Memorandum

DEC 16 1996

Date

From Deputy Inspector General
for Audit Services

Subject Review of the Policies and Procedures for Medical Personnel Credentialing and Privileging at the Indian Health Service, National Institutes of Health, and Health Resources and Services Administration (A-15-94-00006)

To See Addressees Below

Attached is a copy of the Department of Health and Human Services, Office of Inspector General final report entitled, "Review of the Policies and Procedures for Medical Personnel Credentialing and Privileging at the Indian Health Service, National Institutes of Health, and Health Resources and Services Administration."

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact Joseph J. Green, Assistant Inspector General for Public Health Service Audits, at (301) 443-3582. To facilitate identification, please refer to Common Identification Number A-15-94-00006 in all correspondence related to this report.

Thomas D. Roslewicz

Attachment

Addressees:

Philip R. Lee, M.D.
Assistant Secretary for Health

Harold E. Varmus, M.D.
Director, National Institutes of Health

Ciro V. Sumaya, M.D.
Administrator, Health Resources and Services Administration; and Chairman, Interagency Advisory Council on Quality Assurance and Risk Management

Michael H. Trujillo, M.D., M.P.H.
Director, Indian Health Service

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE POLICIES AND PROCEDURES FOR MEDICAL PERSONNEL CREDENTIALING AND PRIVILEGING AT THE INDIAN HEALTH SERVICE, NATIONAL INSTITUTES OF HEALTH, AND HEALTH RESOURCES AND SERVICES ADMINISTRATION

JUNE GIBBS BROWN
Inspector General

DECEMBER 1996
A-15-94-00006

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Subject Review of the Policies and Procedures for Medical Personnel Credentialing and Privileging at the Indian Health Service, National Institutes of Health, and Health Resources and Services Administration (A-15-94-00006)

To See Addressees Below

This final report provides you with the results of an Office of Inspector General (OIG) review of policies and procedures for medical personnel credentialing and privileging in the Indian Health Service (IHS), National Institutes of Health (NIH), and Health Resources and Services Administration (HRSA).

OBJECTIVES

The objectives of our review were to assess the adequacy of Federal policies and procedures for credentialing and privileging:

(1) in IHS and NIH direct care facilities; and

(2) in nonfederally operated, community-based programs that receive funding through contracts and grants with IHS and HRSA.

SUMMARY OF FINDINGS

The credentialing and privileging policies used by facilities operated directly by IHS and NIH are adequate, but Federal credentialing and privileging requirements for nonfederally operated IHS and HRSA funded community-based programs need to be strengthened.

Finding 1 The credentialing and privileging policy prescribed by the Public Health Service[1] Interagency Advisory Council on Quality Assurance and Risk Management (Interagency Council) compares favorably with other governmental policies and professional literature publications. Further, both IHS and NIH have credentialing requirements that meet or exceed the minimum level established by the interagency policy. *(See pages 7-8 for details of Finding 1.)*

[1]**In order to strengthen the Assistant Secretary for Health's leadership and policy role in the Department of Health and Human Services' (HHS) public health agenda, the Public Health Service (PHS) management function (Office of the Assistant Secretary for Health) was merged in October 1995 with the Office of the Secretary and the PHS agencies became operating divisions reporting directly to the Secretary.**

Finding 2 In contrast, nonfederally operated, tribal health care programs funded by IHS are not required to follow IHS' credentialing and privileging policies. In addition, HRSA provides its grantees limited policy instructions on appropriate credentialing and privileging steps. Without adequate credentialing and privileging policies, the Federal Government risks increased liability for acts of malpractice that occur in these programs. Therefore, it is incumbent upon IHS and HRSA to encourage their funded programs to adhere to stringent credentialing and privileging requirements. *(See pages 8-11 for details of Finding 2.)*

Finding 3 The IHS and HRSA are also not required to determine whether providers they hire are excluded from being reimbursed by the Federal Medicare and State Medicaid programs. By not conducting a search of the exclusion list, IHS and HRSA run the risk of employing health care professionals who have been convicted of crimes relating to ethical or professional wrongdoing. *(See pages 11-12 for details of Finding 3.)*

