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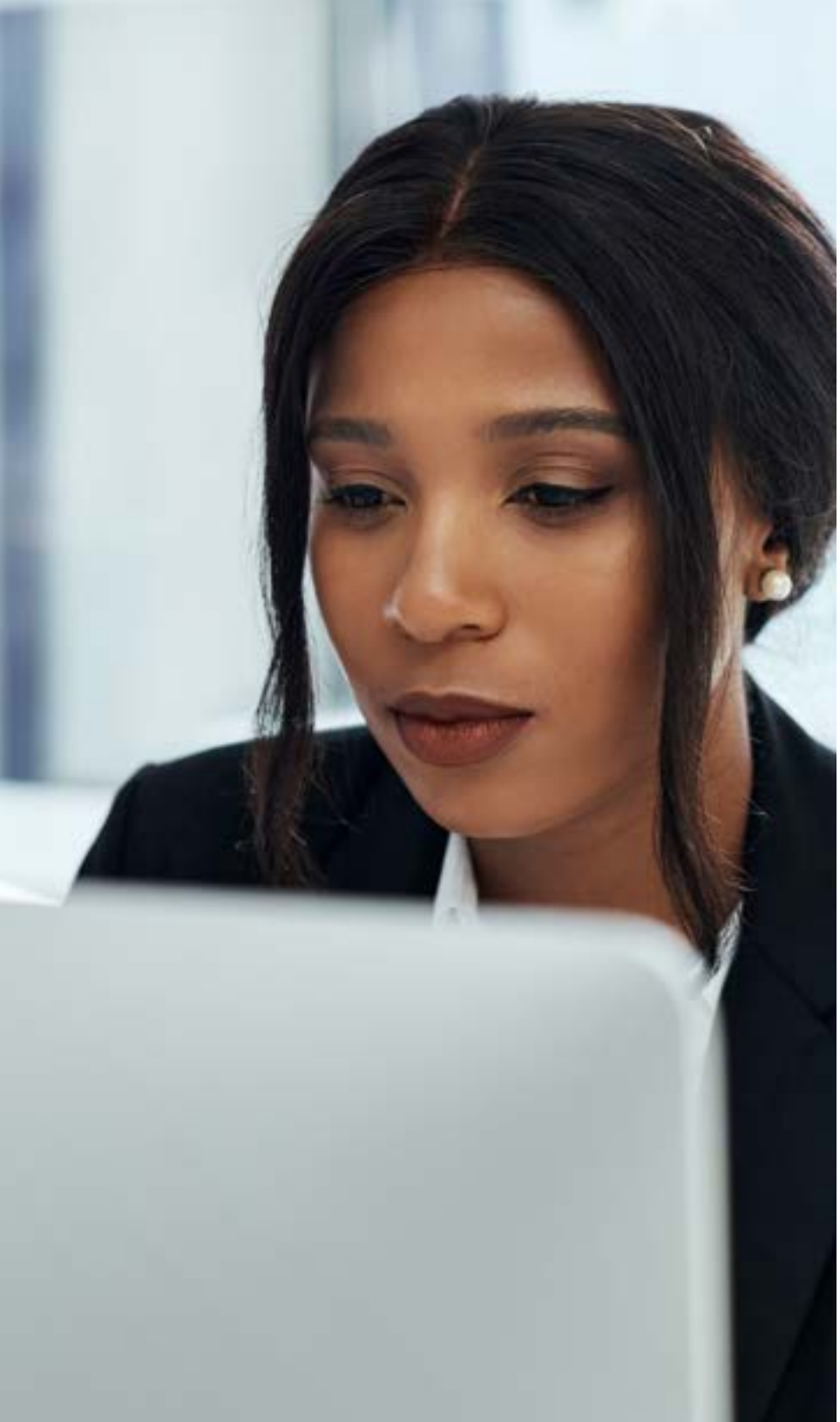
3 Ways Payers Improve Provider Credentialing

External distractions. Data inaccuracies. Information delays. When problems occur during provider credentialing, it wastes your most valuable resources. Staff time and reimbursement revenue are lost for certain, but consider the less-tangible factors, too, such as decreased customer satisfaction among members and providers.

As a result, your organization must do everything possible to cost effectively facilitate high-quality member care. After all, the buck stops with you and the clinicians you partner with to deliver on member safety, satisfaction, and positive clinical outcomes before you reward providers with optimal reimbursement.

