2016 Complete Overview of the NCQA Standards

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Presenter(s): Veronica C. Locke, MHSA
Overview of the NCQA Credentialing Standards

Presentation for NAMSS Conference
By: Veronica C. Locke
September 20, 2016

Objectives/Agenda

• Review how to read a standard.
  • Including data sources
• Provide a comprehensive overview of NCQA's credentialing standards.
  • Including common challenges during survey
• High-level overview of CR Delegation
• Answer your questions and invite discussion!

NCQA Products with Credentialing

Complete credentialing
• Health Plan (HP) Accreditation
• Managed Behavioral Health Organizations (MBHO) Accreditation
• Credentialing (CR) Certification
• Credentialing Verification Organization (CVO) Certification (no decision-making)

Partial credentialing
• Disease Management (DM) Accreditation/Certification
• Case Management (CM) Accreditation
Differences between Accreditation/Certification Programs

<table>
<thead>
<tr>
<th>Criterion</th>
<th>HP</th>
<th>MBHQ</th>
<th>UM-CR</th>
<th>ACO</th>
<th>CM</th>
<th>CH</th>
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<tbody>
<tr>
<td>Credential Verification</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Ongoing Monitoring</td>
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<td>Credentialing Cycle Length</td>
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<td>Notification to Authorities and Practitioner Appeal Rights</td>
<td>Yes</td>
<td>Yes</td>
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<td>Assessment of Organizational Providers</td>
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<td>Only BH standards</td>
<td>Only BH standards</td>
<td>Only BH standards</td>
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ANATOMY OF A STANDARD

Anatomy of a Standard

CR 2: Credentialing Committee—Refer to Appendix B for details

The organization designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions.

Internal
The organization obtains meaningful advice and expertise from participating practitioners when it makes credentialing decisions.

Summary of Changes

- Updated Section I requirements into Element A
- Definitions
- Revised documentation to require documented process and committee minutes (Element A)
- Removed the separate PPS text in the scope of review and added PPS to the ACO and FOIS text (Element A)
- Deleted
- Deleted Element B

Standard statement
- Sentence describing acceptable performance for results

Lessons learned
- Sentence describing importance of standard

Summary of changes
- Changes from year to year
**Overview of Data Sources**

**Data sources:** types of acceptable documentation to show evidence or demonstration of performance on an element.

**Four types of data sources:**
1. Documented process
2. Reports
3. Materials
4. Records or files
Data Source: Documented Process

The following types of documentation classify as *documented process*:

- Policies and procedures.
- Process flow charts.
- Protocols.
- Operating guidelines.
- Outlined methodologies.

*Documented process*—methodologies used by the organization to complete a requirement.

Data Source: Reports

The following types of documentation classify as *reports*:

- Management reports.
- Key indicator reports.
- Summary reports from member reviews.
- System output giving information (like number of member appeals).
- Minutes.

*Reports*—Aggregated sources of evidence of action to show performance

Data Source: Materials

The following types of documentation classify as *materials*:

- Written and electronic communications.
- Web sites.
- Scripts.
- Brochures.
- Reviews.
- Clinical guidelines.
- Contracts/agreements.

*Materials*—Prepared information that the organization provides to members and practitioners.
Data Source: Records or files

The following types of documentation classify as records or files:

- History of cases.
- Proceedings.
- Verification of actions involving members or practitioners.
- Documentation of completion of UM denial or appeal, CCM or CR activities.

NOTABLE CHANGES IN CR

Not much has changed, but...

- Eliminated four elements:
  - Practitioner Office Site Quality, Elements A and B
  - Notification to Authorities and Practitioner Appeal Rights, Elements B and C

- Clarified:
  - Organizations must conduct an onsite quality assessment if CMS/state review is older than three years
    - No grace period for the three-year timeframe
CREDENTIALING AREAS OF FOCUS

Common Denominator

**Intent of all programs:** To have the organization enlist a rigorous process for selecting and evaluating practitioners/providers.