RECOMMENDATIONS

To strengthen requirements and provide more specific guidance on credentialing and privileging to community-based programs receiving Federal funding, we recommend that:

- the Director of **IHS advocate** programs for quality and risk management, specifically those related to credentialing and privileging of medical personnel in self-determination tribal health care programs;

- the Administrator of **HRSA disseminate** detailed information on the operation of a comprehensive credentialing and privileging program to community, migrant, homeless, and public housing health center grantees;

- the **IHS and HRSA modify** their employment or credentialing policies and practices to require, as a routine procedure, a search of the Department of Health and Human Services (HHS) OIG Medicare and Medicaid exclusion list; and

- the **Interagency Council revise** its credentialing policy to require a search of HHS' OIG Medicare and Medicaid exclusion list.

In responding to our draft report, IHS, HRSA, and NIH concurred with our findings and recommendations. The "Agency Comments and OIG Response" section of this report contains a summary of agency comments; the full text of each agency's comments is included in Appendix C.

BACKGROUND

Health Care Activities of the Department

As part of its mission to protect and improve the health of all Americans, HHS operates or funds numerous health care programs for certain populations such as research patients, medically underserved, and Federal employees. Examples of programs HHS directly operates and manages include NIH's Clinical Center and IHS hospitals, clinics, and service units. In terms of programs not directly operated, but supported by HHS, HRSA funds community, migrant, homeless, and public housing health centers in underserved areas for over 7.1 million people yearly; and IHS funds tribally managed health care programs, which, in 1995, provided services to approximately 390,000 American Indians and Alaska Natives.

In the 1980's, HHS convened a task force to address implications of the growing problem of medical malpractice in the United States. In its August 1987 Report of the Task Force on Medical Liability and Malpractice, HHS highlighted the need to reduce medical malpractice claims in the Government, and recommended that the agency "conduct a vigorous credentialing program covering screening, monitoring and discipline of those physicians it employs."

The Interagency Council was founded in January 1988 to support HHS' public health agencies' responsibility and commitment to provide quality health care. In December 1994, the Interagency Council reinitiated its 1992 effort to develop and implement a minimum standard credentialing and privileging policy,[2] one that would apply to HHS health care agencies providing direct care.

On October 25, 1995, the Assistant Secretary for Health issued the "Public Health Service Policy and Procedures on Minimum Standards of Appointment, Credentials Review, and Clinical Privileging" (interagency credentialing policy), and requested it be implemented by HHS agencies employing health professionals.

Role of Credentialing and Privileging in Health Care

A system for credentialing and privileging is considered to be a fundamental element of ensuring high quality patient care.[3] Credentialing consists of verifying education, training, and licensure documents, and contacting recent employers and professional associates to

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[2]Implementation of the interagency credentialing policy was delayed while awaiting consensus on the development of a separate policy addressing medical malpractice reporting practices.

[3]Roberts, Nigel, and Norman M. Charney. 1989. "Recent Legal Developments in the Medical Quality Management Field." In Physician Managers and the Law, edited by James B. Couch. Tampa. The American College of Physician Executives.

determine an applicant's current competence and skills.[4] Verification techniques include the use of carefully worded application questions that request full disclosure. In addition to conventional employment screening practices, the medical profession has a number of supplementary sources that can provide verification of a provider's past professional experiences. State licensing boards, the National Practitioner Data Bank,[5] the Federation of State Medical Boards, and HHS' OIG maintain information on health care providers. These sources provide information on adverse actions that have resulted in suspended, limited or revoked license, malpractice payments, or exclusion from the Medicare and Medicaid programs.

Privileging consists of determining whether a health care provider is qualified to perform specific medical functions and procedures which are supported by a particular facility. Privilege granting delineates the scope of a physician's medical authority at a facility.[6]

Credentialing and privileging requirements are related to protecting both the quality-of-care and financial interests of health care facilities.[7] Credentialing and privileging are two components of broader quality assurance and risk management[8] programs that health care facilities undertake to ensure high quality care and reduce the likelihood of malpractice claims.

