Community Credentialing Workgroup

MAMSS October 21, 2011

AGENDA

- History and Background - How did we get here?
- Documenting the end to end credentialing process
- Key Findings and Options
- Board of Registration in Medicine - Current initiatives
- Community Credentialing Workgroup's additional projects
- Discussion and questions

Why do we credential providers?

“

No, I haven’t performed the procedure myself but I’ve seen it done successfully on “E.R.” and “Chicago Hope.”

History

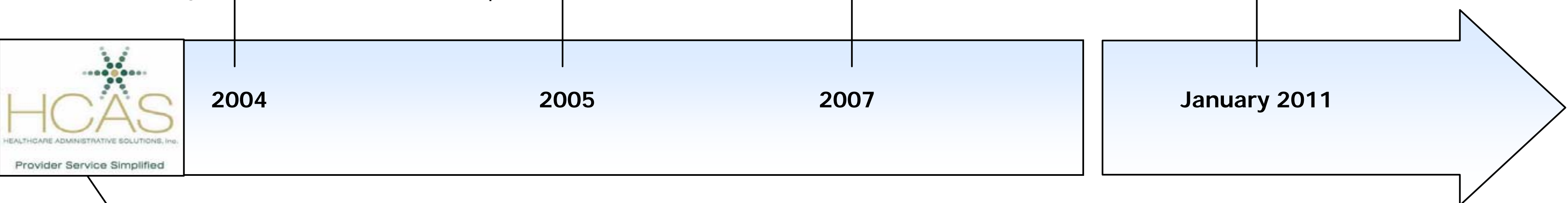
In 2004, health plans and providers began partnering to examine the credentialing process and seek opportunities for streamlining. Since that time, credentialing simplification efforts within the broader health care community have evolved, yet challenges remain.

Health plans and providers convened to begin working on creating a standardized process for participating health plans to use when credentialing physicians; the Massachusetts "Statement of Principles Regarding the Physician Credentialing Process" was issued

Six Massachusetts health plans formed HealthCare Administrative Solutions (HCAS) to collaborate on administrative simplification initiatives

The Massachusetts Hospital Association (MHA) re-convened the Community Credentialing Workgroup (CCW), which is dedicated to improving the credentialing/provider enrollment process

The Community Credentialing Workgroup engaged the Business Consulting Group (BCG)



Participating Plans

- Blue Cross Blue Shield of Massachusetts
- BMC HealthNet Plan
- Fallon Community Health Plan
- Harvard Pilgrim Health Care
- Health New England
- Medical Network
- Neighborhood Health Plan
- Network Health
- Tufts Health Plan

Current Credentialing Challenges:

- While HCAS addresses parts of the health plan credentialing process, it does not include other aspects of the process such as privileging and provider enrollment
- The credentialing process has not been fully documented from end-to-end, resulting in a lack of understanding about the process among stakeholders
- The current end-to-end process takes 3-6 months to complete, which many stakeholders view as excessive

Statement of Principles - 2004

- **Endorsed by the Massachusetts Hospital Association, the Massachusetts Medical Society, the Massachusetts Association of Health Plans and Blue Cross and Blue Shield of MA**

- Addresses the roles and responsibilities of participating health insurance plans, hospitals and health systems and physicians in individual and group practice regarding the credentialing and re-credentialing of physicians in the Commonwealth of Massachusetts.
- Endorse provisions designed to streamline, coordinate, and improve physician credentialing and re-credentialing processes throughout the Commonwealth including:
- Adoption of a uniform application for physicians
- Agreement on a 30 calendar day processing standard with effective dates as of the date the health plan credentialing committee approved the application
- Development of a central repository and primary source verification

Community Credentialing Workgroup (CCW)

- Includes health plans, providers, MHA, MMS, MAHP, BCBSMA
- Began meeting regularly in 2007
- Mapped health plan credentialing process
- Established a successful email notification program for health plans to inform providers who has been credentialed

