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The Handbook of Medical Tourism Program Development

PHYSICIAN AND FACILITY CREDENTIALING & PRIVILEGING FOR MEDICAL TRAVEL

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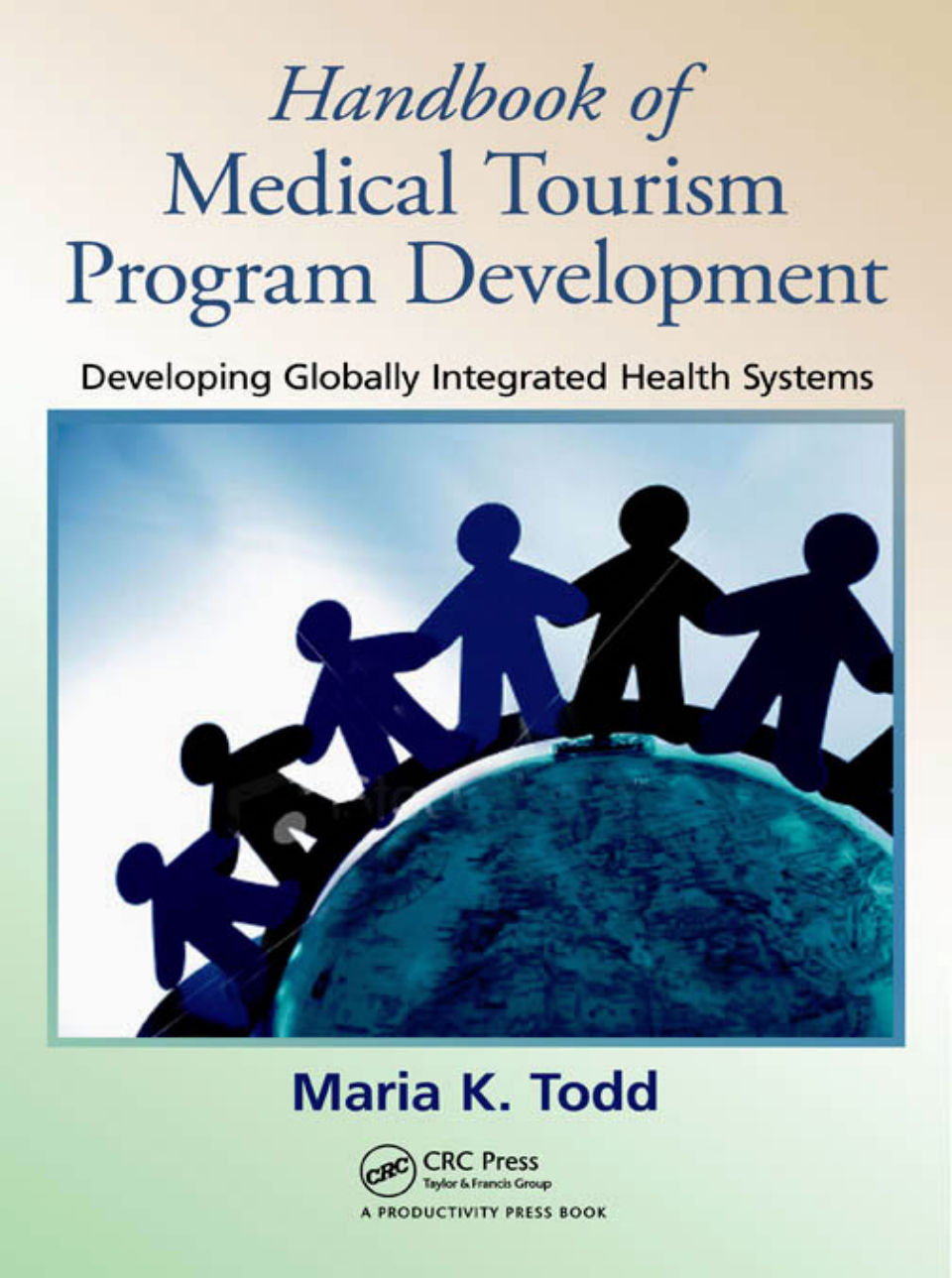

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The Issue

In the world of medical travel, nothing has had less than adequate attention in training and professional development for facilitators than the issue of credentials verification and granting of privileges to perform certain procedures and give medical advice to international patients.

Most facilitators have never been trained on the importance of the subject unless they have years of experience as a nurse, physician, case manager, or some other clinical or administrative professional that has applied for and been granted clinical privileges prior to their entry into medical tourism.