The Federal Government and Medical Malpractice Coverage

In August 1946, the United States Congress enacted the Federal Tort Claims Act (FTCA). Under FTCA, the Federal Government consented to be sued for personal injury or death caused by the negligence or wrongful act or omission of Federal employees who were acting within the scope of their employment.

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[4]**Dimond, Jr., F.C. 1989. "The Credentials Process." In Handbook of Medical Staff Management, edited by Cindy A. Orsund-Gassiot and Sharon Lindsey. Gaithersburg, MD: Aspen Publication.**

[5]**Established by Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended, the National Practitioner Data Bank maintains records of malpractice judgments and disciplinary actions against licensed health care practitioners.**

[6]**Curtis, Tom, and Lynda A. Russell. 1993. "Challenges in Medical Staff Credentialing." The Medical Staff Counselor 7 (Fall): 23-29.**

[7]**Roberts, Nigel, and Norman M. Charney. 1989. "Recent Legal Developments in the Medical Quality Management Field." In Physician Managers and the Law, edited by James B. Couch. Tampa. The American College of Physician Executives.**

[8]**The task force report states that: "Risk management and quality assurance are functions that overlap in many respects. ...many consider quality assurance a subset of the larger issue of risk management. The latter, which requires managerial skills, is directed toward all persons, events, and activities in the health care setting; quality assurance, which requires clinical expertise, is primarily directed toward medical services to the patient."**

In December 1987 and in January 1993, Congress extended FTCA coverage to IHS tribal contractors[9] and HRSA grantees,[10] respectively. Extension of FTCA coverage to these contractors and grantees exposes the Federal Government to medical malpractice liability claims alleged against providers working in facilities funded—but not directly operated—by the Federal Government.

For Fiscal Years (FYs) 1993 to 1995, the Federal Government was named in 291 medical malpractice claims in IHS, NIH, and HRSA programs, including health centers funded by HRSA. In the same time period, the Government paid $5.5 million in settlement[11] of claims against the same agencies.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our review were to assess the adequacy of Federal policies and procedures for credentialing and privileging:

(1) in IHS and NIH direct care facilities; and

(2) in nonfederally operated, community-based programs that receive funding through contracts and grants with IHS and HRSA.

Scope

We evaluated the policies and procedures used by the direct health care operations of IHS and NIH; those required by IHS and HRSA for funded programs; and the interagency policy guidance that applies to HHS health care agencies providing direct health care,[12] to assure that, if appropriately implemented, they would provide hiring officials with information needed to assess a health care professional's competence, experience, and skills. We did not review personnel files to test actual implementation of the policies and procedures.

Our evaluation was limited to the policies prescribed by HHS agencies listed above. We did not evaluate whether nonfederally operated, HHS-funded health care programs had implemented adequate credentialing and privileging programs, which includes the check of

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[9]"The Indian Self-Determination Act (P.L. 93-638, as amended by P.L. 100-202). December 1987.

[10]"The Federally Supported Health Center Assistance Act of 1992 (and) 1995," (P.L. 102-501). October 1992, and (P.L. 104-73). December 1995.

[11]Settlements may include claims filed in previous years.

[12]The HHS operates additional direct care programs which were not included in our review, but would be required to follow the interagency credentialing policy, including: HRSA Hansen's Disease Center and Federal employee occupational health programs.

the HHS OIG Medicare and Medicaid exclusion list, on their own, or in compliance with State, local, or accreditation requirements.

Methodology

Our review was conducted in accordance with generally accepted government auditing standards. To meet our objectives, we performed the following steps:

- to obtain an understanding of credentialing and privileging requirements in HHS, we interviewed officials involved in credentialing, recruiting, and personnel at public health agencies including the former Office of the Assistant Secretary of Health (OASH), HRSA, NIH, and IHS; and

- to evaluate the relative completeness of the HHS agencies' credentialing and privileging policies; we reviewed, analyzed, and compared them to each other and to policies or practices recommended in professional literature, required by an industry-recognized standard setting organization (Joint Commission on Accreditation of Healthcare Organization (JCAHO[13])), and used by the Department of Defense.