But…Still a lot of noise

- Recognition that actual credentialing process is only one part of the overall process of getting a provider “up and running” so that he/she can see patients and get reimbursed. Processes primarily addressed physicians.
- Hiring/contracting; licensing through state agency; credentialing and privileging by hospital; health plan credentialing; provider enrollment

CCW engages the BCBSMA Business Consulting Group

Project Objective

- Document the end-to-end credentialing process for:
  - Doctors of Medicine (MDs)
  - Doctors of Osteopathy (DOs)
  - Advanced Practice Registered Nurses (APRNs)

Project Scope

- Recruitment/hiring through health plan enrollment, including:
  - Board of Registration in Medicine (BORIM)
  - Board of Registration in Nursing (BORN)
  - Hospitals (Community-based and Academic Medical Centers)
  - HealthCare Administrative Solutions (HCAS)
  - Health Plans

Project Phases & Activities

	Phase 1: Information Gathering	Phase 2: Recommendations Development	Phase 3: Prioritization & Implementation
Owner	**BCG**	**BCG**	**CCW**
Timeframe	January 18 – March 31	April 1 – May 31	June 1 – TBD
Activities	✓Scoped project and presented approach to key stakeholders ✓Identified subject matter experts to interview ✓Developed interview guide and scheduled interviews ✓Conducted interviews ✓Created high level end-to-end process documentation ✓Conducted follow up interviews	✓Facilitated sessions with stakeholder groups to identify pain points ✓Analyzed pain points ✓Developed recommendations ✓Validated recommendations with key stakeholders ✓Presented final recommendations to the CCW	• Prioritize opportunities • Determine timing for implementing opportunities • Create detailed implementation plans
Deliverables	✓Project approach ✓Draft documentation	✓End-to-end process flows ✓Opportunities for improvement	• Prioritized list of opportunities • Implementation plans

Key Findings

- All stakeholders acknowledge that numerous redundancies exist with regard to the credentialing process, particularly with primary source verification (PSV).
- Many stakeholders lack understanding of exactly what activities occur upstream/downstream in the process, resulting in disjointed activities, confusion and frustration.
- Many MD/DO/APRNs have extremely limited engagement in the credentialing process, which can cause delays due to submission of incomplete and inaccurate application materials.
- Processes differ at each hospital and each health plan, causing confusion for physicians and their delegates.
- Stakeholders maintain a strong focus on accuracy and precision, which promotes adherence to regulations but also results in delays when information is not submitted a certain way.
- Stakeholders recognize the importance of the credentialing process and acknowledge that the stakes are high if errors are made.
- Numerous parties involved indicate an appetite for change.

Opportunities

Overall

Opportunities involving multiple stakeholders who comprise the end-to-end credentialing process

BORIM

HCAS

BORN

Health Plan

Hospital

Opportunities specific to each stakeholder group

Overall Opportunities

<table>
<tr><td rowspan="2">1</td><td colspan="3">Utilize BORIM/BORN to conduct PSV for initial MD/DO/APRN applications, so that PSV is conducted only once during the end-to-end process</td></tr>
<tr><td><u>Description:</u>
Leverage BORIM and BORN's existing processes for conducting PSV for the initial licensing of MDs/DOs/APRNs, providing an opportunity to eliminate hospitals and health plans needing to gather certain PSV elements themselves.</td><td><u>Background:</u>
BORIM, BORN, hospitals and health plans each require PSV of static elements of the application (such as education and training), which can be verified once in the end-to-end process.</td><td><u>Considerations:</u>
Some PSV data becomes obsolete and needs to be refreshed (e.g., malpractice issues). National Committee for Quality Assurance (NCQA)/Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements may necessitate hospitals/health plans continuing to collect certain PSV elements.</td></tr>
<tr><td rowspan="2">2</td><td colspan="3">Have stakeholders recommend to BORIM/BORN which PSV elements are necessary for them to collect, providing justification for why each is required</td></tr>
<tr><td><u>Description:</u>
Have hospitals and health plans recommend what PSV elements are necessary for BORIM/BORN to collect on their behalf moving forward, eliminating the need for them to gather the same elements. Justifying what elements are required by state law, JCAHO and NCQA, as well as what can be verified once during the end-to-end process, will promote clarity and understanding.</td><td><u>Background:</u>
BORIM, BORN, hospitals and health plans utilize their own unique PSV processes and policies, although there is great similarity.</td><td><u>Considerations:</u>
Hospital by-laws and health plan policies may require additional PSV elements to be collected that are above and beyond BORIM/BORN's requirements.</td></tr>
</table>

