MCAC MANAGED CARE SUBCOMMITTEE

Credentialing

Meeting #2

April 9, 2018

Welcome

Billy West, MCAC Representative

Debra Farrington, DHHS Stakeholder Engagement Lead
Jean Holliday, DHHS Program Lead

Agenda

- Welcome & Introductions — 5 mins
- Review of 3/26 Meeting “Minutes” — 5 mins
- PHP “Objective Quality”/Network Participation Standards — 25 mins
  - Program design presentation
  - Discussion and Q&A
- Transition of Providers to Centralized Credentialing Process — 25 mins
  - Program design presentation
  - Discussion and Q&A
- Preparing for CVO Procurement — 10 mins
  - Discussion and Q&A
- Previous Meetings’ Key Takeaways and Parking Lot Items — 25 mins
- Public Comments — 10 mins
- Next Steps — 10 mins

Charter

- Review and provide feedback on proposed centralized credentialing approach
- Give feedback that will assist with planning and preparing for Credentials Verification Organization (CVO) procurement
- Provide input on parameters for “quality concerns” regarding a PHP contracting decision
- Provide feedback on transitioning current Medicaid providers to the new verification process

Logistics and Member Participation

- Meetings will be available in-person and by webcast/teleconference
- Meetings are open to the public
- Public will have time at the end of each meeting to comment
- Direct written comment to Medicaid.Transformation@dhhs.nc.gov

MEMBERS:

Active participation during meetings will be key to informed input

Offer suggestions, information and perspective

Engage with other members

Ask questions

Overview of Centralized Verification Approach

To ease provider administrative burden, DHHS will implement a centralized credentialing & recredentialing process

- DHHS will procure, through a competitive bid process, a third-party, independent, primary contractor that will act as a CVO to coordinate necessary activities to support provider enrollment and verification
- Providers will use a single, electronic application to become a Medicaid-enrolled provider; providers will submit information once for enrollment in both Medicaid FFS and managed care
- CVO will collect and verify provider enrollment information and share information with PHPs
- PHPs will be required to accept verified information from CVO and will not be permitted to require additional credentialing information from a provider
- Providers will have to negotiate a contract directly with any PHPs with whom they want to contract

PHP “Objective Quality”/ Network Participation Standards

PHP "Objective Quality"/Network Participation Standards

Session Law 2015-245 provides "PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates."

- DHHS' verification processes at full implementation and during transition will be designed to meet standards of a nationally recognized accrediting body.
- PHPs will define and document "objective quality"/network participation standards. The standards must:
  - Be designed to assess a provider's ability to deliver care
  - Include specific examples/thresholds for why a provider or type of provider would not be credentialed by the PHP (e.g., malpractice thresholds)
  - Include the process by which the standards are applied
  - Not be discriminatory
  - Follow DHHS' uniform policies and address acute, primary, behavioral, substance use disorder, and long-term services and supports providers

PHP "Objective Quality"/Network Participation Standards

- PHPs will submit the "objective quality"/network participation standards as part of policies and procedures for DHHS review.
- PHPs will be allowed discretion to apply their approved standards.
- PHPs will make network participation determinations via the Provider Network Decision Committee (also known in the industry as a "credentialing committee" – see next slide).
- DHHS will monitor PHPs adherence to the approved policies and procedures through audits and through provider complaints.

PHP Provider Network Decision Committee (PNDC)

- PHPs will establish and maintain a PNDC that reviews information and makes the network participation determinations.
- PNDC will be chaired by the CMO or a CMO-designee who is a physician.
- PNDC determinations will meet standards established by the selected nationally recognized accrediting organization.
- PNDCs will meet periodically to make determinations within timeframes required by nationally recognized accreditation organization and DHHS-mandated timeframes (see next slide).

Determination Timeframes

- DHHS proposes to require PHPs to complete network participation determinations for 90% of providers within 30 calendar days and for 100% of providers within 45 calendar days
- PHP will then provide written notices of network participation determination to providers within 5 business days of a PNDC's decision
- Overall, DHHS expects enrollment, credentialing and quality review process to take no more than 75 days at full implementation

Provider Appeals

- Providers will have access to two separate and distinct appeals processes (one at DHHS and one at PHPs) to appeal enrollment, credentialing and contracting decisions.
- DHHS will manage appeals relating to enrollment as a Medicaid provider by leveraging the current provider notification and appeals process.
- PHPs will grant providers, regardless of network status, the right to appeal PHP network participation determinations and contracting decisions for managed care as part of the broader appeals process.

