



Delaware Center for
Health Innovation

Licensing and Credentialing Health Care Providers

August, 2016

I. INTRODUCTION

The Delaware Center for Health Innovation (DCHI) is working collaboratively with the State of Delaware Department of Health and Social Services (DHSS) to position Delaware as a “Learning State,” actively engaged in transforming our current health care workforce and training the next generation of the workforce to provide a coordinated, team-based approach to health care delivery.

DCHI initiatives to implement a statewide Health Care Workforce Learning and Re-Learning Curriculum and to recruit and retain a health care workforce reflective of Delaware’s future demographic needs are currently being developed and beta tested. A third, synergistic DCHI initiative involves streamlining the credentialing process for health care providers within the state. Coordinating and simplifying credentialing processes will facilitate more efficient on-boarding of health care personnel while simultaneously reducing system-wide administrative costs.

In this white paper, the Workforce and Education Committee summarizes the consensus of local stakeholders, as adopted by the DCHI Board of Directors, with respect to streamlining credentialing processes for health care providers. Specifically, we (1) address and provide a high level overview of the provider licensing process; (2) outline the rationale for consolidating health care credentialing processes; (3) summarize credentialing strategies utilized by peer states; and (4) recommend Delaware-specific guidelines for streamlining the health care credentialing processes.

Delaware Health Innovation Plan

Delaware aspires to be a national leader on each dimension of the Triple Aim: better health, improved health care quality and patient experience, and lower growth in per capita health care costs.

In 2013, the Delaware Health Care Commission (DHCC) convened stakeholders across the state – including consumers, providers, payers, community organizations, academic institutions and state agencies – to work together to build a strategy to achieve these goals. That work culminated in Delaware’s State Health Care Innovation Plan, representing Delaware’s road map for achieving broad aspirations for improved health, health care quality and experience, and affordability of health care for all Delawareans. In 2014, Delaware was awarded a four-year, \$35 million State Innovation Model (SIM) Testing Grant from the Center for Medicare and Medicaid Innovation (CMMI) to support implementation of the plan.

Combined with additional investments by purchasers, payers, and providers of care in Delaware, grant funds are intended to support changes in health care delivery to create more than \$1 billion in value through 2020.

The DCHI was established in the summer of 2014 to serve as a non-profit organization with the mission of achieving the vision outlined in Delaware's State Health Care Innovation Plan. Collectively, with the DHCC and the Delaware Health Information Network (DHIN), DCHI guides and tracks statewide progress related to the SIM grant.

The DCHI is led by a diverse Board of Directors representing Delaware's major providers, payers, state agencies, community organizations, and the business community. DCHI represents a partnership between the public and private sectors with a shared vision of providing all Delawareans with accessible, effective, and well-coordinated care in a way that supports the Triple Aim.

Our current health care system faces complex challenges requiring critically-needed reform measures. The DCHI recognizes this complexity and is structured accordingly; five DCHI committees address Delaware's priority areas of health care reform: (a) Clinical Care; (b) the statewide Healthy Neighborhoods Initiative; (c) Patient and Consumer Engagement; (d) Payment Model Monitoring; and (e) Workforce and Education.

The DCHI Workforce and Education Committee aims to (a) ensure that Delaware has the health workforce capacity needed to deliver team-based, integrated care for the entire population; (b) apply a forward-looking approach to health workforce planning, with an understanding of projected demographic shifts, market trends, and future patient and provider needs under an evolving delivery system; (c) identify barriers to practicing and accessing care in Delaware and design initiatives to reduce or eliminate their impact; and (d) ensure continuous improvement by sharing best practices.

II. PROVIDER LICENSING

As noted in the Introduction, one of the goals of this paper is to recommend Delaware-specific guidelines for streamlining health care credentialing processes. In order to provide a comprehensive analysis of credentialing, it is helpful to explain the provider licensing process in order to 1) distinguish between the two processes, and 2) identify ways in which the licensing process may impact and/or delay the hospital, insurance, or credentialing processes for providers. This section of the paper defines licensing, describes a statewide effort to streamline the licensing process, and addresses licensing-specific research and data collection efforts conducted to date.

Licensing is a process by which a governmental agency grants time-limited permission to a provider to practice in the health care occupation for which he or she has met standard criteria (including education, experience, and examination). Typically, licensing is performed at the state level; providers must be licensed in each state in which they practice. Additionally, providers must document their medical licensure when completing the credentialing process.

The Delaware Division of Professional Regulation (DPR) is charged with providing assistance to applicants seeking licensure throughout the licensure process, issuing and renewing licenses for qualified professionals and business entities, and maintaining a licensing database to provide the public with vital licensure information. DPR provides regulatory oversight for 34 Boards/Commissions in the form of administrative, fiscal, and investigative support for 54 professions, including health care providers.

Applicants can visit the DPR website at dpr.delaware.gov to learn more about the information and documentation required to ensure a complete licensure application package. Providers can then submit their licensure application package to their respective Board or Commission office for review. If an applicant fails to submit a complete application package, they will experience a delay in receiving their licensure. This delay directly impacts a provider's ability to get credentialed, and therefore bill for services provided, as verification and documentation of medical licensure is required by credentialing organizations. Please see *Appendix A* for a complete list of information required of providers registering with a standardized credentialing application tool as of the publication of this paper.

On April 20th, 2016 Governor Markell signed an executive order establishing a state Professional Licensing Review Committee. Building upon an effort first announced by the Governor in his 2016 State of the State address, the Committee will be made up of representatives from a variety of backgrounds including heads of executive agencies, members of the General Assembly, community advocates and members of Delaware's regulated professions.¹

The Committee is charged with conducting a comprehensive analysis of the composition, State oversight and licensing requirements of all commissions, boards and agencies that are regulated by the Delaware Division of Professional Regulation. After conducting its review, the Committee will issue a report to the Governor and the General Assembly by October 14, 2016. The report will include:

¹ *News.Delaware.Gov.* (2016, April 20). Retrieved from <http://news.delaware.gov/2016/04/20/governor-markell-creates-professional-regulatory-review-committee/>

- Recommendations for legislative or regulatory action that will remove any unnecessary or overly burdensome licensing or certification requirements;
- An examination of the relative burdens of licensing and certification requirements of regulated professions in Delaware as compared to those in neighboring states;
- Recommendations as to whether Delaware’s current system of professional regulation could or should be replaced by an alternative methodology; and
- Recommendations as to the process by which the State considers proposed regulatory or legislative changes that would either add a new profession to the list of regulated professions or increase the licensure or certification requirements for existing regulated professions.

