

Reinventing Credentialing: A Playbook for Health Plans Ready to Modernize, Optimize, or Transform



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Provider credentialing is essential for ensuring compliance with healthcare standards and regulations while protecting patients, members and employers. Despite its critical regulatory importance, credentialing is often a challenge for health plans that are navigating the rapidly evolving compliance, access and data quality mandates.

While payers recognize the importance of credentialing, many still operate on outdated systems, manual workflows or fragmented vendor solutions that fail to meet cost, speed and compliance needs. Provider credentialing can also require endless paperwork and phone calls that result in delays in patient care and lost revenue for network providers.

Transforming and optimizing the credentialing environment can help payers optimize costs and drive efficiencies, essential to address the high demand for healthcare and shortage of providers.



Key takeaways:

- **Credentialing inefficiencies often are delaying provider onboarding, leading to dissatisfaction among providers and can expose compliance risks.**
- **Credentialing is costly, time-consuming and disconnected data sources and siloed teams lead to slow turnarounds and inconsistent provider data.**
- **New compliance mandates are intensifying pressure, raising the stakes for payers still using sub-optimized or outdated credentialing platforms or services.**
- **Modernized credentialing enhances provider onboarding speed, strengthens network access and improves both member and provider satisfaction.**
- **Transformation and automation can unlock major cost and time savings but making such internal changes can be challenging and costly.**
- **Shared credentialing models can provide optimization and cost savings and are potentially the future of credentialing, but market knowledge of existing national shared models is somewhat limited**



The Credentialing Imperative

There are an estimated four million credentialed healthcare providers (HCPs) in the United States and non-delegated providers typically contract with an average of 15 to 25 health plans. Verifying HCP qualifications to get in-network status with payer organizations is essential but it's also cumbersome.

Shared credentialing models emerged in the mid-2000s. Most are limited to several specific Medicaid states that mandate common credentialing and the Medicaid plans in those states follow the one-size-fits-all model, but those programs do deliver an improved provider experience, high quality results and a lower cost.

“Newer shared models now look at delivering discrete packets to plans that participate, ensuring they receive a committee-ready packet if their needs are beyond the ‘core’ NCQA requirements. True automation and shared services can significantly reduce costs well below recredentialing alone while keeping network data confidential and meeting unique compliance needs.”

–Kymberly Eide

Vice President, Healthcare Payer Solutions
Sutherland Healthcare Solutions



Four Models of Credentialing

	1 In-House (Manual)	2 Homegrown Technology	3 Outsourced CVO	4 BPaaS with/without Shared Services
DESCRIPTION	Credentialing handled by internal teams using spreadsheets/shared drives or legacy tools. This model is <u>associated</u> with higher administrative cost and error risk since processes typically are manual rather than automated.	Older, internally built systems with limited automation/integration. Many plans run legacy stacks called out in BPaaS market research as key transformation targets.	An external CVO performs primary source verification and/or file prep. NCQA sets explicit <u>rules</u> for delegation to a third party and requires certified/accredited CVOs with tight delegation oversight.	A fully managed, platform-enabled operating model (process + tech + talent); <u>positioned</u> explicitly as a transformation path off legacy processes.
TYPICAL STATE	Common in regional or mid-sized plans that have grown processes organically rather than investing in platforms.	Seen across large, established payers that built capabilities years ago.	Used to reduce internal administrative load without re-platforming.	Emerging/expanding model among payers.
PRIMARY CHALLENGE	Slow, error-prone, and hard to audit. Manual workflows drive excess cost and delay; spreadsheet tracking increases risk of missed expirations and compliance gaps.	At risk under NCQA 2025+ monitoring requirements if processes aren't modernized. NCQA now <u>requires</u> at-least-monthly reviews of sanctions/exclusions and related ongoing monitoring; legacy systems without automation often struggle to meet cadence and evidence needs.	Variable quality/TAT; not transformative on its own. Delegation to a CVO still requires the health plan to maintain oversight and meet NCQA standards.	Moving to BPaaS entails data integration, control/oversight alignment, and partner governance when shifting from in-house or delegated models. Requires trust, integration, and governance alignment.



