National Credentialing Forum 2024
San Diego, CA Bahia Resort February 8-9, 2024

Assuring Continuing Competence - View from the Accreditors

Industry Leaders	**DNV GL – Troy D. McCann, Director of Accreditation** **CIHQ – Rick Curtis, President/CEO** **NCQA – Tsveta Polhemus, Director Product Accreditation** **TJC – Kathryn Petrovic, Director** **ACHC (HFAP) - Julie Vandenbark, Standards Interpretation Specialist** **URAC – Donna Merrick, Product Enhancement Principal**
DNV GL	• Top ten findings performance parameters (OPPE/FPPE) – currently in top Five. • Hospital accreditation and other entities accreditations • Distinction – annual survey, international ISO 9000 criteria • Fundamental – COPs, framework, and HR as well as medical staff are silent. • Survey is 2-part = regulations and ISO 9000 Revisions • Received CMS approval: less prescriptive for the type of measures for physicians and nonphysicians. Historically there were twelve measures – found hospital struggled to collect data for the nonphysicians attributed to billing systems as well as financial resource. Now – physicians have a defined list, nonphysician – doc how meet the competency as opposed to defined measures. • Medical Staff Chapter language change appointment to the medical staff & anyone who has privileges. • Clarification: there is no plan to add OPPE and will continue to use performance data • Clarification: coding for CNP/PA not available in billing solutions. o Suggestion to add them to the treatment plan and/or team. Add to sub-category in Epic to collect the data. Cybersecurity and AI Implications • Concern and looking forward on CMS guidance.
CIQH	Rick Curtis, President/CEO - Unable to attend.
NCQA	Proposed Change: Time limits • Acknowledged that health plans (HP) time limits will have downstream implication for CVO, Delegate. • Referred to slide deck presented Dec 12, 2023 • PSV Time limits were most controversial.

	• Current CR/HP = 180 days; CVO 120 days.
	  o Proposed Change CR/HP = 90 days
	  o Proposed Change CVO = 60 days
	  o License, Board Cert, Work History, Malpractice History, State Licensing Sanctions, Medicare/Medicaid Sanctions
	• Process to determine time limits are from annualized data with thirty organization.
	• CAQH concern re: 90-day time limit and the implication to the CAQH 120-attestation requirement.
	  o Did they get feedback from the thirty organizations that are paper process as opposed to paperless? Response = no
	  o CVOs contractual obligations to the client – NCQA Response: asked for data on percentage of rework.
	  o Comment – providers are enrolled into NPDB CQ should work to achieve time limits.
	  o Comment – for entities to bring the provider to the Credential Committee instead of Board as a solution.
	  o Comment: There is meaningful change that will require entities to revise analytics. Response: Anticipate the new standards will be released in July 2024 to be effective July 1, 2025.
	  o Comment: The attestation time limit has implication for the workflow process. Response: Not considered. They will take this back.
	
	CR Information Integrity Requirements
	• Parameters for how
	• Education/training: reference to incorporate with other new employee and annual employee education.
	• Question (Q): Phrase "inappropriate standards" language. Response = plan to remove.
	• Q: Inappropriate Modifications audit: how do you prove the absence of the negative. *Scenario – Matthew stated they define anything that was used to render an approval after the committee approval process.* Response: Take this back for review.
	
	Credentialing Committee
	• Discussion: NCQA seeking guidance of need to close gap with ongoing monitoring – the standards are vague.
	  • Who does what and What do they do?
	  • Policy and Procedure - the criteria, upon discovery, what is what needs to done. Some organizations take to an alternative committee others take to the Credentialing Committee.
	