As a healthcare payer, you know how challenging and time-consuming credentialing can be. Not only does provider data change constantly, but the entire process requires transferring multiple layers of sensitive data among participants on an ongoing basis. In addition, your organization likely juggles multiple sets of accreditation standards from groups like the National Committee for Quality Assurance (NCQA), as well as state and federal regulations such as those published by the Centers for Medicare & Medicaid Services (CMS).



What's different about credentialing at payer organizations?

Payer credentialing of providers—in addition to being highly regulated and labor-intensive—often takes three to six months to complete. While your process largely mirrors the initial steps that health systems use to onboard clinicians, other factors make provider credentialing at payer organizations unique and complex. For instance:

- Compared with hospitals and health systems, your organization is more likely to gather and parse providers' utilization data and other information related to value and cost containment. This helps save on costs yet deliver the highest-quality care to your members.
- Meeting contract obligations with provider organizations of all sizes and types means your organization must continually gain visibility into contract assets to set and adjust the providers in-network.
- Your staff must accurately and consistently track precise individual clinician-level details, such as provider IDs, date ranges, tax identifiers, services, panel statuses, and **directory flags**, such as inaccurate addresses and providers' status with regard to accepting new members.

New challenges in a changing environment

- On top of perennial cost, quality, and compliance issues, new external challenges are brewing for healthcare payers. As the pandemic wanes on and new legislation (e.g., the **No Surprises Act**) ups the ante for payer performance, healthcare insurers, their leaders, and staff are:
- Being asked to review more new cost-of-care scenarios that require continuous review of operational policies and procedures.
- Processing more claims for more members seeking record numbers of service offerings, which translates to an increased administrative load.
- Facing acute staff shortages, especially in entry- or mid-level customer-service roles.
- Experiencing low morale among staff, wherein associates cite inadequate training and technology resources for expanding job responsibilities and **work volume**. (Notably, **symplr's own Employer of Choice survey** found that nearly 40 % of all credentialing specialists in all types of healthcare organizations said they'll need additional knowledge or skills to successfully do their jobs going forward).
- Dealing with instances of social backlash as a result of news reports about multiple insurance companies' gaffes in **billing** members for care that should have been free, or payers own staff accusing companies of **putting profit before** members.

For your organization to fulfill its role in reining in healthcare costs generally, you must employ smart strategies to make the entire provider credentialing process easier and more efficient from start to finish—despite the myriad and ongoing challenges.

symplr's credentialing experts recommend focusing on finding the data access hurdles and technological disconnections that are making your workforce, information exchange, and verification problems insurmountable. For example, is data siloed in multiple systems in your organization? Is there a failsafe way to catch data inaccuracies? What flexibilities do you have when you require more staff, and quickly, to accommodate surges in credentialing while still controlling overhead?

Here are three ways your payer organization can improve provider credentialing.

1. Centralize provider data management

A single source of truth that's consistently reconciled and dynamically validated against primary sources is invaluable for maintaining clean, accurate provider data. When your organization maintains a unified, rich data profile for every credentialed provider, the data is instantly accessible to the appropriate parties.

Data management software makes it easier to gather and report data, adhere to changing compliance requirements, and maintain secure access. It's also less burdensome for providers and **credentialing staff** and helps the administrators who assess the provider's application before admitting them to a panel. Software as a service (**SaaS**) is especially suited to centralization of data.

