

Administrative Simplification Project

Case Study – Council for Affordable
Quality Healthcare (CAQH)

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Abstract

The Council for Affordable Quality Healthcare (CAQH) is a national alliance of health plans and networks working to simplify healthcare administration. To that end, CAQH has developed the Universal Credentialing DataSource® (UCD), an online tool designed to overcome the burdensome process of completing separate paper credentialing applications for each organization with which a provider contracts. This case study explores the goal of CAQH to reduce the time and effort associated with the traditional credentialing data collection process. Detailing how the UCD works, the study examines its attendant costs and benefits, the current level of adoption, and goals for wider dissemination.

The authors completed approximately 20 interviews of those who conceived, developed, use or are familiar with the UCD.¹ Among those interviewed are plan representatives, medical office administrators, and individuals who conduct the majority of medical credentialing and are familiar with the hospital market. While the provider office interviews do not form a representative sample, they do offer small snapshots of what are likely to be fairly typical experiences with both online and paper credentialing processes.²

The analysis focuses on the UCD as it relates to health plans and providers. The central role of health plans in the development and adoption of the UCD helped spur the diffusion of this system in a wide range of markets. The experiences of plans and providers with the UCD serve as a blueprint for adoption by other credentialing organizations, such as hospitals and Independent Practice Associations (IPAs).

Note: *The authors examined the development and early deployment of the UCD. This case study represents a snapshot in time and the information reported here is current as of October 2007.*

Background

Administrative costs are one of the fastest growing components of national health expenditures.³ Exacerbating these rising costs is the interaction of providers and multiple health plans, each with its own payment schedules, claims forms and credentialing requirements.

Credentialing is a process used to collect and verify the qualifications and practice history of physicians, chiropractors, podiatrists and other allied health care providers. The standards for credentialing are established by states, regulatory bodies, and accrediting organizations like the Joint Commission, NCQA, and URAC.

Health plans, hospitals and other healthcare organizations have unique credentialing requirements. Providers who become affiliated with these organizations must comply with the varying requirements. Information typically collected on credentialing applications includes education and training, specialties, certifications, malpractice insurance, practice locations, licensure history, DEA certification, and current medical staff appointments and clinical privileges. Related documentation (i.e. copies of state professional license) is required along with the application. (See Table 1)

Why is credentialing a burden? Physicians and other healthcare practitioners often participate in as many as 15-20 different health plans, each with its own credentialing application. These plans require not only initial credentialing, but also recredentialing of providers every three years. In addition, while providers are typically associated with fewer hospitals than plans, hospitals require similar input on a two year recredentialing cycle.

CAQH and Credentialing

CAQH, a not-for-profit national alliance of health plans, networks and trade associations, develops initiatives to simplify healthcare administration.⁴ Among its first goals – create a tool to simplify the administrative complexity associated with the credentialing application process.

CAQH was conceived by the leadership of major health plans. The organization's revenue is derived from membership dues and fees from its different initiatives. Its mission is to serve as a catalyst for industry collaboration on initiatives that simplify healthcare administration. The organization, working by committee, uses the momentum developed by a critical mass of member plans to accelerate action and help get to a “tipping point” on initiatives designed to benefit both member and non-member organizations, says Executive Director Robin Thomashauer. She explains that “CAQH continuously evaluates the business processes that link payers and providers in order to develop initiatives that will alleviate administrative burden and enable providers to concentrate on delivering patient care.”

The paper-based credentialing system presented an opportunity for significant change to a resource-intensive process that is a major source of frustration for providers. “Using technology to squeeze out inefficiency creates a win-win for payers and providers,” says Sorin Davis, CAQH director of business development and marketing.

Building on the early success of the online credentialing project, CAQH launched the Committee on Operating Rules for Information Exchange (CORE), which builds consensus and implements a set of operating rules to streamline eligibility and benefit data transactions.⁵

Table 1

Elements of Typical Credentialing Application

Demographics, Licenses and Other Identifiers

- Full name
- Date of birth, place of birth, gender
- Social security number
- Home address
- Medical license
- DEA registration
- State Controlled Substance Registration
- Medicare number
- Medicaid number
- UPIN/NPI

Education, Training and Specialties

- Professional education
- Undergraduate education
- Internship, residency, fellowship
- Primary specialty, secondary specialty
- Certifications
- Other Interests

Practice Details

- Credentialing, business, billing office contact information
- Practice general information
- Office hours
- Covering colleagues
- Phone coverage
- Practice limitations, age limitations, handicap accessibility
- Practice services

Billing and Remittance Information

Hospital Privileges

- Hospital contact information
- Admitting privilege

Professional Liability Insurance

- Carrier contact information
- Coverage

Work History and References

- Current & previous work history (past 10 years or since graduation)
- Gaps in work history (3 months or more)
- Military service
- Professional references

Disclosure Questions

- Limitations of suspension of privileges
- Suspension from government programs
- Malpractice Cancellation
- Felony conviction
- Drug & alcohol abuse
- Chronic or debilitating illness

Images of Supporting Documents

- Current Professional Liability Insurance Police Face Sheet
- DEA Registration
- ECFMG Certificate
- State Controlled Dangerous Substance Certificate
- State License Certificate
- W-9

A Unique Model: Health Plan Collaboration

The formation of CAQH and the subsequent development of the UCD represents a unique model for collaboration within a distinctly competitive industry. In a series of discussions during the late 1990s, health plan CEOs began exploring the most vexing administrative burdens providers face. Thomashauer describes these conversations as recognition by payers that “there were ways to work together to reduce the administrative complexity that had evolved over time.”