The Workforce and Education Committee will monitor the progress of this group moving forward to determine any impact on licensing and credentialing processes for health care providers.

Finally, the Workforce and Education Committee did incorporate licensing processes into its research and data collection initiatives in order to better understand particular inefficiencies providers may experience. The Workforce and Education Committee developed a 25 question, online survey to compile feedback from a variety of stakeholders on the current licensing and credentialing processes in Delaware. Nine of these questions were licensing-specific and asked respondents to explain what the licensing process entails for them, estimate how long it takes to receive their licensure, and rate their satisfaction with the current licensing process. The Committee also conducted targeted, follow up interviews with providers to understand particular pain points in the licensing and credentialing processes in more detail. Please see Section VII for an identification of key findings the Committee developed specific to licensing.

Dental Licensing

Relative to other medical professions in Delaware, applicants interested in becoming a licensed dentist must complete a number of additional requirements prior to receiving their license. This section of the paper will briefly outline the licensing process for dentists and address how this lengthy process can serve as a barrier to entry for providers, thereby making the provider shortage and patient access to care issues even more pronounced.

Individuals interested in becoming a licensed dentist in Delaware must first document and verify they graduated from a dental college or university accredited by the Commission on Dental Accreditation (CODA) of the American Dental

Association. After completion of their graduate education applicants may sit for the following examinations, all of which are required in order to be considered for licensure:

- National Board Dental Examinations;
- Delaware Practical Board Examination; and
- Delaware Jurisprudence Examination.

Delaware is one of two states in the nation that does not use the services of a regional clinical testing agency. Applicants are thus required to sit for Delaware's state-specific examination. New York, the other state that does not use the services of a regional clinical testing agency, requires a doctoral degree in dentistry, plus completion of a clinically-based postdoctoral general practice or specialty dental residency program, of at least one year's duration, in a hospital or dental facility.

Applicants are also required to pass the Delaware Jurisprudence Examination, which is another post graduate education requirement providers in other states are not subject to. The Delaware Practical Board Examination is only offered twice a year, at the beginning of January and June. The Delaware Jurisprudence Examination is an open-book, multiple choice test based on the Delaware Code and the Board of Dentistry and Dental Hygiene's rules and regulations.

Additionally, applicants must also provide documentation verifying one of the following:

- Proof of one year of experience as a dental intern in a CODA-accredited general practice residency;
- Demonstrated experience of active practicing in another jurisdiction for three years; or
- Proof of four or more years of experience in a CODA-approved specialty residency.

These are other forms of post graduate education or practice experience that are not required across all states, but do ensure Delawareans receive high quality dental care. However, DCHI believes the Delaware Practical Board Examination is an unnecessary barrier to entry for providers interested in practicing in Delaware. Delaware can attempt to alleviate the current shortage of dentists across the State by following the lead of the other 48 states and use regional clinical testing agencies. This post graduate examination requirement, coupled with the additional residency or experience practicing in another state, will ensure only qualified applicants provide high quality dental care to Delaware health care consumers.

Dentist Shortage and Impact on Access to Care

According to the United States Department of Health and Human Services, Delaware has six dental care health professional shortage areas (HPSAs). These designations are used to identify areas and population groups that experience a shortage of health professionals. Federal regulations stipulate that, in order to be considered as having a shortage of providers, an area must have a population-to-provider ratio of a certain threshold. For dental care, the population to provider ratio must be at least 5,000 to 1 (4,000 to 1 if there are unusually high needs in the community).² This information indicates 47.11% of the need for dental care is met, and a total of 31 additional dentists would be needed to remove HPSA designation. By reducing barriers to entry such as the Delaware Practical Board Examination, Delaware could be in a position to attract more qualified candidates in an effort to alleviate the current shortage the State is experiencing with regard to dental care.

The aging population of Delaware's dental community also necessitates the removal of the Delaware Practical Board Examination from the dentist licensing process. The Delaware Division of Public Health's *Dentists in Delaware 2012* survey states nearly 45% of dentists statewide are 55 years of age or older. Just over 20% of dentists statewide are 65 years of age or older. Finally, back in 2012, survey results showed that about 18% of Delaware dentists will either not be practicing dentistry in five years or are unsure if they will be practicing.³ A decline in the number of practicing dentists statewide will only make it more difficult for Delawareans to find high quality dental care.

Behavioral and Mental Health Care Provider Licensing

As stated in the recent report published by the Delaware Behavioral and Mental Health Task Force, Delaware has seen a large number of rapidly occurring changes to its mental health hospitals, partial programs and community clinics over the past few years. These changes coincided with the implementation of the Affordable Care Act (ACA) and the expansion of integrated services, which in some cases, replaced traditional services. Additionally, a number of outpatient mental health facilities have closed in addition to the closure of all state funded mental health clinics. Unfortunately, the state's shortage of providers, the closure of public and private outpatient facilities, geographic constraints, and variable insurance coverage have left many Delawareans without options for mental health care.⁴

² <http://kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/>

³ <http://dhss.delaware.gov/dhss/dph/hsm/files/dentistsinde2012.pdf>

⁴ <http://legis.delaware.gov/legislature.nsf/FSMain?OpenFrameset&Frame=right&src=/LIS/TaskForces.nsf/TKWS>

The licensing process for a number of behavioral and mental health providers must also be analyzed when discussing the state's shortage of providers. This section of the paper will briefly outline the licensing process for psychologists, clinical social workers, and professional counselors of mental health and address how certain aspects of the processes can serve as a barrier to entry for providers, thereby making the provider shortage and patient access to care issues even more pronounced.