Overall Opportunities (cont.)

3	**Gain clarity and consensus about who the "customer" is for credentialing**		
	Description: Hold broad stakeholder discussions about the credentialing customer to build shared understanding and promote alignment of overall goals.	**Background:** Credentialing stakeholders view the "customer" in multiple ways (e.g., patient, physician), resulting in differing perceptions about the process overall.	**Considerations:** Not all stakeholders may reach agreement or feel this is an answerable question.
4	**Adopt the Integrated Massachusetts Application (IMA) for all provider credentialing statewide**		
	Description: Require use of the IMA for all provider credentialing entities in the state, for both credentialing and re-credentialing. This would drive consistency among all providers, hospitals, health plans and private practice organizations statewide. It would also align with Massachusetts law Chapter 288 section 37 that requires uniform standards and methodologies for provider credentialing.	**Background:** The Massachusetts Physician Credentialing Initiative created a standardized application for physician credentialing. It is used by all health plans, but has not been adopted by all hospitals in the state, many of whom use their own "homegrown" applications.	**Considerations:** Hospitals that do not manage the health plan enrollment process may have less incentive to adopt the IMA. May also require substantial changes to current hospital policies and procedures. Also, no obvious "owner" exists to take the lead with this initiative.
5	**Create an educational module about credentialing for 4th-year medical students and NP students**		
	Description: Develop a program to educate soon-to-be MDs/DOs/APRNs about an important process in which they will participate for the rest of their careers. This program can also drive an increase in engagement on the part of MDs/DO/APRNs.	**Background:** Currently, MDs/DOs/APRNs receive no formal education regarding the credentialing process, despite the fact that they are ultimately responsible for accurately representing their credentials. The BORN launched a credentialing educational program for APRNs that is successfully utilized by some local nursing programs and could be used as a model for MDs/Dos and all APRN programs.	**Considerations:** Participation and commitment of medical and nursing schools will be essential prior to creating and launching the program.

Overall Opportunities (cont.)

#	Description	Background	Considerations
6	**Gain consensus on the use of delegation**		
	Description: Collaboratively discuss and promote understanding of if/when delegation is appropriate and in alignment with health plan policies, and identify opportunities for utilizing delegation.	**Background:** Stakeholders express varying views as to whether delegation would reduce or eliminate the need for repetition of certain process steps, suggesting the need for a broader collaborative conversation.	**Considerations:** Current misalignment of health plan and provider policies may need to be discussed and addressed first. This opportunity may not be relevant if Overall Opportunities #1 and #2 are implemented.
7	**Document average credentialing timeframe scenarios for BORN, BORIM, hospitals and HCAS/health plan process**		
	Description: Complete template (see p. 9) with average timeframes to credential providers. This documentation will help uncover additional opportunities for streamlining the end-to-end process.	**Background:** Average credentialing timeframes vary significantly, making it difficult to fully identify important opportunities.	**Considerations:** Data may be difficult to obtain and/or reconcile among stakeholders.