Born out of the payer community, the UCD was initiated in 2000, and is a tangible product supporting a broad vision to relieve administrative burdens and improve the payer-provider relationship.⁶ The timing for such a substantive initiative was ideal as public perception of managed care organizations and insurance

companies deteriorated,⁷ a fact that popular culture bore out with newspaper articles recounting insurance “horror stories” and movies such as “As Good As It Gets,” featuring payers as villains. Thomashauer notes that, “the organization was interested in creating opportunities to improve the relationships between payers and providers.”

The collaboration of competitors in the development, marketing, and implementation of the UCD is a story of strange bedfellows that can serve as a model for other healthcare simplification efforts.⁸ This was “a chance to showcase the health plan marketplace as a forum for solutions and demonstrate that good corporate citizens exist who are working to forward and enact positive change,” says Davis. Setting aside proprietary attitudes, health plans designed a workable solution to tackle administrative redundancy.⁹ The plans focused on the credentialing

process for several reasons: (1) Unique credentialing applications provided no competitive advantage and collaboration would not threaten individual business goals.¹⁰ (2) As a discrete issue, there was large potential to create national change that would build momentum and credibility for future efforts. (3) Improving credentialing practices could contribute to the time available for the delivery of patient care as office staff have more time to focus on clinical treatment.¹¹ (4) Accurate and timely information would expedite the credentialing process. Thus, the founders focused on an initiative that would not be “over reaching” but would nevertheless have a significant effect.¹² Kurt Small, Aetna’s head of strategic contract management, notes that initiating a dialogue between plans and achieving engagement from the beginning gave credibility to the issue. “When many points of view are vetted,” says Small, “you get a better end product.”

Those who conceived and developed the UCD believe that working collaboratively with key stakeholders – NCQA, URAC, JCAHO, NAMSS, AMA, ACP, AAFP, MGMA, CMS, state and local provider organizations, and state insurance departments – is a prominent feature of the project. Indeed, they view this collaboration as critical to its success. Jay Gellert, CEO of Health Net and CAQH Board member, relates that the health plans recognized collaboration as important because “simply mandating a change without input from all concerned can lead to unintended consequences.” Member health plans realized that efforts to create uniformity and efficiency requires broad consensus. In this respect, CAQH believes that the UCD will be most successful if it is embraced by all stakeholders associated with credentialing. Gellert recounts that “the reason we picked credentialing is because it was high on everyone’s list.”

Looking to the future, a challenge for CAQH as they continue to work toward wider dissemination of the UCD is to emphasize the goal of the plans to improve provider satisfaction. While the development of the UCD was designed to benefit both the payer and provider communities, the architects were the health plans – the entities seeking the information from providers. Given

the history of friction between these two groups, a perennial hesitation persists among providers, even though they acknowledge that paper credentialing applications are an administrative burden. The fundamental chicken/egg problem exists. As these groups proceed, they will need to keep their eye on the end product and focus on the benefits for all users. The reassuring news, however, is that as adoption continues to increase in the provider community, the credibility of the initiative continues to grow.

The Universal Credentialing DataSource®

The UCD is an online repository of self-reported provider information that eliminates the need for multiple credentialing applications.¹³ The database system is designed to allow providers to input and update credentialing information online and transmit credentialing information electronically to participating organizations. Recognizing that some providers may resist the electronic approach, CAQH also offers providers the option to complete a paper application.¹⁴ CAQH reviewed 40 different paper applications before developing one standard application.

The UCD is a system – like TurboTax is a system used to complete a standard 1040 form – that helps providers complete and submit a standard CAQH Provider

Application form, either online or via fax. The fax option of this process uses a 17-page paper application that includes more than 250 data points. The online option presents the same questions, but spreads the questions out over a number of different screens in an interview style. In states where there is a state-mandated application, CAQH has adjusted the interview screens of the UCD so that providers in those jurisdictions complete the appropriate state form, instead of the CAQH form.