Licensing Process for Psychologists

Individuals interested in becoming a licensed psychologist in Delaware may apply via examination or reciprocity. Regardless of their path, all applicants must document they possess a doctoral degree from a psychological studies program specifically designed to train and prepare psychologists. This program must be accredited by the American Psychological Association (APA) or the Psychological Clinical Science Accreditation System (PCSAS). If the program is neither APA-accredited nor PCSAS-accredited then the applicant must send course descriptions to the Board of Examiners of Psychologists in order to evaluate the program. Additionally, applicants must document they have completed at least 1,500 hours of post-doctoral supervised experience.

Applicants are required to complete their application via examination if either of the following descriptions applies to them:

- They are not currently licensed in another state; or
- They are currently licensed in another state and all of the following statements are true:
 - They have not practiced continuously for at least two years;
 - They do not hold a Certificate of Professional Qualification in Psychology; and
 - They are not credentialed by the National Registry of Health Service Providers in Psychology (NRHSPP).⁵

The exam for Delaware Psychologists is the Examination for Professional Practice in Psychology (EPPP). If applicants have never passed the EPPP, the Board of Psychology must approve of their application prior to sitting for the examination. This implies that the 1,500 hours of post-doctoral supervised experience must be completed before sitting for the examination, a requirement which is not in place in neighboring states such as Pennsylvania and Maryland. If applicants passed the

⁵ <http://dpr.delaware.gov/boards/psychology/newlicense.shtml>

EPPP over five years ago, they must receive Board approval to sit for the examination again and re-take it.

Individuals may apply via reciprocity if they hold a current Psychologist license in another jurisdiction and comply with at least one of the following statements:

- They have practiced continuously for at least two years;
- They hold a Certificate of Professional Qualification in Psychology; or
- They are credentialed by the NRHSP. ⁶

Licensing Process for Clinical Social Workers

Individuals interested in becoming a licensed clinical social worker can apply via examination or reciprocity. Regardless of their path, all applicants must document completion of their Master's degree. Applicants must also clearly show the number of post-Masters of Social Work degree clinical social work hours completed, which must be a minimum of 3,200 hours. Applicants must also document their completion of 1,600 hours of professional supervised experience under the direction of a LCSW, MSW, licensed psychologist, or a licensed psychiatrist. ⁷

Applicants may apply via examination if they are requesting approval to take the national Association of Social Work Boards (ASWB) licensing examination or if they have already passed the ASWB licensing examination but do not hold a current clinical social work license in another jurisdiction.

Applicants may apply via reciprocity if they have already passed the ASWB licensing examination and also hold a current clinical social work license in another jurisdiction.

Licensing Process for Professional Counselors of Mental Health

Before filing an application, individuals interested in becoming a licensed professional counselor of mental health in Delaware must document they possess a current certification from the National Board for Certified Counselors (NBCC), Academy of Clinical Mental Health Counselors (ACMHC) or other certifying mental health organizations acceptable to the Board. If applicants do not hold a current certification they cannot qualify for Delaware licensure. Individuals can apply via certification or reciprocity. Applicants may apply via reciprocity if they

⁶ <http://dpr.delaware.gov/boards/psychology/reciprocity.shtml>

⁷ <http://dpr.delaware.gov/boards/socialworkers/newlicense.shtml>

hold a current Professional Counselor of Mental Health license in another jurisdiction, otherwise applicants must apply via certification.⁸

Individuals applying via certification must first document completion of a graduate degree. Applicants then must document completion of 30 post-Master's credit hours in the field of counseling. Applicants may substitute these credit hours for up to 1,600 of the 3,200 hours of post-Master's mental health counseling experience that are required. These 1,600 hours must be completed under the direct supervision of one or more approved clinical supervisors.

Individuals applying via reciprocity must submit copies of the other jurisdictions' licensing statute and rules and regulations for the Board to review. The Board will then determine if any of the other jurisdictions' statutes and rules and regulations are substantially similar to those of Delaware.

To conclude and summarize the analysis on behavioral and mental health provider licensing, DCHI believes the requirement for psychologists to complete 1,500 hours of post-doctoral supervised experience prior to sitting for the EPPP is an unnecessary barrier to entry for providers interested in practicing in Delaware. Delaware can attempt to alleviate the current shortage of behavioral and mental health providers across the State by removing this built in waiting period from the list of requirements for psychologist licensure. State Licensing Boards should also continue to make an effort to inform applicants on the status of their application. In the past, providers who had an outstanding issue on their application were never notified and believed their application is clean and complete. This lack of communication leads to unnecessary delays in the licensing process.

III. STREAMLINED CREDENTIALING PROCEDURES REQUIRED TO IMPROVE PROVIDER EFFICIENCY

The Burdensome Process of Traditional Credentialing Procedures

Currently, Delaware is experiencing health care capacity shortages. Multiple geographic areas within Delaware have been designated as HPSAs by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). HPSAs are defined for primary care, mental health, and dental health service areas. Within Delaware, the geographic boundaries of HPSAs may be small (e.g., individual census tracts) or large (e.g., entire counties). Additionally, a defined geographic area may represent more than one HPSA category (e.g., Kent County is identified as both a primary care HPSA and a dental health HPSA).

8

As the state seeks to increase its provider population within the areas of primary care, mental health, and dental health, it is necessary to facilitate the on-boarding of new providers and to maximize the ability of current and future primary care providers to deliver efficient and timely care. Furthermore, Delaware's current and future health workforce needs extend beyond the three service delivery areas considered by the HPSA designation system. Thus, coordinated statewide efforts to reduce and eliminate providers' barriers to practicing and ultimately delivering care will extend to all health care practice areas. The Workforce and Education Committee has identified the burdensome processes of credentialing as a key area for improving provider workflow.

Credentialing is defined as the process of objectively verifying and recognizing that a licensed/certified healthcare practitioner is currently qualified to practice his or her profession. The credentialing process takes into account a provider's training, experience, and competence in the health services field in which they are licensed. Typically, the credentialing process is required by organizations that will bill for, as well as reimburse for, the provider's services (i.e., hospitals, insurance companies, prepaid health plans, third party administrators, provider networks, and other health care entities).

