TRAINING
HANDOUTS

Faster & Easier Commercial Payer Enrollment & Credentialing

HEALTHCARE TRAINING LEADER®
Expert Medical Practice Solutions

Presented by:
Merella Schandl, MHA, CPMSM, CPCS

Inconvenience

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About Your Expert

Merella Schandl, MHA, CPMSM, CPCS

Senior Healthcare Consultant

Merella brings over 25 years of health care experience to Anders as a senior health care consultant, having worked with all facets of the industry.

With over 25 years of healthcare compliance, enrollment and credentialing experience, Merella brings a wealth of knowledge to her clients. She advises hospitals, managed care organizations and physician practices on regulatory compliance and credentialing. As a senior health care consultant with Anders Consulting, Merella designs and implements plans for integrating provider enrollment while delegating credentialing and medical staff services to enhance client revenue cycles. She provides practice assessments to independent/group physicians, identifying areas for improvement related to process improvement, design flow, staffing and other processes.

As a National Association of Medical Staff Services Instructor, she is able to continue industry education to those seeking certification in credentialing and leadership. A frequent presenter, Merella shares her depth of health care knowledge through local and national speaking opportunities. Merella is heavily involved in industry organizations and is currently pursuing a certification as a Six Sigma Black Belt.

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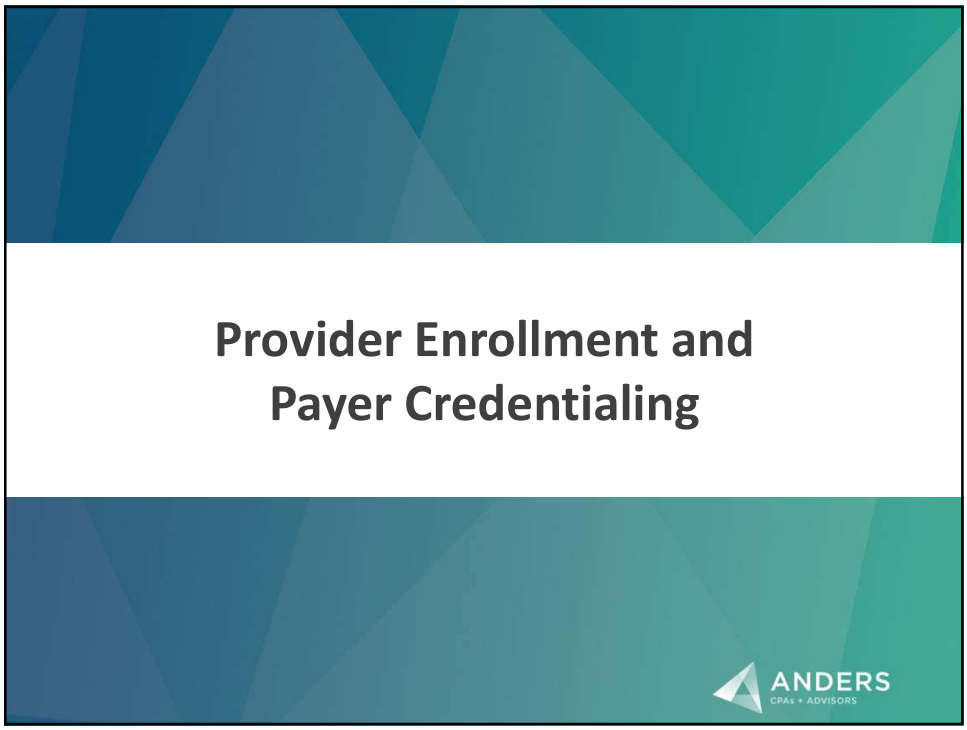

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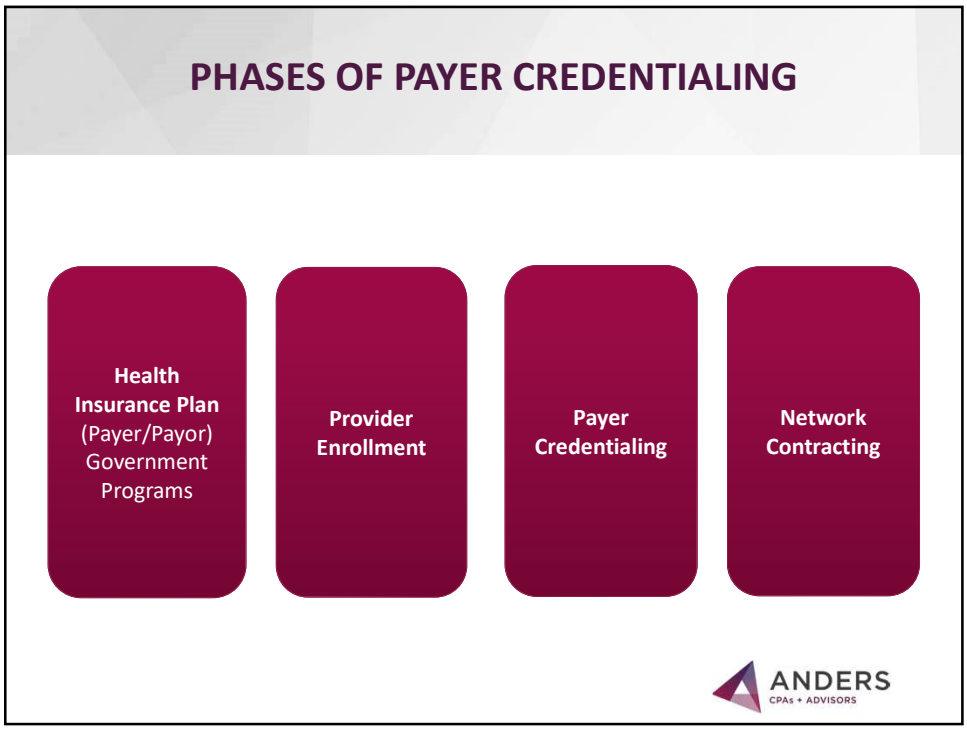
PHASES OF PAYER CREDENTIALING
Health Insurance Plan (Payer/Payor) Government Programs
Provider Enrollment
Payer Credentialing
Network Contracting
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Health Insurance Plans
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TYPES OF HEALTH INSURANCE PLANS

