National Committee on Vital and Health Statistics
Subcommittee on Standards

""Provider Enrollment Forms"

Testimony of

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On Behalf Of
The Healthcare Billing and Management Association

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Madam chair and members of the Subcommittee

On behalf of the Healthcare Billing and Management Association (HBMA), I want to thank you for this opportunity to assist the National Committee on Vital and Health Statistics evaluate whether the application process, including the use of a uniform application form for enrollment of health care providers by health plans could be made electronic and standardized.

My name is Dave Nicholson and I am the President and CEO of Professional Management, Inc., a medical billing and practice management company located in Baltimore, Maryland. I am here today representing the Healthcare Billing and Management Association (HBMA).

My company, founded in 1968, currently employs 55 individuals; we serve 500+ providers in 4 states (Maryland, Delaware, Pennsylvania and Virginia) and the District of Columbia. Last year we submitted claims to over 900 different health plans. Of the 900 health plans, we estimate that we handled provider enrollment services for approximately 250 of those plans.

My company, like most billing companies, specializes in certain types of medical practices. PMI provides a range of services to primarily pathology, radiology, emergency medicine, and hospitalist physicians. In other words, we work primarily for the so-called hospital-based physicians. Our clients provide a very high volume of patient services but they have no office or staff to handle the business side of their medical practice.

HBMA

HBMA's 700+ member companies serve providers in every state and in every specialty and subspecialty, as well as a wide array of non-physician providers, such as ambulance companies, surgery centers, Rural Health Clinics, IDTFs, FQHCs, DME and many others.

The average HBMA member has 40 – 50 employees and processes about 350,000 to 400,000 claims per year. HBMA member companies employ more than 30,000 nationwide and internationally. Our members are constantly seeking ways to improve their efficiency, productivity, technical and operating skills, their ability to serve and anticipate their clients' needs, and of course, grow their companies – profitably.

Most billing companies, including mine, handle a wide range of medical billing and practice management services for our physician clients. Among the many services we provide our clients:

- CPT and ICD-9 CM coding
- Billing and A/R management
- Claims resolution and follow-up
- Audits of coding and coding practices (including prospective or retrospective reviews)
- Reimbursement monitoring

- Comparative data analysis and reporting
- Payment contract negotiation and consulting
- Physician compliance programs;

And, the reason I am here today –

- Assisting with or handling provider enrollment.

HBMA's members have significant experience in assisting with provider enrollment; some do it as an accommodation – a "necessary evil," while others provide this as a fee-based, additional service that clients may elect or decline. Those who provide this service typically have specialized staff (from 1 to an entire department) with full-time responsibility and years of experience.

On the other hand, providers may have to deal with enrollment only a few times in their careers and certainly not even every few years. Their staff has scant experience and is unfamiliar with the regulations, complexities, bureaucracy or the duties owed to them by the enrollment application recipients. One of the most common "work-arounds" noted by our members is to file an application and, while awaiting receipt of a bona fide provider number, bill a new provider – quite inappropriately – under the identity of another, enrolled member of the practice. This is often rationalized under a so-called "incident to" arrangement.

Our remarks today will focus on ENROLLMENT, as credentialing is only indirectly related to the billing process. In preparing our testimony, we attempted to address each of the questions that were submitted to us ahead of time.

1. Differentiate between enrollment for EDI and other electronic transactions such as EFT and the credentialing process.

It has been our experience that the terms enrollment and credentialing are often used interchangeably. This is unfortunate and often serves to confuse discussions around this topic.

In our view***, Credentialing*** is the process of cataloging and verifying the *CLINICAL* credentials of a health care provider or organization. This includes the direct verification of diplomas, transcripts, residencies and fellowships, licenses, medical training, tested skills and competencies in specific clinical procedures, malpractice coverage and litigation history and other professional qualifications. The focus is, as I said, the CLINICAL credentials of a provider.

Whereas we believe ***Enrollment*** is the process of registration of a provider with a commercial insurer or government program so that the provider can conduct business with the insurer. This process typically results in the insurer issuing a "provider number" or similar identifier so that claims can be processed and paid by the insurer without entering standard provider identification data from each individual claim.