CAQH serves as the middleman between the health plans and providers to facilitate use of the UCD. Health plans send a provider roster to CAQH, which sends out UCD registration kits to those listed, including a unique provider identification number. Providers, or their office staff, complete an online application in a secure, password-protected database, designating those organizations they wish to have access to the information. Health plans then go online and download the information necessary to credential a new provider or recredential an existing provider. In order to maintain the online information in a “current state of readiness,” providers are encouraged to update their data or attest that the information remains accurate every 120 days.¹⁵

Between the UCD launch in 2002 and the completion of this case study in October 2007, more than 360 organizations began using the online service and more than 515,000 providers registered from the 50 states and the District of Columbia.¹⁶ Approximately 12,000 new providers register each month. Health plans using the UCD pay an annual administrative fee of \$5,000 for the first year and \$3,000 every year thereafter, plus a per-provider-per year fee of \$4.50 for physicians, chiropractors, podiatrists and dentists, and \$3.50 for all other providers. The service is free to providers.

Online Credentialing In Practice

Technological change in the healthcare industry has been slow to diffuse. Even change that brings the promise of improvement can be arduous. The UCD, in concept, seems flawless and entirely logical.

Key Stakeholders

AAFP	American Academy of Family Physicians
ACP	American College of Physicians
AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MGMA	Medical Group Management Association
NAMSS	National Association Medical Staff Services
NCQA	National Committee for Quality Assurance
URAC	Utilization Review Accreditation Commission

In fact, the majority of people interviewed agree that an online system should reduce both costs and time spent on credentialing. However, the authors found that in practice, the efficiencies the UCD creates vary among offices and depend on a range of environmental and technical factors.

Proponents Outline Advantages of the UCD

The UCD Improves Efficiency

At Englewood Orthopedic Associates, a physician practice in suburban New Jersey with seven clinical staff, the move from paper to computer credentialing made sense. Ed Gulko, the administrator for Englewood introduced the UCD in an attempt to mitigate the complexity that naturally accompanies multiple applications for multiple providers. Why manually complete 15-20 paper credentialing applications, all with different deadlines, when the UCD offers an electronic one-stop option? The redundancy of the paper system created a source of frustration for Gulko, who exclaimed at one point during the interview that “paper credentialing is best described using every bad word you can think of.”¹⁷ The ability of the UCD to eliminate the redundancy of multiple applications has generated tangible savings for the practice. Gulko estimates that the UCD saves staff 250 hours per year on credentialing activities. The time that once was devoted to credentialing has been refocused to a wide range of other office projects. Gulko notes that with a streamlined, online system, office staff are able to turn around credentialing applications at “a much faster rate.”

Administrator Lucien Roberts and colleagues at Neurological Associates in Richmond, Virginia re-enforce the benefits the UCD provides. The office, with 15 physicians and two nurse practitioners, served as a beta site during the initial launch of the UCD. For Roberts, the time spent on completing paper applications is non-productive. “With the paper applications you are just sitting there filling page, after page, after page. A lot of the information [the different credentialing forms] are asking for is redundant.”

The UCD Improves the Content and Processing

The majority of health plan administrators and physician office staff interviewed report that the integrity and quality of their data is higher with a computer based system.¹⁸ Online data collection has dramatically improved problems associated with missing, illegible, incomplete, or inaccurate information. Phone calls and faxed corrections between health plans and providers have diminished.¹⁹

Perhaps the biggest process improvement is the ability of participating plans go online and access the credentialing information themselves. Mailing forms and waiting for their return is eliminated. Cathy Ferrara, manager of professional credentialing, Blue Cross Blue Shield of Michigan/Blue Care Network, reported that the UCD has reduced the number of contacts necessary to get a completed application from providers, which translated directly into saved postage, redirected staff time, and a reduction of “the hassle factor” that results from repeated calls or certified mailings from both plans and providers.

Because providers must submit credentialing and recredentialing information within a window of time in order for it to be considered valid, the online system helps eliminate the risk of receiving a termination notice from plans. Providers at Midwest Orthopaedics in Kansas, says Executive Director Barbara Sack, often waited weeks to receive the appropriate paperwork from health plans. Waiting is not only frustrating but expensive. Because medical offices cannot file claims for providers’ services until they are credentialed, timely processing is critical. Sack prefers the online system for its expediency. “I like [the] online [system] because the information is there and it can be accessed by payers, so you don’t have to rely on a paper form to get them the information. There is a big advantage, convenience wise, to having it online...We need even more standardization like the CAQH form,” says Sack. “The lack of standardization in healthcare drives up costs.”

The UCD’s administrative gains are evident in the recredentialing process. Health plans recredential providers every three years. Davis explains that the UCD was designed to be at “a constant state of readiness” meaning that if office staff are updating provider information every 120 days, they do not need to complete recredentialing forms any longer – participating plans already have access to all of the information that they need. For Debbie Miller, provider enrollment specialist at University Medical Associates in Kentucky, maintaining current information through updates every 120 days makes the recredentialing process easier. When the recredentialing cycle comes around, providers’ updated information is available online. For this reason, another user described the recredentialing process using the UCD as “a cinch.”