- Chicago clinic sued over man posing as psychologist

Reminder!!!

**For NCQA purposes:**
- Practitioner = person
- Provider = facility
Credentialed Guidelines

Written policies & procedures include:
1. Types of practitioners credentialed/recredentialed
2. Verification sources used
3. CR criteria
4. Process for making CR decisions
5. CR file management process that meets the organization’s criteria
6. Process for delegating CR
7. Process for ensuring that the CR process does not discriminate
8. Process to notify practitioners of variances in information
9. Process to ensure that practitioners are notified of the CR decision within 60 calendar days
10. Medical director or designated physician’s role
11. Process to ensure confidentiality of information
12. Process to ensure that practitioner directories and other materials for members are consistent with CR data, including education, training, board certification, specialty

Scope of credentialing

• Licensed to practice independently.
• All practitioners with whom the organization has an independent relationship and to whom it directs members.
• Service is within the medical benefit.

NCQA evaluates policies and actual files.

Quiz:
Organizations must credential...

• Primary care physicians  ✓ Yes
• Pathologists  ✗ No
• Independently practicing NPs  ✓ Yes
• Podiatrists  ✓ Yes
• Radiologists  ✗ No
• ER physicians  ? It depends
• Anesthesiologists  ? It depends
• Mammography center physicians  ✗ No
• PhD Psychologists  ✓ Yes
Practitioner Credentialing Guidelines

- The organization has policies and procedures to address credentialing of additional practitioners not included in file review, but covered in the scope of credentialing.
  - Physical therapists, midwives or others with an independent relationship with the organization would be within the scope of credentialing, but not review.

Practitioner Rights

Written policies must include:
1. Practitioner’s right to review information submitted to support the CR application
2. Practitioner’s right to correct erroneous information
3. Practitioner’s right to be informed of status of application, upon request

Credentialing Committee

1. Committee includes participating practitioners.
   a) Do not need to be at the subspecialty level.
2. Committee reviews credentials of practitioners who do not meet established thresholds (outlined in CR policies).
   a) Files that are not “clean”.
3. Committee makes sure files that meet CR criteria are reviewed and approved by medical director or qualified physician.
   a) Files that are "clean".
Credentialing Committee (cont.)

Things to remember:
• NCQA does not specify committee size or number of participating specialties.
• Regional or national committees are acceptable.
• Must have representation from practitioners within the scope of credentialing.
  o Can have other practitioners not within the scope of credentialing.
• Credentialing policies must specify who reviews “clean” files.

Credentialing Decisions

• Determining the credentialing date for practitioners is based on committee decision date.
  o For clean files: Medical director approval date
  o For files that go to committee: Date of committee meeting when decision was made
• NCQA does not prescribe the decision that the organization makes, only that it:
  o Collects and verifies information, and
  o Makes a decision within a specified period

Credentialing Decisions (cont.)

• One-step process:
  All files can go to credentialing committee

• Two-step process:
  Clean files go to medical director (or other qualified physician) for review and approval
  Files that do not meet established criteria go through the credentialing committee for review
Credentialing Verification and Recredentialing Cycle Length

- NCQA reviews a sample of actual practitioner CR records to determine if the organization meets the standards
- What is evaluated?
  - Verification sources
  - Timeliness of verification
  - Decision process
  - Timing of recredentialing

About File Review

- File review is performed on a sample of files for practitioners that are initially credentialed or due for recredentialing within the look-back period.
  - Cycle length scored for practitioners undergoing recredentialing in the look-back period.
- Files are randomly selected by NCQA prior to onsite survey.
  - Inclusive of delegate files.
  - 8/30 methodology for each file review factor.