Credentialing is an inherently complex process due to requirements surrounding primary source verification. **Primary source verification** collectively refers to procedures used by a credentialing entity, in accordance with standardized national- and/or state-level standards, to collect, verify and maintain the accuracy of documents and other credentialing information submitted on behalf of a health care provider seeking to be credentialed. Please see *Appendix A* complete list of information required of providers registering with a standardized credentialing application tool.

Providers must document in detail multiple categories of data elements to successfully complete a traditional credentialing application. These areas of data elements include, but are not limited to, the following: (a) demographics, licenses, and other identifiers; (b) education, training, and specialties; (c) practice details; (d) hospital privileges; (e) professional liability insurance; (f) work history and references; (g) disclosure questions; and (h) supporting documents. Provider recredentialing is typically required every two years (for hospitals) or three years (for payers) following initial credentialing.

The Council for Affordable Quality Healthcare (CAQH), a national non-profit alliance of health plans and networks, underscores the excessive burden associated with credentialing by noting that providers often participate in as many as 20 different health plans and are affiliated with several hospital systems, each with its

own credentialing application and cyclical recredentialing requirements. Compounding the burdensome process is the lag in technology adoption by health plans and hospital systems that often still rely on paper-based credentialing and recredentialing procedures.⁹

Within Delaware, unique credentialing requirements at the hospital-, payer-, and state licensing division-level create redundancy within the health care system and serve as an obstacle to overall system efficiency. Complexities surrounding provider networks, regulatory standards, and myriad health plans with variable payment schedules, credentialing requirements, and claim forms impede both provider on-boarding and workflow, negatively impacting access to care for Delawareans. On the provider side, the administrative burden associated with credentialing and recredentialing often falls to providers' office staff; in these instances, valuable resources are directed away from the practice, potentially stalemating other efforts to improve patient care quality. Additionally, administrative costs represent one of the fastest growing components of national health expenditures.¹⁰ Exacerbating both of these issues is the complicated and burdensome credentialing process for health care providers under the current system of care.

In an effort to reduce and/or eliminate practice barriers while simultaneously reducing the overall administrative costs of Delaware's health care system, the DCHI Workforce and Education Committee supports development of coordinated credentialing procedures for health care providers.

The Importance of Properly-Implemented Credentialing Reform Efforts

As Delaware explores opportunities to reform and streamline its credentialing processes, the importance of proper provider credentialing is gaining attention on the national legal landscape.

Within the past decade, several high-profile cases exemplify the impact of negligent credentialing claims on hospitals and health care organizations. For a healthcare organization to be held legally liable for negligent provider credentialing, the following four contentions must be demonstrated:¹¹

1. The organization had a legal duty to select and retain competent practitioners;

⁹ Austin, B., & Bosk, E. (2007). *Administrative Simplification Project: Case Study Council for Affordable Quality Healthcare*. Washington, D.C. : Academy Health.

¹⁰ Administrative Simplification Project

¹¹ <http://www.caqh.org/solutions/caqh-proviev-list-participating-organizations>

CNA HealthPro. (2009). *Medical Staff Credentialing: Eight Strategies for Safer Physician and Provider Privileging*. VP 09 .

2. In granting staff privileges to the practitioners, the organization failed to meet established standards of credentialing and privileging;
3. The practitioner was negligent in treating the patient and caused injury while practicing under the medical staff privileges that had been granted; and
4. The negligent granting of medical staff privileges caused or contributed to the plaintiff's injuries.

From a risk management viewpoint, credentialing organizations should use the following eight strategies to protect patients and reduce liability risk:

1. Identify red flags when reviewing applicants' history;
2. Thoroughly document initial findings regarding professional competence;
3. Implement a consistent, evidence-based evaluation program;
4. Collect performance data on an ongoing basis;
5. Establish and enforce evaluation parameters;
6. Provide adequate organizational resources for providers whose credentials are granted;
7. Understand the limits of peer review immunity; and
8. Ensure leadership oversight of the credentialing process.

Members of the DCHI Workforce and Education Committee recognize the importance of considering liability risk reduction as an integral component of future credentialing reform within the state.

IV. NATIONAL-LEVEL CREDENTIALING STANDARDS AND RECOMMENDATIONS

The Joint Commission and the National Center for Quality Assurance (NCQA) have independently developed credentialing standards to which credentialing organizations are required to adhere. Many states utilize third-party credentialing verification organizations (CVOs) to assist with conducting primary source verification, collecting resources, verifying clinical experiences, and related credentialing requirements. Every health organization that contracts with a CVO ultimately bears responsibility for alignment with Joint Commission and NCQA guidelines as they pertain to credentialing.

While the Joint Commission and NCQA credentialing requirements overlap in many key areas, slight differences exist between the two sets of standards. For brevity purposes, only NCQA guidelines are listed below. As Delaware works to streamline its credentialing processes, any new initiatives and improvements must align with both Joint Commission and NCQA credentialing standards.

NCQA Credentialing and Recredentialing standards encompass the following 12 areas of focus:¹²

1. Credentialing Policies
 - Does the organization have clearly defined and documented procedures for assessing its practitioners' qualifications and practice history?
 - Does the organization identify which types of practitioners must be credentialed?
 - Does the organization have policies and procedures that define practitioner rights to review and correct credentialing information?
2. Credentialing Committee
 - Has the organization designated a committee to make recommendations regarding decisions about practitioners' credentials?
3. Initial Credentialing Verification
 - Prior to allowing network participation, does the organization verify practitioners' credentials, including a valid license to practice medicine, education and training, malpractice history and work history within the timeframes specified within NCQA standards and guidelines?
4. Application and Attestation
 - Do practitioners' applications to the organization include a current and signed attestation about why they cannot perform certain tasks, a history of loss of medical license and felony convictions, a history of limitation of privileges or disciplinary actions and current malpractice insurance coverage?
5. Initial Sanction Information
 - Before making a decision on a practitioner's qualifications, does the organization receive and review information from third parties, such as information about any disciplinary actions?
6. Practitioner Office Site Quality
 - Does the plan verify through an onsite visit, after reaching a member complaint threshold, the quality of all practitioners' offices?
 - Does the plan take necessary steps when an office does not meet its standards, and does it evaluate those steps regularly until the office improves?