The UCD Saves Money

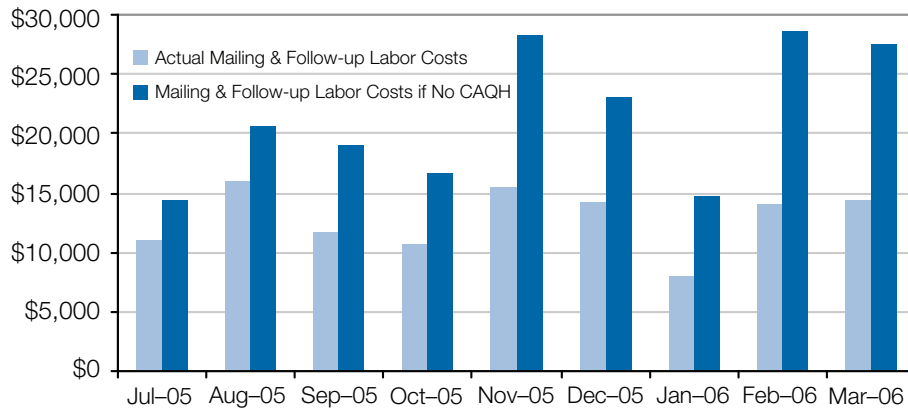
As the UCD creates efficiencies with administrative processes, it has also generated financial savings for health plans and providers. Interviewees reported saving money in the following ways:

- Reduced postage costs, including certified mail and other express services
- Reduced paper costs
- Reduced labor costs

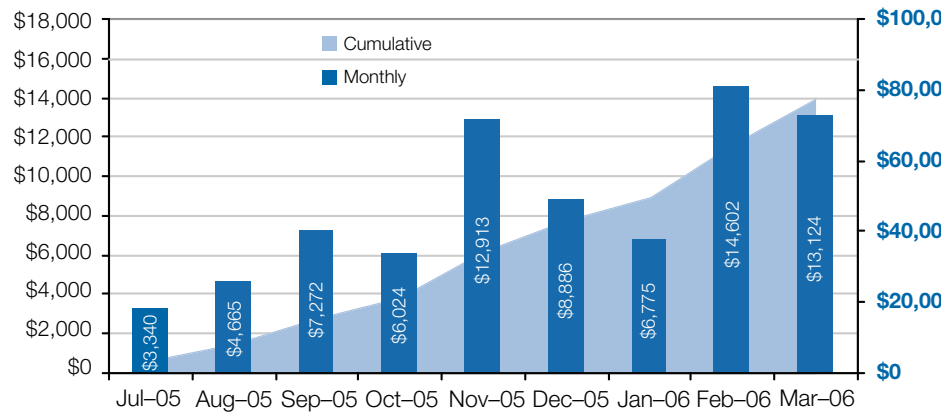
Kim Watson, credentialing manager for Anthem’s Blue Cross Blue Shield Central Region noted that in Ohio, Kentucky, and Indiana, the plan credentials or recredentials a total of 10,000-15,000 practitioners each year. In a paper-based system, the plan may send between one and four credentialing or re-credentialing packets to providers in order to get the necessary response. She estimates that with the advent of the UCD, 50 percent of Anthem’s credentialing-related mailings have been reduced and associated postage costs have been reduced by several thousand dollars. Providers, in turn, also have less mail to deal with in their offices.

Table 2

Mailing & Follow-up Labor Costs with and without CAQH



Mailing & Follow-up Labor Savings



According to Atul Pathiyal, former project director at CAQH, an electronic system not only saves mailing costs, but improves data integrity by reducing the incidence of mailing applications to wrong addresses. Great-West Healthcare, which adopted the UCD, reported that last year, their volume of returned mail was reduced by 85 percent. Since volume is a good indicator of data quality, Great-West attributes this change, and its attendant savings, to its adoption of the UCD.

At a recent CAQH Best Practices Conference, Barbara Riihimaki, assistant vice president, credentialing at CIGNA HealthCare reported that the number of CIGNA providers using the UCD has steadily increased since its roll-out in early 2005. CIGNA credentials approximately 220,000 providers, about half of which have completed the CAQH Provider Application. Over a one year period, CIGNA achieved a

\$24,000 savings in recredentialing mailing costs and a \$78,000 savings in labor costs associated with following up with non-responsive providers. (See Table 2)

While not all plans or provider offices we interviewed have calculated the specific financial savings achieved by using the UCD, the general consensus was that labor costs, printing, mailing, postage, fax and phone costs were reduced through the CAQH online credentialing system.²⁰

Critics Identify Limitations of the UCD

Homegrown Electronic Credentialing
Despite the support of the UCD by many users, the system is not without its critics. For some, there is simply a reticence to adopt change. This is particularly true for those physician offices that have created or invested in their own electronic processes and see the UCD as duplicative. For

example, Central Georgia Medical Care credentials and recredentials approximately 105 physicians. They have created their own online system that populates and re-populates credentialing information onto the Georgia credentialing form. Completing the Georgia form electronically only requires 20-30 minutes to complete a new physician application and 10 minutes to re-populate a recredentialing form. They view the two hours needed to complete the UCD for new physicians as an “unnecessary challenge.”²¹

Also, for some small or rural physician offices, an internet solution is simply not feasible. Finally, some skeptics simply balk at the need to change a system that they would argue is not broken.