BORIM Opportunities

#	Opportunity		
1	**Re-assess current instructions for completing the license application to identify specific opportunities for simplification**		
	Description: Launch an in-depth assessment of the Massachusetts physician license application with the goal of simplifying instructions for MDs/DOs and their delegates.	**Background:** Instructions for the license application appear to cause confusion for those completing the information, as evidenced by the high percentage rate of incorrectly submitted applications.	**Considerations:** Specific, legally-required application language may be necessary due to state regulations and may require changes to legislation.
2	**More broadly communicate the timing/process for Drug Enforcement Administration (DEA) license in relation to BORIM application**		
	Description: Simplify the application instructions to more clearly state interdependencies with other regulatory organizations when obtaining a Massachusetts license to practice medicine.	**Background:** Confusion exists as to whether a DEA license is required prior to obtaining a Massachusetts license.	**Considerations:** The DEA contact information is already included on the BORIM application, but there may be a more effective way to communicate this information to stakeholders.
3	**Convene weekly meetings of both the full board and the licensing committee during high volume months to expedite application review and approval**		
	Description: Increase the number of Board meetings to one time per week during peak volume months (February to August).	**Background:** Depending on the timing of when applications are submitted, more frequent votes can shorten the length of time necessary to acquire a new license.	**Considerations:** Regulations and/or by-laws may need to be modified to allow for increased meeting frequency. Board members would also need to make an additional time commitment to participate in more meetings.

BORN Opportunity

1	Institute email notification of license approval from BORN		
	Description: Discontinue the hard copy application notifications that are generated by the BORN's CVO, Professional Credentialing Services (PCS), in order to provide more timely and efficient electronic notice to stakeholders.	**Background:** While web-based information about license approval is currently available, notifications are sent via hard copy, slowing down the process.	**Considerations:** All nurses may not have access to email, thereby limiting their ability to access the information. PCS would need the operational ability to implement the change, which could also require a contract change between BORN and PCS.

Initiative Currently Underway: Creating an electronic application

Status/Timing: BORN is currently pursuing an online system to reduce the amount of paper and time needed to complete the APRN application.

Benefits: Eliminates the need for a hard copy, signed application by instituting an electronic application. This should results in increased ease with which APRNs accurately complete the required information.

Considerations: PCS's operational capabilities may need to be updated to enable acceptance of electronic applications. Regulations that call for a hard copy signature will also need to be amended.

Hospital Opportunities

1	**Reduce the number of committees for the hospital board approval process**		
	Description: Reduce the total number of board committees and votes necessary to approve a provider once he/she has been primary source verified. Streamlining this process will enable more prompt issuance of the hospital letter, which is required for health plan enrollment.	**Background:** Hospitals typically have three committee votes spaced over the course of three weeks to formalize approval of a provider's credentials, appointment and privileges. While required by hospital by-laws, these votes are often customary rather than functional.	**Considerations:** Hospital by-laws may need to be changed (but they are not dictated by JCAHO).
2	**Increase the frequency of board votes during high volume months**		
	Description: Increase the frequency that hospital boards meet to approve providers during high volume months, in order to drive down volume-based delays in the provider credentialing process.	**Background:** Hospital boards and their multiple sub-committees typically meet one time per month, which can delay the provider approval process during peak volume months (February to August).	**Considerations:** It may be difficult for boards to meet more frequently due to geographic location issues (although virtual meetings may be possible). Scheduling logistics for board members may also be challenging.
3	Explore the expansion of temporary provider privileging		
	Description: Analyze the wider adoption of temporary provider privileging through a collective discussion of its benefits and challenges. Each hospital should evaluate whether temporary privileges would be appropriate for its institution.	**Background:** Some hospitals grant temporary privileges and allow providers to begin their employment without full privileges; however, they may not be able to bill health plans because these providers have not yet been enrolled. Temporary hospital privileges can trigger the health plan enrollment process to begin earlier, before a full board vote takes place.	**Considerations:** Hospital by-laws may need to be changed. A clearer understanding of how temporary privileges are viewed by JCAHO is also needed.

Hospital Opportunities (cont.)

