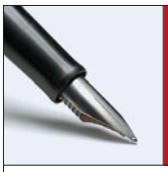


## LETTER FROM THE EDITOR-IN-CHIEF

# Provider Credentialing: An 800-Pound Gorilla

Credentialing has become a recurring nightmare for physicians of all specialties, in every state and in every practice setting.

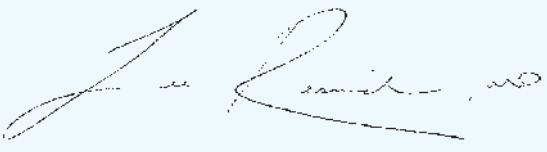
Eager for a fresh start, and energized by new opportunity, we decide to make a job change. Recruiters colorfully praise these openings, as if every job pays more than our current one, is closer to parks and culture, and exists in a region with a lower cost of living and, of course, better weather. After a short courtship, our dream of 300 sunny days per year tips the scales, and we decide to take the plunge. We carefully manage our termination notice to be timed with our new start date, confirm our tail coverage, and happily apply for licensure in our new home state.

Then, shamefully unanticipated, like a New Year's hangover, it arrives on our doorstep: the credentialing packet. More than a pound of paper, with links to several virtual pounds more, is apparently necessary to ensure that we aren't criminals, quacks, or uninsurable hacks. There are the expected attestations that we have not been convicted of felonies, are not addicted to drugs, and are not incapable of performing our duties. There are predictable questions about malpractice claims and extra blank pages for the embarrassing job of explaining them. Then there are the acronyms: CAQH, NPDB, FCVS, PDC, ABMS, and the like. And, of course, there is the task, in the words of Richmeister from *Saturday Night Live*, of "making copies." Lots and lots of copies: DEA licenses, state medical board licenses, board certifications, and a host of others.

All told, physicians and the practices that hire them spend thousands of hours and billions of dollars every year on credentialing. That's right, *billions*—with a capital *B*. And though some centralization has been adopted, the process remains fragmented, inefficient, and wildly unpredictable. Why? Because that's just how the third-party payors like it. After all, the harder it is for physicians to get credentialed, the harder it is for them to get paid. And who's more accomplished at making it harder to get paid than insurance companies? The amount of time it takes to credential a provider with each payor can seem entirely random. For some, it's 30 days; for others, it's 6 months. This disparity reveals something ugly: Payors, it seems, have found a legal loophole to restrict trade, costing physicians and their practices billions of dollars in unpaid claims and needless delays.

The problem is even more acute in urgent care, where the doors must remain open 7 days a week, 365 days a year. We simply don't have the luxury of planning 6 months in advance. When an urgent care practice loses a provider, it is lucky to get a 60-day notice on a voluntary termination (and much less on an involuntary one). Then the practice has to source, recruit, and hire a new provider, which can take months. Once the provider is hired, significant resources must be applied to credentialing. And then the provider waits, often for months, just for the privilege of getting paid. Urgent care operators are often forced to use locum tenens providers to bridge the credentialing gap while delaying the start date of their permanent replacement and thus exposing the practice and its patients to unpredictable risk. In the meantime, the new hires continue to get bombarded with other offers and are frequently lured away, forcing the practice to restart the whole process all over again.

There must be a better way. According to many experts, a more streamlined and centralized credentialing would save billions of dollars. A consistent and legally defined limit on the time it takes for payors to credential new providers would allow practice operators to more predictably time their hires without fear of discontinuity or unpaid claims. Physicians would feel freer to change jobs and pursue new opportunities without the excessive burden of paperwork. Simple reforms like these could easily be introduced into ongoing efforts to reform health care and reduce costs. I wish I were more optimistic about the likelihood this will actually happen. ■



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