How to handle NCQA’s ‘ongoing monitoring’ standard

What exactly does “ongoing” mean? That’s the question many NCQA-accredited managed care organizations (MCOs) ask as they strive to comply with standard CR 10, which requires the ongoing monitoring of provider sanctions and patient complaints. This new standard became effective on July 1, 2001, but continues to puzzle credentialing professionals and MCO administrators alike.

And it’s no wonder. According to industry insiders, the NCQA doesn’t provide any clear definition of “ongoing” at present. But your organization’s approach to ongoing monitoring, as written into your policies and procedures, could influence the NCQA’s final definition. (For a discussion of possible obstacles to provider data collection, turn to p. 3.)

No clear guidance—yet

“We have not yet clearly defined what kind of timetable is meant by ‘ongoing,’ ” says NCQA Director of Communications Brian Schilling. At this point, each organization will have to determine that for itself, write it into its policies and procedures, and follow through consistently.

“What I’m hearing is that people in the field will begin to do [ongoing monitoring], and the NCQA will see what the field is doing and determine whether that fits its view of what the standard means,” explains Carol Cairns, CMSC, CPCS, president of PRO-CON in Morris, IL. Specifically, CR 10 requires the ongoing monitoring of Medicare and Medicaid sanctions, sanctions or limitations on licensure, and patient complaints.

How often is ‘ongoing’?
The NCQA’s move from a two-year to a three-year recredentialing cycle is one likely reason it implemented this new ongoing monitoring standard, suggests Charles Petersen, CMSC, CPCS, consultant and trainer with CACTUS Software, Livonia, MI.

The answer to how often is enough within that three-year period rests with the individual MCO, says Petersen.

“The absolute lowest standard is every year,” Cairns says. “The highest standard is at least quarterly, and some systems do it as often as daily or monthly.”

• **OIG sanctions.** Cairns recognizes that regular monitoring of the Office of Inspector General’s List of Excluded Individuals and Entities would be nearly impossible for an MCO with thousands of providers. Therefore, MCOs must become automated. “Don’t lose any time,” she advises. “If you’re not automated, become automated.” And remember that you have to prove to the NCQA that you’re monitoring, so make sure you keep a tracking or summary log.

• **Licensure restrictions.** As for checking licensure restrictions, many states provide reporting systems that announce such...
sanctions. For example, in Petersen’s home state of Michigan, the Bureau of Health Services issues a report every two weeks listing all health care professionals whose licenses have been sanctioned. As a result, Petersen has set up a schedule alerting him to check this list every two weeks.

When one of his organization’s providers appears on the list, he writes to the licensing board for more information. (See a sample letter below.) He then takes that information to the credentials committee for evaluation and a final decision. The meeting minutes suffice as documentation for the NCQA that his organization did something with the adverse licensure information.

- **Patient complaints.** The ongoing tracking of patient complaints is particularly important, as they offer a long-range look at a practitioner’s performance. MCOs must collect this information continuously. The best place to start is writing this process into the policies and procedures, which should state

  - that your organization will collect this information
  - the mechanism it will use to record it
  - how it will evaluate complaints
  - how it will follow up on complaints

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**Sample letter: Verification of licensure status**

The following is a sample letter credentialing professionals could send to a state licensing agency to confirm (and request further information about) an adverse action taken against a provider’s medical license.

Dear Executive Director:

It has come to my attention that Dr. ___________ appears on the ___(name of licensure sanctions list/report), dated _________. I’m writing to confirm this information. The provider’s name and personal data are as follows:

Provider’s name
Date of birth
License number
Expiration date

Please verify the status of Dr. ___________’s license in your state and inform me as to whether his/her license was suspended, revoked, or otherwise restricted.

Thank you for your assistance in this matter.

Sincerely,

Your name
Your title

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Managed care organizations (MCOs) are focusing more and more on monitoring provider quality for two critical reasons. The NCQA’s new standard CR 10 on ongoing monitoring went into effect July 2001 and an increasing number of state licensing agencies are making physician profiles available to consumers. Gathering performance data is an ongoing challenge for MCOs, especially when it involves hundreds—possibly thousands—of providers they may never see.

But state laws and other restrictions also hinder MCOs from accessing and evaluating relevant provider data. Below is a discussion of the biggest obstacles MCOs should watch for.

Review of NCQA requirements
Provider monitoring isn’t just a good idea—it’s required by NCQA standards. Specifically, NCQA standard CR 9 requires MCOs to use quality improvement information and patients’ complaints when recredentialing primary-care practitioners and high-volume behavioral health care practitioners.

