Healthcare Credentialing and Qualifications Commission: An Alternative to "Any Willing Provider"?

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Abstract

One of the most complicated and perplexing problems facing the evolving healthcare system is that of establishing a suitable balance between containing costs and safeguarding the quality and appropriateness of the delivery of healthcare services. Furthermore, the trust and confidence that are integral to the physician-patient relationship must be maintained. A delicate balance exists among the needs of patients, providers, purchasers, and reimbursement administrators. Of these constituencies, the provider plays a pivotal role in utilization decisions, patient motivation, and coordination of service delivery. The enhanced pressures of accountability, cost containment, and practice guidelines inherent under managed care require physicians to play the role of appropriateness advocates. As a result, provider credentialing has become one tool in the quality management domain for managed care organizations and their oversight bodies. At present, provider credentialing is often fraught with variation, redundancy, accuracy considerations, and, at times, adversity. We propose a "Qualified Credentialed Provider" standard that may help to address concerns of multiple constituencies through the establishment of a Healthcare Credentialing and Qualifications Commission. This commission may help to defuse politics about provider participation, while preserving the ability of managed care organizations to direct subscribers along appropriate care and referral pathways, contain costs, and promote quality and value in their healthcare products.

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America's $1 trillion healthcare marketplace continues to evolve rapidly, with no deceleration in sight. Providers, payers, and purchasers are seeking the most advantageous market position. Increasingly, employers bearing the majority of premium costs have become an important motivating force in defining direct benefits (*Nation's Business*. March 1995:16-21).[1] Preferred provider organizations (PPOs), independent physician associations (IPAs), health maintenance organizations (HMOs) and physician-hospital organizations are responding with health plans that offer greater flexibility and innovation in managed indemnity products. In addition, new organizational designs, in the form of integrated health networks, are forming in response to perceived community needs.[2,3] Every conceivable economic venture is under consideration, and many of the managed care plans currently available to subscribers are unlikely to resemble those that will be available even two years from now.

Under former indemnity and personal injury systems of insurance, healthcare plans competed for market share by offering a variety of benefits packages and provider choices. More recently, managed care plans flourished on the basis of cost containment and lower premiums. In order to maintain future competitiveness, organizations will have to emphasize healthcare delivery cost *and* quality simultaneously (*Nation's Business*. March 1995:16-21).[4,5]

At present, cost control is dependent on the ability of the managed care organization (MCO) to select a limited number of providers and to supply them with a substantial number of patients.[6,7] This strategy allows the MCO to "orient" providers to their healthcare benefit products and claims processes. Justification for the restriction of patient access to a limited panel of providers often is based on a presumption of benefit both to the MCO and to subscribers, primarily arising from the credentialing process. Theoretically, when provider selection criteria are

sufficiently stringent, the resulting network consists of indiviuals who are attuned to compliance with program requirements. At the same time, in either capitated or fee-for-service plans, increased patient volume is presumed to compensate for a lower rate than exists under traditional fee per service reimbursement.

Zalta[4] argues that credentialing affects both consumer utilization rates and quality of care favorably. It is evident from the trends in increasing enrolllment that healthcare purchasers agree. As HMOs compete on price, employer health costs in many firms are dropping, attracting increasing enrollments. However, few operational standards have been developed, and little data exist for assessing how consumer needs are defined and how well those needs are met. Following the collapse of federal efforts to institute major national healthcare reform, marketplace competition seems likely to become the arbitor in determining which managed care products survive. As the market matures, patients and consumer groups may have reason to fear potential harm to their health status resulting from restricted access to a broad panel of qualified providers.

Justifiably, the provider and pharmacy communities as a whole have perceived managed care enrollment trends as a significant threat to their professional independence and economic status. In response, a series of any willing provider (AWP) legislative efforts have been initiated around the country. The AWP regulations seek to enforce an open panel for participation by all providers, offsetting the risk to provider market access. In addition, plans' differing requirements have caused reporting and staffing burdens to rise, thereby increasing practice overhead costs. These higher costs have stimulated grassroots support for AWP efforts.