Self-insured employers take credentialing and privileging of local providers for granted because it is included in the package of services they purchase from a third-party administrator (TPA) or an administrative services organization (ASO) that has already create a network of practitioners and facilities that have been vetted (investigated in order to ensure that they are suitable for a job requiring trustworthiness and competence).

While self-insured employers may be interested to consider medical travel as a cost containment option, the Plan Administrators face fiduciary liability to ensure that plan participants are referred to vetted health professionals and facilities that are reasonably safe. If they require Plan Members to use "in-network" Participating Practitioners and Facilities to get the best and highest level of benefits, then the Plan Administrator is duty bound to ensure proper vetting either by 1) the creation of policies, procedures, standards, and criteria or 2) through delegating the credentialing and privileging tasks to the provider.

In my role as a consultant to both employer self-funded health benefit plans and their Plan Administrators shopping for providers and also to hospitals, clinics, surgeons and ambulatory surgery centers interested to attract self-funded employer business, one of my greatest value propositions has turned out to be my ability to help both sides overcome this challenge.

I help the Plan Administrator by providing a sample industry-standard document set of credentialing and privileging criteria, standards, policies and procedures they can review and adopt to help them meet their fiduciary duties and protect their organization from risks associated with credentialing and privileging.

Delegated credentialing saves time

Few people realize that in the world of HMOs and PPOs, health plans are allowed up to 18 months to complete the process of credentialing and privileging each provider or facility. When a self-insured employer leases a "ready-made" network, part of the value of the network is that the network organizer has already assembled the network, vetted the providers and facilities and executed contracts with them for the performance of certain tasks, administrative procedures, reporting requirements, adherence to rules, regulations, statutes and negotiated rates. In exchange for not having to do all this internally the plan pays a monthly fee to lease the existing network and for the network organizer to assume the liability and indemnify the Plan and its Plan Administrator for any negligence in the credentialing and privileging.

Delegated credentialing saves money

Delegated credentialing saves money for the plan because the Plan Administrator would need to learn about credentialing and privileging or hire someone to advise them who has the combination of training and experience or certification as a Certified Professional Medical Services Management (CPMSM) or Certified Provider Credentialing Specialist (CPCS) to set up the system internally, and then receive the applications,

and perform the required primary source verifications, reconcile any discrepancies, and notify the providers and or the facility that they are accepted into the network and allowed to render services and medical advice to plan members. At that point, they are offered a contract and upon execution of the contract, they are deemed to be Participating Providers. For each physician, the employer can expect to invest hours upon hours per applicant and invest at least $100-150 per physician in fees and costs to process the application, plus the overheads and employment costs of the personnel to do the work.

Many independent healthcare practitioners view credentialing as a tedious and time consuming process of completing forms and submitting requested documents to join an HMO, PPO or obtain privileges at a hospital, health system or ASC to be allowed to consult or perform surgery on patients. Few are aware of the infrastructure, processing details, standards creation, and work intensity that goes on after their submission and before they receive their "appointment letter" that advises that the process is complete and their application has been approved.

Credentialing is an essential process that healthcare organizations and practices must perform to ensure those providing services are qualified to do so. The companion piece to credentialing is "***privileging***," which is the process of authorizing a licensed or certified healthcare practitioner's specific scope of patient care services. Privileging is performed in conjunction with an evaluation of an individual's clinical qualifications and/or performance. The process is repeated in most American healthcare organizations once every three years.

The health facilities (hospitals, clinics, long term care, rehabilitation centers and ambulatory surgery centers) must perform credentialing and privileging and maintain records associated with the process in order to pass their accreditation or state certification and licensing requirements. This represents an ongoing, sunk cost for the facilities that costs them just as much as if the employer's Plan Administrator hired out the work to a contracted **Accredited Credentials Verification Organization** (ACVO) or if they brought the task in-house.

The provider's composite value proposition and competitive advantage

In shopping for medical travel program suppliers, the provider who can demonstrate readiness to deliver not only surgical and consultation services to Plan Members but also deliver the required outputs of the time consuming and costly credentialing and privileging tasks and documentation will have a distinct advantage over those not prepared with both the outputs and the paperwork in the form of a Delegated Credentialing Agreement ready for attachment to the Service Agreement Contract.

As the consultant to the provider, again my value and competitive advantage is enhanced over marketing generalists because I have the experience and can guide them through the drafting of the Delegated Credentialing Agreement. Alternatively, I can supply them a custom-tailored draft Agreement. That way, they can modify, submit for legal review, and finalize in a matter of a few hours rather than weeks of work by internal staff who may know how to perform the credentialing and privileging but not have a clue as to how to document the delegation and draft the Delegated Credentialing Agreement, itself.

