

# MARKET WATCH

## Physician Credentialing In A Consumer-Centric World

Consumers should not be penalized through higher premiums to support a process that no longer benefits them.

by **Derek van Amerongen**

**ABSTRACT:** As managed care responds to the rising tide of consumerism in medicine, it is necessary to reexamine the functions that health plans have performed. Chief among the activities that demand resources but return minimal value is the process of physician credentialing. As consumers are asked to assume more control in their health care decisions and to pay more for their care, the credentialing process must be changed if it is to add value for consumers. This paper discusses the role of credentialing and how it might be reconfigured to become more meaningful to consumers.

**T**HE STRATEGIES and tactics implemented by managed care plans in the early 1990s, many of them heavy-handed and intrusive, are becoming less relevant in the twenty-first century. Hastening this transformation is the advent of consumerism in medicine.<sup>1</sup> The increasing influence of the consumer is causing many health plans to reevaluate the rationale for many of the functions they currently perform. Some new products coming to market do not even use the labels “HMO” or “PPO.”<sup>2</sup> The issue is whether the plan is creating value and delivering it to stakeholders. Processes that do not return value divert resources from other activities that may be more likely to add value, thereby actually harming consumers.

We must examine the work we do in medicine in the context of how it supports or detracts from a consumer-centric model. Consumer-centric care delivers choice and control, as well as accountability and responsibility, to the consumer. This will lead to more

cost sharing by individuals as the system moves away from the traditional managed care mindset of care being “cheap,” as exemplified by copayments of \$10 for physician office visits and \$20 for brand-name drugs. As people are asked to pay more for their care, they will demand that the administrative services supporting that care be efficient and value-laden.

A routine and ubiquitous task of the managed care plan for the past decade has been credentialing of the plan’s panel of physicians. A redesign of how health plans operate might well start with this function. The purpose here is to identify the currents that led to the institutionalization of credentialing as a core competency of managed care plans, requiring large investments of time and dollars over the years. We must then ask what kind of credentialing process would best serve consumers.

### Credentialing In Managed Care

Managed care was thrust into the national consciousness following the 1992 presidential

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elections, when the cost of health care became a prime topic. In just two years, between 1992 and 1994, health maintenance organization (HMO) enrollment grew 23 percent, reaching 51.1 million.<sup>3</sup> The Clinton health plan had tight networks of physicians as its centerpiece. The original vision of a system of “managed competition” would feature parallel networks of providers who would compete on service, price, and quality. Selection of a provider network would be based on objective data. The transition from a chaotic, decentralized cottage industry to a coherent, outcomes-based system would result.<sup>4</sup> In this scenario, it would make sense to perform careful credentialing of physicians to ensure that only high-performing doctors were part of the tight network.

■ **Hospital credentialing.** In the early 1960s the landmark *Darling v. Charleston Hospital* case established the obligation of the hospital to perform a verification of the competency of the physicians who practice within its walls.<sup>5</sup> Previously, the hospital maintained that the attending physician was an independent contractor who was exempt from oversight. *Darling* changed this approach and set the stage for an organized, systematic review of all physicians who wished to practice in the inpatient setting. The verification and evaluation of a physician’s credentials then became the norm before inpatient privileges would be granted. The status of the hospital as an authority on physicians’ competence has diminished in recent years as the emphasis has shifted to ambulatory care. However, as I discuss below, this situation is amenable to change.

■ **The public weighs in.** Nevertheless, what works in the inpatient setting does not readily apply to other areas. While the concept of the selective panel may have appealed to health policy theorists and benefit managers, the public soundly rejected it, making its preference abundantly clear: Include as many physicians and hospitals as possible to offer maximum choice. The steady growth of the loose preferred provider organization (PPO) model is evidence of consumers’ ongoing fear of being locked into a restrictive environment that may prove deleterious in the event of a major health

crisis. In a marketplace that includes 95 percent of all physicians in all networks, credentialing loses its purpose as a tool to aid in selection of a doctor.

■ **Employers’ view.** Many employers have embraced accreditation of managed care plans as an objective method to validate the quality of care in the plans they offer.<sup>6</sup> Indeed, it was a collaboration of employers and health insurers that led to the formation of the National Committee for Quality Assurance (NCQA), now the most widely known accrediting organization for health plans. Its criteria have influenced how plans have functioned, just as the Joint Commission on Accreditation of Health-care Organizations (JCAHO) has influenced the nation’s hospitals.