The enrollment of a provider in a health plan is, essentially, the gatekeeper function for each insurer. Without sufficient verified data, payors would be highly vulnerable to being defrauded by criminals and imposters, as well as by real providers that could misrepresent their locations, corporate identities, tax ID numbers, etc.

We believe the principle purpose of enrollment is to handle the "business" aspects of dealing with the third party payer.

We note that the Council for Affordable Quality Healthcare characterized credentialing as a subset of enrollment:

> "That one aspect of provider enrollment is credentialing. "Credentialing" includes the process of collecting data on a health professional's credentials, training, experience, or demonstrated ability, practice history and medical certification or license to determine if clinical privileges to practice in a particular place are to be granted."

It is our experience that enrollment and credentialing are frequently independent of each other, although there are certainly examples where commercial insurers require both. For example, Medicare and Medicaid programs require enrollment, but do not require or provide for credentialing, whereas insurers with specialty panels serving a geographic area will require both credentialing (qualifications in their specialty), as well as enrollment.

HBMA believes it would be helpful for NCVHS to recommend that the Secretary establish a standard definition of the word "Enrollment" so that definition can be consistently used in the outside world. HBMA recommends the following:

> **Provider enrollment is an administrative process to ensure the timely and accurate completion of a provider application for participation with a government or commercial health plan (payor). This process includes management of a reasonable amount of supporting documentation, and follow-up as necessary to facilitate a billing relationship with the payor.**

HBMA strongly supports having an efficient, effective and secure process to assure payors that the claims they receive are from providers they know and trust. However, at the moment, the process is more secure than it is effective or efficient, and we applaud NCVHS' efforts to initiate changes that will bring about needed improvements.

2. How many provider enrollment forms and processes exist today? Discuss the issues this creates for providers and their business associates.

While it would be difficult to come up with an exact count, one could envision there being a different enrollment form for each of the more than 2,000 health plans. I would estimate that for

the providers and states we work in, we have completed dozens and dozens of unique enrollment applications for our physician clients.

Along these lines, Madam Chair, I collected some sample enrollment documents that we have for various plans and would ask that these be entered into the record or shared with the Committee, whichever is the most appropriate way to bring this to your attention. Some of these are from my company and some are from colleagues from around the country who shared other enrollment forms for this hearing.

As business associates of the physician, one of the tasks my employees often perform for our physician clients is provider enrollment.

Since my company's inception in 1968, we have enrolled thousands of physicians in government and commercial health plans. However, like many medical billing and practice management companies, provider enrollment for us is a so-called "added value" service rather than a core service. We gladly provide this service (and most physicians gladly turn this task over to us) but we do not view provider enrollment as a core part of our business.

Last year we submitted claims to over 900 different health plans. Of the 900 health plans, we estimate that provider enrollment services were required for approximately 200 of those plans at some point in time.

Most billing companies got into the business of handling provider enrollment because getting a provider enrolled in a health plan is the first step in ensuring that the provider gets paid for his or her services. And, since billing companies typically don't get paid if the provider doesn't get paid, we have a vested interest in making sure enrollment occurs in a timely and efficient manner.

Provider enrollment requires countless hours of duplicative and redundant work. Although we, and most billing companies, maintain a significant amount of provider-specific information for enrollment purposes, maintenance and storage consumes valuable resources that could be better directed at other activities.

And even though we maintain a great deal of information in our system, this does not simply download or transfer to a health plan's database. Instead, the information must be manually transferred from our database to a paper application or entered manually onto a Plan's web-based application. Because this information is essential to ensuring that the provider gets paid, we go to great lengths to avoid errors. This means that the information must be printed out so it can be manually reviewed before we submit the enrollment form for the provider, regardless of whether we submit the enrollment form in hard copy or electronically. Depending upon the requirements, we may send the completed enrollment form to the provider to either verify that the information is correct and/or hand-sign the enrollment form. This takes time and delays the process for getting the provider enrolled and cash flowing to the provider.