¹² National Center for Quality Assurance. (2015). *CR Standards & Guidelines*. Retrieved October 14, 2015, from <http://www.ncqa.org/tabid/404/Default.aspx>

7. Recredentialing Verification

- Does the organization reevaluate practitioners' qualifications every 36 months?
- Before reevaluating its decision on a practitioner's qualifications, does the organization receive information from third parties, such as information about disciplinary actions?

7. Recredentialing Cycle Length

- Does the organization reevaluate practitioners' qualifications every 36 months?

8. Ongoing Monitoring

- Between recredentialing cycles, does the organization conduct ongoing monitoring of practitioner sanctions, complaints and quality issues?
- Does the organization take appropriate action when issues are identified?

9. Notification to Authorities and Practitioner Appeal Rights

- Does the organization have a process for discontinuing the contracts of practitioners who demonstrate poor performance?
- Is there a process in place by which the practitioner can appeal the organization's decision?
- Does the organization report to appropriate authorities when it suspends or terminates practitioners?

10. Assessment of Organizational Providers

- Does the organization confirm that hospitals, home health care agencies, skilled nursing facilities, nursing homes and behavioral health facilities are in good standing with state and federal agencies and accrediting organizations?
- Does the organization re-review these standings at least every three years?

11. Delegation of Credentialing

- If the organization delegates to a third party decisions on evaluating or reevaluating a provider's qualifications, is the decision-making process—including the responsibilities of the organization and delegated party—clearly documented?
- Does the organization evaluate and approve the delegated party's plan on a regular basis?

V. NATIONAL-LEVEL EFFORTS TO REDUCE THE ADMINISTRATIVE BURDEN ASSOCIATED WITH PROVIDER CREDENTIALING

The Council for Affordable Quality Healthcare (CAQH) / ProView electronic credentialing resource

In 2002, the Council for Affordable Quality Healthcare (CAQH), initiated ProView (formerly known as the Universal Provider DataSource). ProView represents an online tool borne out of the collective frustration of major national health plans, networks, and trade associations surrounding the traditional provider credentialing process. ProView aims to capitalize on technology to expedite the credentialing process, maximize provider data quality and accuracy, and improve patient care.

Briefly, ProView serves as an online repository of self-reported provider data. Providers (or their office staff) enter and update credentialing and recredentialing data, making it available in real-time to participating payers, hospitals, large provider groups, and health systems. The process of on-boarding a new physician into the ProView database is initiated when a health plan contacts CAQH with a provider roster; in turn, CAQH sends ProView registration kits to the listed providers along with a unique provider identification number. Providers complete the online application, designating which health plans they wish to have access to the data. Participating organizations pay an annual administrative fees to maintain access to ProView data (the service is free for providers).

Proponents of ProView cite wide-ranging benefits stemming from its inception, including reduced paper costs, reduced labor costs, redirected staff time, improved data accuracy, and expedited claims processing and adjudication. In 2007, a major national health plan estimated that participation in ProView resulted in an annual savings of \$24,000 in recredentialing mailing costs and \$78,000 savings in labor costs associated with contacting non-responsive providers.¹³

Several states have enacted legislation mandating use of the standardized ProView credentialing application for all credentialing organizations operating within state borders; other states have developed their own standardized credentialing form using CAQH and ProView as a preferred model. To date, ProView effectively

¹³ Austin, B., & Bosk, E. (2007). *Administrative Simplification Project: Case Study Council for Affordable Quality Healthcare*. Washington, D.C. : Academy Health.

streamlines the credentialing process for more than 1.3 million providers and nearly 800 participating health plans, provider groups, and hospitals.¹⁴

However, many states have not yet enacted legislation mandating the use of ProView and the CAQH credentialing application. Likewise, not every U.S. health organization participates in the ProView initiative; thus, providers are still responsible for completing traditional credentialing procedures for health plans, provider groups, and hospitals unaffiliated with ProView. The full potential of ProView to alleviate the burdens associated with traditional provider credentialing procedures will not be realized until all states and health plans participate in a single universal standardized credentialing application.¹⁵

Multiple credentialing agencies within Delaware currently partner with CAQH for credentialing purposes. However, Delaware has not yet enacted legislation mandating credentialing organizations' participation in the CAQH/ProView application.

VI. PEER STATE STRATEGIES TO STREAMLINE CREDENTIALING PROCEDURES

Several peer states already have implemented legislation aimed at addressing glaring inefficiencies in traditional credentialing procedures. In general, these initiatives fall under two main categories: (a) legislatively mandating utilization of the CAQH standardized credentialing application (via ProView) or (b) legislatively mandating utilization of a non-CAQH standardized credentialing application (typically via another electronic database). These two categories are briefly explained in further detail below.

States that do not fall into either of these categories represent a third grouping that have not yet adopted a statewide mandate to utilize a standardized credentialing application for its providers.

States with legislated mandated use of the CAQH standardized credentialing application

As previously mentioned, several states have enacted legislation mandating use of the CAQH ProView standardized credentialing application. West Virginia is one example of states falling under this category of credentialing reform.

¹⁴ CAQH. (2015, October 31). *CAQH ProView List of Participating Organizations*. Retrieved from Council for Affordable Quality Healthcare (CAQH): <http://www.caqh.org/solutions/caqh-proview-list-participating-organizations>

¹⁵ Austin, B., & Bosk, E. (2007). *Administrative Simplification Project: Case Study Council for Affordable Quality Healthcare*. Washington, D.C. : Academy Health.

In 2001, West Virginia passed state legislation enacting the Uniform Credentialing Advisory Committee (UCAC). Fourteen committee appointments are made by the West Virginia Secretary of the Department of Health and Human Resources and the West Virginia Insurance Commissioner. UCAC members represent hospitals, other health care facilities, health care practitioners, indemnity health care insurers, preferred provider organizations, health maintenance organizations, third party administrators, and the NCQA. Committee terms are three years in length and committee members may serve an unlimited number of terms.