These steps provided the basis for our February 27, 1995 memorandum to the Interagency Council Chairman in which we suggested that the interagency credentialing policy be applicable to grant and contract funded nonfederally operated facilities.

However, because legal and programmatic limitations prevented the interagency policy from being expanded to grant and contract health facilities, we continued our review through April 1996 in order to examine ways credentialing and privileging policies could be strengthened. Additional review steps included:

- to address unresolved issues of the interagency council credentialing policy, we participated in an ad hoc committee convened by the Interagency Council;

- to determine private insurance industry practices related to medical facility credentialing, we contacted several insurance company risk management representatives; and

- to obtain Medicare and Medicaid exclusion information, we consulted with our Office of Civil Fraud and Administrative Adjudication, Health Care Administrative Sanctions Staff.

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[13]**The 1994 JCAHO publication, "Understanding the Hospital Performance Report," states that it is the leading health care accrediting body in the world. Its one basic purpose is to improve the quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement. Health care organizations seek JCAHO accreditation primarily as a means to enhance performance. To earn and maintain accreditation, a hospital must undergo an on-site survey at least every 3 years, in which compliance with standards developed by JCAHO is evaluated.**

RESULTS OF REVIEW

The credentialing and privileging policies used by facilities operated directly by IHS and NIH are adequate, but Federal credentialing and privileging requirements for nonfederally operated IHS and HRSA funded community-based programs need to be strengthened.

Finding 1 The credentialing and privileging policy prescribed by the Interagency Council compares favorably with other governmental policies and professional literature publications. Further, both IHS and NIH have credentialing requirements that meet or exceed the minimum level established by the interagency policy.

Finding 2 In contrast, tribal health care programs funded by IHS are not required to follow IHS' credentialing and privileging policies. In addition, HRSA provides its grantees limited policy instructions on appropriate credentialing and privileging steps. Without adequate credentialing and privileging policies, the Federal Government risks increased liability for acts of malpractice that occur in these programs. Therefore, it is incumbent upon IHS and HRSA to encourage their funded programs to adhere to stringent credentialing and privileging requirements.

Finding 3 The IHS and HRSA are also not required to determine whether providers they hire are excluded from being reimbursed by the Federal Medicare and State Medicaid programs. By not conducting a search of the exclusion list, IHS and HRSA run the risk of employing health care professionals who have been convicted of crimes relating to ethical or professional wrongdoing.

FINDING 1: CREDENTIALING AND PRIVILEGING POLICIES FOR IHS AND NIH OPERATED DIRECT CARE FACILITIES ARE ADEQUATE

The IHS and NIH direct care facilities prescribe adequate credentialing policies. The interagency policy requires agencies to develop procedures to implement the agreed-upon minimum standards of appointment, credentials review, and clinical privileging. The credentialing and privileging policies implemented by IHS and NIH for their direct care facilities either meet or exceed the requirements specified by the interagency policy.

Interagency Credentialing Policy Provides A Framework for Direct Care Agencies

The recent initiative of the Interagency Council to develop a credentialing policy represents a proactive move on behalf of HHS to ensure that patients in direct care settings receive high-level health care services. The policy compares favorably to other governmental and professional literature publications on credentialing. It provides for a thorough examination and verification of an applicant's professional history including: professional education; postgraduate training; licensure status (past and present); competence, experience, and skills

through professional references; adverse action reports; and claims history. The policies provide not only minimum expectations of credentialing documents to review and verify, but also suggested questions to ask of applicants during the credentialing process.

IHS Credentialing and Privileging Policies for Direct Care Facilities are Adequate

The IHS has adequate credentialing and privileging policies and has developed a supplementary resource to facilitate the process. The IHS Circular, "Credentials and Privileges Review Process for the Medical Staff," was written as a guideline to assist in the development of facility-specific policies throughout IHS. For review of its nine required credentialing elements, the Circular includes "special considerations" that provide specific details on the information to be reviewed. In addition, the January 1995 Indian Health Service Medical Staff Credentialing Resource Handbook provides the information needed to perform timely and thorough credentialing reviews. The handbook is an organized, easy-to-understand, "how to" manual. It provides addresses, sample documents, and thoughtful pointers to facilitate the credentialing process.