Private, Federal, State and Commercial Payers…

- Health Maintenance Organizations
- Preferred Provider Organizations
- Exclusive Provider Organizations
- Point-of-Service Plan
- Private Fee-For-Service
  - Medicare Advantage (Medicare Part C)
- Federal and State Programs
  - Medicare, Medicaid, Children's Health Insurance Program, TRICARE, Veterans Administration

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COMMERCIAL PAYERS

Processes vary by payer

Phase I Credentialing

- Provider request participation
- Ensure CAQH is current
- Primary Source Verification
- Complete credential file submitted to the Credential Committee for review and consideration of approval
- Process time up to 90 days
- Do not retro effective dates

Phase II Contracting

- Extend contract/participation agreement
- Provider reviews/signs
- Network receives signed agreement
  - Issues effective date and provider number for billing
- Process time 30-45 days after credentialing is complete

"In-Network" reimbursements are not received until the contracting is complete and an effective date is received"

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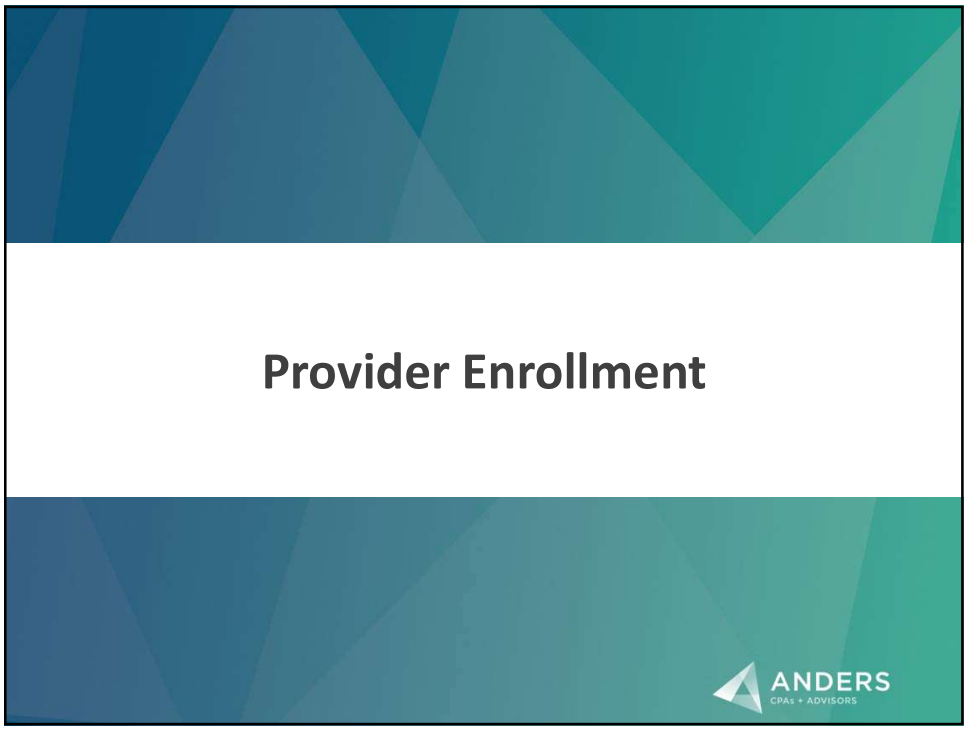

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WHAT IS PROVIDER ENROLLMENT?

Also known as payer enrollment…

The process referring to a provider or practitioner who request to join and participate in health insurance networks for the purpose of submitting claims so they can be reimbursed for services.

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PROVIDER CREDENTIALING TYPES

Who must enroll to maximize financial benefits…

Facility

- Hospital
- Ambulatory Surgery Center
- Extended Care Facility
- Rehabilitation Facility
- Hospice
- Clinic
  - Federally Qualified Health Center (FQHC)
  - Rural Health Clinic
  - Medical Clinic
  - Family Planning
  - Nurse Practitioner
  - Dental Clinic
  - Outpatient Mental Health
  - Community Mental Health
- School Corporation
- Public Health Agency
- Pharmacy
- DME/Medical Supply Dealer
- Transportation Provider
  - Ambulance
- Laboratory

Practitioner

- Advanced Practice Registered Nurse (APRN, CNM, CRNAs, CNS)
- Physician Assistant
- Physician
- Behavioral Health Provider
  - Health Service Provider in Psychology
  - Behavioral and Primary Healthcare Coordination
  - Licensed Psychologists - clinic and school based
  - Licensed Clinical Social Workers
  - Licensed Clinical Addiction Counselor
  - Licensed Mental Health Counselor
- Dentist
- Podiatrist
- Chiropractor
- Optometrist
- Therapist
- Audiologist
- Genetic Counselors

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ENROLLMENT TYPES

Understanding enrollment statuses…

- Participating (in-network)
- Non-participating (out-of-network)
- Opt-out (Medicare)

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PROVIDER ENROLLMENT PROFESSIONAL

Establish a tracking plan for turnaround times…

- Receipt of onboarding application and documents
- Application completion to payer submission
- Payer request for additional documentation
- Days in payer credentialing to final determination notice to provider or enrollment professional
- Days in network contracting

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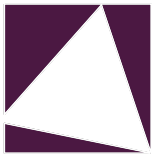
PRE-ENROLLMENT STRATEGY

Create an enrollment matrix…



- Identify payer selection by highest payer mix
- Research payer websites to determine:
  - Process to join the network
  - Specific criteria (CAQH, Volume Data, Collaborative Agreements, etc.)
  - Checklist of required documents
  - Timeframe for credentialing and contracting
  - Follow-up methodology
  - Telephone and fax numbers and email addresses
- Contact payers and obtain:
  - Names of payer representatives (if applicable)
  - Preferred method of contact
  - Start building relationships
- Notate key payer information onto the Matrix
  - Include process to renew and term providers