Even when we have the information and believe we have accurately completed the enrollment form, this does not mean that enrollment will go smoothly. Each plan may have certain idiosyncratic ways in which it wants information.

- Do we need the middle name or initial of the provider on the form?
- Is a P.O. Box an acceptable form of address or must we include a physical street address?
- Does the zip code need to be out to the 9 digit level or is 5 digits sufficient?
- Is the form case sensitive (i.e. McCardle vs. MCCardle or Mc Cardle or Mccardle)

Because we work in specific markets, we generally know the way in which different forms have to be filled out. Basically, the trial and error method of our early clients now benefits our newer clients because we "know the code" for a particular payer. But this should not be the case. And, while billing professionals end up having lots of experience with many payors, individual practices must frequently engage in trial-and-error at considerable cost and delay in payments.

We believe opportunities exist to dramatically reduce the amount of time and resources that must be devoted to provider enrollment. In addition, streamlining the enrollment process can ensure that provider cash flow moves more quickly, allowing a new practice to see cash flowing into the practice more quickly than is currently the case.

Streamlining the enrollment process can also save the health plan money by reducing duplicative processes, correspondence and problem-solving, staffing levels and call centers to answer questions from applicants.

3. Is anyone sharing an enrollment system for providers to allow for one gateway that serves several entities?

Yes. Several years ago, health plans and provider organizations got together to create the Council for Affordable Quality Healthcare (CAQH). This represented an unprecedented alliance of health plans and associations, to serve as a catalyst for industry collaboration on initiatives that simplify healthcare administration.

NOTE: In the next two paragraphs the use of term "Credentialing" is used in the formal names of programs for CAQH and Maryland's UCF (Uniform Credentialing Form), but we believe they are really referring to enrollment. These are examples where the lack of consistent definitions to confuse the industry and the discussion of these topics. While the names of formal programs may be difficult to change, once formal definitions exist, the program names will also have to change. Can you imagine the confusion if we still called soccer "football" in the US?

Out of this, CAQH established the Universal Provider Datasource (UPD) as part of CAQH's *credentialing* application database project. This initiative sought to make the provider *credentialing* process more efficient for providers as well as healthcare organizations.

The CAQH initiative is voluntary and while many plans are using the UPD – most do not – including Medicare and most Medicaid agencies.

In addition to the CAQH UPD initiative, individual states, such as Maryland, where my company is located, have established their own uniform provider databases and forms for use with health plans in those states. In some cases, the state-specific forms have been modified to mirror the CAQH process but others continue to maintain a separate, state-specific form/database. In 1999, the Maryland general assembly passed a bill mandating the use of a Uniform *Credentialing* Form (UCF) and in 2000 the Maryland UCF came into existence and has been the sole application form that a health plan or its *credentialing* verification organization can use for *credentialing* or *recredentialing* providers in our state. Beginning in 2008, the Maryland form was changed to substantially mirror the CAQH form. Consequently, providers now have the option of either completing the Maryland form and entering their information in the states database or entering their information in the CAQH electronic database, which can then be accessed by the plans.

Finally we would note, Madam Chair, that several Medicaid programs piggyback on the Medicare program's enrollment process as a means of saving administrative money. By requiring Medicare enrollment to serve as a proxy for Medicaid enrollment, the states do not have to support (pay for) this activity. This often has unfortunate, unintended consequences, such as when a pediatrician must obtain an otherwise useless Medicare number in order to bill Medicaid, only to have their Medicaid billing number voided when Medicare deactivates the provider's enrollment for inactivity. A national database with provider information could dramatically reduce the cost of enrolling providers to the health plans in the same way the Medicaid programs used Medicare enrollment.