Primary Source Verification (PSV)

- PSV:
  - Process for verifying credentialing information comes directly from the entity that originally issues the practitioners’ credentials.
    - Example: State licensing board that issues practitioners’ licenses.
- NCQA also allows verification from accepted sources that are specified in the credentialing standards.
Verification Components

- What needs to be verified?
  - Licensure
  - DEA/CDS certificates
  - Education/training
  - Board certification, if applicable
  - Work history
  - Malpractice history

How to obtain information

- Oral
- Written
- Internet
  - Web sites
  - Cumulative reports
  - Automated systems
  - Agents of approved sources

Where to obtain information

<table>
<thead>
<tr>
<th>Information</th>
<th>Verification Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current, valid license</td>
<td>State licensing agency</td>
</tr>
<tr>
<td>DEA/CDS (for all states where the practitioner is providing care for the organization)</td>
<td>Copy of certificate</td>
</tr>
<tr>
<td></td>
<td>Visual inspection of certificate</td>
</tr>
<tr>
<td></td>
<td>DEA/CDS Agency confirmation</td>
</tr>
<tr>
<td></td>
<td>NTIS database entry</td>
</tr>
<tr>
<td></td>
<td>AMA Masterfile</td>
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<tr>
<td></td>
<td>State pharmaceutical licensing agency</td>
</tr>
<tr>
<td>Work history</td>
<td>Application</td>
</tr>
<tr>
<td></td>
<td>Curriculum vita</td>
</tr>
<tr>
<td>Malpractice claims history</td>
<td>NPDB query or initial report from NCQA-recognized disclosure service</td>
</tr>
<tr>
<td></td>
<td>Five years claims history from malpractice carrier</td>
</tr>
</tbody>
</table>
Where to obtain information

<table>
<thead>
<tr>
<th>Information</th>
<th>Verification Source</th>
</tr>
</thead>
</table>
| Education/training (MD/DO) as board certification as highest level | • ABMS entry
• AMA Masterfile
• AOA Profile Report or Physician Masterfile
• Confirmation from specialty board
• Confirmation from state licensing agency (proof of PSV needed) |
| Education/training (MD/DO) as residency as highest level | • Confirmation from residency program
• AMA Masterfile
• AOA Profile Report or Physician Masterfile
• Confirmation from state licensing agency (proof of PSV needed) |
| Education/training (MD/DO) as education as highest level | • Confirmation from medical school
• AMA Masterfile
• AOA Profile Report or Physician Masterfile
• ECFMG (intl graduates after 1986)
• Confirmation from state licensing agency (proof of PSV needed) |
| Education/training (non-MD/DO) as education as highest level | • Confirmation from professional school
• Confirmation from state licensing agency (proof of PSV needed)
• Confirmation from specialty board or registry (proof of PSV needed) |

Verification Time Limits

- **NCQA specifies time limits for verifying credentials**
  - **Objective:** Information that decisions are based on should be reasonably current
  - **Time limit:** How much time may pass between verification decision:
    - Licensure: Up to 180 calendar days
    - Malpractice history: Up to 180 calendar days
    - Work history: 365 calendar days
    - Education and training: No limit
    - Board Certification: Up to 180 calendar days
    - DEA: No limit

**Example:**

Time limit for current license is 180 calendar days

- The organization verifies the license on 7/1/2014.
- The file is presented to the committee on 1/2/2015.
- NCQA counts backward from 1/2/2015 (the CC decision date) to determine if the limit is met.

The timeliness requirement is **NOT MET**...
Information is **185 days old**
Sanction Information

1. State sanctions, restrictions on license or limitations on scope of practice.
2. Medicare and Medicaid sanctions.

Acceptable sources:
- **License/practice:**
  - State agencies, NPDB, FSMB
- **Medicare/Medicaid:**
  - FEHBP, OIG, FSMB, NPDB, Medicare/Medicaid sanctions report

Credentialing Application

- The organization requires practitioners to disclose information that may adversely affect their ability to provide care.
- **Application includes:**
  1. Reasons for inability to perform
  2. Lack of present illegal drug use
  3. History of loss licensure and felony convictions
  4. History of loss/limitations of privileges/disciplinary action
  5. Current malpractice insurance coverage to include dates and amounts
  6. An attestation that the application is correct and complete

