Use of Board Certification and Recertification of Pediatricians in Health Plan Credentialing Policies

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Context  Health plans conduct credentialing processes to select and retain qualified physicians who will provide high-quality care to their subscribers. One of the tools available to health plans to help ensure physician competence is assessment of board certification status.

Objective  To determine the credentialing policies of health plans regarding the use of board certification and recertification for general pediatricians and pediatric subspecialists.

Design, Setting, and Participants  Telephone survey conducted February through July 2005 of credentialing personnel from a US national sample of 244 health plans stratified by enrollment size, Medicaid proportion, and for-profit or not-for-profit status.

Main Outcome Measures  Proportion of health plans that require general or subspecialty board certification at initial contract or at any time during association with the plan and recertification to maintain credentialing or to bill as a specialist or subspecialist; percentage of physicians credentialed in each health plan and credentialing goals for each plan regarding the proportion of physicians to be board certified.

Results  Response rate was 193 of 244 (79%). Overall, 174 (90%) of the plans do not require general pediatricians to be board certified at the time of initial credentialing, and only 41% ever require a general pediatrician to become board certified. Similarly, only 80 (40%) ever require subspecialists to become board certified in their subspecialty. Although 80 of 192 (41%) report requiring recertification of general pediatricians, almost half do not have a time frame in which recertification must occur. Seventy-seven percent of plans allow physicians to bill as subspecialists with expired certificates.

Conclusions  These findings, although specific to pediatrics, likely apply to other primary care disciplines and raise questions regarding the ability of plans to ensure initial or continued competence of their credentialed physicians. Growing public concern regarding patient safety, as well as demonstrated patient preferences for certified physicians, will likely result in greater emphasis on quality assessments in physician credentialing.

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One of the tools available to health plans to help ensure the competence of physicians is assessment of their board certification status. The American Board of Pediatrics (ABP) declares in its purpose statement that “The intent of certification is to provide assurance to the public and the medical profession that a certified pediatrician has success-

See also pp 905 and 939.
fully completed an accredited educational program and various evaluations, including an examination, and that the individual possesses the knowledge, skills, and experience requisite to the provision of high quality care in pediatrics.3 The “public” refers to patients, families, health plans, state licensing boards, and others. The ABP posits that these entities should have the expectation that both generalist and subspecialty pediatricians remain knowledgeable and competent in their respective areas of expertise.

To further this goal, in 1987 the ABP began issuing time-limited certificates requiring recertification every 7 years for a physician to maintain his or her certification status as a diplomate. There has been little research that identifies health plan requirements for certification and recertification of their participating physicians. As there is no uniform mandate for health plans to require certification, little is known regarding the manner in which health plans use certification or recertification in their credentialing processes. Further, the concordance of health plan policies regarding certification with the beliefs or expectations of their members is also unknown.

The objective of this study was to determine the credentialing policies regarding the use of board certification and recertification of general pediatricians and pediatric subspecialists among health plans. However, the information provided serves as an example of how health plan credentialing policies currently may be more broadly applied to the primary care disciplines and perhaps all disciplines for which credentialing is performed.

**METHODS**

The initial sample of 432 health plans was taken from the InterStudy database. InterStudy is a research organization that publishes data and directories and performs analyses for the health maintenance organization and preferred provider organization industries.

Initial contacts with health plans indicated that large multistate plans maintained central certification policies. The database was then resorted to include only 1 representative plan of those with multistate plans. This resulted in a final sample of 267 plans, all of which were selected for potential inclusion in the study.

To be eligible, a health plan had to have at least 1 pediatrician. Five health plans were geriatric-only health plans. Another 18 plans were out of business, bringing the total study sample to 244.

Health plans were stratified by enrollment size (low [<150 000 members] vs high [≥150 000 members]), Medicaid enrollment (low [<50% members enrolled] vs high [≥50% of members enrolled]), and profit status (for-profit vs not-for-profit).

Credentialing staff in each plan were selected as the focus of data collection because of their knowledge of health plan policies and procedures related to the board certification and recertification of pediatricians.