NIH Credentialing and Privileging Policies are Adequate

The NIH has an adequate credentialing and privileging policy which is designed to be supported by all levels of its medical staff and an information support section. The NIH policy, Credentialing Health Professionals at the Clinical Center, was written for specific implementation at the NIH's Clinical Center. Certain management controls and procedural steps used by NIH appear critical in ensuring objectives of credentials verification and privileging are met. For example, several layers of management review and approval of Clinical Center appointment and privilege requests are required; and organized, readily accessible documentation of credentialing activities facilitates required periodic credentialing reviews.

The NIH's Clinical Center uses specialty-specific Delineation of Privileges forms. The forms establish defined limits of medical authority for Clinical Center physicians; and increase supervisory awareness of a physician's training, proficiency, and clinical competence on specified medical procedures.

FINDING 2: **CREDENTIALING AND PRIVILEGING REQUIREMENTS FOR FEDERALLY FUNDED COMMUNITY-BASED PROGRAMS CAN BE STRENGTHENED**

The IHS and HRSA can do more to strengthen the credentialing and privileging requirements of federally funded community based programs. Although health programs funded by these agencies in tribal and community-based settings benefit from FTCA coverage, IHS funded programs are generally not required to follow Federal credentialing and privileging policies, and HRSA funded programs have not been provided sufficient instructions from the programs providing their funds. The absence of adequate

credentialing and privileging policies is critical because of the potential financial liability borne by the Federal Government under FTCA coverage. Thus, IHS and HRSA programs providing funds for tribal and community health care should emulate IHS and NIH direct care providers and the private sector, which actively seek to limit the likelihood of adverse actions and bolster the quality of care by requiring stringent credentialing and privileging requirements.

Tribally Operated Health Facilities are Not Required to Follow IHS Policies

Tribally operated, IHS funded health care facilities, although protected by FTCA coverage, are not required to follow IHS or interagency credentialing policies, unless agreed to in the self-determination agreement. Such facilities do not have to follow IHS or HHS policies because of the Indian Self-Determination Act Amendments of 1994, which specifically release self-determination contractors or compactors from the requirements of program guidelines, manuals, or policy directives of HHS unless otherwise agreed to by the contractor and the Secretary, or otherwise required by law.

Although not required to follow Federal policy, tribal programs are concerned about quality assurance, according to cognizant IHS officials. These officials indicated that managers of tribal health care programs are interested in maintaining operating standards that would ensure continued JCAHO accreditation. Since IHS' policy and credentialing resource handbook incorporate JCAHO core criteria, and provide additional procedural steps to help achieve and maintain accreditation, IHS should advocate for their use by tribally operated health care facilities.

Community, Migrant, Homeless, and Public Housing Health Centers Receive Limited HRSA Credentialing and Privileging Instructions

The Federal credentialing requirements for community, migrant, homeless, and public housing health centers are prescribed in the Federally Supported Health Centers Assistance Act of 1992 and 1995 (Assistance Act) and in the Program Expectations for Community and Migrant Health Centers (Program Expectations). The health center requirements do not provide instructions for the specific source and form for credential verifications, and, consequently, do not meet the minimum interagency policy. For example:

- Experience and competence: The Program Expectations state that experience and competence should be assessed, while the interagency policy requires an assessment of experience and competence using written attestations from more than one current or former employer or training director. The interagency policy also requires verification of board certification, which indicates achievement of a high level of knowledge in a specialty field.

- Training: The Program Expectations for health centers state that training should be assessed, while the interagency policy requires review and verification of specific programs of training including professional educational degrees and postgraduate training.

- Claims History: The Assistance Act states that an applicant's claims history should be reviewed, while the interagency policy provides for a review of responses to probing questions concerning prior malpractice claims, suits, or adverse actions. A list of 13 questions is provided, which, if answered affirmatively, must be fully explained.