Many Health Plans Not Using UCD

The number of health plans in this country underscores the logic behind CAQH’s ultimate goal of one uniform online application. However, despite the adoption of UCD by nearly every national plan, as well as by many regional and local plans, there are still more plans not using the UCD than those using it, with the unintended consequence of creating even greater complexity in some physician offices.

Initially, CAQH anticipated that all health plans would participate once a significant number of providers registered for the service. CAQH’s initial estimate of substantial provider registration was 18-36 months.²² However, despite eclipsing a half-million registered users, the health plan growth curve has been much longer than anticipated.²³ As a result, physician offices are still confronted with non-standardized paper forms for some plans, and a requirement to use the UCD for others.

A number of reasons account for the imbalanced uptake by health plans:

- Some plans delegate their credentialing to third parties.
- Some plans are focusing their efforts on more pressing issues.

- Some plans are interested and considering the change, but simply have not implemented the change.
- Work-flow changes take time and financial investment. Some plans are not convinced that the change makes sense unless all providers use the system. Because some providers are unwilling to use the system, stalemate ensues.
- Some plans are not interested in a new credentialing process unless it significantly improves their current process.

This dual system creates frustration. Debbie Miller with University Medical Associates handles credentialing for 92 internists who participate in approximately 30 plans. Of these 30 plans, only eight employ the UCD application. While Miller appreciates the ease of CAQH, she audibly sighed with exasperation when questioned about juggling online and paper-based systems. “It’s hard to keep track of which plans want UCD and which ones want other individual ones. Keeping track of who wants what is the difficult part,” she said.

“CAQH is fairly easy to use once the user has become familiar with it. The concept of a standard application, used by all parties, is a good idea if it truly would replace the use of many different applications,” says Sue Flanders, physician network coordinator for MaineGeneral Health. But not all plans require the UCD so physicians in the state are credentialed using the two systems.

The sentiment expressed by Miller and Flanders is representative of the office managers the authors interviewed.²⁴ While incremental change is generally the most palatable approach to restructuring the health care system, in the short term, transformation can increase rather than reduce administrative burdens. Unless and until all health plans participate in the UCD, providers will continue to use different forms and different processes for different payers.

Working Through System Irritations

New systems face inevitable technical difficulties. The general sentiment from users is that the system kinks have been improved over time, but some concerns remain. For example, some of the office administrators interviewed complain that at times, CAQH’s Web site can be very slow.²⁵ The length of time spent completing an application can negate some of the benefits of using the UCD. Proponents would argue, however, that the up to two hours is time well-spent. Once the work is done, the application is saved online, and designated health plans pull the information electronically.

Office managers articulated concern that there is no mechanism to know whether the application has been received by CAQH.²⁶ Some who use the system found the interface difficult.²⁷ Other providers fault CAQH for not having adequate staffing during call center hours,²⁸ an issue which has been addressed by the expansion of call center staffing. The lack of original or “wet” signatures can pose a problem for some organizations. Also, there is no consensus on whether the 120 day attestation requirement to keep information current represents an added hassle or convenience. The authors noted that some practices felt that this eased the recredentialing process, while others found this additional requirement to be aggravating, with one office manager confessing that he skips this step entirely. At this time, however, more than 80 percent of participating providers comply with this request.

It is rare that physicians themselves fill out credentialing forms. Since office staff generally fulfill this task, there is some conceivable risk that physicians in multiple practices lose security by passing along their personal information and password to multiple people. However, the authors did not encounter a specific example where this threatened provider security.

Additionally, there is a disconnect between regular data updates by providers and accessing updated data by providers.

Participating plans are advised through daily or weekly extracts or by looking at an online “activity log” that providers have updated their information. Plans may elect to access these updates on a regular basis or only at the time of recredentialing. Accordingly, plans may not be making internal updates to their own records unless they know that all or most of their providers using the UCD keep their data current. Conversely, providers may not sustain their upkeep activities unless they see that plans take advantage of the updates they provide.²⁹ This confusion exemplifies ways in which communication (electronic or personal) can be enhanced between CAQH, plans, and provider groups. CAQH recognizes this and is working with plans to expand their use of the UCD as a data source for operations outside of the credentialing department.

CAQH also continues to address these complaints by creating new iterations of the UCD. For example, CAQH deployed the fifth incarnation of its Provider Application to address specific stakeholder reactions to the form.³⁰ Other system changes that improve user friendliness and system responsiveness continue to be implemented.