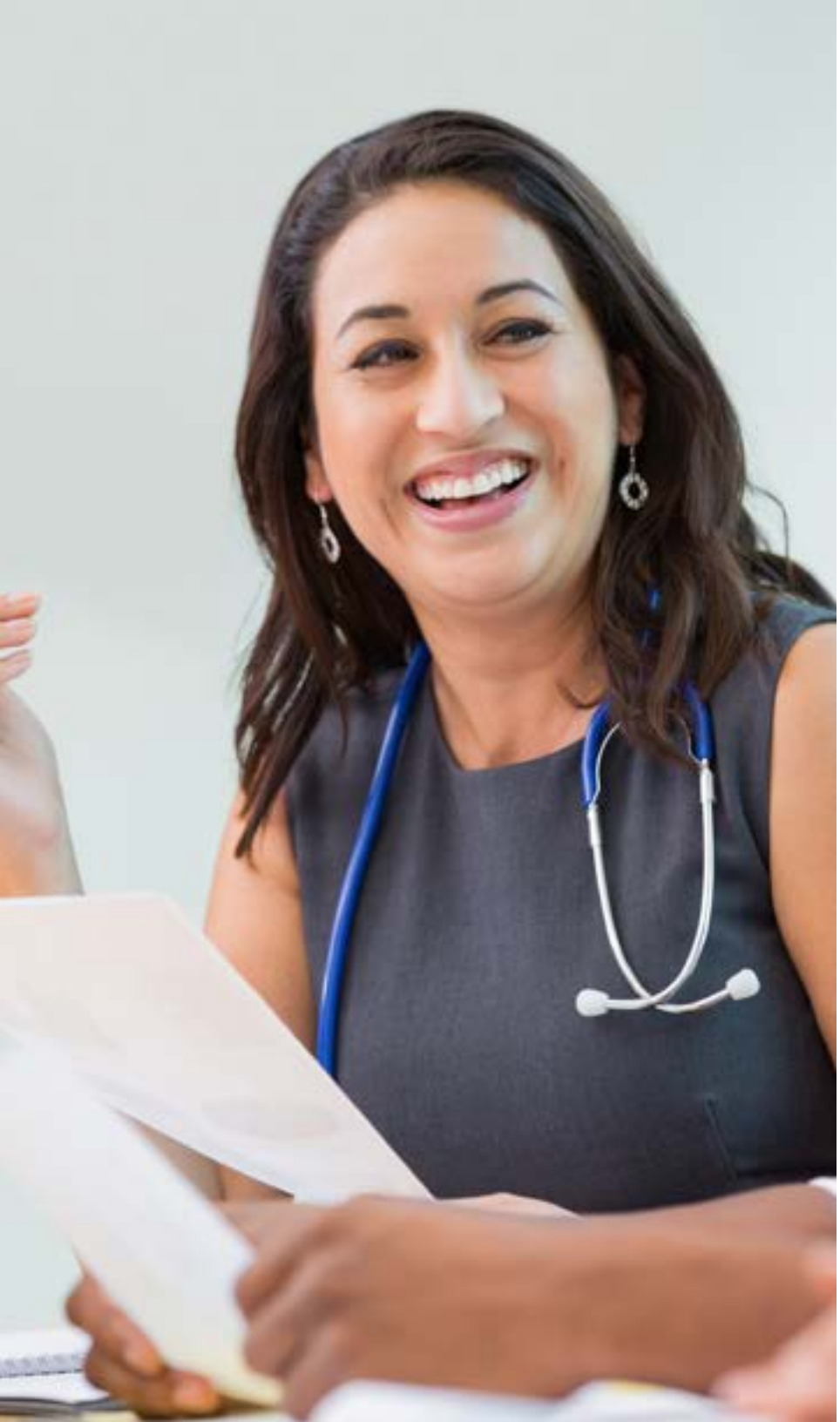
Current, clean provider data is essential for maintaining accurate provider directories, ensuring speedy member care, and **complying with CMS** and other regulators. However, provider data comes from multiple sources and is often stored in numerous systems and departments.

Disparate data storage leads to a lack of communication, repeated requests for information, and delays in provider credentialing and enrollment processes. Plus, when provider data is entered several times into separate systems, instances of human error increase.

It's also impossible to manage the multi-step process of credentialing for thousands of physicians and advanced practice professionals using spreadsheets as the vehicle to exchange data between systems.

Centralizing provider data eliminates duplicate work, speeds the verification process, and reduces administrative costs and burden when:

- **Tracking providers:** To avoid having Medicare billing privileges revoked, providers must report an adverse legal action or change in ownership or practice location **within 30 days**. All other changes must be reported within 90 days.
- **Managing provider data changes:** Provider data changes frequently: **2-3% of provider demographic data** changes each month, requiring it to be **updated and reconciled** regularly. Even slight discrepancies in an address, for example, can derail the process.
- **Complying with the No Surprises Act:** Payers can face stiff penalties for instances of **surprise out-of-network care**, so it's imperative to ensure that your provider directories are current and accurate. Doing so ensures that providers are verified and attested as being in-network. It also helps to jumpstart the process for quickly removing those who aren't.



2. Expedite credentialing with tools designed for managed care

To handle the tremendous workload and foster data access and transparency, your organization requires automation in the form of batch processing, web crawlers, and form-automation technology. These tools create efficiencies across payer-specific workflows for primary source verification and credentialing.