- References: The Assistance Act states that references should be verified, while the interagency policy requires review of references from sources who have professional, independent, and supervisory knowledge of the applicant's training and experience.

- License Status: The Assistance Act states that license status should be reviewed, while the interagency policy requests a listing of licenses held presently or in the past, which may lead to the identification of past disciplinary actions taken on the applicant's licensure in other states.

Appendix A contains a chart illustrating health center instructions, interagency credentialing policy instructions, and important differences between them.

In discussing HRSA's role, officials acknowledged the limitations of the credentialing guidance provided, but pointed to the quality assessment review program carried out every 3 years at health centers funded by the agency. Such reviews are valuable because they involve independently examining documents existing in clinical staff personnel files in terms of licensure, training, experience, and competence. The reviews, however, do not serve to provide funded programs with the criteria and instructions for performing primary source verifications of credentialing and privileging documents.

Coverage Under the Federal Tort Claims Act Should Be Met With Measures Aimed at Reducing the Likelihood of Claims

Through extension of FTCA, the Federal Government is liable for damages resulting from personal injury or death caused by the negligence, wrongful act, or omission of employees of these community-based programs. In effect, the Government is taking on the role of a medical malpractice insurer. This increased potential liability for the Government should be met with adequate risk reduction initiatives to reduce the likelihood of malpractice claims. According to representatives of private industry malpractice insurance providers,[14] such initiatives are routine in the private medical malpractice insurance industry.

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[14]We spoke to risk management officials in the following companies: Mid-Atlantic Insurance Co., Massachusetts Medical Professional Insurance Association, Medical Association of Georgia Mutual Insurance Co., and the Kentucky Medical Insurance Co.

According to these insurance industry contacts, the private sector actively implements risk management practices aimed at reducing the likelihood of claims. These insurance companies develop a thorough knowledge and maintain a recurrent and supportive relationship with their insured facilities. Specific emphasis is placed on evaluating the organization and operation of the facility to reduce the risk of adverse actions occurring. These private insurers employ their own risk management professionals who provide their insured facilities with technical assistance on risk management practices. One insurance company representative has been requested to provide formal training on credentialing and privileging, while others provide feedback on various risk management practices to their insured facilities either in person on their site reviews or through formal written risk analysis recommendations based on their site visits. These risk management functions exist within the insurance companies, even though three of the four States represented by these companies have credentialing requirements.

FINDING 3: IHS AND HRSA HEALTH CARE DELIVERY PROGRAMS NEED TO CHECK ON MEDICARE AND MEDICAID ELIGIBILITY STATUS OF PROVIDERS

The IHS and HRSA are not currently required to determine if their providers are eligible to receive reimbursement under the Federal Medicare and State Medicaid programs. This information is readily available from the General Services Administration (GSA)[15] and HHS OIG. Appendix B contains information on the "Cumulative Sanctions Report" of exclusions compiled by OIG, and the procedures for accessing this data.

Until the dissolution of OASH in 1995, its Office of Personnel Management would verify that health care providers hired by HHS and processed through its personnel system, were eligible for Medicare and Medicaid reimbursement. However, in OASH's delegation of credentialing activities, there was no explicit requirement to continue to make this important verification. Consequently, this procedure has not been continued in IHS and HRSA (although NIH continues to consider the exclusion status of prospective staff in employment decisions). Without such a consultation, IHS and HRSA programs may inadvertently hire health care providers who have been excluded from participation in Medicare and Medicaid for serious professional wrongdoing. When making employment decisions, it is, therefore, incumbent upon IHS and HRSA to consult the list and consider the conduct that gave rise to the exclusion. Such consultation may reduce the likelihood that IHS and HRSA are

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[15]Under the Governmentwide debarment rules, GSA is required to compile, maintain, and distribute a list of all persons who have been debarred, suspended, or voluntarily excluded by all Federal agencies. Federal agencies are to provide GSA with current information concerning debarment actions, for inclusion in the Governmentwide list. In accordance with this requirement, HHS OIG regularly furnishes GSA with information on individuals and entities who have been excluded from Medicare and Medicaid. However, we have learned that other agencies that operate Federal health care programs have not done so. Ideally, the GSA "List of Parties Excluded from Federal Procurement and Nonprocurement Programs" should contain the names of medical professionals who have been debarred, suspended, or excluded by any Federal agency; in practice, it appears that at present, the GSA list may be no broader than that compiled internally by HHS OIG.

employing or funding health care providers who pose risks to both the patient and to the financial liability of the Federal Government.