	Health Equity Update
	• This has been a controversial standard.
	• Not required to collect the information, NCQA clarified not required to populate data, require to add this to the application data collection.
	• Suggestion/Comment – not required and option to collect the data; not to be confused with what is considered a complete application.
	  • Concern Shared: Expose organizations to litigations (lawsuits –discrimination)

TJC	• OPPE/FPPE – hospitals request to be less prescriptive, trigger to implement FPPE. • Goal is to be more data driven. • Peer Learning Network – Case studies of radiology impact to evidenced based practice. TJC – do not put in policy that data received from Peer Learning Network into OPPE/FPPE. • The complexity of measures, welcome TJC provide guidance. • Welcome TJC observation of results with post/previous survey performance. • Discussion: The Radiology measures are clearly defined criteria as opposed to measures attributed to emergency medicine and other specialties. Inherent industry challenge with opportunity to establish national standards. • Support the AMA and interested in hearing more about the Foundation. • Comment: move the 3-year reappointment, what are they seeing. Response: smooth transition. • Discussion: some organizations implemented without a prescribed mindful process, document change.

ACHC *(formerly known as HFAP)*	Minor Revisions
	• Modified explanation – OPPE/FPPE collect annual, 2year reappt have two reports.
	
	Sited Standards
	• Eleven elements sited of which included performance (here is no report/checklist). Elements are in the policy, not in the review – not following policy.
	• OPPE – asking for feedback. The metrics are not reflective to the provider specialty.
	
	Discussion of how the hospital develops performance metrics annually.
	  • Physician participation
	  • Fear of impact to the physician
	  • Need to relevance to their practice, meaningful to them.
	  • Issue: collection of the data
	  • Deliver the reports in person is received better with opportunity to obtain improvement recommendations.
	
	Comment of workforce cutback – see a shift with increased Value Based contracts impacts revenue.

URAC	• Nov 2021 standards 8.0 • June 2022 8.1 which included change for technical information that did not include core implications. • Updated 8.1 version – decrease the document upload from 60-70% • 10-day notification from 10 day to 30 day is an improvement that helps organizations with batch update • Continue with the approval process of the clean applications. • No change to the 180-day time limit • Implications for Dental Plans – previous 8.0 standards with improvements in the the 8.1 standards.

	• Implications for Pharmacy PBD – PSV / approved source is a bit challenging. • Observing Pharmacists are become more involved in the care team. Next Revision for HP – 2025 for release in 2026 • AI to evaluate prior to implement. Oct 2023 – Launch Health Equity, no credentialing implications. Noted that there is a CIN Accreditation set of standards. Q: Will URAC consider the implementation of time limits that NCQA is planning? Response: not currently although there is an upcoming standards revision.

Group Discussion of the Lorna Breen Conundrum

Mark Smith and Erin Muellenberg

Discussion: Physician fearful of sharing information. Inclusive of substance abuse, mental health, other health issues of concern. Attestation that brings that failure to submit information can result in loss of membership/privileges.

Proposed Solution: No longer a part of the credential/privilege process. The questions are reviewed and managed by the Wellness Committee upon receipt of a completed application.

- Do you have mental health diagnosis now and/or in the past? Response can be both. Schizophrenia or Brain tumor.
- Implication to address all health issues: called out the provider with diabetic with blood sugar(s) of greater than three hundred who has not opted to not have regular A1C, blood sugar level.
- Single question

TJC: Reference change related to mental health. Response: the question they have no current health issues that impact their ability to perform the requested privileges.

NCQA: Reasonable ability to perform is their question.

Implication: What if the physician does not answer the question correctly.

Implications to consider –

- ADA employment = unable to pose the question until employed.
- Medical staff governance with rights to appeal
- Is it subject to Discovery?

Refer to Brian Bettner legislature from 2022 with reference to EAP.

Other consideration – add the question to the professional application for state license (attestation)

Implication: Currently there is a gap as the providers that provide care only in the outpatient/clinic setting? Agreement that this is true and not in scope.

H.R.1667 - 117th Congress (2021-2022): Dr. Lorna Breen Health Care Provider Protection Act | Congress.gov | Library of Congress

Credentialing and Enrollment: definitions, roles, and responsibilities

Cheryl Cisneros and Mathieu Gaulin

Discussion on the differences of credentialing and enrollment with following takeaways.