Physicians Remain Unaware

The authors found that physicians, on the whole, are largely unaware and uninvolved in the credentialing process. Office staff report that the provision of UCD to providers has made little or no difference with increasing goodwill toward plans. Thomashauer recognizes that efforts in this area constitute a start rather than an end. “Relationships with providers did not go sour overnight and it would be naive to think that they will turn around overnight. The health plans have been working closely with the provider community to address their concerns and enhance their relationships,” says Thomashauer. “UCD supports that goal.”

Variation among the States

CAQH would like to see movement to a national credentialing standard as this presents the greatest opportunity for

simplification for providers and health plans alike. Currently, however, that uniformity does not exist.

- Most states do not, through legislation, require the use of a statewide credentialing application.
- Some states either mandate or recommend use of the standard CAQH Provider Application; these include: District of Columbia, Indiana, Kansas, Kentucky,³¹ Louisiana, Rhode Island, Tennessee, and Vermont.

In 2005, Indiana passed legislation specifying the CAQH Provider Application as the state's standardized credentialing form. No one testified in opposition to the legislation. According to Elizabeth Eichhorn, associate director of government relations for the Indiana State Medical Association, the physicians in the state were very interested in pursuing this online system. One Indiana physician laments that the local pizza parlors in the state are more computerized than many physician offices and urges the medical community to catch up with other technology-savvy industries.

- Other states have developed their own standardized credentialing form. In these states, the UCD system has been modified to conform to local widely-used applications. These states include: Arkansas, Colorado, Georgia, Illinois, Maryland, Massachusetts, Minnesota, Missouri, Mississippi, North Carolina, Nevada, Ohio, Oklahoma, Oregon, Texas, Washington, and West Virginia.

For example, Georgia has its own uniform credentialing application, which can be downloaded, completed, saved online and faxed or mailed to plans and hospitals.³² As plans in the state begin using the UCD, skeptics, while acknowledging the potential benefits of the UCD, still question the need to replace what works. One physician

association managing 55 physician practices uses the Georgia form and doubts the need to make a wholesale change to the current state form, which they find easy and familiar.³³ Nevertheless, in Georgia more than 13,600 providers have registered and are using the UCD system.

Ideally, CAQH would like all states with a mandated credentialing application to adopt the CAQH Provider Application as the statewide standard. While the UCD can support the standard CAQH Provider Application in states where no mandate exists, or any of the state-mandated forms, uniformity is the goal.

In sum, there are differing opinions on the need for states to mandate or even recommend any administrative solution. In fact, CAQH has seen some of its greatest success in states where no or minimal government involvement occurred, such as Connecticut, Michigan, and Virginia, in addition to areas where the state was very involved, such as Indiana and Kentucky.

Hospital Markets

Medical staff services, who handle hospital-based credentialing, face the same burdens of redundancy, cost, and time as health plans and physician office practices. Yet, hospitals remain largely outside the UCD process. Given its potential for reducing administrative complexity, why have hospitals not capitalized on the advantages the UCD system offers? Hospitals credential and grant privileges to their providers. The privileging process ensures that doctors have clinical competence, while credentialing documents physicians' practice history and medical certification. These separate activities require distinct sets of questions and documentation. For example, hospitals often require a full employment history from their physicians, while the CAQH form only asks for a recounting of the previous ten years.³⁴ Some interviewees suggested that because the current UCD does not serve all the credentialing and privileging needs of hospitals, they are reluctant to

use it. "CAQH is continuing to work with hospitals to develop a meaningful value proposition," says Thomashauer. The Joint Commission's recent statement that the CAQH application collects all of the information required by their 2007 Hospital Standards has reopened discussions with a number of hospitals.

CEOs of health plans, for whom the elimination of administrative burden resonates, oversaw the design and implementation of the UCD. Their engagement and vested interest was critical in keeping the transition to a new system on track and overcoming the inertia that sometimes prevents massive organizational change. However, hospital CEOs have not been similarly engaged. This leaves the impetus for wholesale change with hospitals' medical staff services departments, whose primary job is credentialing and who have had their own system and competencies for many years.

Some individuals familiar with the hospital credentialing process speculated that comfort with the status quo prevents hospitals from fully investigating the advantages of UCD. Sack articulated how major adjustments present a challenge to hospital culture, "Hospitals have their own way of doing things and they will change only when compelled to do something." According to Sack, a typical response from current medical staff services personnel is, "Why would I do something new, when I can do what I do now in my sleep?"³⁵ Greater communication between the CAQH and hospital staff could facilitate such a transition. Carol La Pine, president of the National Association of Medical Staff Services (NAMSS), sees the potential utility of UCD, provided that CAQH responds to concerns from medical service staff about the system. She states, "If hospitals can find a way to benefit from using the CAQH application, it could be a win-win for everyone."³⁶ While La Pine is impressed with the level of collaboration by health plans during the development of UCD, she believes that CAQH could benefit from collaboration with hospital organizations and in-depth discussion with medical services professionals

who are hospital-based. La Pine emphasized that NAMSS shares the collaborative vision that is at the heart of CAQH's endeavors. "NAMSS is committed to working with a variety of stakeholders to set consistent standards," she says.³⁷