While the facility may not receive payment for this readiness and output, in the negotiation between the parties, the value can be traded or expressed in other *in-kind* consideration in the form of slightly higher reimbursements, quicker pathways to program launch, and mutual convenience between the parties that enhances relationships because the Plan Administrator can begin saving money sooner rather than later.

Discussion

Health plans, regardless of ownership and healthcare organizations are charged with providing the proper environment and adequate resources to support safe patient care.

Paramount to this responsibility is having medical staff bylaws that define minimum credentialing and privileging requirements for validating the competency of providers. That's actually one of the primary differences between "insurance" companies and health plans.

In the indemnity insurance world, the patient purchases a policy and choses any provider willing to advise them or perform services for them for a price. The insurance pays its share after the deductible for services covered under the policy and the patient pays the rest. There is no negotiated discount unless one has been arranged and agreed between the parties. There is no vetting of the providers or network creation or maintenance. In a "health plan" there is a network of participating providers under contract. Rates, behavior, deliverable are all addressed in a Participation or Service Agreement. To get in the network, credentialing and privileging must be completed before the practitioner is allowed to interact with Plan Members.

The fees and costs associated with credentialing and privileging

The first expense associated with credentialing and privileging incurred by either payers or providers is the creation of their policies, processes and standards. The second expense is the legal review to ensure that all policies are consistent with state laws and professional requirements and that the process is fair and has a process in place for appeals, grievances and issues that may arise in the final determination. The third expense is the process itself along with fees and costs paid out to those primary sources who charge a fee for verification and the software to manage the process of initial credentialing and privileging and the fourth expense is the re-credentialing that usually occurs biennially or triennially. The fifth expense is the professional liability insurance for errors and omissions that could arise if the process is not carried out exactly as stated in the process as documented.

Overview of the process

To give you an idea of the process tedium and complexity at a very high level, I'll explain the key points, phases and milestones that occur along the way.

Healthcare organizations typically use a two-step application process. The first step is completion of a pre-application to ensure that providers meet basic qualifications for membership in the network.

The pre-application process saves time and resources by identifying candidates who do not meet the minimum requirements for staff membership prior to the full application process. Pre-application documents usually clearly state that they are not applications.

Pre-application questions minimally address:

- Disciplinary action or sanctions by licensing boards, payers, or professional organizations;
- Unrestricted licensure;
- Criminal history;
- Board certification, if required;
- Clinical specialty and any specialty-related requirements; and

- Health status.

The pre-application may also require the candidate to submit a curriculum vitae (CV) with his or her pre-application responses. Sometimes, a healthcare organization will request that this information is submitted without any special form in a letter of interest that includes the qualifications outlined in the bullet points listed above.

Upon determination that the applicant meets the minimum requirements, the organization may send him or her a full application. Although some states have standardized credentialing applications, all applications should include the effect of completion of the application. If forms are used, pre-applications and applications must comply with the Americans with Disabilities Act (ADA).

Generally, all applications as the applicant to agree to certain terms and conditions, namely:

- Agree to provide continuous care to his or her patients.
- Confirm receipt of the organization's bylaws, rules and regulations, and/or applicable policies.
- Agree to exhaust administrative internal remedies prior to litigating adverse credentialing decisions.
- Notify the organization in writing if he or she becomes the subject of certain actions (e.g., investigation or complaint by the state licensing board).
- Agree to unconditionally release the organization's representatives (and those who provide information to the organization) from any and all liability for obtaining, reviewing, and evaluating applicant information for the purpose of staff membership.
- Agree to provide access to medical records of patients treated in the organization for ongoing review of competency and quality.
- Agree to provide any change in home or office address and phone number, and affirm that any notice sent to the addresses on file will be deemed to have been delivered.
- Agree to provide information on current health status and vaccinations.
- Agree to submit to unannounced mental or physical exams as requested by the organization's designees. Failure to do so may result in suspension or termination of privileges without a right to a hearing.
- Agree to provide a written request for specific privileges.
- Affirm that all statements are truthful and complete to the extent of his or her knowledge. Misstatements or omissions may be grounds for immediate suspension or revocation of application.

Additional information to be supplied usually includes, among other things, a copy of a government-issued ID with the applicant's photograph.

In many states, it is mandatory that the credentials verification organization or its designee perform a background check on all providers. A background check is different from verification of application information. Organizations usually hire a reliable firm to provide a comprehensive search of court records — both criminal and civil — at the county, state (including surrounding states), and federal level. There's always a fee per provider for this service. A separate and specific consent might be required for performing background checks along with confidentiality protection of the reports and information submitted and returned.