- Variation on roles and responsibilities as to who completes credentialing and enrollment is unique to each entity.
- Single medical staff will often complete credentialing tasks required for medical staff membership and privileges.
- Health System with an internal CVO complete the agreed upon verifications required for credentialing, privileging, payer delegation, and/or enrollment. The CVO completes the required verifications and may create a "packet." The decision as to the user permissions to see the data and manage the provider verified data is determined by user and group permissions, policies, and procedures.
- Commercial CVO contracts to provide credentialing, privileging, payer delegation, and/or enrollment services. The commercial CVO provides data in an agreed upon method that is often referred to as a "packet." The decision as to the user permissions to see the data and manage the provider verified data is determined by the contracted client.
- Enrollment Specialists/Coordinators are in some organizations required to complete credentialing verifications to ensure compliance with delegated payer and regulatory requirements.
- Industry discussion found that enrollment specialists/coordinators commonly complete credentialing tasks to complete their work.

National Associations' Current Initiatives	
Industry Leaders	**ABMS - Jennifer Michael, COO** **AOIA – Christel** **AANP/NCB – Not represented this year.** **FSMB – Christine, Director of SCS and Mike Dugan, COO** **NCCPA/PA Certification/AAPA – Greg Thomas, Sondra DePalma** **AMA -Tammy Weaver – VP, Masterfile Products** **NPDB – David Loewenstein, HRSA, Director** **CAQH – Cheryl Hughes, Sr Manager** **NAMSS – Lisa Goodwin, President** **ECFMG – not represented this year.**
ABMS	Current Project: expand the different statuses on the Physician Profile. Recommendations in June with a long-extended implementations d/t 24 Boards and the communication to their clients. Examples: revoked, suspension, inactive, resignation, etc. Goal – consistency across all Boards. • Consideration: There may be Boards that will not use a status. Effective in Jan 2024: Annual verification with current license. This is requiring some data clean up by ABMS. Part 4 – Self Assessment – 360: more work is underway that includes baseline metrics. New 5-year strategic plan • Consumer campaign • Branding, content knowledge to support the ask – "What is Board Certification? What do we do? Why do we do it?" • Professionalism (skill & behavioral), Metrics, Innovation (will spin up innovation group by end of 2024) Research Foundation • New Director – Dr Martin Quan • Grant Foundation – in play. Application for grant closed in Jan 2024. Received 29 applicants. Important to have external funding to work to provide the value statement/proposition of certification. New Certification Report (Book) • Dashboard data • Interactive Self-service: Board, certificate, age, state • Aggregate data • Map visual aide Q: Use of the term "display agent." No longer using this name with no replacement, they are partnering with considerable number of entities like AMA and FSMB.

	• Plan to follow up on the use of "display agent" within the NCQA standard. Q: What is going on at state level lobbying regarding board certification. Response: their policy area is working at the state level. Plan is to work at the federal level to define as opposed to the state. Additional information: • 8 Boards have an annual recertification of ongoing education that results in an annual new. • Other boards have an annual check that have the time limited recertification
AOIA	Recently joined AOIA and provided an overview of the organization and the Strategic pillars
AANP/ NCB	AANP/NCB – Not represented this year
FSMB	• Focus on automation of processes working w/ state medical boards using APIs. • Licensing Trends – 21% increase of physician • Improve cycle time of 5 days. • New: Member Services Profiles • New: Redesign application to improve for the physician • Improve ID verification thru software as opposed to current notary process. • Working on a wallet for recredentials: currently NCQA not accepting.
NCCPA AAPA	Slides to be provided after meeting. **<u>NCCPA 4 items</u>** • Single certifying and accrediting body • Certification maintenance – exam included. • 90% maintain certification which is driven by employer requirements. • Annual – free on website of statistical reports are available. • Exploring a licensure compact – Four (4) organizations are in support of this industry initiative: FSMB, Council of State Compact, NCCPA, AAPA. 3 States have passed. 15 states pending. When hit seven states it triggers implementation of Compact. **<u>AAPA</u>** • Professional advocacy organization • 180,000 current PA total • 20% increase now to 2032. • Recent certified – 50% are on hospital. • Initiative: Loosen the state regs on the state PA – physician supervisory requirements. Looked at 6 elements and implication with malpractice. Study and data results will be available in article in the next few days. Implication: as state release barrier, opportunity to move revise bylaws.