In addition, standard CR 10 requires “ongoing monitoring” of Medicare and Medicaid sanctions, restrictions on licensure, and patient complaints (see related story on p. 1).

The challenge: Access to info
The difficulty in complying with the NCQA’s standards lies in the politics surrounding the issue of gathering provider information, according to Ira Rosenberg, chair and chief executive officer of Managed Care Resource Management Group, LLC, and president of The Managed Care Group, Burr Ridge, IL.

Restrictions on access to provider data have led to MCOs’ inability to aggregate data, analyze it, and agree on how best to monitor performance, according to Rosenberg. “Common practice is different for every state, but for the most part, organizations will only monitor a portion of the physician population because the number of physicians in networks has grown so large,” he explains.

Many MCOs rely on hospitals’ credentialing processes and physicians’ signatures to attest to the accuracy of quality information, Rosenberg continues.

“It’s a complicated issue because people want to know that their [physician] is qualified and to be reasonably assured that their need will be met by that [physician] without complications,” Rosenberg says. “On the other hand, people have become manic about the access to information, and that has resulted in confidentiality restrictions.”

Rosenberg says the following obstacles prevent MCOs from comprehensively assessing their providers:

1. Peer review information is not communicated to MCOs. For example, Illinois appointed a professional review organization as part of the state credentialing process, but the information it gathers is not readily available to MCOs.

2. State laws vary on what information can be shared with MCOs, making it difficult for those operating in several states to develop an organization-wide process.

3. The industry lacks a single-source credentialing form. Rosenberg contends that a single-source credentialing form would allow easier gathering and sharing of comprehensive quality data.

“Quality and credentialing information [must be] readily available to MCOs so they can begin to rely on that information to support the documentation that the physician or delegated organization provides,” he concludes.
Survey reflects mixed feelings about patients’ rights
Results of a recent survey suggest a level of confusion among consumers regarding patients’ rights legislation, reports the National Underwriter, Life & Health Edition. The survey, conducted in July and August by Princeton Survey Research Associations, interviewed 1,205 adults over age 18. Statistics appear to contradict one another, according to some health care officials.

For example, 81% of respondents said they want Congress to pass a patients’ bill of rights, but only 16% said such a bill should give patients the right to sue their health plans for “compensation of economic loss, pain and suffering, and punitive damages.” And only 7% considered patients’ rights as the most important health policy issue in America today.

Colorado docs consider suing HMOs
Physicians in Colorado are asking the Colorado State Medical Society to help them bring suit against the state’s largest health maintenance organizations (HMOs), reports Rocky Mountain News. The physicians allege that health plans routinely undermine physician-patient relationships by requiring non-negotiable contracts, denying medically necessary treatments, and overruling physicians’ decisions.

Medical societies in Florida, Georgia, and Connecticut have filed similar suits against their state’s major health plans. Some physicians believe a significant legal initiative is the only way to catch HMOs’ attention and bring them to the negotiating table.

Colorado HMO executives argue that such “mis-guided” lawsuits would take money away from patients and hand it to lawyers.

HMO costs to increase next year
Health insurance costs will increase by 18.2% in 2002, according to a recently published report by UBS Warburg, an international financial services firm, says PR Newswire. The report predicts this hike might result in higher insurance premiums, which in turn would drive employers to reevaluate their health benefits and find innovative ways to control costs.

Doc excluded from Medicare keeps his job
The Department of Health and Human Services’ Office of Inspector General (OIG) published an advisory opinion this fall that accepted the employment of a Medicare-excluded psychologist at a large HMO, according to Medical Newswire.

Because the psychologist serves as a “senior program developer” for the HMO and does not actually provide health care services to plan members, he poses “minimal risk” and therefore won’t be subjected to sanctions. The senior program developer position involves leadership training, performance improvement consulting, and other professional development endeavors for HMO employees only.

To read the advisory in full, go to http://oig.hhs.gov/advopn/2001/index.htm and click on the item marked “10/05/01.”

Introducing Briefings on Managed Care Credentialing
HCPro now offers a 12-page monthly newsletter dedicated to credentialing issues in the managed care environment: Briefings on Managed Care Credentialing. This publication provides advice on implementing credentialing processes and discusses topics such as NCQA, JCAHO, and URAC credentialing standards; delegated credentialing; and criminal background checks, to name a few.

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