The Need for Change

Escalating compliance requirements and workforce and data constraints complicate credentialing and add to the administrative burden. In 2025, the National Committee for Quality Assurance (NCQA) updated license monitoring requirements for monthly provider licensure reviews and implemented a 30-day response window for expired licenses to avoid compliance risks.

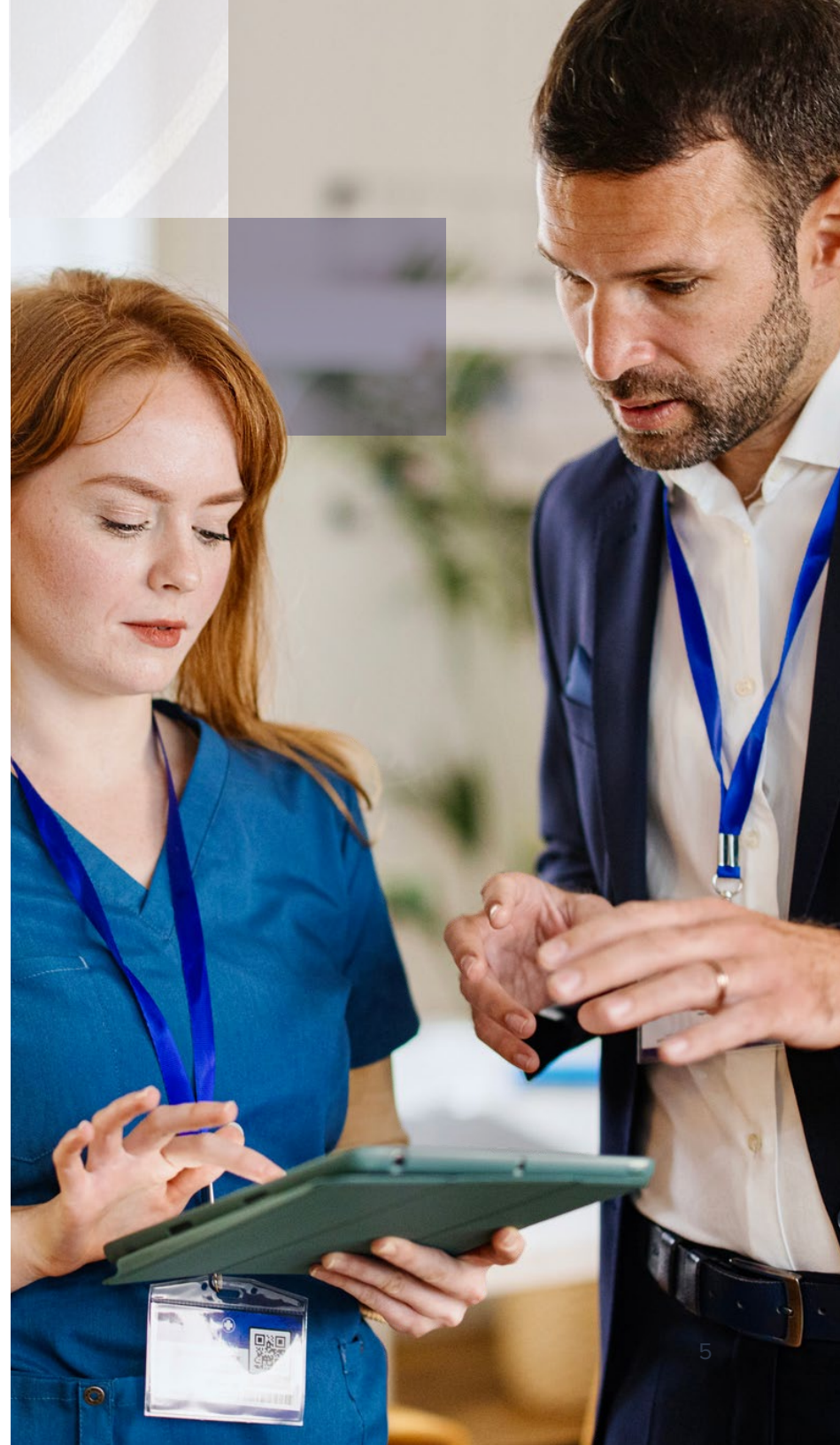
“NCQA’s 2025 standards turned credentialing from a two-to three-year event into a monthly proof-of-control. Payers must continuously monitor sanctions, exclusions, and license expirations and show timely evidence and often leverage manual and legacy processes that simply can’t keep pace.”