	• 22-23% of the states have moved from supervisory to collaborative agreements. Alaska was one of the first states to move to collaborative. • 7-10% of hospitals report that PAs are members of medical staff. Self-reported by PA survey. • One state has their own PA licensing board. The majority fall under the medical board. • Q: Malpractice liability attributed to supervisory requirement, what did the data provide? Response: spoke to several reference resources. • Q: what is the rate of reports to the medical board and reported to NPDB for licensure action. Response: reporting of privilege not mandatory.
AMA	• Released revised race/ethnicity publish date = month • Collect data from school, residency/fellowship. • Q2 – release language proficiency data • Impairment: current/prior – collection of data. (reference 40% of residency – check if medical school). • 2019 Joy of Medicine – focus on burnout and a resource for roadmap. • AI: recent survey – 41% are excited, 41% concerned (Q- is there an age correlation?) – 50% eliminate administrative work. – Privacy is big concern. – Patient relationship is a concern. – 80% oversite concerns – Principals of the use of AI = the bible for AMA, released Sept 2023. Available on website – d/c summary 38% • End of March – webinar from newly hired Digital leader Implications of AI in the Medical Staff. • Collaboration with FSMB: utilize NPIs to pull data attributed to physician compact. Output: decrease to one report, improved time limits *NEW Offering:* from a pilot. Collect the data submitted on the application, move it to the front which results in a pre-populated form. AI pulls artifact single pdf document as a primary source verified document. Working with Boston Childrens and FSMB. • Adding SAM and Controlled substance to the AMA profile. • Includes the ability to pre-populate state mandated forms. • Working with MD Staff 2/09/24 Press Release: 2 Big wins on physician credentialing that will support well-being: Credentialing application question changes. 2 big wins on physician credentialing that will support well-being | American Medical Association (ama-assn.org) 2/6/24 3 steps to make meaningful, lasting physical well-being changes. Link to article, recording and tools. 3 steps to make meaningful, lasting physician well-being changes | American Medical Association (ama-assn.org)

NPDB	• 70,000 reports in 2023
	• CQ outpace the on-demand query. Working to eliminate the on-demand query.
	• MFA Project
	  o Optional for now
	  o 1,000 users, one-third of users -with mostly positive
	  o Third party vendor – issues b/c they are solely reachable via website.
	  o Goal to complete: September 2024
	• HRSA Concerns - Congress has not approved bills for renewal due March 2024. CQ meets the requirement of every two years.
	• Topic Updates in Litigation
	  o Subjective intent to surrender, reaffirmed by District court.
	  o Due process is reportable.
	  o Due process, investigation, inalienable right to choose his profession as a physician. Appellate court decision for an event that occurred 25 years ago. Went to the supreme court – which denied being heard.
	• Currently in collaboration with FSMB -permission by the states as an agent to run an NPDB query that goes to the state as task to complete.

CAQH	• Sorin Davis retired recently and continues to work on projects.
	• New CEO in Sept after 25 years – innovation, Highmark, and Humana background
	• Multiplayer pilot reappt date alignment
	  o One year pilot
	  o Eliminate provider abrasions.
	  o Q: what are the dates? Design is in development.
	• Work Group: Universal Group payer roster – health plan collaboration. Refer to Wednesday press release.
	