**Instrument Design**

The interview instrument was designed to be completed in 10 minutes or less. The survey addressed the following descriptive research questions: (1) Do health plans require board certification for general pediatricians and pediatric subspecialists at the point of initial contract? (2) Are non–board-certified pediatricians required to have completed a pediatric residency? (3) Are non–board-certified subspecialists required to have completed a fellowship? (4) For those plans that do not require certification at initial contract, is there a provisional time frame during which board certification must be achieved? (5) What are the policies and requirements of each health plan regarding recertification for general pediatricians and pediatric subspecialists? (6) Are health plans tracking certification and recertification? If so, how? How often? (7) What percentage of pediatricians in each health plan are board certified? and (8) Does the health plan have a percentage goal for pediatricians to be board certified? If so, what are the goals? In addition, specific questions addressed requirements for certain situations; ie, Does the health plan require pediatricians with permanent and time-limited certificates to recertify? Is there a time frame in which recertification must occur? If certification as a subspecialist has expired, could the physician still bill as a subspecialist? Has the health plan ever revoked or not renewed credentialing status for failure to recertify?

The instrument was pilot tested for clarity and ease of completion with credentialing representatives from health plans in the state of Michigan. Pilot tests were not included in the sample for analysis. The project was approved by the University of Michigan Medical School institutional review board.

**Data Collection**

From February through July 2005, research staff attempted to contact the 244 health plans in the sample. Interviewers asked to speak with the department responsible for credentialing at the health plan—typically the credentialing or provider relations department. When the appropriate person was located, interviewers explained the purpose of the study and obtained oral consent to participate. The interviewers then conducted the structured interviews or, when requested, allowed the respondent to complete the survey via mail or fax. When necessary, research staff contacted other plan representatives to verify accuracy of the responses or to obtain additional information.

**Data Analysis**

Initially, frequency distributions of all items were computed for each question. Next, bivariate analyses by enrollment size, for-profit/not-for-profit status, and Medicaid enrollment were calculated along with Pearson χ² to determine any significant relationship among these variables. For data stratified by for-profit and not-for-profit status, only data that represented a significant difference are presented. The most important findings...
were the overall assessments of the health plans. However, the final response rate of 193 provided 80% power to detect a difference of at least 20% between high vs low overall enrollment or high vs low Medicaid enrollment. Analyses were performed using SAS version 9.1 (SAS Institute Inc, Cary, NC); \( P < .05 \) was considered statistically significant.

**RESULTS**

**Respondents**

Of the 244 health plans with unique names in the database sample, 193 completed the telephone survey, representing a response rate of 79%. The table lists the proportion of participating health plans by enrollment size, proportion of Medicaid enrollment, proportion of for-profit and not-for-profit plans, and their response rates. The response rate for subgroups varied from 77% for the low Medicaid enrollment group to 86% for the high Medicaid enrollment group. Not all health plans responded to every question, therefore the total N for each question may differ slightly.

A health plan was categorized as a nonresponder if it was not reached after a minimum of 8 attempts (n = 4), if it did not return the requested faxed survey (n = 34), or if it declined the interview (n = 13). Assessments of the demographic characteristics of the plans among responders vs nonresponders demonstrated no response bias among the plans.

**Overall Findings**

Overall results demonstrated that 174 (90%) of the 193 health plans do not require general pediatricians to be board certified at the time of initial contract in order to be credentialed. Subgroups ranged from 92% in the low Medicaid enrollment group to 86% in the high Medicaid enrollment group. Of the 174 plans, 161 (93%) require general pediatricians to have successfully completed residency training. However, the question asked did not specify if this referred to a US residency program. There were no differences among the categories of plans.

Of the 161 health plans that require a pediatric residency, 98 (61%) have no time frame in which certification must be achieved. Significant differences were seen between low- and high-enrollment plans (69% vs 47%, \( P = .03 \)) for this finding.

To determine how many health plans “ever” require certification of their enrolled physicians, we identified those health plans that responded either that certification is required for all pediatricians at initial contract (n = 19 [10%]) or that certification is not required for any pediatrician at initial contract but is required after some time has elapsed (n = 61 [32%]). Thus, a total of 80 (41%) of the 193 health plans require their general pediatricians to be certified at some point in their association with the health plan.