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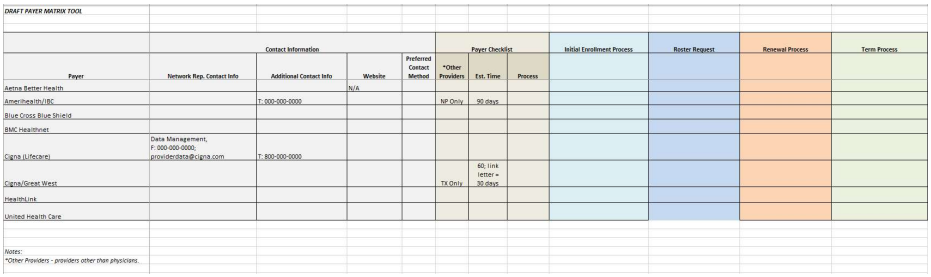
PAYER MATRIX EXAMPLE

Draft – see handouts for your editable version



DRAFT PAYER MATRIX TOOL

	Contact Information				Payer Checklist			Initial Enrollment Process	Roster Request	Renewal Process	Term Process
Payer	Network Rep. Contact Info	Additional Contact Info	Website	Preferred Contact Method	*Other Providers	Est. Time	Process				
Aetna Better Health			N/A								
Amerihealth/IBC		T: 000-000-0000			NP Only	90 days					
Blue Cross Blue Shield											
BMC Healthnet											
Cigna (Lifecare)	Data Management, F: 000-000-0000; providerdata@cigna.com	T: 800-000-0000									
Cigna/Great West					TX Only	60; link letter + 30 days					
HealthLink											
United Health Care											

Notes:
*Other Providers - providers other than physicians.

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POLICIES AND PROCEDURES

Align your matrix with accrediting body and your organization's policy and procedure requirements…

Sample Policy and Procedure Criteria

- Establish turn around times
  - Internal review of an application
  - Practitioner to submit required elements of an application
  - Return incomplete applications
- Scanning
- Expiration Management
- Required Outstanding Application Verification Requests
- Recredentialing and revalidations
- Demographic changes and/or updates
- CAQH Profiles

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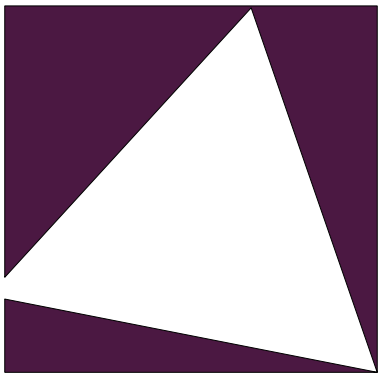
PROVIDER ENROLLMENT WORKFLOW

Refer to your organization's policy and procedures and payer matrix…

- CAQH Profile
  - Requires a signed CAQH Statement of Authorization
  - Review, update, attest
- Ensure Data Transparency
  - CV is in the mm/yyyy format
  - Correct addresses, expiration dates, etc.
  - Identify work history and gap explanations
  - Malpractice history
  - Sanction information
  - Application/attestation questions answered
- Set Payer Follow-Up Alerts



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COMMERCIAL PAYER ENROLLMENT CHECKLIST

See handouts for a full version

Collect provider information and documents

- ☐ Preapplication, CAQH, NPI registry, rosters
- ☐ Review/QA for completeness/accuracy
- ☐ Check addresses, ZIP codes, and counties on USPS website
- ☐ Check names/addresses/expiration dates on licensure and supporting documents

Obtain, complete, and submit application

- ☐ Health plan–specific enrollment instructions (e.g., on website or application)
- ☐ Provider identifying information, education, training
- ☐ Provider licensure, certifications, affiliations
- ☐ Work history and gap information
- ☐ Practice information/description/services
- ☐ Professional liability insurance
- ☐ Billing information/clearinghouse/third-party administrator
- ☐ Attestation questions/disclosures
- ☐ Ownership/controlled interest disclosure
- ☐ Information release/acknowledgments
- ☐ Provider agreement(s)/EFT agreement
- ☐ Checklist of attachments