4	Establish a standardized process for notifying health plans of updates to the provider roster		
	Description: Develop and implement one standardized process for updating and submitting the roster of providers with hospital privileges to health plans and or Ingenix (for HCAS plans) in order to expedite the credentialing and, ultimately, the enrollment process. Hospitals should also evaluate sharing rosters in order to increase communication and assist in the re-application process for physicians with privileges at multiple hospitals.	**Background:** Hospitals utilize different methods of updating health plans about changes in the roster of physicians, resulting in confusion and rework. As a best practice, some hospitals use an electronic update on a monthly or quarterly basis. This could be adopted broadly since it enables health plans to complete the credentialing and enrollment processes more promptly.	**Considerations:** Hospitals will need to reach consensus on a notification process and format that works for all stakeholders.

HCAS Opportunities

#	Opportunity		
1	**Align CAQH's criteria with each health plan's criteria for a completed application**		
	Description: Eliminate gaps between CAQH and health plan criteria for when an application is considered complete (particularly with regard to the hospital letter) in order to drive consistency and expedite processing.	**Background:** CAQH and the MA "Statement of Principles Regarding the Physician Credentialing Process" have different definitions of a "complete" application that can move forward in the credentialing process. Health plans are required by law to gather the hospital letter in order for an application to be considered complete, but CAQH follows national standards that do not require it.	**Considerations:** It may be difficult to influence CAQH to align its process more closely with local plans, given that it is a national organization.
2	**Have Aperture better coordinate missing information requests to providers**		
	Description: Send providers only one missing information request containing a full list of what information is missing for each health plan, in order to reduce confusion.	**Background:** Currently, Aperture may send multiple missing information requests to providers, resulting in confusion about exactly what information still needs to be submitted.	**Considerations:** It may be difficult for Aperture to modify its systems and processes for assigning work.
3	**Create an application form that allows providers to check-off multiple health plans**		
	Description: Have Aperture act as the single point of contact and gatekeeper that notifies health plans of an enrollment request, in order to reduce the volume of individual applications that a provider must submit for local plan credentialing.	**Background:** Currently providers must send an enrollment form to each HCAS-participating health plan whose network they wish to join.	**Considerations:** There may be privacy issues and concerns regarding the sharing of competitive information between health plan providers. It may also be difficult to overcome varying health plan policies that guide which information should be included on the standardized application form.

Health Plan Opportunities

#	Description	Background	Considerations
1	**Standardize the manner by which providers submit HCAS enrollment forms to each health plan**		
	Description: In lieu of a single HCAS application form for all health plans (see HCAS opportunity #3), establish a standardized submission method such as a centralized, dedicated email address. This would simplify the process and reduce the likelihood of misplacing information.	**Background:** Currently, some health plans require that providers email the enrollment form, while other plans require forms be sent via fax or hard copy by mail.	**Considerations:** It may be challenging to align health plans around a standard process. This opportunity may not be relevant if HCAS Opportunity #3 is implemented.
2	**Educate stakeholders about what information is required on each local health plan's enrollment application**		
	Description: Broadly communicate to providers and their delegates the listing of health plan requirements, (as outlined on the HCAS website) and evaluate opportunities for aligning requirements among HCAS plans.	**Background:** Health plans require different information from providers for their applications, yet providers appear unaware that a list of each health plan requirement is available through the HCAS website at: http://www.hcasma.org/attach/Health_%20Plan_%20Contracting_%20and_%20Enrollment_%20Required_%20Documents%20List.pdf	**Considerations:** It may be difficult to determine the best way to get this information to providers.
3	**Standardize a daily committee vote for "clean" applications at all local health plans and communicate daily approvals via email**		
	Description: Standardize the practice of daily voting across Massachusetts-based health plans to further reduce the time it takes for providers to become credentialed. Increase the use of a daily email communication of approval status to hospitals to further streamline the process.	**Background:** Some health plans have instituted daily votes to successfully shorten the length of the credentialing process.	**Considerations:** Health plan policies and procedures may need to be changed.

Health Plan Opportunities (cont.)