■ **Value and redundancy.** The applicability of criteria more suited to inpatient than office-based care becomes problematic when we return to the question of how the credentialing process is supposed to generate value. It becomes clear that for the physician who is credentialed by a JCAHO-certified hospital, credentialing by the NCQA-certified health plan is redundant. It also adds nothing to the information the consumer needs to make an informed choice.

■ **Plans’ discretionary powers.** Regulations often impose a requirement for verification of physician status. However, for many states the obligation of the plans is left largely undefined. Ohio, for example, mandates that health plans’ quality assurance programs “include a process to credential, recredential and monitor participating providers and health care facilities to ensure the selection and retention of quality providers and health care facilities.”<sup>7</sup> This broad description avoids the overly prescriptive nature of the NCQA. There is ample room for a plan to design a process that most physicians would find less intrusive and expensive than the NCQA-prescribed one. Yet it would still permit the plan to build a program that delivers relevant, consumer-oriented information on its physicians.

■ **Less need for differentiated networks.** Credentialing has also been cast as a method for health plans to differentiate them-

selves in the marketplace. However, in a community where consumers and employers demand broad access to virtually all available physicians, it is impossible to create differentiated networks via a credentialing mechanism. If a health plan wants to include or exclude a physician or medical group, the most appropriate way is by selective contracting and rate negotiation. This highlights the disconnect between theory and practice. Benefit managers often demand tight, rigidly credentialed network offerings for their employees. They see these as high-quality provider networks capable of better outcomes and lower costs. Rarely do these results occur. More typically, employees overwhelmingly select the large, diverse networks regardless of the presumed differentiating characteristics of the small panels. Credentialing as a tool to provide consumer choice has been woefully inadequate.

### **Credentialing And Quality**

This leads to a key point: Credentialing is not tied to reimbursement. Having met the basic criteria, a physician is in the network and is typically reimbursed at the level calculated for his or her specialty. Quality, which is presumably such an important driver of the entire credentialing function, is irrelevant. A surgeon who is marginal is paid exactly the same for a given procedure as is a surgeon who is a renowned expert. This anomaly happens nowhere else in our economy. Moreover, if credentialing were a mechanism for identifying high-quality physicians, this would not occur.

The difficulty is that *quality* means different things to different people. The health plan may perceive a high-quality physician as one who adheres to best practices, who bills electronically, and who has high levels of patient satisfaction. An employer may feel that high quality is demonstrated by the physician's ability to reduce employee absences from work. The consumer's definition may revolve around short waiting times in the office, prompt return of phone calls, convenient office locations, and reasonable appointment availability. Among a physician's peers, high quality is often presumed to stand for good medical decision

making, few obvious errors of judgment or technique, and adherence to the normative behavior expected of a medical practitioner.<sup>8</sup>

■ **Overlapping definitions, less meaningful information.** The obvious conclusion of this exercise is that multiple overlapping definitions of *quality* exist. This vagueness has allowed the term to be applied in a loose and haphazard fashion. This also means that when health plans undertake to credential physicians, they are unable by definition to provide their customers with complete information. The data collected on the physicians and the criteria used to construct the provider networks are essentially two separate and parallel events. Although the rare physician may be excluded from participation because of information collected by the credentialing department (in 2001 Humana/ChoiceCare terminated only 7 of 1,749 primary care physicians in its panel), at the end of the day participation typically hinges on business, not medical, factors.

■ **Cost and burden.** The inability of credentialing to give consumers meaningful information to differentiate between physicians calls into question the entire value proposition of credentialing. For a health plan to complete a credentialing application for a physician may run from \$60 to \$100. Multiply this by the number of physicians in a panel who must be credentialed at least every three years per NCQA requirements, and it is clear that substantial resources are being devoted to this activity. The criteria derived from the inpatient setting render credentialing increasingly irrelevant in an ambulatory-focused medical care delivery system. If consumers want to know about the clinical track record of their doctor, which is the kind of data they are able to find about most other products and services, they cannot find it in the credentialing file. Where, then, is the value of this work, and how can we justify its burden on the system?

### **A More Active Role For Consumers**

As we move to a consumer-centric system, consumers will be asked to take a more active role in their health care. This role will include becoming better-informed purchasers and

taking greater responsibility for making wise choices. This does not mean that people must be transformed into physicians or be left to fend for themselves. It does mean that they will need to select their doctors on more objective criteria than in the past if they want to maximize the value of their health care spending. A list of what consumers might want to see follows, but it is by no means all-inclusive.