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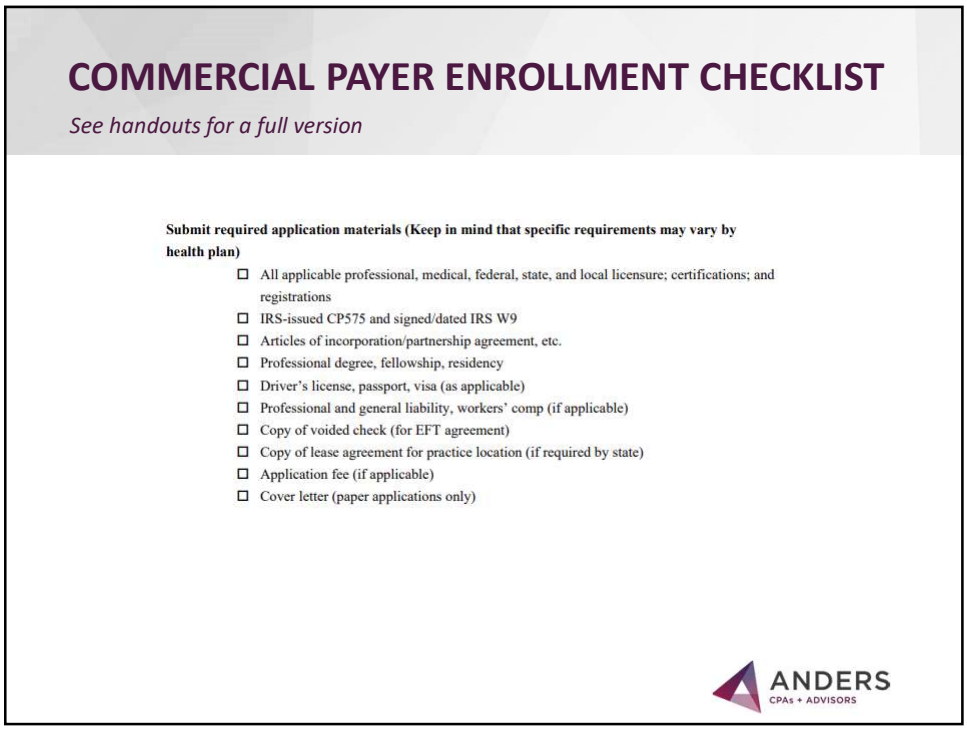
COMMERCIAL PAYER ENROLLMENT CHECKLIST
See handouts for a full version
Submit required application materials (Keep in mind that specific requirements may vary by health plan)
All applicable professional, medical, federal, state, and local licensure; certifications; and registrations
IRS-issued CP575 and signed/dated IRS W9
Articles of incorporation/partnership agreement, etc.
Professional degree, fellowship, residency
Driver's license, passport, visa (as applicable)
Professional and general liability, workers' comp (if applicable)
Copy of voided check (for EFT agreement)
Copy of lease agreement for practice location (if required by state)
Application fee (if applicable)
Cover letter (paper applications only)
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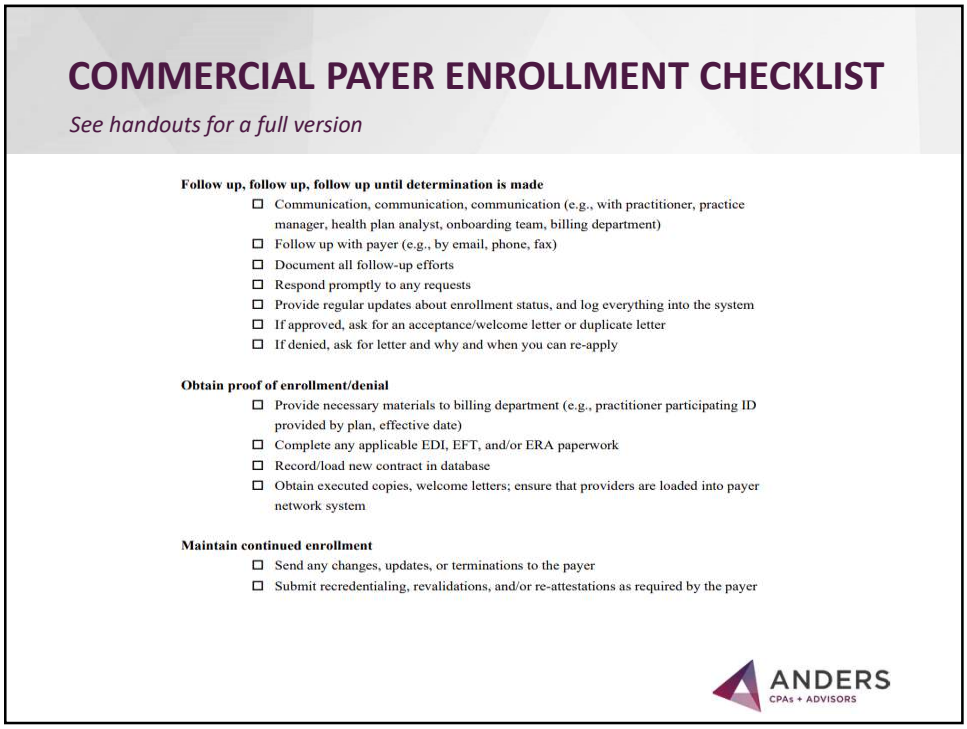
COMMERCIAL PAYER ENROLLMENT CHECKLIST
See handouts for a full version
Follow up, follow up, follow up until determination is made
Communication, communication, communication (e.g., with practitioner, practice manager, health plan analyst, onboarding team, billing department)
Follow up with payer (e.g., by email, phone, fax)
Document all follow-up efforts
Respond promptly to any requests
Provide regular updates about enrollment status, and log everything into the system
If approved, ask for an acceptance/welcome letter or duplicate letter
If denied, ask for letter and why and when you can re-apply
Obtain proof of enrollment/denial
Provide necessary materials to billing department (e.g., practitioner participating ID provided by plan, effective date)
Complete any applicable EDI, EFT, and/or ERA paperwork
Record/load new contract in database
Obtain executed copies, welcome letters; ensure that providers are loaded into payer network system
Maintain continued enrollment
Send any changes, updates, or terminations to the payer
Submit recredentialing, revalidations, and/or re-attestations as required by the payer
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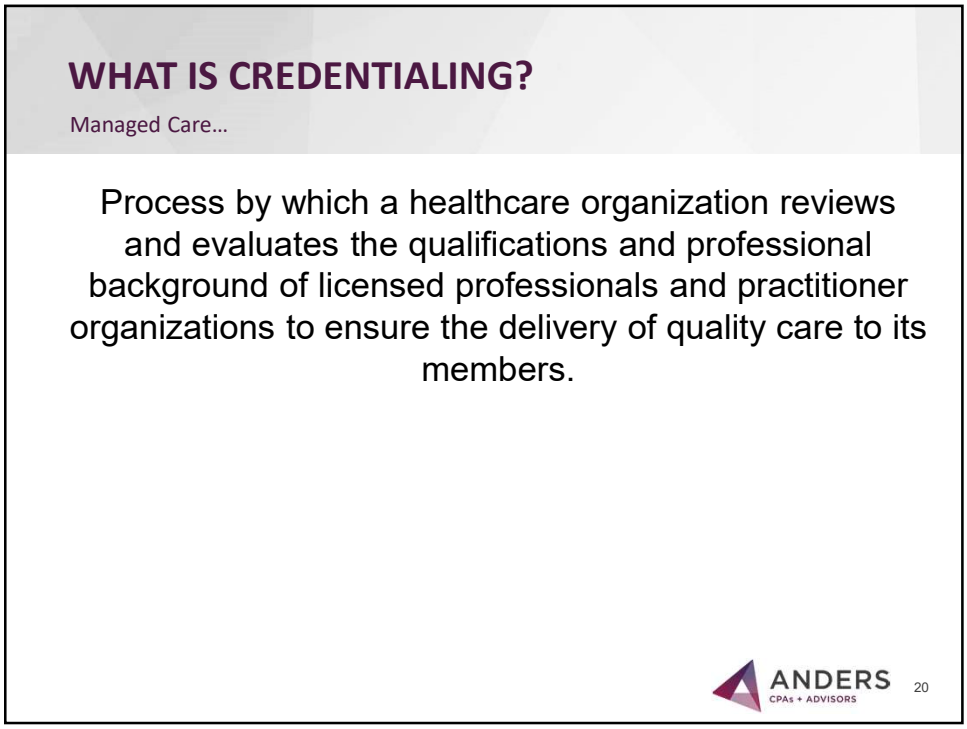