#	Item		
4	**Standardize the health plan welcome letter/notification process**		
	Description: Implement one standard, uniform welcome letter and notification process across all health plans to eliminate confusion on the part of providers and their delegates.	**Background:** Health plans send the welcome letter to different contacts (e.g., MD, delegate) depending on the plan. Notice is not always sent to the credentialing contact on the enrollment form.	**Considerations:** It may be challenging to align health plans around a standard process.
5	**Increase transparency regarding the exception review process**		
	Description: Promote understanding of the definition of an exception and how it should be handled by posting guidelines on health plan websites as to what constitutes an exception.	**Background:** Not all health plans post exception guidelines on their respective websites, leading to confusion about the process.	**Considerations:** Creating an exhaustive list may not be possible. Also, some health plans may be uncomfortable posting their exception lists online.
6	**Establish a dedicated email address for inquiries about the status of an application**		
	Description: Create a dedicated email box to ensure health plan employees have access to incoming application questions from providers and their delegates. After launch, explore establishing specific turnaround time for responses.	**Background:** Inquiries about the status of applications are not always answered promptly when a specific analyst is out of the office due to vacation, illness, etc.	**Considerations:** Operational challenges to creating a dedicated email box may exist. It may also be difficult to reach consensus among stakeholders for a reasonable turnaround time for responding to inquiries.

Opportunity Summary

Category	Opportunities
Overall	1. Utilize BORIM/BORN to conduct PSV for initial MD/DO/APRN applications, so that it is conducted only once during the end-to-end process 2. Have stakeholders recommend to BORIM/BORN which PSV elements are necessary for them to collect, providing justification for why each is required 3. Gain clarity and consensus about who the "customer" is for credentialing 4. Adopt the Integrated Massachusetts Application (IMA) for all provider credentialing statewide 5. Create an educational module about credentialing for 4th-year medical students 6. Gain consensus on the use of delegation 7. Document average credentialing timeframe scenarios for BORN, BORIM, hospitals and HCAS/health plan process
BORIM	1. Re-assess current instructions for completing the license application to identify specific opportunities for simplification 2. More broadly communicate the timing/process for Drug Enforcement Administration (DEA) license in relation to BORIM application 3. Convene weekly meetings of both full board and the licensing committee during high volume months to expedite application review and approval
BORN	1. Institute email notification of license approval from BORN
Hospital	1. Reduce the number of committees for the hospital board approval process 2. Increase the frequency of board votes during high volume months 3. Explore the expansion of temporary provider privileging 4. Establish a standardized process for notifying health plans of updates to the provider roster
HCAS	1. Align CAQH's criteria with each health plan's criteria for a completed application 2. Have Aperture better coordinate missing information requests to providers 3. Create an application form that allows providers to check-off multiple health plans
Health Plan	1. Standardize the manner by which providers submit HCAS enrollment forms to each health plan 2. Educate stakeholders about what information is required on each local health plan's enrollment application 3. Standardize a daily committee vote for "clean" applications at all local health plans and communicate daily approvals via email 4. Standardize the health plan welcome letter/notification process 5. Increase transparency regarding the exception review process 6. Establish a dedicated email address for inquiries about the status of an application