**Pediatric Subspecialists**

Only 29 (15%) of 190 health plans (3 plans did not have any pediatric subspecialists) indicated that they require subspecialty certification for initial credentialing as a pediatric subspecialist. Of these 29 plans, 24 (83%) require a pediatric subspecialty board certification and 5 (17%) do not require a pediatric subspecialty board certification but will accept a corresponding adult subspecialty certification. There were no significant differences among the plan types.

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Table. Response Rate, Recertification Requirements, and Goal Reporting

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>Overall</th>
<th>Medicaid</th>
<th>Profit Status</th>
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<tr>
<td></td>
<td>Total</td>
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<td>High</td>
</tr>
<tr>
<td></td>
<td>No.</td>
<td>response Rate</td>
<td>No.</td>
</tr>
<tr>
<td></td>
<td>193 (79)</td>
<td>133 (78)</td>
<td>60 (82)</td>
</tr>
<tr>
<td>Recertification not required</td>
<td>122 (63)</td>
<td>81 (61)</td>
<td>31 (52)</td>
</tr>
<tr>
<td>Recertification required</td>
<td>80 (42)</td>
<td>51 (39)</td>
<td>29 (48)</td>
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</tbody>
</table>

**Plans Reporting Goals**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Low</th>
<th>High</th>
<th>For-Profit</th>
<th>Not-For-Profit</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>No.</td>
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<td>109</td>
<td>51</td>
<td>119</td>
</tr>
<tr>
<td>Goals not reported</td>
<td>103 (64)</td>
<td>74 (68)</td>
<td>29 (57)</td>
<td>76 (64)</td>
<td>27 (66)</td>
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<tr>
<td>Goals reported</td>
<td>57 (36)</td>
<td>35 (32)</td>
<td>22 (43)</td>
<td>43 (36)</td>
<td>14 (34)</td>
</tr>
</tbody>
</table>

*Indicates health plans requiring recertification if a time-limited certificate has expired. Difference between for-profit and not-for-profit is significant at \( P = .04 \).
†Indicates health plans that report goals for certification of pediatricians. Difference between for-profit and not-for-profit plans is significant at \( P = .047 \).
require no gap in certification, 24 (30%) require that recertification occur prior to the next credentialing cycle, 16 (20%) require recertification within 1 to 2 years after expiration of certification, 11 (14%) indicated that a unique plan is established with individual pediatricians, and 6 (7%) were coded as “other,” which indicated that the responses did not fall into the other categories (eg, “whatever the board requires”). There were no significant differences among the plan groupings.

Two health plans require 50 continuing medical education credits per year if a physician does not recertify.

Recertification of Subspecialists and Billing Practices

The health plans were asked if their pediatricians have time-limited subspecialty certificates and if the plan would allow a pediatrician to continue to bill as a subspecialist should the subspecialty certification expire. Of 163 respondents, 125 (77%) allow a pediatric subspecialist to bill as a subspecialist even if certification has expired. There were no significant differences among the plan groupings. Of these 125 plans that allow pediatric subspecialists to continue to bill as a subspecialist even when certification has expired, 116 (93%) indicated that recertification must be achieved, 16 (13%) require recertification and indicated there must be no gap in certification, 6 (5%) require that recertification must occur prior to the next credentialing cycle, 17 (14%) indicated that recertification must occur within 1 to 2 years after expiration of certification, and 6 (5%) reported they will create a unique plan for each physician regarding recertification. One plan did not know its policies in this area. There were no significant differences among the plan groupings.

Additional Requirements and Restrictions

Of 191 respondents, 21 (11%) require recertification for holders of permanent certificates. Of these 21 plans, 18 (86%) require recertification for holders of permanent certificates in general pediatrics, and 17 (81%) require recertification for holders of permanent certificates in pediatric specialties. Of 182 respondents, 43 (24%) require subspecialists to also keep current their general pediatric certification. Some health plans indicated that this requirement is necessary if the physician is practicing as both a general pediatrician and as a subspecialist. Some plans also indicated that a subspecialist is required to keep the general certification if they want to be listed as both a general pediatrician and a subspecialist in the health plan’s clinician directory. Of 175 respondents, 28 (16%) have revoked or not renewed credentialing status for not recertifying.