CONCLUSIONS AND RECOMMENDATIONS

The Federal programs providing funding for health care have a dual responsibility to (1) provide high quality care for people relying on their health programs; and (2) safeguard Federal financial interests. By promoting the use of comprehensive credentialing and privileging programs, IHS and HRSA can increase assurance that they are supporting both responsibilities.

The IHS and NIH have adequate credentialing and privileging programs for their directly operated health care facilities, but requirements for IHS and HRSA funded, nonfederally operated community-based programs need strengthening. The IHS and HRSA can do more to protect the quality of care in community-based programs and Federal financial interests.

Consequently, we recommend that:

- the Director of **IHS advocate** programs for quality and risk management, specifically medical personnel credentialing and privileging, in self-determination tribal health care programs;

- the Administrator of **HRSA disseminate** detailed information on the operation of a comprehensive credentialing and privileging program to community, migrant, homeless, and public housing health center grantees;

- the **IHS and HRSA modify** their employment or credentialing policies and practices to require, as a routine procedure, a search of the HHS OIG Medicare and Medicaid exclusion list; and

- the **Interagency Council revise** its credentialing policy to require a search of HHS' OIG Medicare and Medicaid exclusion list.

AGENCY COMMENTS AND OIG RESPONSE

In response to our draft report, **IHS** indicated that it: (1) will continue to advocate for the use of comprehensive credentialing and privileging procedures in the tribally operated facilities; and (2) has been requesting credentialing information, which includes the Medicare and Medicaid exclusions, from secondary sources other than the OIG's Cumulative Sanctions Report. While we acknowledge that the secondary sources referenced in IHS' comments contain the Medicare and Medicaid exclusions as well as other important credentialing information, we continue to encourage IHS to use OIG's Cumulative Sanctions Report of Medicare and Medicaid exclusions. The Cumulative Sanctions Report is an easily

accessible (through the Internet or the mail) and economical (free of charge) primary source of credentialing information that can be consulted directly by IHS or tribal personnel.

In **HRSA's** response to our draft report, it concurred with our findings and recommendations and indicated that corrective actions are underway. The HRSA is currently distributing IHS' Credentialing Handbook to grantees, and its Office of Human Resources Development is searching the Cumulative Sanctions Report of Medicare and Medicaid exclusions before a provider is hired. Responding to our recommendation that the Interagency Council revise its credentialing policy to require a search of the Medicare and Medicaid exclusion list, HRSA indicated that there is support for such a recommendation, but it would not be considered until the Council's next biennial review of the policy in FY 1998. This timeframe appears reasonable given that IHS and HRSA have agreed to perform such searches.

The **NIH** had no specific comments regarding our recommendations.

Appendix C contains each agency's comments in their entirety.

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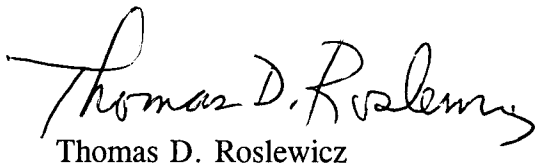
We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact Joseph J. Green, Assistant Inspector General for Public Health Service Audits, at (301) 443-3582.

To facilitate identification, please refer to Common Identification Number A-15-94-00006 in all correspondence related to this report.