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COMMERCIAL PAYER CREDENTIALING

Process varies by payer and typically includes…

- Collection of required data and documents
- Access to provider authorized CAQH application and documents
- Completing a thorough review of information
  - Notify provider of incomplete CAQH or missing information request
- Conduct primary source verification
- Obtain Credentials Committee approval
- Network Contracting issues agreement
- Participation determination

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COMMERCIAL PAYER CREDENTIALING

Required to achieve payer participation…

Primary Source Verification

- Licensure (State, Controlled Substance, DEA)
- Board certification
- Education and training
- Work history
- Hospital privileges or admitting arrangements
- Professional liability insurance
- National Practitioner Data Bank
- Sanctions

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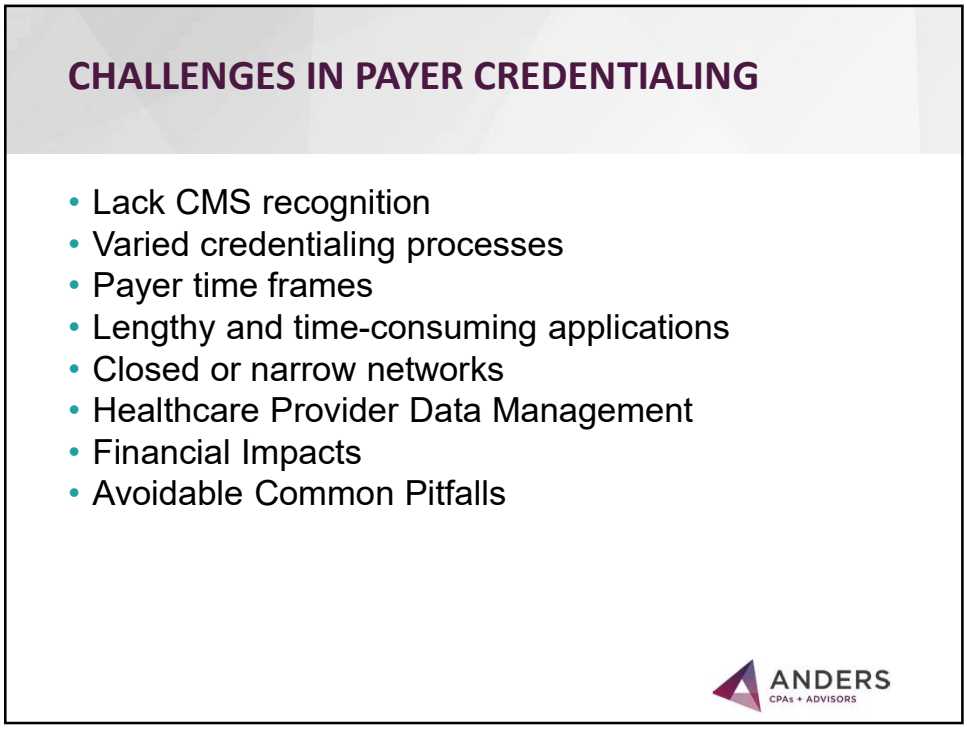

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OUT-OF-NETWORK PROVIDERS

- Can results in higher costs for patients
- HMO plans do no allow for coverage of patients treated by out-of-network
- No guarantee that claims will be processed
- Claim acceptance by a payer depends on whether or not the patient's policy allows out-of-network benefits
- Medicare and Medicaid do not pay for out-of-network services

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AVOIDABLE DELAYS

Invest the time, expect to spend upward of 10 hours on each application from initial submission to contract receipt…

- Overlooked details on applications (work gaps, claims history)
- Missing data fields (signatures and dates)
- No structured follow-up with payers
- Lapse in CAQH information
  - Not re-attesting timely
  - Expired items and documents
  - Incorrect credentialing contacts
  - Practice addresses not updated

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ENCOUNTERING CHALLENGES WITH PAYERS

Working with closed or narrow networks…

- Closed network
  - Doesn't accept new providers/groups
  - Network maintains volume of similar providers
- Narrow network
  - Maintain enough par providers of a specific type and is usually not seeking to expand further

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CLOSED NETWORKS

Create a strategic appeal to open closed networks…

- Clarifying merits to be an in-network provider:
  - unique value add
  - rare or otherwise desired specialty
  - volume of patients
  - profile quality
  - clean claims record
  - type of patient population
    - *rural*
    - *inner-city*

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APPEALING CREDENTIALING DECISION

Follow the payer's requirements regarding appeals procedures…

- Call the payer
- Document efforts
- Develop a value proposition letter
  - include your unique clarifying information
  - no longer than one page
  - address to the executive of payer contracting

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KEY CHALLENGES IN HEALTHCARE DATA

Payer inefficiencies that weigh down the enrollment process…

- Inaccurate provider data
  - potential lost revenue
- Ability to manage compliance and risk
- Disparate systems
- Lacks transparent interfacing
- No uniform process

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PAYER COMMUNICATION BARRIERS

Provider Enrollment and Credentialing…

- Work in silos
- Lack interfacing systems
- Absence of transparency
- Single source for provider data

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AVOID FINANCIAL IMPACTS

Be proactive to challenges associated with payer credentialing…

- Build relationships with health plan representatives
  - Streamlines application concerns timely
  - Allows providers the ability to be proactive
  - Provider Reps alerts in advance of changes
- Keep your data up-to-date
- Respond to payer requests timely
- Create a payer enrollment matrix

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AVOID COMMON PITFALLS

Credentialing and enrollment bottlenecks…

- Initiating the process too late
- Submitting incomplete applications
- Untimely responses to payers
- Not challenging delays
  - Payer backlog of applications
  - Inefficient follow-up
- Expired Documents

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WORKFLOWS / PROCESS MAPPING

From onboarding to payer effective dates…

- Develop workflows to ensure the enrollment process is mapped accordingly across departments that it impacts.
- Streamline efficiencies to create a seamless process.
- Create ongoing process improvement to reduce risk to bottom line revenue.
- Understand payer contracts and processes to establish accountability for potential errors/omissions.

