NCQA launches two-part, Web-based surveys

How the new process will affect credentialing personnel

The NCQA announced in early fall the transition of its accreditation and certification programs from a paper-based, purely on-site process to a Web-based, partially on-site process. The electronic system aims to streamline surveys and provide organizations with immediate compliance feedback. All NCQA-accredited/certified organizations will be surveyed under this new process starting July 1, 2004. But will this change affect the credentialing portion of surveys?

MCC talked with NCQA Assistant Vice President for Product Development Ann Carson and learned that the Web-based approach won’t change the credentialing standards with which organizations must comply—but it will change the way surveyors review credentialing policies and other documents prior to on-site visits. It also means credentialing professionals will have to compile and organize documentation up-front for the online portion of the survey.

Carson acknowledges that the new process will involve some extra effort from credentialing professionals at first, but says it will make surveys run more smoothly in the long run. The new approach will shift the focus from the once paperwork-intensive preparation to the actual survey content.

How the new process works

The Web-based process—called the Interactive Survey System (ISS)—functions as a two-part survey. The first part involves the organization’s completion and submission of an online survey tool to the NCQA. The tool is accessible through a password-protected Internet site, Carson says. The organization answers questions and uploads for your reference documents that demonstrate compliance with the NCQA standards. These documents must be in electronic format.

“When an organization applies for accreditation, two dates are set,” Carson says. “The first date is when the online tool should be finished and submitted, and the second is for the on-site visit.” Eight weeks generally separate these dates, but there is some variation depending on the type of organization involved.

As it prepares for a survey, an organization can use the survey tool to receive immediate feedback on its performance. Specifically, if the organization scores below the established threshold of a given survey element, the system sends an automated response to it, complete with recommendations for improvement.

“These responses . . . are not customized to the particular organization,” Carson points out. “But they serve as a starting point so the organization can begin to make improvements.”

When the survey tool is ready for submission, organizations can run a “completeness check” to make sure all questions have been answered. “The tool won’t submit successfully unless everything is filled in,” Carson explains.

Once an organization successfully submits the tool, it receives immediate feedback on...
its score. Specifically, if the organization scores below the established threshold of a given survey element, the system sends an automated response, complete with recommendations for improvement. “These responses are quite general; they’re not customized to the particular organization,” Carson points out. “But they serve as a starting point so the organization can begin to make improvements before the on-site survey date.”

When the tool is submitted, the organization’s NCQA survey team reviews it and assesses the uploaded supporting documents (e.g., policies, procedures, etc.). From there, the surveyors discuss their findings with the organization in a follow-up conference call. “This off-site review allows the surveyors to identify areas where more information, such as medical records, is needed. During the on-site survey, they can focus on those areas, and that makes the process much more efficient,” Carson says.

When the survey date arrives, the organization doesn’t have to worry about gathering and organizing documentation because the online tool has already taken care of it.

**The real impact on credentialing**

The real effect of the ISS on credentialing will come in the form of more focused and meaningful on-site surveys, according to Carson. After all, credentialing professionals have always had to prepare and organize documents prior to survey—but the online tool provides a new vehicle for delivering that information to surveyors so they will know which areas to concentrate on when they arrive.

“Surveyors won’t be bogged down with questions such as, ‘Does your credentialing policy include verification of licensure?’ They’ll already know if it does because they will have already reviewed the policy,” she says.

**Where credentialing professionals fit in**

So where do credentialing professionals’ responsibilities lie in this new process? According to Carson, it depends on an organization’s structure. Managed care organizations typically take one of two approaches to completing the tool. “Some organizations designate a small committee that’s responsible for gathering pertinent information and documents from the different departments and inputting it into the tool,” she says. Others assign an individual from each department to collect and input the appropriate data.

Carson points out that the ISS allows organizations to customize user names and passwords so that designated individuals may access and fill in only parts of the tool. “For example, they can set it up so a credentialing professional can make changes to the credentialing portion, but the [utilization management] and other sections are ‘read-only,’” she says.

Regardless of an organization’s approach, credentialing staff will have to collect policies, procedures, and other information that demonstrates compliance with the NCQA’s credentialing standards. “They just might not have to actually input that information into the tool themselves,” Carson notes.

**Help with the learning curve**

But what if an organization doesn’t have all of its policies, procedures, and other pertinent documents in electronic format? Carson acknowledges that a few organizations will have to go through a transition period, but most already have computerized documents.

“We’ve gotten really positive feedback overall,” she says. “And we are committed to working with organizations that face any challenges. But people are behind us because [electronically based systems] is where the industry is going.”