4. ***How different is the data that is compiled by each health plan?***

Not surprisingly, there is little difference in the data the various health plans ask for as part of the provider enrollment process. HBMA's Commercial Payer Relations Committee compiled a list of the most commonly requested information on a provider application form. In addition to the basic, name, address (practice location[s]) and contact information (phone and/or email), the list of items most often requested by a health plan are:

1) Curriculum Vitae
2) Federal DEA Certificate
3) State Controlled Substance Registration (CDS)
4) Malpractice Face Sheet
5) NPI Number – Group
6) NPI Number – Individual
7) Group Tax ID Number (IRS Form CP575 or 147C)
8) Malpractice Case Histories
9) Professional License(s)

10) Explanation of Gaps in Professional Career
11) Explanation of Gaps in Professional Education/Training
12) CLIA Certificate of CLIA Waiver
13) Signed W-9
14) Professional Diploma
15) Residency Certificate(s)
16) Specialty Board Certificate(s)
17) ECFMG Certificate
18) Copy of ACLS/BLS Certification
19) Proof of Citizenship
20) Copy of VISA/Green Card
21) CAQH Number, User Name, Password
22) Photo ID
23) Social Security Card
24) Privilege Sheet
25) References
26) Managed Care Checklist
27) Signed Release Form
28) TB Test Document (less than 12 months old)
29) CME Credits
30) Internship Certificate(s)
31) Fellowship Certificate(s)

5. Would it be onerous to consolidate an enrollment data set?

No. CAQH and the various states that have done this on a statewide basis demonstrate that there are no rational impediments to establishing this type of system – nationwide. We would point out that there are several pieces of information that never change and could easily be captured in a national database:

(1) College
(2) Medical School
(3) Residency
(4) Date of Birth
(5) SSN
(6) DEA Number

As well as other consistently requested information that may change but could be easily updated by the provider (or provider's agent). This information would include:

(7) Tax I.D. Number (business, not individual)
(8) Addresses
(9) Names/Surnames

(10) License numbers
(11) Group affiliations
(12) Employment status
(13) Participation status
(14) Specialty(s)

6. Are there systems that could be leveraged to be s shared enrollment system for providers with all health plans?

Yes. Certainly CAQH is an obvious place to start. But we could envision the Medicare NPPES database being expanded to capture more provider information than is currently submitted and the NPPES database could also serve as a Uniform Professional Database.

7. Are paper enrollment forms still used <u>extensively</u> across health plans? Are "wet" signatures required on enrollment forms by <u>most</u> plans?

As to the question on whether "wet" signatures are required on enrollment forms by most plans – in my experience the answer is yes. While we would not characterize the use of paper enrollment forms as "extensive," they certainly are still in existence.

Most of the plans that I am familiar with require original signatures. In fact, some plans dictate that the signature must be in "blue" ink. Even with plans like Medicare's new online PECOS system, the initial set-up for enrollment in PECOS (setting up to an Authorized Official) requires a form with an original signature.

In the packet of enrollment forms we are sharing with the Committee, there is a form that Idaho mandates for use by all providers and health plans. Idaho's uniform application is called the Idaho Practitioner Credentials Verification Application. It requests all of the information that one might expect, name, address, medical school, practice location, DEA, etc.

Clearly the state recognizes the value of a centralized data tool. The only problem with the Idaho form – you must either type or handwrite the information onto the form. It cannot be done electronically. I'm tempted to ask how many people in this room still have a typewriter – very few I imagine.

Presuming that Idahoans are like us and don't still have typewriters, this means that most of these forms are being completed by hand (legibly no doubt), using either "blue or black" ink as required.

Madam Chair, think about the hours wasted doing this by hand and the potential for errors because someone then takes this information and transcribes it into a database. It seems almost absurd that in 2011, a state still asks providers to fill out multi-page enrollment forms – by hand, even though the state's insurers are capable of – and would much prefer – electronic submissions.

The Idaho form, like many others, requires a "wet" signature. As you may or may not know, Medicare still has a similar requirement.

I want to specifically make some remarks about the Medicare enrollment process at this point, Madam Chair.

First, I want to acknowledge that Medicare and their enrollment staff are working diligently to improve and enhance the Medicare enrollment process. PECOS is an improvement and HBMA has been part of the PECOS Power Users Group that is working with the CMS enrollment staff to make the system more efficient and under friendly. We can say that there have been some dramatic improvements in the past year.