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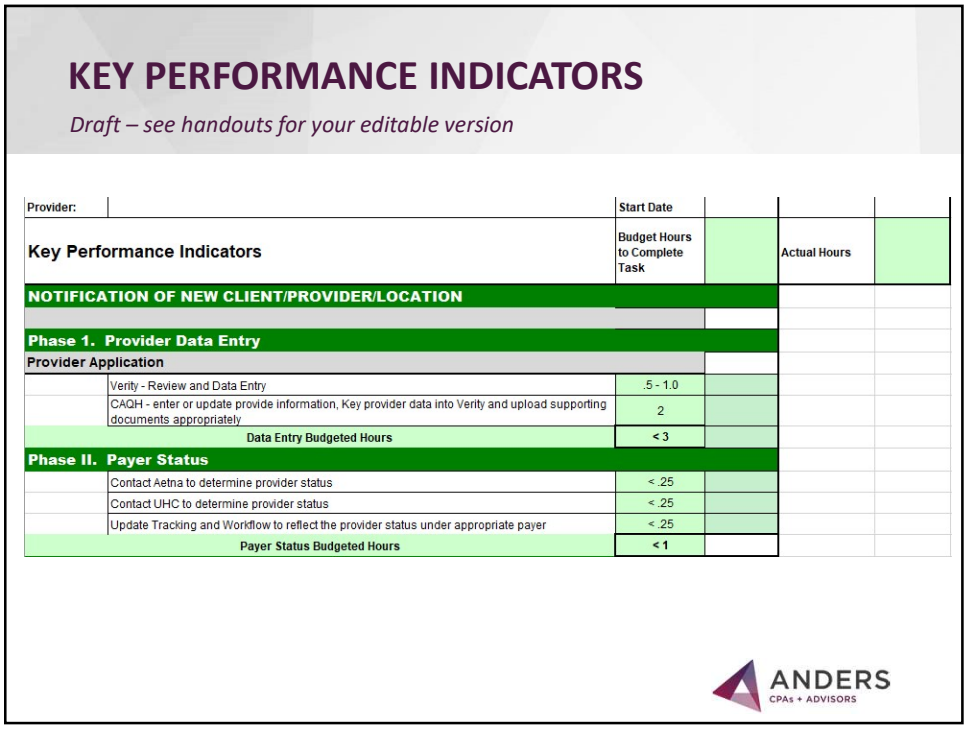

KEY PERFORMANCE INDICATORS

Draft – see handouts for your editable version

Provider:		Start Date			
Key Performance Indicators		**Budget Hours to Complete Task**		**Actual Hours**	
NOTIFICATION OF NEW CLIENT/PROVIDER/LOCATION					
Phase 1. Provider Data Entry					
Provider Application					
	Verity - Review and Data Entry	.5 - 1.0			
	CAQH - enter or update provide information, Key provider data into Verity and upload supporting documents appropriately	2			
	Data Entry Budgeted Hours	**< 3**			
Phase II. Payer Status					
	Contact Aetna to determine provider status	< .25			
	Contact UHC to determine provider status	< .25			
	Update Tracking and Workflow to reflect the provider status under appropriate payer	< .25			
	Payer Status Budgeted Hours	**< 1**			

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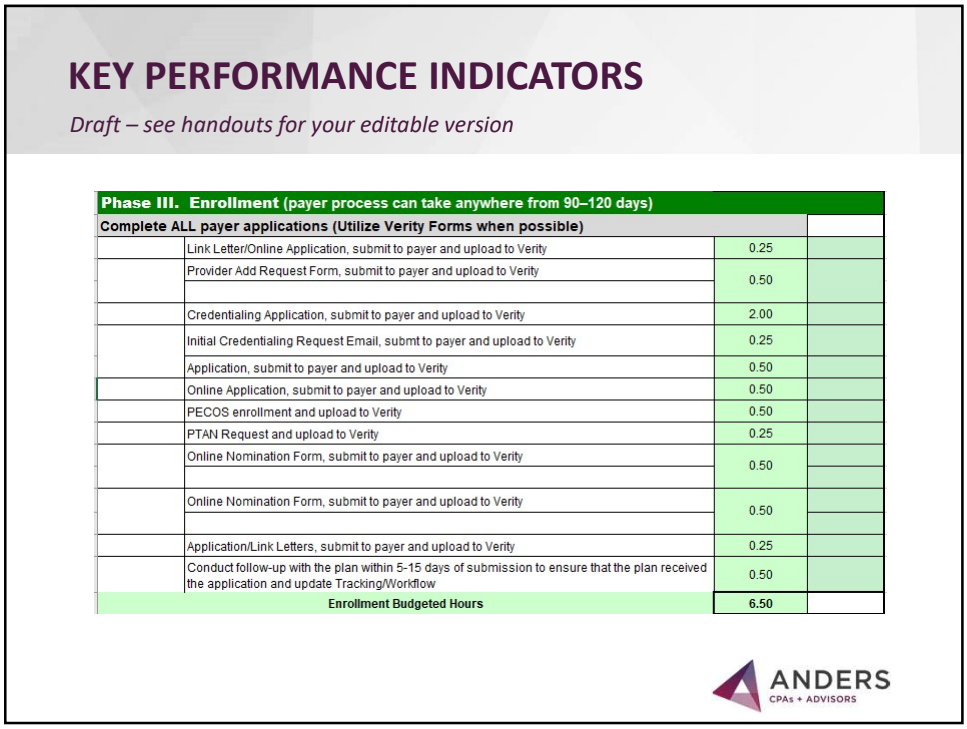