Percentage of Board-Certified Pediatricians

Of the 193 health plans surveyed, 138 (72%) reported tracking the percentage of their pediatricians who are board certified. The mean percentage of pediatricians who are board certified in these plans is 87%. It is noteworthy that 55 (28%) of the respondents did not know the percentage of their pediatricians who are board certified or have access to this data. Many of these health plans reported that they only track primary care physicians as a single group and do not have board certification data separated by pediatricians or pediatric subspecialists.

Less than half of health plans report having a percentage goal for the number of pediatricians to be board certified (Table).

Other Aspects of Certification

Of 185 health plans, 100 (54%) indicated they offer Medicaid-only plans and that they use the same credentialing process for their Medicaid plans. Of 192 health plans, there was some variation in the type of pediatric certification accepted. Most plans (115 [60%]) recognize ABP certification only, while 32% also recognize the American Osteopathic Association and 5% also recognize Canadian specialty certification boards.
A small number of health plans reported that certification is linked to incentive systems and is required for certain classifications of physicians. Some health plans give pediatricians the option of being in a specially designated career track. If a pediatrician chooses this track, certification is required and financial rewards are tied to the track. Another health plan indicated it has implemented a salary penalty for physicians if there is a delay in certification or recertification.

Another health plan indicated it has financial rewards are tied to the track. If a pediatrician chooses to become certified, the health plan in which subspecialists participate in a health plan network in which subspecialty physicians are not certified or have not recertified in a timely fashion.

A related issue is patient preferences in choosing a physician or, by extension, the health plan in which their physician participates. Only a few studies have explored the importance placed by patients on the board certification status of their physician. A study of 600 community residents found that patients perceived professionally relevant factors, including board certification, as the most important in choosing a physician. This study also found that the patients believed such factors had the greatest effect on the quality of health care they would receive. These patient expectations and beliefs appear to be in significant variance with the policies of many health plans. However, other plans have embraced the marketing potential of a high rate of board certification among their physicians because many patients have come to view the plan, not their physician, as the source of their care.

In an effort to ensure that health plans provide quality-of-care measures to the public, some states (eg, New York) are now requiring plans to publish the proportion of board-certified physicians in their clinician panels. However, there is variation in this process regarding the manner in which

**COMMENT**

The most significant finding of this study is that only 41% of health plans require contracted general pediatricians to be board certified at any time during their association with the plan. This number is derived from the 10% of plans that require general pediatricians to be board certified at the time of initial hiring and the 31% of plans that require certification at some point in the future. The remaining 59% never require certification of their credentialed general pediatricians. However, some of these plans do, in fact, target specific goals for the percentage of their physicians who are board certified.

Similar results were found for the credentialing of pediatric subspecialists, with 15% of plans requiring certification at the time of initial contract and 26% requiring certification at some point in the future. Most (86%) of the plans that do not require pediatric subspecialty certification do require the pediatricians to have at least completed some type of fellowship in the area in which they are designated a specialist.

The finding that so few health plans require board certification for a pediatrician to bill as a subspecialist raises questions as to the ability of the plans to ensure the initial or continued competence of these physicians. Such actions also may be self-defeating to plans' quality improvement efforts, as they negate an incentive for these physicians to become certified.

Health plans use a variety of measures to assess whether the applicants' credentials are appropriate for the requested privileges within the plan, usually including professional licensure, undergraduate and graduate medical education, and history of problems with peers, patients, or other plans or institutions. Because the credentialing process is designed to aid health plans in choosing competent physicians for the care of their members, the lack of use of board certification is a significant issue for the plans, the public, and the ABP, which represents the public interest.

There is a strong rationale for health plans to exercise significant caution and review in determining their credentialing criteria. From the public interest vantage, there is an increasing demand for greater accountability in health care for ensuring the quality of care provided. Given momentum from the recent Institute of Medicine reports, raising public alarm regarding the current state of clinical care, efforts to provide better care abound at the national, regional, and local levels. In addition, significant legal risk to the health plans exists for negligent credentialing, in that health plans may be held liable for exposing an injured subscriber to an unqualified physician by failing to establish and conduct a proper credentialing review. Despite this, our results demonstrate that a high proportion of plans do not use certification or recertification in their credentialing process.