Application Processing

The credentials verification organization or delegated entity collects information regarding each practitioner's current licensure status, training, experience, competency, and ability to perform the

requested privileges.

Through this process all providers must be willing to answer orally or in writing, any questions about their credentials, behavior, references, training, and education or gaps in work history.

The policies and processes set forth how the credentials verification organization determines approval of applications and reapplications. All credentialing and re-credentialing recommendations and decisions are documented and ultimately approved by a governing board.

Privileging

Once the demographics, work history and other information has been vetted, the applicant is then reviewed for the purpose of assigning privileges to interact with patients. Applicants specify which procedures they wish to perform at the facility, and the committee renders a decision to grant, limit, or deny privileges as requested by the applicant.

One reason that my document set must be custom tailored is that privileging of each licensed or certified healthcare practitioner should be specific to each of the healthcare organization's care delivery settings. Considering the care delivery setting is particularly important for managing risk within a healthcare network or among hospital-owned physician practices or ambulatory surgery centers.

Information regarding each practitioner's scope of privileges should be updated when changes in scope occur. Privilege information should be readily available to all who might need to know the status. This might include making the information available on new procedures and supplying periodic updates to the employer's Plan Administrator. When a practitioner is granted additional privileges, a letter is placed in their permanent file and updated to involved individuals such as scheduling and billing personnel, various committees, pharmacy, and other departments who may have a need to know.

To gain approval for new privileges after continuing medical education, focused professional practice evaluation (FPPE) is a process used to confirm a practitioner's current competence at the time new privileges are granted. FPPE has more frequent and intense monitoring than Ongoing Practice Performance Evaluation. Proctors, or reviewers, who evaluate a healthcare provider should be appointed based on criteria determined by the organization's medical staff. After that, Ongoing Practice Performance Evaluation (OPPE) begins when competency has been established.

Once the credentialing and privileging are completed, the employer's Health Plan Administrator is ready to proceed with site inspections, rate negotiations, and setting up the patient movement process.

Delegated Credentialing

As you can see, the process of credentialing and privileging is time consuming, tedious, costly and very process oriented. Rather than take this on and duplicate all that has been done by the facility, the Plan Administrator may elect to offer the facility delegated credentialing. Below, I review the basics of the delegation.

Delegation is a formally contracted process whereby Plan Administrator gives another entity authority to perform certain functions on its behalf. While the Plan Administrator may delegate authority to perform a function, it cannot delegate responsibility for assuring that the function is performed appropriately.

An accredited healthcare organization and its medical staff and allied health personnel that provides health services in accordance with this Agreement may be appointed and authorized by the Plan Administrator as a ***Qualified Entity***. This qualification means that the Plan Administrator has determined have the capability of performing all require delegated credentialing processes. Coupled with this, the Plan Administrator has responsibility for ***oversight***, which involves the monitoring and directing of a set of activities in order to assess performance. In addition, an annual evaluation of a delegate's capacity to perform delegated

credentialing activities in accordance with policies and processes that meet or exceed the standards of the Payer, as applicable. This is referred to as a ***Delegation Audit***.

Many international medical, dental, rehabilitation and other providers are very interested in attracting U.S. employers that operate self-funded health benefit plans for employees, dependents and retirees because the revenue opportunity can be far more lucrative than attempting to grow market share on a one off consumer-by-consumer basis.

But when I explain that they must be prepared with all the forms, policies, standards and documentation - in English - and in accordance with these generally accepted U.S. norms to which the U.S. Plan Administrator holds fiduciary liability, they realize that there's more to the business of medical travel than scheduling surgeries at cheap prices. Upon this new information, they prefer to refocus their sights back on individual consumers. Still others have actually taken offense that their processes, standards and policies would be subject to external review.

I've encountered this reticence in India, the Middle East, Turkey, Germany, Ukraine, Asia, and in several Latin American countries.

In addition to reviewing and oversight of the policies, procedures and standards, the evaluation includes a comprehensive and in-depth review of the following:

1. The delegated entity's credentialing criteria, policies, and procedures to assure they meet or exceed those of the Plan Administrator/Employer; and

2. The delegated entity's quality assurance written plan and/or policies and procedures to assure that the entity's network panel is sufficient to provider accessibility, availability and continuity of the Covered Services being delegated to the entity; and

3. The official Minutes of the delegated entity's Credentials Committee meetings to verify critical review of the practitioner's credentials.