KEY PERFORMANCE INDICATORS

Draft – see handouts for your editable version

Phase III. Enrollment (payer process can take anywhere from 90–120 days)			
Complete ALL payer applications (Utilize Verity Forms when possible)			
	Link Letter/Online Application, submit to payer and upload to Verity	0.25	
	Provider Add Request Form, submit to payer and upload to Verity	0.50	
	Credentialing Application, submit to payer and upload to Verity	2.00	
	Initial Credentialing Request Email, submt to payer and upload to Verity	0.25	
	Application, submit to payer and upload to Verity	0.50	
	Online Application, submit to payer and upload to Verity	0.50	
	PECOS enrollment and upload to Verity	0.50	
	PTAN Request and upload to Verity	0.25	
	Online Nomination Form, submit to payer and upload to Verity	0.50	
	Online Nomination Form, submit to payer and upload to Verity	0.50	
	Application/Link Letters, submit to payer and upload to Verity	0.25	
	Conduct follow-up with the plan within 5-15 days of submission to ensure that the plan received the application and update Tracking/Workflow	0.50	
	Enrollment Budgeted Hours	**6.50**	

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KEY PERFORMANCE INDICATORS

Draft – see handouts for your editable version

Payer Follow-up			
	At 30 days (update Tracking/Workflow)	0.25	
	At 60 days (update Tracking/Workflow)	0.25	
	At 90 days (update Tracking/Workflow)	0.25	
	Incomplete Application Response from Payer (need more info, rejected or denied applications) (must be completed within 2 days of notification) Create tracking/workflow and/or tracking events, document accordingly and upload material items	0.25	
	Follow Up Budgeted Hours	**< 1**	
Misc Items			
	Contact with Provider		
	Contact KS Superior Select for Enrollment Instructions		
	Metrics Created		
	NPI Update		
	Misc Budgeted Hours	**0**	

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REVENUE CYCLE MANAGEMENT

Impacts of fragile credentialing efforts…

- Out-of-network services
- Frustrated patients
- Lost revenue
- Delayed payments
- Rejected or denied claims

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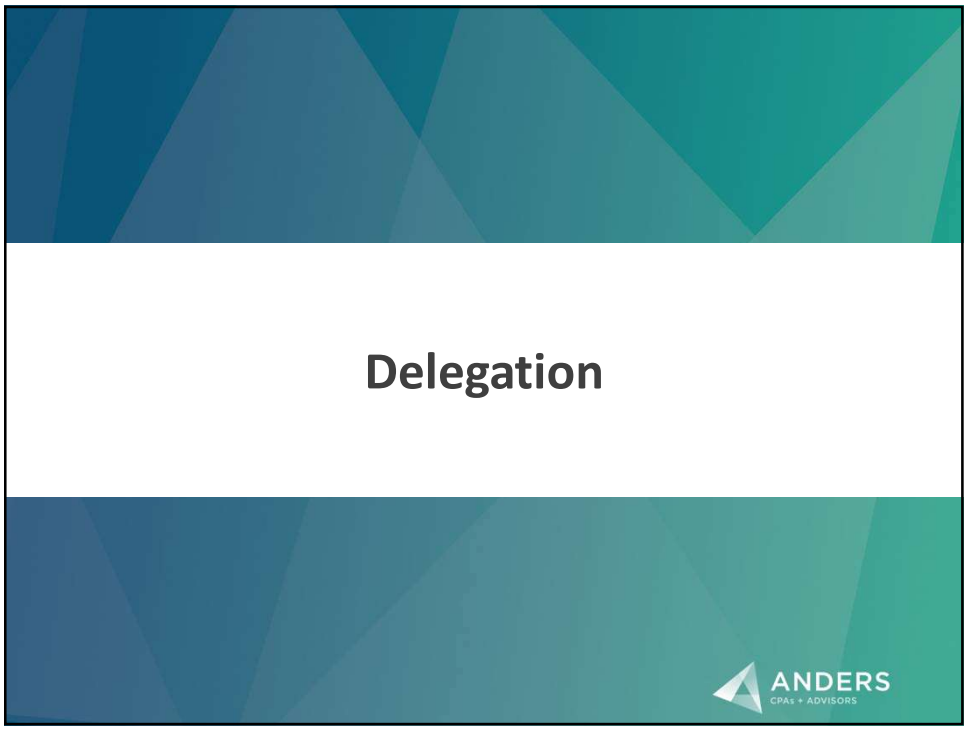
Delegation
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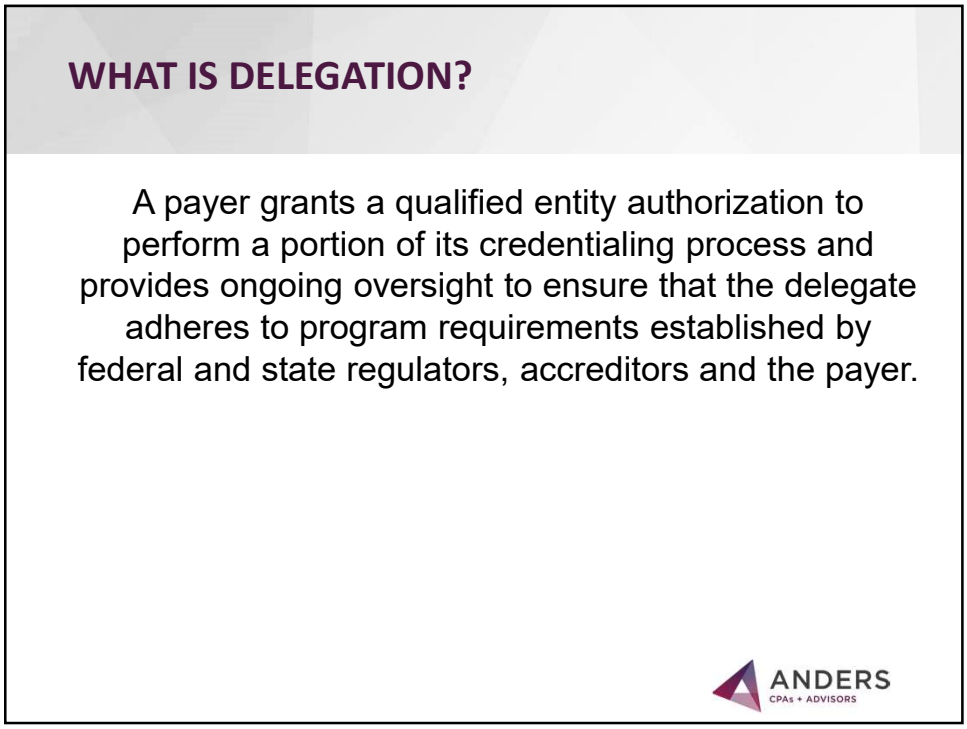
WHAT IS DELEGATION?
A payer grants a qualified entity authorization to perform a portion of its credentialing process and provides ongoing oversight to ensure that the delegate adheres to program requirements established by federal and state regulators, accreditors and the payer.
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DELEGATED ENTITY

