

Delegated credentialing and physician performance reporting:

URAC's proposed revisions for health plan, health network standards answer market outsourcing trend and demands for measurement

In an increasingly competitive environment, health plans and health networks must bridge the dichotomy between the purchaser's desire for assurance about the quality and efficiency of practitioners with the health plan's burden to provide broad access to desirable providers. Regulatory interest in evaluating network tiering practices is also on the rise. This push-pull dynamic points to the relevance of an independent, multi-stakeholder entity such as URAC and its ability to balance operational capabilities with market and regulatory demands. URAC's proposed revised standards for Health Plan and Health Network accreditation offer clarity that organizations need in this rapidly changing arena.

Two important areas that have changed in the standards are delegated credentialing and physician performance reporting. The first is a revision to existing standards on a vital part of the core business for health plans and health networks: gathering and evaluating information about the quality of the network. The second, physician performance reporting, is a relatively new venture addressed with the creation of a new standards module.

Robust standards, external validation hallmarks of URAC accreditation

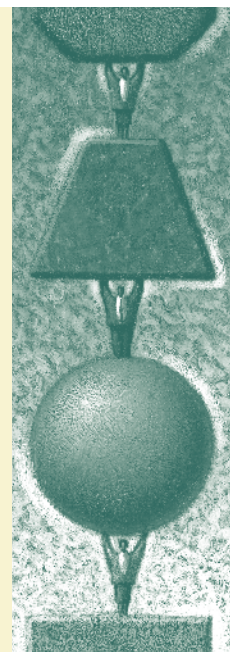
For the more than 3.5 million members of Horizon Blue Cross Blue Shield of New Jersey, access to quality providers is just one of the benefits they receive that enhances consumer protection and quality. Horizon serves both the commercial and Medicare populations, with about 35,000 unique practitioners

credentialed in either its managed or PPO networks. Horizon does about 90 percent of its credentialing internally.

"Many of the URAC standards are designed with consumer advocacy in mind," said Naim Munir, MD, Horizon's executive medical director for quality management and care management. "Some of these standards may seem unimportant to individuals, such as turnaround time to credential a new practitioner, or that an independent and impartial individual

Credentialing a cornerstone of health plan and health network quality

Credentialing is the process health plans, health networks and other health care provider organizations use to authenticate the education, training, licensure, board certification and practice history of practitioners before they become part of any health plan network. URAC defines practitioners as "an individual person who is licensed to deliver health care services without supervision." A highly qualified, robust network of providers is a cornerstone of health plan and health network business. Ongoing monitoring of credentialed providers assures consumers that patient safety is a key concern of the health plan or health network.



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—CHRISTINE LEYDEN, URAC’S CHIEF ACCREDITATION OFFICER

is looking at the nature of medical information we gather and process prior to making decisions. These safeguards are not immediately apparent to a member receiving care, but they are critically important to health plans. We can hold ourselves to a higher standard to ensure our members are receiving quality care.”

Munir said that URAC’s Health Plan and Health Network accreditations aid in ongoing efforts to meet and exceed state and federal credentialing requirements.

“An external benchmark, such as URAC accreditation, is another way we make sure we satisfy state and federal requirements. From an industry perspective URAC gives us guidance to ensure we are meeting those government standards. URAC Health Plan and Health Network credentialing standards are important. It is similar to seeking a second opinion that we are performing well.”

Munir said the standards bring rigor to the credentialing process. For

instance, Horizon has a “standing in the community” requirement that excludes practitioners from the network who have had an action taken on their license in the last five years by either a hospital or a managed care organization.

“That rigor is built into our credentialing standards, ensuring we’re providing a safe network for our membership,” he said. “And we put that same rigor into making sure that licenses are kept up to date. The standards are our check and balance—they institutionalize and formalize our quality aims in a policy format.”

Munir said day-to-day process improvement is a discipline he values in URAC accreditation.

What is delegated credentialing?

Most health plans and health networks still do the majority of credentialing in-house, although a growing number of organizations delegate credentialing by contracting with a qualified vendor to assist in the process. Vendors may be located either in the United States or abroad. According to both quantitative and qualitative research conducted by URAC in 2007, credentialing is among the top administrative functions currently outsourced by U.S.-based health care management organizations.

For this reason, URAC rolled out Credentialing Support Certification as its first vendor certification program directed to both the domestic and international markets. URAC’s certification program requires credentialing support companies to meet a discrete set of standards that focus on the non-clinical aspects of credentialing. URAC’s Credentialing Support Certification assures organizations which delegate credentialing to accredited vendors

that they are aligned with URAC’s quality standards.

URAC-accredited health plans and health networks are still responsible for oversight and final approval of all providers even when they delegate to outside vendors. And at least every three years, organizations delegating this process must conduct surveys of each entity that performs credentialing functions on their behalf. That survey doesn’t necessitate an on-site visit, but it does require that organizations pull files, evaluate quality controls, pay attention to complaints, ensure the credentialing vendor is compliant with HIPAA standards, and evaluate timeliness issues and contractually established quality service monitoring indicators.

“The standards require that the plan or network still is the party that renders the decision to allow the provider to participate in the network,” said Christine Leyden, URAC’s chief accreditation officer. “In addition, vendors have to meet URAC credentialing standards pertaining to verification of the provider’s credentialing information and HIPAA requirements. The delegated credentialing requirements ensure that plans and networks are still applying the same quality standards to their vendors’ credentialing process and keeping consumer protection top-of-mind.” Additionally, if the vendor is URAC certified the requirement for an onsite visit by the plan or network to review delegated credentialing files is waived because URAC is performing the physical onsite review of the vendor.