–Kymerly Eide

Vice President, Healthcare Payer Solutions
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Credentialing timelines and provider credentialing application processes can vary from plan to plan, requiring providers to navigate these dynamics and spend significant time responding to outreach or attesting to submitted data to the plans with whom they are contracted.

The Council for Affordable Quality Healthcare (CAQH) has an excellent shared model for credentialing applications. However, many health plans choose not to utilize CAQH and rely on their own application or other third-party models. Moreover, fragmented data between credentialing, rosters and directories can create rework and compliance risk.



Lengthy onboarding timeframes create real and meaningful challenges for both the provider who wants to see patients and plans that want to provide access to care. Providers desire digital self-service, rapid network entry and transparent status tracking. However, changes in healthcare market funding are forcing plans to carefully prioritize investments and funding – and accelerating internal technology to enable these programs can be costly. This shift has driven plans to more seriously consider commercial solutions and outsourced credentialing as they seek to minimize capital spend and align internal staff with higher value work initiatives.

“Many plans have evaluated outsourcing their credentialing. In the past, they found options to be expensive and felt quality and turnaround time for credentials would be negatively impacted. Today, plans are having to prioritize their capital bets and in evaluating outsourced credentialing are often finding just the opposite: costs are significantly lower, automation is higher and outsourcing alleviates capital and IT reliance concerns.”

–Kymberly Eide

Vice President, Healthcare Payer Solutions
Sutherland Healthcare Solutions





Defining the Transformation Options

OPTION 1: Internal Optimization

- Invest in modern credentialing software (third party SaaS software or homegrown rebuilds)
- Introduce robotic process automation (RPA) for PSV and license lookups
- Standardize forms and implement digital provider intake portals
- Strengthen governance: clear KPIs for turnaround time, quality, and compliance

Outcome: Likely can efficiency by 10 to 20 percent but still resource-intensive and may not scale with 2025 compliance demands.

OPTION 2: Outsourced CVO (Traditional Vendor Model)

- Leverage NCQA-accredited CVOs for PSV, recredentialing, or monitoring
- Offload administrative tasks but retain decision-making in-house

Outcome: Can potentially cut internal verification workload by up to 50% and turnaround time by 10-25% if implemented through a high quality CVO. Vendor quality and data handoffs can still create rework and audit findings but typically are lower than those found without automated validations and system checks. Contracts for services should include significant SLAs to support quality targets.

“While credentialing is a non-negotiable function, all organizations are trying to figure out how to do it faster, cheaper, better. Provider data management is a fairly administrative function that doesn’t have significant value add but must be done to manage risk and meet regulatory compliance objectives and feed directory data. As organizations start to pivot, particularly in this current environment, they are looking at ways to leverage their assets better, use their talent more effectively and deliver a better provider onboarding and ongoing credentialing experience.”

–Kymberly Eide

Vice President, Healthcare Payer Solutions
Sutherland Healthcare Solutions



OPTION 3: Business Process as a Service (BPaaS) / Managed Credentialing Service

- End-to-end model encompassing data intake, PSV, recredentialing, monitoring, and other support roles, configured uniquely to client-specific compliance needs
- Combines people + process + platform + automation + AI for measurable outcomes
- Shared service and multi-payer credentialing as add-on option reduces duplication and optimizes provider data intake/outreach

Outcome: Can reduce cycle time 40 to 60 percent, costs 20 to 30 percent and improves compliance confidence and frees plan resources for other critical, high-value activities such as network strategy, access improvement, and provider engagement.