■ **Cost data.** What is the cost of a visit to the physician? How does this compare with that of a visit with other physicians in the same specialty? How does it vary by geography, hospital affiliation, and so forth? What are the additional costs for tests, procedures, and so forth? This information is available now and would be eye-opening for most consumers. For example, the California Medical Association estimates the true cost of a follow-up visit with a doctor at \$75, a far cry from the \$10–\$15 copay the consumer actually pays.<sup>9</sup>

■ **What services the physician actually provides.** When a plan member finds a physician's name in a directory, virtually the only insight into the type of services available is contained in the listing of that physician's specialty. This says little about whether a doctor has the competence or interest to treat various conditions. The ideal consumer-focused approach would detail what a physician can do and the evidence of his or her competence.

■ **Results of the physician's care.** Outcomes of treatment must be measured in terms that make sense to the consumer. The ability to gather this kind of information before seeking care will be as important to consumers as the research a prospective purchaser now does before buying a house or car. Rather than stating how many days one might be in the hospital, consumer-relevant indicators might be how soon one usually returns to work after treatment; the number of visits a doctor needs to resolve a common problem; the average blood sugar levels of the diabetics the doctor treats; and the volumes of procedures the doc-

tor performs.

■ **The physician's professional experience and background.** Much of these data are already being collected, particularly by state medical boards, and are online in some states. But consumers are usually unaware of their existence and how to obtain them.

■ **Information on the intangibles.** What about bedside manner, the accessibility of the physician and staff, the physician's philosophy of medical practice (aggressive versus conservative, interventional versus medical)? These demands are rising to the top of consumers' list of concerns as they find their out-of-pocket costs increasing and demand for value growing.

**“Health plans should function as a resource for consumers to do their own evaluations of physicians.”**

### Where Do We Go From Here?

To meet these needs, the current system of physician credentialing by health plans should be abandoned. In its place, health plans should function as a resource for consumers to do their own evaluations of physicians to the level they need and choose. Plans should verify that physicians who enter their panels are in fact licensed to practice, have no professional sanctions, and have the necessary business elements in place (such as insurance, a tax ID, and the infrastructure to communicate and bill electronically with the plan). Such information, basic as it is, would likely identify the vast majority of truly “dangerous” physicians who should not be practicing. Web links to the state medical board and the relevant local and national professional societies would permit the consumer to do more in-depth analysis of a physician. But the real opportunity to contrast and compare physicians will likely come from outside the managed care industry.

Health care needs to take a page from the financial services industry, which saw an explosion of informational resources for investors when 401(k) plans were established. The presence of objective third parties acting as resources and advisers has enabled the average person to assume control of his or her financial

planning, which was unthinkable a decade ago. Likewise, the medical industry is ripe for this kind of support service.

Such a change is already under way. Health plans, private vendors, professional societies, and others are engaged in creating and disseminating information to consumers to empower them to make educated care decisions. For example, in California, PacifiCare rates physician groups on a number of indicators and posts the scores on the Web. Empire Blue Cross and Blue Shield has compiled comparative data on New York hospitals (at [www.hospitaliq.net](http://www.hospitaliq.net)). Healthgrades.com offers free reports on hospitals and nursing homes; a recent news article profiles a consumer who acted on the information to travel to Louisiana from Maryland for care.<sup>10</sup> Primary care physicians in Cincinnati and Portland are profiled at [www.DoctorGuide.com](http://www.DoctorGuide.com). Some professional societies, such as the American College of Obstetricians and Gynecologists, recognize this opportunity and will help their members to set up Web sites.<sup>11</sup> These early efforts are relatively basic, but it is reasonable to expect that as consumers become increasingly aware of their existence, the richness of this information will evolve.

This might also have the interesting effect of reinvigorating the credentialing process performed by hospitals. Hospital review has typically centered on what a physician is capable of doing. The list of an attending physician's credentialed procedures should be part of the research done by the consumer searching for a specific treatment. In the near future, the hospital might reestablish itself as an evaluator of physician skill for the community. Hospitals' Web sites, with this information freely available, could be a key resource to answer questions consumers have about which doctor is right for them. It would offer information that no health plan could ever duplicate.

**T**HE BASIC PRINCIPLE is that consumers will seek out the information they want if they feel it is valuable. Given that the credentialing of physicians by health plans has become a value-negative burden to the system, consumers should not be penal-

ized through higher premiums to support a process that does not benefit them much. As the wave of consumerism in medicine continues to build, we must be ready to jettison the outmoded tasks that no longer help consumers but instead diminish the return on the resources they devote to health care.

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*These comments reflect the author's own opinions and not those of Humana, Inc.*

**NOTES**

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