Survey to Prioritize Options

- Harrington Memorial Hospital
- Sturdy Memorial Associates
- Mt Auburn Professional Services
- North Shore Medical Center/North Shore Physicians Group
- Berkshire Health Systems
- MGH
- Beth Israel Physicians Organization
- Beth Israel Deaconess Medical Center
- Lawrence General Hospital
- Faulkner Hospital
- Hallmark Health
- Hallmark Health Medical Associates
- UMass Memorial Medical Center
- Hamden County Physician Associates
- Boston University Psych Associates
- St. Vincent Hospital
- Wing Memorial Hospital and Medical Center
- Cape Cod Healthcare
- Lahey Clinic
- Tufts Medical Center
- Merrimack Valley Hospital
- Seacoast Affiliated Group Practice
- Dana Farber Cancer Institute
- Childrens Hospital
- Cambridge Health Alliance
- Cambridge Health Alliance
- Baystate Health
- Holyoke Medical Center
- Quincy Medical Center
- Health New England
- BCBSMA
- Boston Medical Center Healthnet Plan
- Neighborhood Health Plan
- Tufts Health Plan
- Mass. Association of HealthPlans
- HPHC
- Network Health
- Anna Jaques Hospital
- Board of Registration in Medicine
- Mass. Coalitionof Nurse Practitioners
- Mass Eye and Ear Infirmary
- Board of Registration in Nursing
- BWH/BWPO
- HCAS
- Harvard Vanguard Medical Associates

Board of Registration in Medicine Projects

- Primary Source Verification
- Simplifying licensing application instructions
- Increasing frequency of BORIM Board and licensing committee meetings during high volume months

PSV Elements Collected: this table demonstrates the major elements collected and reviewed and illustrates the significant redundancy in the process

	Application	CV	Education - Undergraduate	Education - Medical	Examination Scores	Postgraduate Training	Specialty Board Certification	Other State Licencse	Moral and Professional Character Form
BORIM	✓	✓	✓	✓	✓	✓		✓	✓
BORN	✓	✓	✓					✓	✓
Hospital	✓	✓	✓	✓		✓	✓	✓	
HCAS/Health Plan	✓	✓	✓	✓		✓			
MassHealth	✓					✓	✓		

	Professional References	Malpractice History Report	Malpractice Claims	Disciplinary Actions from other state Boards	State Controlled Substance Certificate	Drug Enforcement Authorization	Medicare/Medicaid Sanctions	Criminal History	Provider Identifier Numbers (NPI, CAQH, Medicare, Medicaid)
BORIM		✓	✓	✓					
BORN									
Hospital	✓	✓	✓		✓	✓	✓	✓	✓
HCAS/Health Plan		✓				✓			✓
MassHealth							✓		

Source: Websites and information provided by CCW members

Why does BORIM want to share primary source verified information?

- Reduce redundancy and administrative duplication
- To help physicians, hospitals and health plans
- It makes sense
- It is the right thing to do

Why does a Medical Board want to become a certified CVO?

- BORIM leadership met with various health care organizations including hospitals, health plans, state and federal governments, NCQA and Joint Commission
- BORIM concluded that in order to share primary source verified information we need to be NCQA CVO Certified
- The Joint Commission does not provide CVO certification however NCQA CVO standards meet their CVO guidelines

The Joint Commission CVO definition

*Any organization that provides information on an individual's professional credentials. An organization that bases a decision in part on information obtained from a CVO should have confidence in the completeness, accuracy, and timeliness of information. To achieve this level of confidence, the organization should evaluate the agency providing the information initially and then periodically as appropriate.**

The Joint Commission Manual, 2011

CVO Certification by the National Committee on Quality Assurance (NCQA)

- Provides BORIM a set of standards or measures to which we are accountable to
- NCQA CVO certification is the gold standard
- NCQA accredited Health Plans must use NCQA certified CVOs
- On-site survey visit by the NCQA
- The NCQA will review policies and procedures and our files to ensure that we are in compliance with their quality standards

NCQA CVO Certification Process

- Two surveys: electronic and on-site
- The NCQA will review BORIM policies and procedures
- Random review of our files to ensure that we are in compliance with their quality standards
- There is a 6 month look-back period

What information does BORIM collect during the licensing process?