At the state level, some legislative efforts have succeeded in modifying the freedom of payers to define the constituency of their provider panels. Patient advocacy efforts seek to increase provider choice and the amount of consumer information on physician incentives and formularies (*New York Times*. October 31, 1995:A26). In Texas alone, at least seven initiatives were introduced during the 1995 state legislative session in an attempt to create AWP provisions. Five states enacted patient protection acts in 1995, bringing to 10 the number of states that have passed anti-HMO legislation (*Washington Post*. August 22, 1995: A4). New York's law mandates that HMOs offer "point-of-service" plans giving consumers' their choice of physician (*New York Times*. August 23, 1995: B5). Effective January 1995, health plans in Minnesota having more than 50,000 covered lives must offer "extended networks" that accept "all allied health practitioners" under conditions that the provider meets network credentialing requirements, accepts contract terms, and abides by managed care protocols set by the networks.[6] Similarly, in Maryland, all contracts to be in force after July 1, 1995, must include a point-of-service option[8]; this option allows patients to seek treatment from nonplan providers in exchange for a higher deductible.

AWP efforts such as the ones described here may be most popular in rural areas, in which access to healthcare already is limited.[6] Under pressure from consumer groups and organized medicine, Congress is considering "provider-sponsored networks" as a new option for Medicare enrollees, giving physicians limited antitrust protection to set prices and care standards (*New York Times*. October 3, 1995:A1, A6).

A problem with limited-selection processes is that confining a patient's access to providers who are plan members may disrupt continuity of care.[8] Narrowly gated provider panels may prohibit consumer access to other qualified professionals, who offer lower-cost care that also earns higher patient ratings.[9,10] Because many providers are restricted from joining particular managed care plans, their patients are forced to seek care from a plan provider member, interrupting established physician-patient relationships. In response, providers often seek to maintain as broad an accessibility for their patients as possible, by joining every managed care plan offered in their area.

Furthermore, because of lack of knowledge, inexperience, possible bias, or financial disincentives, gatekeepers may limit referrals of patients for appropriate services. Patient and provider frustration, as well as potential harm may result from errors in a gatekeeper's judgment. The Agency for Health Care Policy and Research (AHCPR) was created in the mid-1980s to critically assess and synthesize the scientific literature for the purpose of developing practice guidlines. The AHCPR's evidence-based, condition-specific guidelines focus on disorders commonly seen in primary care settings.

Credentialing may also limit provider access to managed care panels and seems to place unreasonable and arbitrary limitations on patient volume. Although a significant concern from the perspective of the provider, patients and plan administrators may be dissatisfied by this situation as well. Obviously, administrative inconveniences and provider discontent can negatively affect a patient's satisfaction with the care that he or she receives. Many administrators see a need for accommodation in the credentialing process that will align their providers, making them mem-

Table 1. Elements of Credentialing

Basic Elements of Credentialing	Additional Credentialing Requirements
Professional training	Maintenance of unrestricted licenses
Specialty board eligibility or certification	No history of disciplinary action
Current state license status	No unfavorable action by other PPOs, HMOs, MCOs, etc
Hospital/HMO privileges	Years in practice (weighted)
Malpractice insurance	No history of alcoholism or narcotic addiction
Record of continuing education	History of malpractice action adequately resolved
Social security number/TIN	Established professional liability coverage
Locations and telephone numbers of all offices	Established number of continuous years of clinical experience
Hours of operation	
Provisions for emergency care and backup	
In-office diagnosis capabilities	
In-office treatment capabilities	

HMO = health maintenance organization; TIN = taxpayer identification number; PPO = preferred provider organization; MCO = managed care organization

bers of the managed care team with a vested interest in the plan's success. Without a strong degree of provider satisfaction, the full potential of patient satisfaction is less likely to be obtained. The American Medical Association, recognizing the inevitability of the credentialing process, is insisting on stringent conditions to offset provider concerns, including the removal of threshold exclusions, identification of objective criteria based on professional competence and clinical performance, and the provision of due-process procedures for excluded physicians.[6]

However, the AWP concept undercuts a chief strategy of MCOs, that is, to supply a panel provider with substantial volume and to ensure more-than-minimum competence in provider performance. The managed care industry, flush with early success in containing costs and securing high corporate profitability, has reacted predictably, arguing that AWP will result in a return to higher premiums and higher administrative cost.[4,6,7] According to this argument, costs will rise from the need to deal with providers who are unfamiliar with or intolerant of the plan's treatment protocols. Plan administrators further predict a potential loss in quality-management control. They contend that, under AWP, providers who are unwilling to abide by the treatment protocols and algorithms, developed to reduce inappropriate care while enhancing quality, will force the MCO to operate in a state of constant turmoil. Such uncertainty causes purchasers to gamble on the preservation or enhancement of quality by managed care in exchange for savings in premiums.