Provider Appeals

- Providers will submit a written request for an appeal with the PHP within 30 calendar days from the date the PHP takes adverse action.
- For recredentialing appeals related to the provider's ability to deliver care, appeals requests must include a peer review of the submitted information, by a clinical peer of the provider who filed the dispute.
- All appeals decisions will be rendered no later than 60 calendar days following receipt of a complete appeal request.
- PHP provider appeal process will be submitted to DHHS prior to use, and will be included in the Provider Manual and provider contracts.

Discussion and Q&A

Transition of Providers to Centralized Credentialing Process

Transition to Centralized Credentialing Process

- Expected differences for providers at full implementation
  - Move from 5-year to 3-year recredentialing process
  - A single, web-based application and process to collect information that:
    - May collect additional or different information than is currently collected due to accreditation standards
    - May differ from the current electronic enrollment process in terms of the look and feel
    - Will auto-populate with information maintained in the Provider Data Management/CVO (PDM/CVO) platform
    - Will have drop-down lists and look-ups to populate data elements for which only pre-determined choices are valid

Transition to Centralized Credentialing Process

- Expected differences for providers at full implementation (cont.)
  - A single, electronic application and process to collect information that (cont.):
    - Will permit providers to continuously update information submitted through the PDM/CVO application
    - Will permit providers to track the status of their application for enrollment.
  - Will work with the PDM/CVO vendor to resolve issues relating to service, data integrity, complaints, etc.

Transition to Centralized Credentialing Process

- Expected differences for providers during the transition period
  - Medicaid-enrolled providers for whom the Provider Data Clearinghouse (CH) cannot find a match may find it necessary to provide* certain data to the CH to be able to complete the PHP network determination process.
  - To begin the transition to a 3-year recredentialing process, some providers may have to go through recredentialing on a shorter than 5-year cycle before full implementation.
  - Providers will have to work with the CH to resolve issues relating to the additional data elements the CH is providing to PHPs.

* DHHS expects there will be no charge for a provider to "join" the provider data clearinghouse

Transition to Centralized Credentialing Process

- DHHS expects to engage in provider-focused education and outreach to help providers make the transition from the current Medicaid provider enrollment process to the transition period processes, and then to the full centralized credentialing process under full implementation.
  - This process may include communications to enrolled providers through NCTracks; outreach to provider associations; training; and stakeholder engagement opportunities.
  - DHHS is committed to making the transition to managed care as smooth as possible for providers.

Discussion and Q&A

Preparing for the CVO Procurement

Credentials Verification Organization (CVO) Procurement

- DHHS will procure, through a competitive bid process, a third-party, independent, primary contractor that will act as a CVO to coordinate necessary activities to support provider enrollment and verification at full implementation.
- Procurement will include a provider data management (PDM) solution and a CVO solution.
- DHHS' goal is to have the PDM/CVO solution operational and stable as quickly as possible, but DHHS understands that this may take a significant amount of time – around 2 years.

Discussion and Q&A

Key Takeaways and Parking Lot from Previous Meetings

Discussion and Q&A

Public Comment

Next Steps

- Schedule a conference call in the next few weeks to:
  - Provide the group with a recap of the meetings, key takeaways for DHHS, and update on how DHHS is incorporating feedback into the program design and other work.
  - Discuss the draft of the subcommittee's report to be given to the MCAC.

Contact Information

Debra Farrington, Senior Program Manager
DHHS Stakeholder Engagement Lead
Debra.Farrington@dhhs.nc.gov
919-527-7025

Jean Holliday, Senior Program Analyst
DHHS Program Lead
Jean.Holliday@dhhs.nc.gov
919-527-7021

Sharlene Mallette, Senior Program Coordinator
Sharlene.Mallette@dhhs.nc.gov
919-527-7009