Following its establishment, the UCAC developed a statewide uniform credentialing process as well as uniform credentialing forms used by all West Virginia providers. In 2009, the West Virginia UCAC facilitated state contracting with CAQH and its ProView application for credentialing data collection, storage, and analysis. Through legislation, West Virginia also mandated that all credentialing entities (other than health care facilities, such as hospitals) must issue a credentialing decision within 60 days of receiving a completed report from the third-party credentialing verification organization.¹⁶

Since 2005, Indiana, Kansas, Kentucky, Louisiana, Maryland, Montana, New Jersey, Ohio, Rhode Island, Tennessee, Vermont, and the District of Columbia have also followed suit, passing state legislation mandating universal use of the CAQH standardized credentialing application.

States with legislated mandated use of a Non-CAQH standardized credentialing application

Oregon: In 1999, Oregon House Bill 21444 established the Advisory Committee on Physician Credentialing Information (ACPCI), housed within the Office for Oregon Health Plan Policy and Research. The ACPCI successfully reviewed myriad credentialing applications within the state and developed the Oregon Practitioner Credentialing Application, a universal credentialing application specific to Oregon's health care needs and in line with NCQA credentialing standards. While development of a common credentialing application represented the first step in reducing the burdensome process of traditional credentialing in Oregon, it did not limit the number of data storage systems and data collection processes used to capture and verify provider credentialing data.

¹⁶ West Virginia Code. (2015). *Chapter 16. Public Health Article 1A. Uniform Credentialing for Health Care Practitioners*. Retrieved from <http://www.legis.state.wv.us/WVCODE/ChapterEntire.cfm?chap=16&art=1A>

Therefore, in 2013, Oregon state legislation required the Oregon Health Authority to convene the Common Credentialing Advisory Group (CCAG) to establish an in-house, shared electronic database to consolidate credentialing procedures. The CCAG meets monthly and is comprised of committee members representing credentialing organizations, health care providers, and health care regulatory boards. Collectively, the CCAG works with the Oregon Health Authority to evaluate implementation progress of the consolidated credentialing database and make any necessary recommendations for revision.¹⁷

Via the shared database (scheduled for full implementation in 2017), credentialing information must be accessible to health care practitioners, credentialing organizations, and health care regulatory boards at all times. Similar to states who have adopted the CAQH standardized application, credentialing organizations are not permitted to request credentialing information from health care providers if that information already exists within the consolidated credentialing database. Every 120 days, Oregon health care providers must attest to the credentialing information in the database.

While the database is capable of verifying multiple portions of credentialing information, each credentialing organization will continue to partially complete its own primary source verification procedures (including peer references). Each individual credentialing organization will be responsible for making the ultimate decision as to whether to credential or recredential an applicant. Similar to the CAQH ProView system, credentialing organizations will pay a fee to gain access to the credentialing database.¹⁸

Washington: Using a strategy similar to Oregon, the Washington State Legislature passed Senate Bill 5346 in 2009 mandating that the Insurance Commissioner appoint a third-party, private sector organization to select and implement a statewide provider database for credentialing purposes.¹⁹ OneHealthPort, the third-party, private sector organization appointed by the Insurance Commissioner, selected Medversant as the vendor to oversee credentialing data collection, analysis, and storage. Washington utilizes ProviderSource, the electronic application developed by Medservant, for these

¹⁷ 77th Oregon Legislative Assembly. (2013). *Senate Bill 604 B: Relating to Credentialing of Health Care Practitioners*. Retrieved from

<https://olis.leg.state.or.us/liz/2013R1/Downloads/MeasureDocument/SB604/Enrolled>

¹⁸ Oregon Health Authority. (2015). *Frequently Asked Questions: Credentialing Organizations*. Retrieved October 13, 2015, from Oregon Common Credentialing Program:

<http://www.oregon.gov/oha/OHPR/occp/Pages/FAQ-Organizations.aspx>

¹⁹ State of Washington 61st Legislature. (2009). *Senate Bill 5346*. Retrieved from

<http://www.onehealthport.com/sites/default/files/pdf/5346-S2.PL.pdf>

purposes. ProviderSource is capable of performing a multitude of credentialing-related functions, including the following:

- Conducting state and national background checks;
- Ensuring applicants meet all educational, clinical and profession-specific requirements;
- Assessing each application for military training and experience;
- Coordinating with state agencies, boards and commissions and secretary-regulated programs; and
- Providing technical assistance to the public, providers, and credentialing organizations.

VII. QUALITATIVE DATA COLLECTION VIA PROVIDER SURVEY AND KEY INFORMANT INTERVIEWS

In addition to the extensive literature review addressed above, the DCHI Workforce and Education Committee collected data on current licensing and credentialing standards and evidence-based credentialing improvement initiatives using two more strategies: (1) an electronic provider survey and (2) qualitative data collection via key informant interviews to gather information about Delaware's current licensing and credentialing processes. Findings from these two data collection strategies are discussed below.

With respect to key informant interviews, committee members posed the following qualitative, open-ended questions to stakeholders, including the State of Delaware, Delaware Department of Insurance (DOI), DPR, Delaware Division of Medicaid and Medical Assistance (DMMA), hospitals, providers, and insurance companies.

- What are the current licensing and credentialing requirements for each provider, facility, payer, etc.?
- What is driving the variation in credentialing processes?
- What may be needed to streamline the credentialing process?
- What entities exemplify best practice with respect to credentialing?
- What legislative and policy options should Delaware consider when attempting to streamline credentialing processes?
- How can the state integrate improvements in credentialing and in licensure across stakeholders?
- What opportunities for credentialing revisions exist as part of the Interstate Medical Licensure Compact?

Additional areas of interest included the following:

- How can Delaware make provider licenses and credentials portable within the state?
- What new licensures and credentials will be required for the new workforce under the fully transformed system of care? (e.g. community health workers, drug counselors, telehealth providers, etc.)