Provider Selection Criteria

To capture a population of capable healthcare providers possessing characteristics conducive to quality management, some manner of credentialing is fundamental. Without proper credentialing, a healthcare organization will have little or no knowledge of the quality or acceptability of a physician. Knowledgeable, clinically mature physicians theoretically use fewer and more appropriate diagnostic tests and related services than do their less experienced colleagues. Although intellectually appealing, no scientific evidence supports the idea that it is possible to identify these physicians (as opposed to those who underutilize in response to the pressures of economic credentialing), or that restricting panel membership enhances quality.[5,11,12] According to a recent report by the General Accounting Office, research has failed to show that board certification, for example, results in better care.[5]

Elements and Benefits of a Standardized Approach to Provider Credentialing

Credentialing has significant implications with respect to quality of care and is the first step in standardizing a fair process in panel selection. However, the issue of credentialing may have legal meaning in a variety of situations.[13-15] The strong precedent set by the *Darling v Charleston Community Hospital* decisions, which suggests that it is logical and appropriate to apply the doctrine of corporate negligence to IPA-model HMOs and PPOs, is cited often. In plans that limit and restrict a patient's choice of provider, the managed care entity has the duty to properly review and investigate the credentials of provider applications. The process of selecting, credentialing, and recredentialing must be well documented within the records of the MCO. In addition, when the duty of credentialing is delegated to subcontractors (ie, specialty networks and hospitals), the chain of liability follows the path of delegation.[15]

Table 2. Benefits of Universal Credentialing to a Managed Care Network

· Assurance of participation in continuing education and voluntary competency testing
· Willingness to work within structured quality assurance and standards of care
· Demonstration of cost-efficiency even outside of formal quality assurance programs
· Interest in keeping current with professional literature

The basic elements of credentialing have been summarized by Krongstvedt[16] and are listed in Table 1. Credentialing should select for providers who can deliver the necessary care efficiently, communicate well interprofessionally, and are willing to comply with quality management processes. It is likely that some providers will disenroll voluntarily from the network for such reasons as discomfort with the idea of working within the confines of added administration and accountability requirements or difficulty accepting discounted reimbursement.

Table 2 identifies some benefits that a universal credentialing process might offer to a provider network. Credentialing may focus in part on targeted continuing education and may offer elements of voluntary competency testing. Credentialed practitioners are thought to be more amenable to using the critical literature as a source of contemporary information, implying a willingness to improve practice behavior as better information becomes available. Although this potential attribute may not occur by design, it is a favorable outcome of evidence-based healthcare delivery that can be of ongoing benefit to both patients and the network.

Table 3. Potential Qualifying Benchmarks

Higher education
Computer literacy and training
Understanding patient-satisfaction surveys
Commitment to clinical protocol development and use
Understanding quality assurance
TQM/CQI training
Communication skills and training
Interpersonal relation skills
Facility compliance with quality assurance regulations

TQM = total quality management; CQI = continuous quality improvement

Basic provider credentialing typically serves as a minimal screening tool, by itemizing and verifying attributes of legal and responsible practice (eg, graduation, licensure, and malpractice coverage). The next level, termed "qualifying," focuses on more specific needs of individual MCOs. Table 3 identifies optional qualifying benchmarks that allow the MCO or a healthcare purchaser (eg, insurance company or self-insured business) to offer more competitive plans to their subscribers. Although meeting credentialing requirements does not guarantee a provider panel membership, these standards help to ensure a more objective for such membership. It is reasonable to anticipate that the managed care marketplace increasingly will emphasize attributes of quality of healthcare delivery and customer/patient wants, including panel strength, diversity, and value of services provided.