“We also provide training opportunities for organizations,” adds NCQA Communications Director Brian Schilling. Most notably, the accrediting body offers training sessions limited to 15 people at its office in Washington, DC. For more information about ISS training, go to www.ncqa.org/Education/edcal.htm and click on “NCQA Educational Seminars.”
Hospitalists: A growing managed care credentialing challenge

By Wendy Cherner Maneval, Esq.
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As a managed care credentialing professional, you’ve no doubt faced a growing challenge with hospitalists. These physicians, usually primary-care internists or critical care specialists, take over a patient’s care during hospitalization. Although there are estimates of only 3,000–4,000 hospitalists practicing in about 10% of the country’s hospitals, that number is predicted to grow exponentially in the next decade.

Managed care organizations (MCOs) are pressuring physicians, especially primary-care physicians, to refer patients in need of hospital care to a hospitalist to help cut costs. However, in doing so, MCOs may assume special responsibility—and greater legal risk—for credentialing those physicians. The NCQA (and many state laws) requires MCOs to credential hospitalists. In turn, many physicians are disturbed by MCO rules making such referrals mandatory. While most MCOs merely encourage primary-care physicians to refer patients to hospitalists, some have required such referrals. One Missouri lawsuit alleged that this requirement constitutes a “limitation of care” that must be disclosed to subscribers. MCOs in Florida and Texas encountered legislative opposition to such mandatory referrals in 2000 and 2001.

The ins and outs of hospitalists
What exactly is a hospitalist? As stated above, this type of physician takes over the care of a primary-care physician’s patient during hospitalization. The hospitalist keeps the primary-care physician informed of the patient’s condition, but makes all major decisions regarding the patient’s care. The primary-care physician can choose to visit the patient, but will not be paid for his or her time. At the end of hospitalization, the patient returns to the primary-care physician for follow-up.

Why the advent of hospitalists? Preliminary studies have found that they increase the efficiency, cost-effectiveness, and quality of inpatient care, leading to reduced lengths of stay and overall hospital costs. Consider the following benefits:
• They have greater expertise with critical conditions
• They are better able to manage a patient’s hospital care because of their greater familiarity with hospital procedure, facilities, and personnel
• They permit greater contact with patients

However, there are potential problems with hospitalists. For example, many primary-care physicians worry that the use of hospitalists will erode the physician-patient relationship. Further, some physicians are concerned that their skills to provide inpatient care will deteriorate.

In turn, hospitals are concerned that they will have increasing difficulty credentialing and privileging primary-care physicians who refer patients to hospitalists, and therefore won’t have enough clinical activity on which to base reappointment decisions. In that case, MCOs should take the following steps:
• Inform consumers that your MCO uses hospitalists
• Have appropriate provisions in their contracts with all pertinent hospitals requiring the sharing of all pertinent credentialing information
• Carefully supervise any delegated credentialing functions to ensure that such physicians are appropriately evaluated
• Tailor the referral to a hospitalist to the patient’s needs (i.e., ensure that the hospitalist selected is competent to provide the specific services needed by the specific patient)
• Adopt rules, policies, or contract provisions clarifying the hospitalist’s responsibilities regarding communication with primary-care physicians, follow-up of patients, and return referrals
• Monitor the effectiveness, efficiency, and quality of care of individual hospitalist physicians
Patients' rights department releases HMO report card

The Office of the Patient Advocate, an independent office under the California Business, Transportation, and Housing Agency, this fall released its third annual “Quality of Care Report Card,” reports the San Francisco Chronicle. The report rates California’s 10 largest HMOs, which cover 95% of the state’s insured population.

The report card rates HMOs by claims-processing time, whether they offer certain preventive screenings (i.e., cholesterol), and patient satisfaction data, among other factors. Kaiser Permanente’s Northern California division scored the highest overall. To access this report, go to www.opa.ca.gov/report_card/.

New California law mandates health insurance for employees

Just prior to the October 7 recall election in California, Governor Gray Davis signed into law a bill that requires companies to offer their employees health insurance, according to the Associated Press. Specifically, businesses with more than 200 employees must provide health benefits to workers and their families by 2006, while businesses with 50 to 199 employees must provide only workers with coverage by 2007.

Companies will pay 80% of each employee’s premium, and the employee will pay the remaining 20%. Companies can buy insurance or pay a fee to the state, which will in turn buy insurance for workers through a new purchasing pool.

Criminal past prompts PPO to drop doc

Private Healthcare Systems, Inc., a national preferred-provider organization, recently terminated its contract with participating physician Albert Torres when it discovered he had been found guilty of stealing patients’ credit card numbers from their medical files and using them to pay for phone calls to adult entertainment hotlines, reports Health Law Express. Torres was fined and reprimanded four years ago by the Connecticut Medical Examining Board as a result of this misconduct. He failed to mention these disciplinary actions on his provider panel application.

An arbitrator overturned the contract termination, alleging that the physician’s behavior resulted from a mental illness. But the Connecticut Supreme Court overruled this decision, citing the state’s public policies against theft.