	Q – Ability to have a proxy? User and Password – Health System Compliance does not allow to delegate to another user on behalf of the provider. Regulatory body requirements? Response: will research and report back.

NAMSS	Update • Focus on tomorrow's MSP; Job description builder; PE Glossary • Tool Kits: onboard, merger & acquisition, closing hospital, telemedicine. Discussion: Close Hospital tool kit • FSMB provides service to store GME closed residency/fellowship programs. Response: Plan to discuss collaboration. 2024 Update and Plans • Ideal Credentialing Standard in coordination with AMA • NAMSS feedback to NCQA on the proposed standards. NAMSS has not made public their comments.

	• Task Force on Leadership Program • Conference changes in format • Strategic Partnerships Conversations: ABPM, ACCME • Working on building relationships with MGMA, AMGA, ASCS Discussion • Q: Why did NAMSS remove honorarium? Response: Conference fee registration is covered, decision driven by budget as well as research as to how other organization manage honorariums • Q: Cannot be an instructor if you are a state leader? Response: will take this back and provide an update • Q: In the new Candidate handbook, why is the test a 2-part process implemented and guidance on can you go back to review part one? Response: will go back and provide an update • Q: Candidate Handbook – Enrollment Specialists are no longer eligible for CPCS certification, why? Response: will take it back and have CCN provide a communication • Q: Partnership – how about working with HRSM especially in lieu of NAMSS DOL change in job description initiative? Response: MGMA is a means to work in this direction. Working on other relationship opportunities. o 2024 DOL will be opening public comment.
ECFMG	Not represented this year
NAMSS Pass	• 750 hospitals sharing data of the 6,200 hospitals. • Working with HealthStream and MDStaff to bridge the gap. • Goal is to increase the number of hospitals agreeing to share data.

NCF Charter Discussion
Mark Smith, M.D.

Discussion on proposed NCF Charter sent to members prior to the meeting.

- Motion to approve with revisions and seconded.
- Approved with majority and three members deferred.

Credentialing Legal Update
Brian Betner, JD, AHLA

Litigation Update: predictable, stay consistent.
(credentialing, peer review, enrollment, privileging)

- Immunity/Due Process: 90% the organization prevails. Consideration of intention and "sloppy" documentation and process.
- Confidentiality peer review: overwhelmingly litigation is at the state law level for peer review. Commented that significant amount of education is completed by attorney(s) during the judicial process that includes the judge.
- Data Bank: almost never founded with reference to HRSA, federal documentation.
- Less likely to see health plan litigation.

AHLS's Top 10 of which the two below have implication for the 4 Core areas.

1) Health Care's AI Transformation (augmentation): How will this be regulated? HHS and federal government are researching this.

- Antitrust Trends - Federal Trade Commission proposed plan for non-compete bans that are taking off and already present at the state level. For example: 6200 hospitals that have agreements with Radiol, Anest, Path, EM…

Initiatives to Overhaul State Licensure Applications

- Thirty have completed shared by L Green
- Content are mental health questions – truthful response yes/no. Wellness Committee is the solution.
- Implication from the practitioner: *Do you hear me? Do you see me?*
- CAQH has updated their application.

Q: Volume of negligent credentialing? Response: same and with some increase

National and Local Trends/Initiatives/Hot topics

Sally Pelletier, Chartis Group

AI Discussion Highlights

- High Priority is to incorporate new role of Chief AI Officer (CAIO)
- Clinical decision making that includes diagnostic and treatment.
- Governance structure is in early development and needed.
- Discussed the authenticity of verified source, reliability.
- AI is being incorporated into prior authorization of patient services as well as concerns regarding bias.
- Data security is at biggest level of threat with an organization that has experienced four million attempted attacks in 12-month time limit.
- AI sources for certification which are currently "self-declared."

Next NCF Meeting is scheduled for Feb 6 and 7 2025