Processes Vary by Payer

Payers have their own **processes** for Enrollment.

- Sometimes Payers evaluate the Provider/Services for “network need” to decide if they can move forward
- Payers may ask you to submit:
  - Prep-application
  - Online form to request a contract or enrollment
  - Letter of Interest & IRS W-9
  - Information/details about the provider’s services offered and geographic area served
  - Request for Proposal (RFP)

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How Requirements Vary by Payer

Payers have their own **requirements** for Enrollment/Applying to their network

- Some Payers require (and some don't):
  - Application/Enrollment fees
  - Specific licensing or certification requirements for certain provider types or Out of State providers
  - Screenings for certain, high (fraud) risk providers, such as DME or Home Health Care Agency
    - Background checks, fingerprints/LiveScan, identity documentation
    - Detailed or additional information on the Ownership of the provider organization

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How Requirements Vary by Payer

Payers have their own **requirements** for Enrollment/Applying to their network.

- Some Payers require (and some don't):
  - Unique Out of State (OOS) provider requirements
    - Border state requirements (providers within a certain radius of the state border)
    - Some payers reimburse differently for OOS providers
      - IE: some State Medicaids will only reimburse OOS providers secondary to Medicare
    - Enrollment processes can be different for OOS providers.
      - Either shorter form or more lengthy process

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How Submission Methods Vary by Payer

Payers have their own preferred **methods of submission.**

- Via Online/web portal
  - Pros – Ability to upload documents and track application process in Real Time
  - Challenges- keeping track of URLs, passwords, who has admin rights, how to assign end users, etc.
- Via Email
  - Sometimes to a dept, a general email repository, a specific person, receipt confirmation, ATN assigned.
  - Challenges – having to follow up so many times to confirm receipt and to check processing status

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How Submission Methods Vary by Payer

Payers have their own preferred **methods of submission.**

- Via Fax
  - Can go to an eFax to a dept or general repository for processing
  - Challenges – fear of the application going into a Black Hole; having to follow up to ensure receipt
- Electronic Signatures
  - DocuSign, etc.
- CAQH
  - Electronic repository of individual provider information and documentation

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How Processing Times Vary by Payer

Payers have their own **processing time frames** for Enrollment applications/ requests.

- What is a normal processing time to expect for Payer Enrollment?
  - Varies by payer, but expect 60-120 days
  - Some payers take longer, some take less time.
  - Federal, State and Private Payers all have different processing times.

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How Processing Times Vary by Payer

Payers have their own **processing time frames** for Enrollment applications/ requests.

- What can you do to impact the process?
  - Contact each payer and ask their typical processing time.
  - If you work with certain payers consistently, keep a log of their typical processing times:
    - Medicare, State Medicaid and Commercial Payers
    - Keep a directory of each Payer you work with on a regular basis, including any contacts
  - After submission to Payer, follow up until you're ensured receipt and processing
  - When received by the Payer, ask the payer for an Application Tracking Number/ATN and follow up using that ATN.
  - Try to establish a contact and rapport with the Payer, so you can leverage that relationship
  - Communicate with all stakeholders and be transparent with processing time. Don't over promise!

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What Can You Do to Impact the Process?

Be Proactive. Before you start, contact each payer and ask questions!

- In addition to asking the Payer the information in the previous slides, ask questions such as:
  - Are there any special requirements or processes for enrolling the provider type?
  - Does the Payer allow backdating? If so, how far back?
  - If paper application, does the Payer require original/wet-ink signatures?
  - Does the Payer accept CAQH for individual providers?
  - What are the Payer's processes for setting up Electronic Funds Transfer (EFT) so that your provider can be paid electronically instead of by paper checks?
  - What are the Payer's processes for setting up Electronic Remittance Advice (ERA) for matching payments to claims?

Habit No. 1: **BE PROACTIVE!** If not now when?

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What Can You Do to Impact the Process?

Be Proactive. Before you start, contact each payer and ask questions! (cont.)

- More questions to ask:
  - Where can you get a copy of the Payer's fee schedule, so that you can know the allowables/reimbursements expected from that Payer for your provider's services? (If needed)
  - How will you be notified of approval or denial?
  - If denied, can you appeal their decision and what is that process?

- Asking questions like this in advance can give answers ahead of needing them, reducing time spent on the phone.

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Streamlining the Enrollment Process

What else can you do to streamline the Payer Enrollment Process?

- Become an expert in the TMG Payer Enrollment Process Model.
- Familiarize yourself with the TMG Payer Enrollment Competency Model.
- Know your Payers and **ask questions**!
- Whenever possible, connect with Payer representatives on LinkedIn to build a rapport.
- Automate with software – there are plenty of options to chose from!
- Use Payer web portals whenever possible, vs. paper applications.

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Streamlining the Enrollment Process

What else can you do to streamline the Payer Enrollment Process?

- Use auto-fillable forms and Adobe Acrobat whenever possible.
- Submit a **clean** application on the first submission, every time.
- Respond immediately to Payer requests for any additional information.
- Track your enrollment online if possible.
- Keep all stakeholders informed along the way to minimize unwanted surprises.
- Follow up consistently to ensure final processing and receipt of the welcome letter.
- If Enrollment is denied, be sure to appeal the denial and use your skills to sell the Provider to the Payer.

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"When you know better,
you do better."

- Maya Angelou

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