Recredentialing Cycle Length

- The length of the recredentialing cycle is within the required 36-month time frame
- NCQA counts the 36-month cycle to the month, not to the day
- Do the following meet the requirement?
  - Initially credentialed 6/5/2013
    - Recredential 6/29/2016  ✔
  - Initially credentialed 3/31/2013
    - Recredential 4/1/2016  ❌
**Ongoing Monitoring/Interventions**

The organization collects and reviews:

1. Medicare and Medicaid sanctions
2. Sanctions or limitations on licensure
3. Member complaints
4. Information from adverse events
5. Appropriate interventions for identified instances of poor quality

NA if there are no sanctions, complaints or adverse events during the look-back period

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**Ongoing Monitoring/Interventions (cont.)**

- Demonstrate a systematic monitoring process for evaluating quality, safety issues between recredentialing cycles.
  - NCQA reviews documented process and examples of monitoring reports
  - Regularly obtain and review data
  - Responsible for verifying schedules
- Must review information within **30 calendar days** of its release.
- Sanctions alert service: The organization must review the information within **30 calendar days** of a new alert.

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**Actions Against Practitioners**

- The organization has:
  1. Policies and procedures for the range of actions available
  2. Policies and procedures for reporting to authorities
  3. A well-defined appeal process:
     - Making the appeal process known to practitioners
     - Written notification of appeal decisions, including the specific reasons for a decision
Let’s talk about facilities...

Review and Approval of Providers

The organization’s policies specify that before it contracts with a provider, and for at least every 3 years thereafter, it:

1. Confirms that the provider is in good standing with state and federal regulatory bodies, and
2. Confirms that the provider has been reviewed and approved by an accrediting body, or
3. Conducts an onsite quality assessment if the provider is not accredited

Accrediting Bodies

- NCQA does not prescribe accrediting bodies for organizations to use.
- Organizations should outline in its policies/procedures which accrediting bodies it uses.
- Examples of accrediting bodies:
  - The Joint Commission (TJC)
  - Commission on Accreditation of Rehabilitation Facilities (CARF)
  - Accreditation Association for Ambulatory Health Care (AAAHC)
Site Visits for Nonaccredited Providers

- If provider is not accredited, the organization must conduct an onsite quality assessment.
  - NCQA is not prescriptive: Parameters may vary by type, size, complexity of provider.
- May substitute CMS or state review in lieu of a site visit.
  - The organization must obtain a copy of the report, verify that review was performed and that the provider met the standards.
  - Report may not be >3 yrs old at time of verification

Medical Providers

- Includes:
  - Hospitals
  - Home health agencies
  - Skilled nursing facilities
  - Freestanding surgical centers

*Critical factor: Score cannot exceed 20% if the factor is not met.

Behavioral Healthcare Providers

- Includes:
  - Inpatient
  - Residential
  - Ambulatory
Medical/BH Provider Review

- Assessing medical care and behavioral healthcare providers.
  - The organization has documented assessment of contracted medical healthcare delivery providers
  - **NOT** a file review element (even though a data source is “Records or files”.
    - i.e., actual examples of cases processed throughout the look-back period.
  - NCQA reviews the organization’s tracking mechanism
    - e.g., checklists or spreadsheets as examples

CR Summary

- Ensure that CR policies are complete and an effective credentialing committee is in place.
- Confirm that CR criteria and verification sources meet NCQA requirements.
- Ensure timely verification and decision-making.
- Implement a process for ongoing monitoring.
- Institute a well-defined appeal process.
- Ensure mechanisms in place for organizational provider credentialing.

DELEGATION and CREDENTIALING
What is “Delegation”?  

• When an organization (client) gives authority to another organization (delegate) to perform an activity that the client would otherwise perform to meet NCQA’s requirements.  
• Client organization retains responsibility (or accountability).