Provider credentialing as a screening tool for participation in MCOs currently is perceived by providers as an administrative obstacle and, thus, can be a source of adversity.[17] In its present form, credentialing may be further limited by inaccuracies in existing, redundant, and variable databases.[18] However, if a credentialing standard can be adopted, it can be transferable from one organization to another. Providers and their organizations often seek and endorse certification and credentialing. Medical specialization, board certification, and advanced academic degrees are obvious examples of such credentials. Moreover, various components of credentialing have been characterized as building blocks for career advancement.[19-21]

Many of the criteria outlined in Table 1 may serve as indicators of provider quality. However, two criteria—continued professional advancement and economic credentialing—warrant elaboration.

Continued Professional Advancement: Willingness To Engage in Continuing Education, Practice Modification, and Scholarship. Ideally, continuing education should have an impact on the appropriate use of services. Targeted education is the preferred method of improving behavior in clinical decisionmaking processes. However, education alone usually is not sufficient. Adequate reinforcement and the role modeling of appropriate behaviors by professional opinion leaders and peers can be essential for acceptance by the greater provider community. The Harvard Community Health Plan exemplifies this practice by involving community-based attending physicians in the review, development, and dissemination of guidelines in order to create peer pressure and a commitment to change inappropriate practice behaviors.

Although most practitioners do not routinely do so, an even greater indicator of willingness to pursue excellence may be a provider's interest and willingness to engage in scholarship and research. In addition to ongoing learning, scholarly activity and publication in the refereed clinical and scientific literature subjects one to peer scrutiny and facilitates critical appraisal skills that may be extremely valuable in accountable and competitive practice settings.

Economic Credentialing. Economic credentialing is a method that MCOs and insurers use to assess a provider's cost efficiency. Its use is a source of concern to provider and consumer groups. Properly applied, review and contrast of provider-utilization profiles within a plan can be a valuable means of gving physicians feedback on how their practice patterns compare with those of their peers. Provided that a balance is maintained among cost effectiveness, appropriateness, high-quality service delivery, and patient satisfaction, this method may help to influence practice patterns and improve quality.

Economic performance also can be used to help to determine which physicians should be dropped from or added to a panel. However, an understanding of the quality, applicability, and generalizability of the data must be incorporated into provider assessment processes. Credentialing that is primarily cost-driven may serve as a disincentive to adequate and appropriate care. Although this approach may appear to afford short-term financial benefit, potential long-term effects, including the risk of future professional and institutional liability resulting from inadequate care, should not be ignored.

The Qualified Credentialed Provider Concept

How do we balance a community's needs for assurance with the issues of fairness in provider selection? Reconciling the concerns of the various constituencies within managed care while reducing many of the fear-based motivations inherent in current market strategies will benefit both patients and the healthcare system as a whole. The concept of a "qualified credentialed provider" can help to provide assurance to stakeholders involved in the delivery and quality oversight of managed care. Ideally, under this system, the resources of MCOs and providers can be better directed to the patient-centered and clinical appropiateness issues on which outcomes of care depend. For example, risk stratification, development of optimal treatment protocols, and establishment of critical care pathways might be more readily dealt with by these groups under such a system than is possible in the current state of turmoil over market share.

The National Committee on Quality Assurance (NCQA) currently imposes standards for credentialing processes on MCOs; however, most HMOs have not yet sought NCQA accreditation. Individual plans may have unique sets of provider credentialing criteria and variations in provider selection/deselection processes. Establishing minimum accreditation criteria for MCOs, used by all plans to accept or "qualify" providers within those plans, could help to eliminate some of the controversy surrounding AWP language. Adhering to an external standard of accreditation may decrease the administrative costs associated with following the plans' guidelines and treatment protocols. As an added advantage, reducing the "hassle factor" created by the existence of multiple credentialing exercises may lower both costs and aggravation.

Establishing a more universal accrediting process for credentialing procedures could help to address the needs of providers and MCOs. Providers who would be willing to obtain universal credentialing could have an enhanced opportunity to compete for panel memberships, thereby minimizing disruption in physician-patient relationships. The credentialing process also would serve as a form of targeted education, which would include an appreciation of evidence-based and outcome-oriented treatment protocols, interdisciplinary relationships, and quality-of-care attributes for the MCO. Providers could then be better informed about the benefits, requirements, and responsibilities of becoming a panel member.