Contrary to popular perception, hospitals' resistance to an online credentialing system is unlikely to stem from threat of job loss. La Pine points out that even with standardization of forms, there remains ample work for medical services staffs, including the verification of all information entered into any online form. Thus, credentialing departments within hospitals are an essential cost of doing business.³⁸

Finally, financial constraints could limit adoption of the UCD by hospitals. Institutions that are financially strapped may not be in a position to support the annual participation fee and per provider fee. In this area, CAQH has recently developed a hospital specific pricing model that allows local hospitals to band together under an administrative umbrella agreement and reduce their annual participation fees. The Vermont Hospital Association is currently reviewing this arrangement on behalf of its member hospitals.

Where Does the UCD Go from Here?

Financially, CAQH would like to see the UCD become a self-sustaining enterprise, with operating costs covered by those entities accessing the information. As of this writing, CAQH was nearly at break even, and as a nonprofit, the organization is committed to keeping the costs for participation low and fair, without charging the individual provider.

Practically, the leadership of CAQH would like to see the UCD become the ubiquitous, nationally-accepted standard for all entities which require providers to complete credentialing applications. Additional uses for the UCD may be more challenging to implement, but could serve to simplify even more administrative complexity. For example, CAQH has had discussions with the Centers for Medicare and Medicaid Services around the enrollment in Medicare³⁹ and

implementation of National Provider Identifier (NPI). The NPI, required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is a unique 10-digit number assigned to all healthcare providers. Until 2008, providers have the option of using the NPI in lieu of any legacy identifier when engaging in HIPAA-based electronic health care transactions. CAQH has made provisions for providers to report their NPI numbers in the UCD and has discussed with CMS whether there is an opportunity for coordination as providers apply the identifier.

In the meantime, CAQH is playing a more limited, but important role in the NPI implementation. Specifically, more than 200,000 providers had entered their NPI into the UCD. As more continue to do so, the UCD will be a valuable tool for health plans to make the notification process easier for providers.⁴⁰

While no groundswell is pushing the UCD to do too much too soon, some forward-looking health plans are increasingly looking beyond the credentialing function and are developing ways to take full advantage of the "data stream" features of the UCD. Great-West Healthcare uses an automated integration process to transmit the UCD application information to other business areas in the organization. The data are used to create physician directories, and update addresses for claims payments and other non-credentialing functions, which require current provider information.⁴¹ The ability to utilize provider-related data may become more relevant for plans as the demand for information from consumers increases.

While no specific plans to broaden the scope of the UCD to emergency preparedness exist as of this writing, CAQH is exploring the applicability of the UCD data for this purpose. In a disaster, identifying properly-credentialed first responders is essential. A repository like the UCD, which provides current information on the medical qualifications of clinical personnel, could serve as a critical public health resource.

Conclusion

The development and use of the UCD underscores the challenges that exist in trying to balance standardization with independent control and choice. Organizations like CAQH that seek to achieve administrative simplification need to recognize that effective system changes must take into account competing interests. The strengths and weaknesses of the UCD's development, adoption, and dissemination act as an allegory for many more difficult decisions that the nation will have to make around standardization. Achieving wholesale adoption of the UCD highlights the larger policy void that organizations like CAQH are operating in. Without broad policies in place to facilitate the transformation from large scale paper to computer-based systems, the emergence of dual systems and greater complexity during times of transition is inevitable. As information technology becomes more commonplace in the healthcare industry, policymakers must be mindful of the need for broad-based standards that address the needs of a variety of stakeholders.

CAQH is making a commendable effort to tackle a long-standing problem. They have engaged in a collaborative process and produced a tool that inarguably makes more sense than paper credentialing. Yet, the story of technology is the story of those who use it. Technologies like the UCD which promise to achieve greater efficiencies can be limited by the fact that these changes must be integrated into profoundly human and long-established systems. It would be a mistake to assume that technology can fix what are often system, rather than efficiency problems.

To date, for many providers, the UCD has lived up to its promise to dramatically reduce the administrative burdens associated with credentialing. Thanks to the persistence of those who understand the enormous burden of administrative complexity in today's health care system, the UCD is rapidly becoming the credentialing standard. But, the true promise of the online credentialing might be one of the next generations.