There are limited data describing the differences in clinical outcome for patients treated by board-certified physicians compared with their noncertified counterparts, especially in pediatrics. Although some studies have shown board certification to be a useful marker for higher quality of care, others have not. Unfortunately, many studies of this issue are poorly designed. A comprehensive review of the literature in this area revealed that only 5% of published studies used research methods appropriate for the research question asked. Of the minority of studies judged to be appropriate, more than half supported an association between board certification status and clinical outcomes.

Even though the link between clinical outcomes for patients and the provision of care by a board-certified physician is tenuous, a recent study by Kinchen et al demonstrated that physicians consider board certification an issue of major importance when choosing a specialist for referral. This should be of significant importance to health plans and the networks they create. Since approximately 4.5% of all primary care visits in the United States result in a referral, the confidence of the referring physician in the competence of the referral physician can have a significant impact on the process of treatment, clinical outcomes, and cost. There also may be an eventual impact on the willingness of general physicians to participate in a health plan network in which subspecialty physicians are not certified or have not recertified in a timely fashion.

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pioned certificates and recertification efforts are reported.

One reason that certification is seemingly overlooked in many efforts of quality assessment and quality improvement is that there is an implicit assumption that nearly all physicians in this country are certified. In fact, as of 2002, approximately 85% of licensed physicians were certified. However, the lack of attention to recertification by health plans raises the issue of the degree of assurance provided to health plan members of the continued competence of their credentialed physicians.

Seemingly in contrast to the current practices regarding the lack of using recertification by the majority of health plans, but in sync with the apparent desires of the public, the American Board of Medical Specialties—the umbrella organization of the 24 specialty boards—has embarked on an even more rigorous physician assessment initiative, Maintenance of Certification. The Maintenance of Certification program is meant to address perceived deficiencies in the quality of health care in the United States. This initiative is likely being undertaken for many reasons but is at least in part a response to 2 recent Institute of Medicine reports that have challenged the medical establishment to bridge the chasm in quality of care affecting delivery of health care. This expanded recertification program includes requirements for physicians to demonstrate evidence of (1) professional standing, (2) commitment to lifelong learning and involvement in a periodic self-assessment process, (3) cognitive expertise, and (4) evaluation of performance in practice. Ultimately, the ABMS and its member boards believe they can assume a leadership role in the quality movement through this effort.

A recent study commissioned by the American Board of Internal Medicine found that the public highly valued board certification and Maintenance of Certification. Although only a minority of respondents ever directly inquired about their physician’s certification status, most reported they would change their own physician if they were aware he or she had not recertified. It thus would seem that a health plan could distinguish itself to potential subscribers in the appearance of, if not actual dedication to, quality by including board certification and recertification as part of its privileging requirements.

CONCLUSION

These findings, although specific to pediatrics, very likely apply to the credentialing processes for other primary care disciplines if not more widely to all who undergo plan credentialing. Although there has been variation among specialties in the initiation of time-limited certificates, the ABP has required recertification for almost 20 years. We believe it unlikely that our finding represents a time lag by health plans in incorporating pediatric recertification into their credentialing processes. Many health plans currently do not use board certification in their credentialing processes. Likely, increasing pressure from the public regarding preferences for demonstrable efforts in patient safety will result in a greater emphasis on quality assessments in physician credentialing. As such, the new Maintenance of Certification program will provide health plans with a useful tool in this process.

Author Contributions: Dr Freed had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Freed, Wheeler, Stockman.

Acquisition of data: Singer, Wheeler.

Analysis and interpretation of data: Freed, Singer, Lakhani, Wheeler.

Drafting of the manuscript: Freed, Singer.

Critical revision of the manuscript for important intellectual content: Lakhani, Wheeler, Stockman.

Statistical analysis: Freed, Lakhani, Wheeler.

Obtained funding: Freed, Stockman.

Administrative, technical, or material support: Singer, Wheeler, Stockman.

Study supervision: Freed, Singer.

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REFERENCES