Provider credentialing should be balanced among all disciplines and specialties. The criteria of selection should be proportionate to the types of provider resources available in the community and to patient demand for services. Provider representation commensurate with community needs and access to services can facilitate patient satisfaction and provide an environment for the efficient delivery of healthcare. Balancing provider specialties would ensure availablity and continuity of service in a timely manner, with reduced medical–legal risks to all parties involved in the process.

Proposal for a Healthcare Credentialing and Qualification Commission

As a seed for discussion, the central purpose of this paper is to propose a government or private consortial initiative to establish universal provider credentialing, with oversight at the federal level. This commision might be funded through existing agencies' appropriations or, if necessary, through a small fee levied on users of the credentialing process.

The commission should be broadly constituted, with providers from recognized health disciplines, hospital administrators, self-insured businesses, third-party payers, and patient advocates. For example, members could be appointed as follows. One fourth of the commission membership and one Public Health Service official would be appointed by elected government officials; the Senate would appoint one half of those members, and the House would appoint the other half, with the Public Health Service member being appointed by the President of the United States. The payer sector, the provider sector, and the private sector each would appoint one fourth of the remaining members. The commission might consist of no fewer than 21 members and no more than 29. Having an odd number of members would reduce the likelihood that political or self-serving interests would control an outcome that is in the public interest. The composition of California's Industrial Medical Council, within the Division of Workers' Compensation[22] provides an example of a model for the appointment process and duties to be performed.

Selection of providers through a standardized qualified credentialed provider process can be likened to Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) accreditation of healthcare facilities. However, credentialing in a managed care context differs from credentialing in an acute-care facility setting.[15] Several options are available for establishing an oversight body for provider credentialing (Table 4). The authoritative body, whether a federally established or governmentally approved organization, could serve to establish minimum quality-centered credentials for healthcare providers and their office facilities, as well as to determine enforcibility through a publicly accessible accreditation process.

If established legislatively, the commission's domain would be governed by the intent and scope of its enactment, prioritizing the needs of federal programs (eg, Health Care Financing Administration, US Department of Labor, or US Department of Defense). If it is a broad system developed and administered by private interests, but obtaining federal approval, it can provide oversight functions for practitioner and office credentialing to federal, state, and regional purchasing authorities, or their respective contractors. As an alternative application, the qualified credentailed provider commission also could be included as an expanded part of an existing accreditation system, such as the NCQA or the JCAHO.

The authority of the proposed commission to establish credentialing standards likely would depend on legislative intent; on authority given by federal or state regulation; or through program and policy development sequences involving a representative cross-section of providers, purchasers, and the consumer public. Enforcement of the standards could be subject to regulatory or accreditation authority, or some sort of contractual understanding of private sector players.

As envisioned here, the commission operating at the federal level would have oversight in the development and publication of quality-centered credentialing standards. Federal and state programs legislated to abide by these standards would then implement them through rule-making processes and would ensure appropriate regulation and enforce-

Table 4. Options for Authority of Commission

	Federally Legislated-Federally Administered (Regulatory or Advisory)	Privately Administered-Federally Approved (Advisory or Accrediting)	Administered as Part of Existing Accreditating Systems (Advisory or Accrediting)
Federal Purchasing	Separate commission as a part of existing agency (eg, HCFA, DOL, DOD, etc.)	Public commission serving Federal programs (eg, HCFA, DOL, DOD)	Separately administered accrediting commission (as a part of NCQA, JCAHO, etc.)
State Purchasing	Provides oversight to state authorities, including Medicaid and workers' comp	Oversight to state mediated purchasing, including workers' comp, employee benefits	Recognized by state agencies and other public purchasing authorities
Regional Purchasing	Provides oversight to regional purchasing authorities, including Medicare and Medicaid carriers	Oversight to public and private sector regional purchasing authorities	Accredits managed care organizations serving regional purchasing authorities

ment. Competitive managed care plans seeking accreditation could develop their networks on the basis of the standards and could apply to the commission for recognition of compliance. If the commission were to operate outside of a federal agency, it could serve advisory and accreditation functions in response to the needs of the market, with consideration given to input from stakeholders.