OPTION 4: Shared-Service or Consortium Model layered on BPaaS Services

- Multi-payer collaboration with common credentialing events shared across payers, reducing provider burden and shared outputs

Outcome: Can dramatically reduce duplication and improve data consistency; optimizes application and data intake and any outreach/ collection efforts to providers, reducing provider abrasion factors. Can improve quality, meet full compliance requirements and lower costs additional 20 to 30 percent beyond standalone BPaaS, depending on vendor and approach.



The Path Forward

Efforts to streamline credentialing, reduce the administrative burden and eliminate silos have led to significant advances. The trends include digital automation for credentialing services, shared credentialing models and use of artificial intelligence (AI) to enhance multiple areas of the credentialing cycle.

For health plans that continue to manage credentialing internally, the first step is to map existing processes and measure cycle times to identify bottlenecks and inefficiencies. From there, automation pilots can help streamline repetitive tasks and provide early wins that demonstrate value.

Plans should also evaluate accredited vendors that offer primary source verification (PSV) outsourcing or credentialing workflow platforms to enhance scalability and compliance.

Plans that already outsource credentialing should perform a comprehensive quality audit to assess vendor performance across data accuracy, PSV timeliness and credentialing committee preparation. Based on their findings, shifting to a performance-based CVO or BPaaS model that is supported by outcome-based service level agreements may be warranted.



Sutherland is at the forefront of transforming credentialing environments to optimize costs and drive efficiencies with provider and health plan credentialing services and credentialing automation.

Services like end-to-end credentialing services, automated primary source verification and real-time reports and analytical dashboards that meet NCQA, Utilization Review Accreditation Commission (URAC) and Centers for Medicare and Medicaid Services (CMS) standards can cost-effectively replace legacy solutions and streamline the credentialing process.

Plans that are still relying on manual or non-automated technology have some tremendous options today that can deliver higher quality credentialing at lower cost, according to Eide. Vendors like Sutherland have invested heavily in modern technology to streamline credentialing and automate the verification processes for truly optimized end-to-end credentialing that meets plan-specific compliance needs.

While credentialing is still considered a back-office compliance function; it's also a strategic enabler of access, compliance and provider engagement – and onboarding providers quickly can drive strong member experience through accessible and available providers. Plans that move forward with modernized credentialing models can quickly achieve faster onboarding, lower credentialing costs and increased member and provider satisfaction.



Appendix: Quick Self-Assessment

Complete the table below to benchmark your credentialing performance on a few relatively standard credentialing KPIs. While many organizations aim to exceed these baseline targets, they represent the minimum standard for an effective, compliant credentialing program. If your cycle times are longer, your manual entry is high, or your throughput is inconsistent, partnering with a vendor who can streamline systems, apply technology, and consistently outperform these benchmarks can help you accelerate improvement.

Start by seeing where you stand today by rating your organization (1-5) on the following:

Category	Current Score (1-5)	Target	Gap
Average initial credentialing TAT	_____	≤ 30 days	_____
Recredentialing on-time compliance	_____	> 98%	_____
Recredentialing backlog	_____	< 5% of monthly volume	_____
Credentialing file accuracy / packet accuracy	_____	≥ 98%	_____
% of applications requiring manual data entry	_____	< 5%	_____
Monitoring cadence (license, sanctions, exclusions)	_____	At least monthly	_____

Contact Sutherland today to learn more.





Sutherland is a leading digital transformation company that partners with healthcare organizations to reimagine and modernize their operations. Leveraging deep industry expertise and cutting-edge capabilities in AI, automation, and analytics, Sutherland helps health systems, payers, and providers build future-ready revenue cycle operations that improve efficiency, accelerate reimbursements, and enhance patient and provider experiences. Our human-centered, technology-driven approach enables clients to achieve measurable outcomes — driving smarter decisions, sustainable growth, and better health for all.

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