- Postgraduate training, verification from all residencies, fellowships, etc.
- State license verifications
- Evaluations from most recent training program or healthcare

Affiliation(s)

- National Practitioner Data Bank (NPDB)
- Medical school verification and transcripts
- Examination scores
- ECFMG status report
- AMA Physician Profile
- Legal documents (malpractice history reports, malpractice complaints, criminal reports, police reports, documentation for medical issues

NCQA CVO Standards

- **CVO1: Written Policies and Procedures**
- **CVO 2: Process for Internal Continuous quality improvement**
- **CVO 3: Protecting Credentialing Information**
- **CVO4: Verifying and Reporting Licensure**
- CVO5 - Verifying and Reporting DEA or CDS Certification
- **CVO 6: Verifying and Reporting Education and Training**
- **CVO 7: Verifying and Reporting Work History**
- CVO 8: Verifying and Reporting Malpractice History
- CVO 9:Verifying and Reporting Medical Board Sanctions
- CVO10: Verifying and reporting Medicare/Medicaid Sanctions
- **CVO11: Processing Application and Attestation**
- **CVO 12: Application and Attestation Content**
- CVO 13: Ongoing Monitoring of Sanctions

How will the CVO work for physicians, hospitals and health plans?

- The Full Initial application will also be the CVO application
- Health Care Organizations currently use BORIM website to verify licenses
- We would provide access to the CVO information in a similar format
- The service would be provided at minimal to no charge

ADOPT THE IMA STATE WIDE For all providers

PROJECT	ADOPT THE INTEGRATED MASSACHUSETTS APPLICATION (IMA) FOR ALL PROVIDER CREDENTIALING STATEWIDE
TEAM LEADER(S)	Deb Cremonti (Baystate Health Partners) Stancel Riley (BORM)
TEAM MEMBERS	• Nelie Lawless (HCAS) • Linda Guerra (BIDPO) • Lainie Kemp (MEEI) • Jean Klugman (Tufts Health Plan) • Sandy Dussault (Fallon) • Rose Foss (BORM) • Laurie Talarico, (BORN)
KEY ACTIVITIES	List steps and decisions that will be necessary to carry out the project work and implement the opportunity
TIMING	Document proposed implementation timing and key milestones

Standardized process for inquiries about status of an application

PROJECT	Establish a standardized, dedicated process, including time frames, at health plans for inquiries about status of an application*
TEAM LEADER(S)	Nancy Marotta (BCBSMA) Betsy Maloof (BMCHP)
SUBGROUP MEMBERS	• Vivian Olsten (Network Health) • Kathleen Marcin (Lahey Clinic) • Kim Larko (HPHC) • Kara Cotich (MAHP) • Jean Klugman (Tufts Health Plan) • Julie Manganiello (BIDPO) • Nancy O'Rourke (MA Coalition of Nurse Practitioners)
KEY ACTIVITIES	List steps and decisions that will be necessary to carry out the project work and implement the opportunity
TIMING	Document proposed implementation timing and key milestones

Standardize process for notifying health plans of updates to roster

PROJECT	Establish a standardized process for notifying health plans of updates to roster
TEAM LEADER(S)	Nancy Dunn (Childrens Hospital) Mathieu Gaulin (Childrens Hospital)
TEAM MEMBERS	• Mary Penta (NHP) • Kate Power (BWH) • Sandy Dussault (Fallon) • Debbie Blackak (HNE) • Lainie Kemp (MEEI) • Kathleen Marcin (Lahey Clinic) • Nelie Lawless (HCAS)
KEY ACTIVITIES	List steps and decisions that will be necessary to carry out the project work and implement the opportunity
TIMING	Document proposed implementation timing and key milestones

Increase frequency of hospital board votes during high volume months

PROJECT	Increase frequency of hospital board votes during high volume months
TEAM LEADER(S)	Kathleen Scheibel (Lahey Clinic) Nancy Dunn (Childrens Hospital
SUBGROUP MEMBERS	• Mathieu Gaulin (Childrens Hospital) • Kate Powers (BWH) • Debbie Blackak (HNE)
KEY ACTIVITIES	List steps and decisions that will be necessary to carry out the project work and implement the opportunity (see separate template)
TIMING	Document proposed implementation timing and key milestones

Questions?

Karen Granoff, Massachusetts Hospital Association

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