Those within the insurance industry that participated in CAQH's formation note that the UCD is only a beginning.⁴² According to Health Net's Jay Gellert, "the UCD is a first step, and the first step is an opportunity to do more."⁴³

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Endnotes

- 1 Interviewees included individuals from CAQH staff; four health plans; six provider practices; one state insurance department; and various other stakeholders, including medical societies and credentialing services.
- 2 The specific physician practices identified in the case study were selected with the assistance of the Medical Group Management Association. The authors drew from a list compiled by MGMA of members with varying levels of adoption and success with the UCD.
- 3 Catlin A. et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, Vol. 26, No. 1, January/February 2007; The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance*, The Commonwealth Fund, September 2006, pp. 26-27 (noting that "[a]s a percentage of national health expenditures, U.S. insurance administrative costs are more than three times the rates found in countries with the most integrated insurance systems."); K. Davis, *Making Health Care Affordable for All Americans*. Invited testimony before the Senate Committee on Health, Education, Labor and Pensions, Jan. 28, 2004.
- 4 Seven of the 12 CAQH staff work on credentialing. The organization subcontracts it database maintenance, imaging workflows, call centers, and other activities. Subcontracted activities are supported by 80-100 FTEs. For more information, see www.caqh.org
- 5 See <http://www.caqh.org/benefits.html>
- 6 Interview of Robin Thomashauer, Executive Director, CAQH
- 7 Harris Interactive Poll, June 2002. www.harrisinteractive.com
- 8 Interview of Sorin Davis, Director of Business Development and Marketing, CAQH
- 9 Interview of Kim Watson, Credentialing Manager, Anthem BC/BS Central Region
- 10 Ibid.
- 11 Interview of Jay Gellert, CEO, Health Net
- 12 Ibid.
- 13 While the case study focus on physician credentialing, the UCD can be used by other clinical and allied health professionals.
- 14 See online application system at <http://www.caqh.org/credapp/>
- 15 Cathy Ferrara, Blue Cross Blue Shield of Michigan/Blue Care Network reported that the UCD has reduced the volume of contacts necessary between providers and the plan. Processing paper-based credentialing applications involves multiple contacts, follow-up letters, faxing of requests and releases for information, and telephone calls. Moreover, multiple mailings and contacts are required to obtain completed recredentialing applications. In addition, multiple paper files need to be maintained and pulled as needed.
- 16 Currently, the states with the greatest penetration include Connecticut, Virginia, Indiana, Kentucky, Tennessee, Florida, Maine, Michigan New Hampshire, New York, and Ohio.
- 17 Interview of E. Gulko
- 18 Interview of Lucien Roberts, Administrator, Neurological Associates Inc.
- 19 Cathy Ferrara, Blue Cross Blue Shield of Michigan/Blue Care Network, reported that the UCD has reduced the number of contacts necessary to get a completed application from providers. Since June 2004, 14,972 providers have completed UCD applications out of approximately 28,800 in the plan.
- 20 Using a cost analysis from the Medical Group Management Association, CAQH estimates that the UCD is eliminating nearly \$56 million per year or more than 2 million hours of provider and support staff time required to complete paper applications.
- 21 Interview of Nancy Hilderbrand, Executive Director, Central Georgia Medical Care
- 22 Interview of Atul Pathiyal, former Project Director, CAQH
- 23 Ibid.
- 24 Barbara Sack, Executive Director, Midwest Orthopaedics, reported that of the 66 plans that their physicians are affiliated with only five use the UCD and for these five, its use is compulsory. "The online idea is a good one," says Sack. "I just wish everyone subscribed."
- 25 Interview of D. Miller
- 26 Interview of N. Hilderbrand
- 27 Interview of D. Miller
- 28 Interview of K. Watson
- 29 Kim Watson of Anthem BC/BS recounted that the "plans get a weekly roster from CAQH with changes to provider information to update claims systems, directories, etc."
- 30 Interview of A. Pathiyal
- 31 According to Robert Bronke, Certified Provider Credentialing Specialist – CAPS, a division of the Greater Louisville Medical Society, Kentucky's credentialing systems is complicated by the fact that Part A of the state-mandated form is the CAQH Provider Application. Part B is a standardized hospital credentialing form, which is not mandated by the state. See <http://doi.ppr.ky.gov/kentucky/Documents/Health/appeal.pdf>
- 32 See Georgia Uniform Healthcare Practitioner Credentialing Application Form at <http://www.georgiacredentialing.org>
- 33 Interview of N. Hilderbrand
- 34 Interview of Carol La Pine, President, National Association Medical Staff Services
- 35 Interview of B. Sack
- 36 While NAMSS has not endorsed the CAQH application, they have stated that it meets the credentialing elements they have developed in a white paper entitled "Credentialing Elements Task Force Position Paper." <http://www.namss.org/about/>
- 37 Interview of C. La Pine
- 38 Ibid.
- 39 For more information on current Medicare provider enrollment requirements, see <http://www.cms.hhs.gov/MedicareProviderSupEnroll/>
- 40 Trevor Stone with the American Academy of Family Physicians believes "it makes total sense to include the NPI number on the UCD application." He notes, "the NPI requirement is one that physicians will become aware of quickly when claims are rejected for lack of the identifier."
- 41 Interview of Kelly Toman, Credentialing Manager, Great-West Healthcare.
- 42 Interview of K. Watson
- 43 Interview of J. Gellert