- Health system
- Hospital
- Medical group
- Independent practice association
- Credentials Verification Organization (CVO)
- Health plan
- Health care entity performing specific credentialing functions on behalf of a payer (under contract)

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DELEGATED CREDENTIALING

Results in expeditious enrollment…

- Clinicians can begin practicing earlier
- Timelier reimbursements
- Patient access to health care
- Health plans conserve resources and expand their networks

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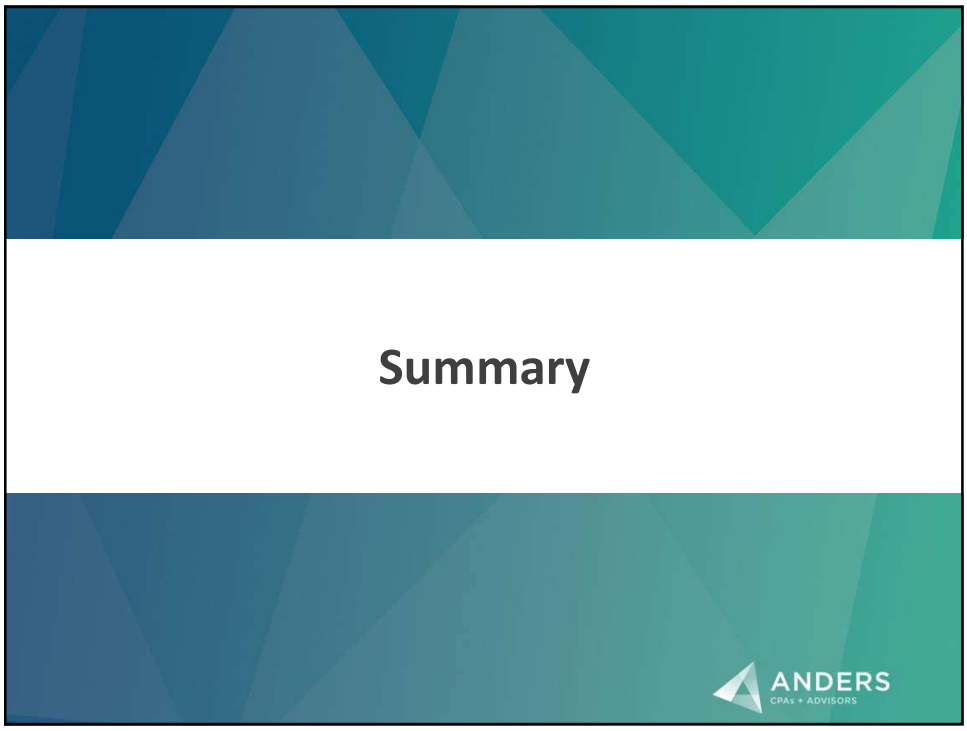

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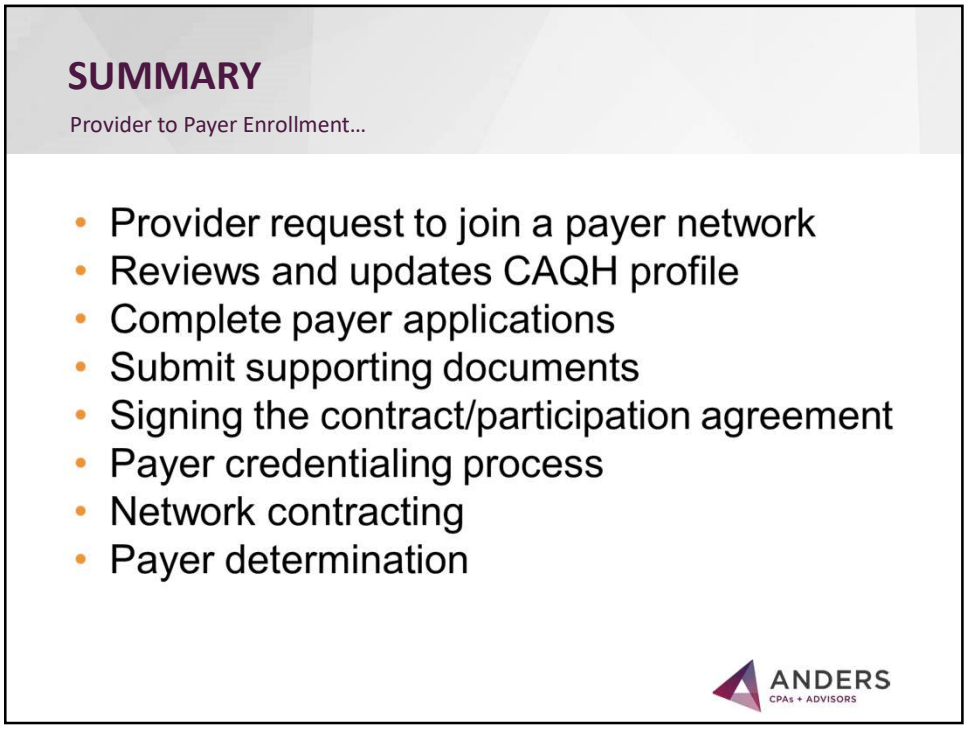

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KEY TAKE AWAY

Enrollment lacks standardization – a long and complex process…

- Health insurance plans – contracted
- Government programs – non-contracted
- Varies by payer to initiate the process
  - a phone call to the payer
  - complete standard forms
  - complete online credentialing applications
- CAQH intent to standardize
  - requires manual intervention
  - consistent follow up to ensure accuracy and timeliness
- Understand key terms used in payer contracts
- Relationships with Provider Reps

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KEY TAKE AWAY

Benefits of Payer Credentialing…

- Allows patients better access to care
- Providers access to a higher volume of patients in your service area
- Maximizes financial benefits

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