But even with these improvements, you still cannot go through the entire enrollment process electronically. You must still print out and submit a hand-signed form that will then be on-file with the Medicare Contractor. We recognize the very real fraud and abuse concerns with electronic filing. And, we realize that there must be a balance between an enrollment process that is smooth and efficient and the very legitimate concern that only real providers be allowed to enroll in the system or that someone other than the provider could change data or divert provider payments without a provider's knowledge.

We would like to encourage CMS to work with us and others to come up with a more efficient process that still ensures that the physician has verified all of the information on the 855I but simplifies the physician verification process.

Sitting here today, we don't have the answer to this dilemma but we would like to continue to work with CMS to try to come up with a more efficient provider enrollment/verification process.

8. X12 has a potential standard for provider enrollment. What is the industry's perception of that transaction?

We are not familiar with the X12 initiative but would welcome the opportunity to learn more and provide them with some feedback on their proposal.

CONCLUSION:

HBMA strongly supports the establishment of a centralized data collection source to simplify the provider enrollment process.

Can this work? Absolutely. We have ample examples in other areas of commerce and healthcare where similar types of centralized systems work quite well. We have every confidence that a centralized system could work well for healthcare provider enrollment.

Enrolling in a health plan costs time and money. Whether a physician uses in-house staff to enroll in a health plan or uses a billing company or some other third party for this service, there is a cost. And if a physician does this personally, that's even more costly to the practice because this means the physician is spending time doing administrative work rather than seeing patients.

Lowering a physician's overhead costs means less pressure to raise reimbursement rates, although enrollment is an infrequent event for most practices. Reducing the amount of time and resources that must be devoted to provider enrollment is a savings to the healthcare delivery system. In addition, streamlining the enrollment process can ensure that provider cash flow moves more quickly, allowing a new practice to see cash flowing into the practice more quickly than is currently the case.

From both a technological and security standpoint, one or more entities could be identified as provider information service, put all of the universally required information in a database maintained by the CVS and then, when the provider seeks to enroll in a health plan, let the plan know which service he/she uses and from which they can obtain the necessary information.

Plans can be given "read only" or "download only" access to the database whereas the provider (or his/her designee) would be the only persons authorized to change/update the information in the database.

As noted earlier, CAQH has gone a long way towards establishing this service and we applaud them for their efforts. They've truly been in the forefront on this type of initiative. In fact, HBMA would welcome the opportunity to work more closely with CAQH on improving and streamlining the UPD service.

CAQH has established an impressive array of security measures to protect the information in their database and ensure that only authorized individuals are able to make changes to the information contained in their database. Be we have also heard from some billing companies that do not use CAQH for their providers that the quarterly updating requirements are onerous. For a company that manages a large group of physicians, the quarterly updating process could be extremely time-consuming and difficult to manage. This is something we'd like to explore further with CAQH to see whether there are opportunities to streamline this process without compromising accuracy or security.

Although the marketplace has been moving in the direction of a central source, progress has been slow. To date, fewer than one million providers have put their information in the CAQH database. While that is an impressive number, it is still far short of where we might hope to be at this point.

We believe that one of the principle reasons the CAQH – or some other data repository – has not taken off – is Medicare's refusal to allow providers to use CAQH instead, and requiring their own enrollment process.

If Medicare and, to a lesser degree, Medicaid were to announce that in lieu of using the PECOS system, providers could put all of their information in the CAQH database – or some other certified database – we believe that providers would flock to some type of centralized system.

We believe that using such a system would save countless hours of time and money for the providers, dramatically reduce application errors which cost both the provider and payers money and make the system much more efficient.

We urge the NCVHS to recommend to the secretary that Medicare immediately begin discussions with CAQH or other equally reputable organizations with the goal of coordinating the Medicare enrollment process with the UPD database by the end of 2013. As noted earlier, Maryland has adopted this process and we see no reason why Medicare could not follow suit.