Leveraging automation can eliminate steps in processing provider applications. For instance, providers enrolling into payer networks that cover multiple states must be credentialed in each one where they deliver care. States have different credentialing requirements and time frames, which results in never-ending information to track, requests to respond to, and documents to share.

Instead of directing credentialing staff to manually verify credentials—by calling or emailing medical schools and state licensing boards and searching the National Practitioner Data Bank for malpractice payments or adverse actions—automate the process. For providers and their health systems, submitting required documentation on time becomes easy. Finally, automation eliminates the errors and inefficiencies rife in manual processes, saving payers from fines and other disciplinary actions.

Efficiency and consistency are essential because primary source verification and credentialing are just the start when you add new providers. Data management and maintenance continue throughout the payer-provider relationship, including:

- Managing multiple rounds of applications (such as ones requesting access to provider personal data or to join plans)
- Verifying primary source data on education, training, and licensure
- Fraud checks
- Internal/external status communication
- Maintaining qualifications and recredentialing

Incomplete or inaccurate information regarding a provider's professional certifications, work history, or malpractice insurance coverage can lead to extensive credentialing delays. Such setbacks can have dire consequences, from member access issues to lost revenue and compliance penalties. In addition, after providers are added to panels, their information must be updated regularly, opening the door to yet more issues.

The use of a managed care credentialing software for the entire lifecycle of a practitioner's relationship with your organization ensures data integrity and transparency, demonstrates accountability for large volumes of traceable data, and enables rapid growth.

Finally, having efficient, easy-to-use processes can help boost your reputation. Providers and members are accustomed to the high level of customer service that automation provides in every other industry, viewing manual processes as outdated and not confidential. Automation offers assurances that your processes—and your customer service—are efficient, secure, and up to date.

3. Partner with a CVO

Due to high volumes of credentialing files, most payers create their own internal credentialing verification organization (CVO) or outsource to a trusted CVO partner who can often better integrate the provider contracting, credentialing, and enrollment processes.

Partnering with a CVO can eliminate administrative burden on your credentialing department and free up personnel for tasks that require human intervention and expertise. For instance, most CVOs have access to tools such as CAQH ProView, an online provider data-collection solution that streamlines provider data collection by using a standard electronic form.

In addition, CVOs that carry NCQA accreditation in credentialing go above and beyond credentials verification to handle the entire credentialing and recredentialing processes, licensure application, and monitoring of provider performance between credentialing cycles. symplr's CVO, for example, also can provide professional services consulting on model policies and procedures and more.

Outsourcing to a CVO can be beneficial during short- or long-term special circumstances, such as being short-staffed or working through a merger or acquisition. Partnering with a CVO can also help payers and their staff stay nimble as they continue to navigate unexpected crises that might leave them struggling to keep up with new rules and other changes that could arise overnight.

The industry watched such complexities play out in real time, from the early days of the COVID-19 pandemic—when health plans relaxed guidelines and expedited credentialing and enrollment—to today, when payers must start recredentialing and re-enrolling providers as the public health emergency winds down.

Looking to improve your credentialing process?

Automate and optimize provider data management with symplr. symplr Payer is a leading provider of credentialing software tailored for payer organizations to meet the healthcare needs of their member populations. Plus, symplr is the only cloud-based healthcare provider management solution to achieve HITRUST CSF Certification and was recently recognized as a major player in an **IDC MarketScape report**. Our solution serves as the single source of truth for provider data management to streamline:

- Credentialing
- Provider relations
- Contracting management
- Automated workflows
- Network management
- Quality performance improvement

Are you ready to take the next step in optimizing provider credentialing?

Visit our website to learn more about how our **symplr Payer integrated software solution** can help or **get a demo** today.

About symplr

symplr is the leader in enterprise healthcare operations software and services. For more than 30 years and with deployments in **9 out of every 10 U.S. hospitals**, symplr has been committed to improving healthcare operations through its cloud-based solutions, driving better operations for better outcomes.

Our provider data management, workforce management, and healthcare governance, risk management, and compliance (GRC) solutions improve the efficiency and efficacy of healthcare operations, enabling caregivers to quickly handle administrative tasks so they have more time to do what they do best—provide high-quality patient care. .

Learn how at **symplr.com**.

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