In an effort to receive more robust feedback from a broader array of providers across Delaware, the Workforce and Education Committee developed an electronic survey to receive detail on the above-mentioned questions and more. The Committee received feedback from 44 respondents across the below provider classifications and professions:

- Behavioral Health Specialist
- Credentials Coordinator
- Dentist
- Employer
- Health Insurance Company Professional
- Hospital/Health System Administrator
- Federally Qualified Health Center Administrator
- Manager for Clinical Operations
- Nurse
- Nurse Practitioner
- Optometrist
- Physician
- Physician Assistant
- Physical Therapist
- Psychologist
- Speech Pathologist

Survey Key Findings – Licensing

- 1) The initial licensing process for physicians is tedious and can prevent practices from recruiting and retaining talented staff.
- 2) A number of providers indicated Delaware is losing talented providers to neighboring states, in particular Pennsylvania and Maryland.
- 3) The licensing renewal process for select provider classifications is much more efficient due to electronic submission.

Survey Key Findings – Credentialing

- 1) A majority of providers experience variation in the credentialing process.
- 2) Current credentialing structures are impeding the ability of providers and systems to transform in a meaningful way.
- 3) Credentialing delays result in decreased access to care for patients.
- 4) There is a need for a single, centralized credentialing process across Delaware which is accepted by the State, insurance companies, hospitals, payers, and providers.
- 5) Applicants need to be held accountable and responsible for collecting all required information in a timely fashion.

Finally, the Committee also conducted targeted, follow up interviews with select providers to focus on the pain points and efficiencies providers experience during both the licensing and credentialing processes. Representatives from the following organizations provided feedback on the current state and recommendations on how to streamline the processes moving forward:

- Mid Atlantic Behavioral Health Care
- University of Delaware Physical Therapy Department
- Delmarva Affiliation Medical Staff Services
- Delaware Division of Public Health, Bureau of Oral Health and Dental Services
- Delaware Academy of Physician Assistants
- University of Delaware Nurse Managed Primary Care Center
- Delaware State Dental Society
- Westside Family Healthcare
- Delaware Guidance Services

The interview key findings outlined below reflect feedback received from a number of interview respondents on the licensing and credentialing structures specific to their provider classification or the provider classification they assist through the process.

Interview Key Findings – Licensing

- 1) The delay certain mental and behavioral health providers experience in sitting for their licensure examination can lead to qualified candidates seeking licensure in other states. Once providers are licensed in another state they are less likely to return to Delaware to seek licensure.
- 2) There is an increased demand for discounted or free dental care across the state. To address this issue, Delaware has made a provisional license available to providers who have yet to take the three examinations required for the full Dentist license. This provisional license is valid for two years

and allows providers to practice dentistry under the general supervision of a Delaware-licensed dentist at an FQHC. However, this provisional license deems these providers ineligible for the State Loan Repayment Program, which requires a full license.

- 3) The exams required for the full Dentist license are only offered two times per year, resulting in additional on-boarding delays.
- 4) A handful of behavioral and mental health providers reported delays in the licensing process due to a lack of communication with State Licensing Boards on the status of their application. This can deny providers with outstanding issues on their applications the opportunity to correct these in a timely manner.

Interview Key Findings – Credentialing

- 1) Practices must work to have all providers credentialed on an individual basis. This lengthy process could be expedited by shifting towards a facility credentialing arrangement.
- 2) Delaware is one of twelve states in the country that does not enroll Physician Assistants (PAs) as medical providers under Medicaid. Thus, the prescriptions written by PAs to their Medicaid patients are not covered.
- 3) While advancements have been made in the collection and maintenance of provider information for credentialing purposes, providers would benefit from automated reminders on any upcoming deadlines for recredentialing.
- 4) There is substantial variation among dental carriers in the information they require from Dentists interested in becoming a participating provider.
- 5) Credentialing delays for Dentists practicing at an FQHC result in significant lost revenue for the state’s FQHCs, as their providers are unable to bill for their services.
- 6) Behavioral and mental health providers are experiencing delays in having their credentials approved in order to get onto certain panels and see patients within that network.

Appendix A contains a crosswalk of credentialing and licensing requirements for providers to demonstrate the scope of the issue and the redundancy of the requirements. Committee members used the information gathered from these research activities to develop the credentialing recommendations set forth in this document.

VIII. COMMITTEE RECOMMENDATIONS

Following research and review of national- and state-level credentialing initiatives, the Workforce and Education Committee suggests the following initial recommendations as Delaware begins the process of streamlining licensing and

credentialing procedures for health care providers and making credentials portable within the state:

1. Identify the end goal for streamlined credentialing procedures within Delaware
 - a. Ensure that the envisioned procedural improvements are safe, secure, and in accordance with Joint Commission and National Center for Quality Assurance (NCQA) standards related to credentialing, privileging, and primary source verification (Note that the streamlined credentialing process should allow for 90% of the work to be mandated/regulated to allow 10% for the organizations/facilities to do their due diligence of ensuring candidates)
 - b. Decrease processing times to facilitate more efficient on-boarding of health care personnel and reduce system-wide administrative costs
 - c. Eliminate any redundancies and duplicative steps in the procedures

Responsible Party: DCHI

2. Operationally define and set parameters related to the following:
 - a. “Clean Application” (i.e., what, specifically, constitutes one?)
 - b. Processing Time Limits (e.g., allow a maximum of 30 days for credential processing after an application is deemed “clean” / complete)
 - i. 36% of survey respondents indicated it takes 90+ days to get credentialed.
 - ii. The real loss comes from the number of patients who providers cannot see due to delays in credentialing processing. More importantly, patients experience a lack of access to care.
 - c. Application Red Flags (e.g., what, specifically, represents an application red flag?) Define transparent remedies and timelines to address application red flags in an effort to keep the credentialing process proceeding in a timely manner

Responsible Parties: Providers, hospitals/health systems, payers

3. State legislation should be used as a policy lever to set streamlined credentialing parameters for hospitals, provider networks, and payers. Parameters such as credential processing time limits could be included in such legislation.
 - a. 77% of survey respondents see variations among organizations involved in the credentialing process.
 - b. A memorandum of understanding could be a first step.