4. Five percent (5%) or twenty-five (25) of individual practitioner's credentialing files, whichever is less. A minimum of ten (10) initial credentialing files and ten (10) re-credentialing files are audited.

5. At the discretion of the Plan Administrator/Employer, a site visit prior to delegation and a detailed review of the delegate's understanding of the standards and delegated tasks, staffing capacity and performance records. The pre-delegation evaluation may be accomplished through a site visit, or by the exchange of documents and/or through pre-delegation meetings and interviews.

I always recommend that for serious inquiries with high value revenue potential, that the facility invite the Plan Administrator and possibly its Medical Advisor at the facility's expense to tour the facility, personally observe operations and patient flow, meet the team and some of the physicians and get a feel for the travel, the airport transfers, the hotels that will be used, and more.

6. If the Provider has been accredited or certified by a accrediting or certifying body recognized by the Plan Administrator/Employer, Plan Administrator/Employer may elect at its sole and absolute discretion to use the accredited or certified Provider's audit or survey results in its pre-delegation evaluation as an additional mechanism of ensuring Provider's credentialing program and quality assurance program meets or exceeds Plan Administrator's/Employer's standards and applicable U.S. state and federal standards to which the Plan Administrator/Employer are obligated to comply.

Accreditation or Certification is never the sole method for determining if the Provider is deemed by Plan Administrator/Employer to be capable to complete the specific delegation functions (i.e. credentialing and re-credentialing).

7. Plan Administrator/Employer evaluates any changes to policies, procedures, and criteria made by

the Provider prior to implementation date. Provider is required to give Notice to Plan Administrator/ Employer in accordance with Notice provisions set forth in the agreement.

In Thailand, some of the providers had a credentialing file that was a CV from 10 years prior and two sheets of notes written in pencil on lined notebook paper. Nothing else. When I asked for the attestation statements, they stated that the permission to verify the credentials by primary source from the Thai medical council would be required, I went to the Thai Medical Council and was presented with various obstacles such as a form wet-signed by the physician, in Thai in blue ink, and no photocopies, facsimiles or other duplications were acceptable. The response of the prospective Plan Administrator/Employer: Next option! Not interested in the game and the time to play.

In Germany, we never got to the discussion because on per-qualification of the provider, they balked at the prospect of arbitration and professional liability and insisted that all contracts be interpreted according to German law and regulations of the EU, and refused to move venue to a neutral location such as the Hague. Arms folded and stubborn they've lost several lucrative opportunities and are no longer invited to propose through my firm.

In India, several of the larger private hospital chains were approached with these requirements and despite entertaining the discussion, ultimately they were only willing to tender a roster in a form and level of detail that was unacceptable and then ceased all subsequent communication.

In Mexico, more blockades were encountered with both the credentials and privileges of the medical staff. They refused to include any physicians and surgeons who were not employed directly by the hospital, refused to allow the Plan Administrator/Employer to elect to refuse any provider, refused to discuss any detail about professional liability insurance beyond 10,000 pesos, and required that the contracts be in Spanish with interpretation according to Mexican laws and venue in Mexico. Again, a non-starter.

For these reasons, an increasing number of American Plan Administrators/Employers have all but given up on international candidates unless then indicate readiness and willingness to accept delegated credentialing under these terms and conditions. Their fall back strategy has been to consider high-value / high-performing providers throughout rural and other destinations and a mixture of ASCs, Academic Medical Centers, and smaller hospitals and health systems, or to go all out and adopt a "Center of Excellence" model with highly-recognized, branded healthcare providers (e.g., Mayo, Cleveland Clinic, Johns Hopkins, et al).

Another reason for remaining stateside is the increasing trend of American nationalism by union members and negotiators that don't are reluctant to support off-shoring of any health services.

With more than 10,000 acute hospitals, rural hospitals, academic medical centers and ambulatory surgery centers throughout the USA, many of which are interested to discuss disintermediation and direct contracting with Plan Administrators, travel to destinations outside the USA without a compelling reason to do so simply doesn't make sense. Reasonable, cost saving alternatives and transparent prices consistent with U.S. laws for privacy and medical records and payable in U.S. currency are available at a drivable distance or a 2-3 hour flight.

Employers: If you would like assistance with drafting credentialing and privileging standards for your health plan, or to find U.S. based hospitals, health systems and ASCs ready to accept delegated credentialing and help you launch a pilot program, please call on me for assistance.

Providers: if you need assistance to prepare for the prospect of medical travel business development or to draft direct contracts with employers or delegated credentialing agreement attachments, please call on me.

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