URAC’s standards also allow for more timely completion of credentialing when the practitioner has no infractions and meets the credentialing criteria established by the plan by permitting the medical director to approve these “clean credentialing

applications.” The medical director approval process requires documentation of a review of the credentialing information and sign-off. The “clean applications” do not require a formal committee review. However, the committee is expected to approve the policy and procedure delegating clean applications approval to the medical director.

“If there is verification that the provider meets all the criteria, that application can be approved by the organization’s medical director—it doesn’t need to be approved by the whole credentialing committee,” Leyden said. “That improves timeliness and ensures consumers have faster access to a quality network provider.”

New clarity for tiered networks: Physician performance reporting

Some of the hottest discussion in health care management today centers around the call for more information about provider cost and quality, and the most equitable way to measure and report that information.

Employers seeking value-based options in health benefit design saw their cause leap forward with the Bush administration’s Four Cornerstones campaign calling for transparency in both cost and quality data. The Four Cornerstones effort began with an executive order in August 2006 that called for all U.S. employers doing business with federal health entities to prioritize four criteria when they purchase health insurance: interoperable health care information technology; reporting of quality-of-care measures; reporting of health care price information; and incentives for high-quality, cost-effective care. The campaign charged forward with a \$600 million employer awareness effort led

by Health and Human Services Secretary Mike Leavitt in 2007.¹

Health plans took notice, with many collecting data to develop “tiered” provider networks reflecting their own proprietary criteria for what constitutes high-value providers, or otherwise providing public information on physician quality and cost. But lack of standardization in the provider profiling process, along with, in some cases, inadequate notice to providers about how data is collected and analyzed, introduced significant push-back from the provider community.²

The Oct. 29, 2007 settlement statement by New York Attorney General Andrew Cuomo set new parameters for the way health plans in that state can equitably measure and report physician performance and create tiered networks. The cause of action that led to the settlement statement has raised questions about ways health plans and health networks balance the purchaser’s desire for transparency against the need to equitably identify benchmark providers.

Accreditation—a tool to demonstrate transparency in provider performance measurement

The new standards module within the proposed revisions to URAC’s Health Plan and Health Network accreditation standards provides a means for accredited organizations to demonstrate to purchasers and regulators that there is transparency in their provider performance benchmarking process. The proposed standards address the call for transparency in health care from a broad base of stakeholders, including the Department of Health and Human Services’ Four Cornerstones for health care improvement, the Consumer-Patient Disclosure Project’s “Patient Charter for Physician Performance Measurement, Reporting and Tiering Program,” and the New York Attorney General’s voluntary “Agreement Concerning Physician Performance

Proposed standards clarify oversight requirement for delegated credentialing



URAC standards for delegated credentialing begin with the requirement that accredited organizations comply with the Core Standards for any credentialing functions it delegates to another entity. In addition, the standards require that an organization:

- ◆ Retains authority to make the final credentialing determination regarding any provider; and
- ◆ Conducts an onsite survey of each entity that performs credentialing functions on behalf of the organization, or requests that randomly selected credentialing files are sent to the organization within 24 hours of the request. This survey function must be completed at least once every three years.

SOURCE: URAC’s Proposed Health Plan Standards, version 6.1; and URAC’s Proposed Health Network Standards, version 6.1

Measurement, Reporting and Tiering Programs.”

The standards are for plans or networks that choose to publicly report provider performance benchmarking information, offering a way for organizations to demonstrate that there is transparency in their process.

“The proposed new standards meet a need in the marketplace for clarification, and that there is statistical validation and a process for the

provider to inquire about their specific information,” Leyden said. “These are requirements that really help promote transparency between the provider, the payer and the consumer.”

The proposed new guidelines for provider performance networks do not dictate what measures organizations must use, but instead promote existing measures that have been accepted by the provider community and are currently available. The changes also

demonstrate URAC’s support for the general principles put forward by the Consumer-Purchaser Disclosure Project in its Patient Charter for Physician Performance, Measurement and Tiering Programs. The Patient Charter is supported by leading consumer, labor and employer groups and aligns with URAC’s work over the past four years to enhance consumer education, safety and empowerment through its accreditation programs.³ ■

Footnotes

¹Gingrich, Newt and Galvin, Bob. “Four Cornerstones’ Will Transform Health,” 31 Jan. 07, http://www.forbes.com/opinions/2007/01/30/gingrich-healthcare-prescription-oped-cx_ng_0131gingrich.html 16 May 08.

²Carroll, John. “Early Tiered Networks Encounter Many Obstacles,” *Managed Care Magazine*, Oct. 2007, <http://www.managedcaremag.com/archives/0710/0710.narrownet.html> 12 May 2008.

³“Patient Charter” for Physician Performance Measurement, Reporting and Tiering Programs. 01 April 2008, <http://healthcareDisclosure.org/activities/charter/> 15 May 08.



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Dr Munir previously served as senior

medical director for UM operations at Horizon. His past experience includes senior leadership positions with Intergroup of Arizona, Prudential Healthcare and PacifiCare. In addition to his operational experience, Dr. Munir served for 10 years as a physician reviewer for the National Committee on Quality Assurance (NCQA) and was appointed to NCQA’s national oversight committee.

Dr. Munir graduated from Rush Medical College in Chicago and is a board-certified family physician. He practiced medicine in Phoenix where he was a partner in a large multispecialty group.