The credentialing standards developed by the commission should be designed as minimum attributes and competencies for quality-centered credentials, as listed in Tables 1 and 3. To meet needs unique to their market, MCOs would be free to apply additional criteria to select appropriate practitioner panels. Minimum attributes and competencies may change over time, as new demands or needs from public interests, the marketplace, or advances in technology are met. In fact, the commission might want to develop a standardized, tiered system of critera to meet basic elements of credentialing, components of qualifying, and/or other higher standards of training and experience.

At a minimum, the commission would:

- Establish the mechanisms necessary to accredit credentialing and qualifying programs submitted by application to the commission
- Review all applications submitted for accreditation of credentialing and qualifying programs
- Register credentialing and qualifying programs that have followed the established process
- Publish, at least annually, a listing of accredited programs
- Establish an appeals process leading to mediation and, as a last resort, binding arbitration, thus helping to alleviate tort liability and the continually escalating burden on the judicial system
- Prepare an annual budget, self-funded through such mechanisms as fees for review services
- Establish a fee structure for application review, consulting, accreditation, annual renewal, data retrieval, and other appropriate charges
- Maintain a database of all credentialed providers

As an appointed independent body, the commission should be free from self-serving market forces that may seek to discriminate against a specific class of provider, or to single out a particular MCO. Including patient advocates as members will serve the interests of the consumer. In addition, an independent body will circumvent the temptation to establish a financially driven or solely economic credentialing program. Financially focused criteria can offset the balance necessary to deliver an appropriate level of care.

Representatives of payers, providers, businesses, hospital administrators, and patient advocates would bring to the table their own unique perspectives, which each believes necessary to protect their respective groups' collective interests. Rather than any one group having a substantial leverage against another, this membership structure would help to maintain a level playing field. As a new initiative, monitoring of the commission's performance, with appropriate ongoing modification and revision of its criteria, should be incorporated into the design, thus increasing the credibility and usefulness of such a credentialing standard.

Conclusion

Society seeks better answers to complex questions that relate to healthcare resource allocation, decision-making, and patient–provider relations.[23] The managed care marketplace has become increasingly competitive, driving down premium prices in order to maintain market share. Competition for subscribers has contributed to an environment that promotes development of different plan benefits structures throughout a wide array of products, as a means of attracting premium-generated revenues.[24] Although administrative efficiencies have absorbed some of the cost cutting, reduced physician reimbursement has been a significant factor. Physicians find themselves caught between the need to be included on preferred provider lists in order to maintain patient flow and the need to maintain a profitable practice. With MCOs using witholds and year-end profit sharing as incentives for physicians to minimize resource use, a paradigm shift is occurring that requires a change in the way that physicians make clinical decisions.

Although these new market and economic pressures are a significant source of frustration for physicians, the spiraling cost of healthcare and excessive practice variation provide evidence that the healthcare system as a whole has been out of control. As a result, efforts at healthcare reform stimulated political and regulatory interventions and increased market competition. The evolving managed care environment is a response to these changes. However, for the system to work properly, all constituents must buy into accountability processess, quality management strategies, and new forms of clinical and administrative efficiencies.

The concept of a qualified credentialed provider may represent an opportunity to foster win-win partnerships with MCOs, payers and purchasers, provid-

ers, and patients working for common goals in the evolving healthcare delivery system. The formation of a Healthcare Credentialing and Qualifying Commission would help to ensure that providers have a more level playing field to compete for panel membership; purchasers, a representative set of resources for health plan subscribers; and patients, access to necessary services. This action also would enhance continuity of credentialing through various interorganization agreements, alliances, and future iterations of integrated networks. The qualified credentialed provider panel system also might enhance the capacity of an MCO to compete for subscribers on the basis of the quality of its provider panels.

A managed care credentialing process that is meaningful, understandable, standardized, transferable, and quality centered is overdue. In the absence of a clear design and a push at the national level, it is unlikely that any single private-sector plan or MCO will gravitate toward becoming such a standard. In this age of regulatory reform and of expectations that the government do more with less, such an initiative will have to be well thought out, developed carefully, and implemented collaboratively between the private and public sector. Although this proposal is just one small potential solution to an existing limitation of the managed care environment, the qualified credential provider concept could help to meet important needs of providers, purchasers, payers, and policymakers alike.

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