Authority ≠ Responsibility

Activities often delegated

Client organization delegates…

Special Situations

Activities that may not be delegated:  
• CR Delegation Oversight*

Structural Requirements:
• Credentialing Policies
• Notification to Authorities & Practitioner Appeal Rights

*Delegates can oversee subdelegates.
Delegation Evaluation

NCQA evaluates delegation in two ways:
1. Directly evaluating delegate performance for delegated functions.
   • With the exception of structural requirements, NCQA looks at the delegate directly for file review and non-file review elements.
2. Evaluating the client organization’s oversight.
   • NCQA looks to see that the organization provided oversight to the delegate organization or subdelegate organization (based on the language in the delegation agreement).

De Facto Delegation

• An entity performs a function or activity that is subject to NCQA standards, whether the entity performs it or the organization performs it and regardless of the existence of a formal delegation agreement
  • This is not the type of delegation the organization identifies for NCQA.

Subdelegation

• Occurs when the organization’s delegate gives a third entity the authority to carry out a delegated function
  • Oversight may be performed by the organization or delegate to ensure that it meets the organization and NCQA standards
    ◦ The organization is ultimately accountable for functions addressed by NCQA standards performed by both the delegate and subdelegate on its behalf
Example of Subdelegation

Client organization

Delegate organization

· Health Plan (HP) delegates credentialing responsibilities of BH practitioners

· Managed Behavioral Healthcare Organization (MBHO) delegates verifications

· Credentialing Verification Organization (CVO) performs verifications

Subdelegate

CR Delegation Oversight Components

<table>
<thead>
<tr>
<th>Delegation Oversight Components</th>
<th>Written delegation agreement</th>
</tr>
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<tbody>
<tr>
<td>Provisions for PHI</td>
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<tr>
<td>Pre-delegation evaluation</td>
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<tr>
<td>Annual review of policies and procedures, including file audit, as appropriate</td>
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<tr>
<td>Semiannual reporting</td>
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<tr>
<td>Opportunities for improvement</td>
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Written Delegation Agreement

The written delegation document*:  
1. Is mutually agreed upon (e.g., signed by both parties)  
2. Describes specific delegated activities and responsibilities of both parties  
3. Requires at least semi-annual reporting by delegate  
4. Describes process by which performance is evaluated  
5. Describes remedies if delegate does not fulfill obligation

*CR 9, Element A has an additional factor for approval and termination of practitioners that should be addressed in the delegation agreement.
Right to Approve/Terminate

For Credentialing delegation agreements only:
• The delegation document must state the organization “ retains the right, to approve, suspend & terminate individual practitioners, providers & sites if it has delegated decision-making.”
• N/A if organization has not delegated credentialing decision-making

Review of CR Policies

• Annual requirement (at a minimum) must be performed even when delegating to an NCQA-Accredited/Certified organization
• Document review via committee meeting minutes or other confirmation by staff
• If selected activities are delegated, and not entire function, must review delegate’s policies & procedures used to perform selected activities

Annual Evaluation & File Audit

Method options:
• Audit that includes either 5% or 50 CR files (whichever is less)
• 8/30 methodology to review files
• May use NCQA’s CR file review workbook
• Not required to perform file audit if delegate has not credentialed or recredentialed any practitioners before next audit scheduled to occur
  • Must provide documentation

*100% score for NCQA-Certified in CR or NCQA-Accredited (i.e., HP, MBHO) delegates
Keys to success to delegation

- Designate internal staff and/or committee responsible for delegation oversight
- Ensure delegate capacity to perform is evaluated prior to signing the delegation agreement
- Agree on responsibilities
- Ensure delegation document is specific and includes applicable PHI requirements
- Ensure delegation documents are signed/dated
- Meet regularly with delegate, determine reporting requirements & ensure reports are received & analyzed
- Schedule specific date to perform formal annual assessment and ensure delegate receives timely feedback
- Implement corrective actions & reassess, as necessary

Questions?