Responsible Parties: Providers, hospitals/health systems, payers.

4. Delaware should transition to an Automated Credentialing System in the future.

Responsible Parties: DCHI, DHCC, DPR

5. Ensure providers new to Delaware have access to licensing and credentialing resources, such as a list of required documentation and credentialing organization contacts.

Responsible Parties: DPR, provider practices, payers

6. Remove the Delaware Practical Board Examination as a requirement for dental licensure.

Responsible Parties: Delaware Board of Dentistry and Dental Hygiene, DPR, DHCC, Governor Markell's Professional Licensing Review Committee (to review)

7. Allow psychologists to sit for the Examination for Professional Practice in Psychology while completing their post-doctoral hours of supervised experience.

Responsible Parties: Delaware Board of Examiners of Psychologists, DPR, HCC

8. State Licensing Boards should continue to make a concerted effort to inform applicants of the status of their application.

Responsible Parties: Appropriate Licensing Boards, DPR

APPENDIX A: LICENSING AND CREDENTIALING REQUIREMENTS CROSSWALK

As mentioned earlier in the paper, multiple credentialing agencies within Delaware currently partner with CAQH for credentialing purposes. Providers registering with CAQH ProView for the first time must submit the information identified in the left-hand column of the below table.

To demonstrate the duplicative nature of the current licensing and credentialing processes, the table identifies information from the CAQH credentialing process that is also required for a particular provider during the initial licensing process.

Required Credentialing Information	Physician	PA	Nurse	APRN	PT	OT	LCSW	LPCMH	Psychologist	SP	Dentist	Dental Hygienist
Personal Information	X	X	X	X	X	X	X	X	X	X	X	X
Professional IDs												
DEA Registration	X	X		X								
CDS Registration	X	X		X								
Education	X	X	X	X	X	X	X	X	X	X	X	X
Professional Training	X	X	X	X	X	X		X	X	X	X	X
Specialties												
Practice Locations												
Hospital Affiliations												
Credentialing Contacts												
Professional Liability Insurance												
Employment Information	X				X			X		X	X	X
Professional References	X		X				X	X	X	X		
Disclosure												
State Medical Licenses	X	X	X	X	X	X	X	X	X	X	X	X
Malpractice Insurance												
Authorization, Attestation, and Release form	X	X	X	X	X	X	X	X	X	X	X	X

Provider Classification Key

PA: Physician Assistant

APRN: Advanced Practice Registered Nurse

PT: Physical Therapist

OT: Occupational Therapist

LCSW: Licensed Clinical Social Worker

LPCMH: Licensed Professional Counselor of Mental Health

SP: Speech Pathologist

APPENDIX B: ACRONYMS AND GLOSSARY

Following is a list of acronyms and glossary of terms referenced in this paper:

Acronyms

ACA	Affordable Care Act
ACMHC	Academy of Clinical Mental Health Counselors
ACPCI	Advisory Committee on Physician Credentialing Information
APA	American Psychological Association
ASWB	Association of Social Work Boards
CAQH	Council for Affordable Quality Healthcare
CCAG	Common Credentialing Advisory Group
CDS	Controlled Dangerous Substance
CMMI	Center for Medicare & Medicaid Innovation
CODA	Commission on Dental Accreditation
DCHI	Delaware Center for Health Innovation
DEA	Drug Enforcement Agency
DHCC	Delaware Health Care Commission
DHIN	Delaware Health Information Network
DMMA	Delaware Division of Medicaid and Medical Assistance
DOI	Delaware Department of Insurance
DPR	Delaware Division of Professional Regulation
EPPP	Examination for Professional Practice in Psychology
FQHC	Federally Qualified Health Center

HPSA	Health Professional Shortage Areas
HRSA	Health Resources and Services Administration
NBCC	National Board for Certified Counselors
NCQA	National Center for Quality Assurance
NRHSP	National Registry of Health Service Providers in Psychology
PCSAS	Psychological Clinical Science Accreditation System
SIM	State Innovation Model
UCAC	Uniform Credentialing Advisory Committee

Glossary

Council for Affordable Quality Healthcare ProView: the healthcare industry’s premier resource for providers to self-report professional and practice information to payers, hospitals, large provider groups and health systems. CAQH ProView eliminates duplicative paperwork for these organizations that may require provider profile information for claims administration, credentialing, directory services, and more.

Credentialing: the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization. Credentials are documented evidence of licensure, education, training, experience, or other qualifications (JC).

Credentialing Verification Organizations (CVOs): any organization that provides information on an individual’s professional credentials (JC).

Federally Qualified Health Center Provisional License: The Dentist-FQHC Provisional license allows providers to practice dentistry in Delaware:

- before you have passed the three examinations required for full Dentist licensure;
- *only* at the FQHC named on the license; and
- *only* under the general supervision of a Delaware-licensed dentist (DPR).

Insurance panel credentialing: the process conducted by insurance companies to evaluate the qualifications and practice history of a provider. Providers must go through this process prior to providing care to patients in the health insurance company's network.

Interstate Medical Licensure Compact: a new licensing option under which qualified physicians seeking to practice in multiple states would be eligible for expedited licensure in all states participating in the Compact. (FSMB)

Licensing: a process by which a governmental agency grants time-limited permission to a provider to practice in the health care occupation for which he or she has met standard criteria (including education, experience, and examination). Typically, licensing is performed at the state level; providers must be licensed in each state in which they practice.

Primary source verification: collectively refers to procedures used by a credentialing entity, in accordance with standardized national- and/or state-level standards, to collect, verify and maintain the accuracy of documents and other credentialing information submitted on behalf of a health care provider seeking to be credentialed.

Standardized credentialing application: a tool that would allow all credentialing organizations within a state's borders to collect the same information from all providers.

Sources

DPR = Delaware Division of Professional Regulation

FSMB = Federation of State Medical Board

JC = Joint Commission