Thomas D. Roslewicz

APPENDICES

COMPARISON OF CREDENTIALING REQUIREMENTS IN HRSA HEALTH CENTER INSTRUCTIONS AND THE INTERAGENCY CREDENTIALING POLICY

HEALTH CENTER INSTRUCTIONS	INTERAGENCY POLICY INSTRUCTIONS	DIFFERENCES THAT MAKE THE INTERAGENCY POLICY INSTRUCTIONS SUPERIOR
Assess training. (Program Expectations for Community and Migrant Health Centers (Program Expectations), page 19.)	Review and verify professional education degrees and postgraduate training. (Interagency Policy Section 5(a) and (b))	The interagency policy specifically requires verification of medical education and residency training. The health center instruction does not require that the degree be verified, or that specific training programs be reviewed.
Assess experience and competence. (Program Expectations, page 19.)	Review and verify evidence of professional competence through letters of reference and peer recommendations. Identifies specific sources for the reference letters depending on career level. Board certification is also reviewed and verified. (Interagency Policy Section 5(c) and (e))	The interagency policy requires an assessment of experience and competence using attestations from more than one current or former employers or training directors. The review for board certifications indicates an applicant's achievement of a high level of knowledge in a specialty field. The health center instruction does not provide guidance on the source and form of the assessment.
Review the National Practitioner Data Bank Report. (Program Expectations, page 19.)	Review the National Practitioner Data Bank Report. (Interagency Policy Section 5(f))	None. The Health Care Quality Improvement Act of 1986 allows voluntarily querying by health centers with formal peer review processes. We did not determine the extent the centers used this service.
Verify references. (Federally Supported Health Center Assistance Act of 1992 and 1995, P.L. 102-501, Section 2(h)(2))	Review letters of reference regarding professional competence from persons in positions of authority from the applicant's past training and experience. (Interagency Policy Section 5(e))	The interagency policy requires references from sources who have professional, independent knowledge of the applicant's training and experience. The health center instruction does not provide guidance on the source and form of the verification.

HEALTH CENTER INSTRUCTIONS	INTERAGENCY POLICY INSTRUCTIONS	DIFFERENCES THAT MAKE THE INTERAGENCY POLICY INSTRUCTIONS SUPERIOR
Review claims history. (Assistance Act.)	Review responses to probing questions concerning prior malpractice claims or suits and adverse action. A list of 13 questions is provided which if answered affirmatively must be fully explained. (Interagency Policy, Section 5(h), Attachment 2(A-M))	The Interagency policy provides examples of questions that inquire about: liability claims; judgments; liability insurance history; license history; disciplinary history, medical staff denials; privilege limitations; and Medicare/Medicaid sanctions. The health center instruction is limited to a nonspecific claims history review.
Review fitness. (Assistance Act.)	Review information regarding physical and mental fitness for practice. (Interagency Policy, Section 5(i))	The interagency policy specifically inquires about alcohol or drug abuse or dependency. The health center instruction does not define fitness.
Review professional review organization findings. (Assistance Act.)	No similar instruction.	Reviews of health center's by professional review organizations are optional and may not assess individual providers.
Review license status. (Assistance Act.)	Review listing of past and present licensure or registration. (Interagency Policy, Section 5(d))	The interagency policy asks for a listing of licenses held presently or in the past. This information may lead to the identification of disciplinary actions taken on the applicant's license in other states. The health center instruction is limited to current license status.
No further instructions.	Review information from available information data bases, such as the Federation of State Medical Board's Disciplinary Data Bank or the America Medical Association's Physician Masterfile. (Interagency Policy, Section 5(g))	The interagency policy refers to specific secondary sources of information on disciplinary actions and professional endeavors have been recorded. These data bases have policies to verify information with primary sources before it is recorded on the physician's file. The health centers do not have similar instructions.

HHS OIG MEDICARE AND MEDICAID EXCLUSION INFORMATION

Title XI (Sections 1128 and 1156) of the Social Security Act (Act) provides the HHS OIG authority to exclude health care providers from receiving payment for services that would otherwise be reimbursable under Medicare and State health care programs, including Medicaid. Exclusions may be based on a broad array of conduct such as program-related crimes, patient abuse, fraud against a private health insurer, obstruction of an investigation, controlled substance abuse, revocation or surrender of a health care license, failure to repay health education assistance loans, or failure relating to provision of substandard quality of care. The authority to exclude individuals and entities from the Medicare and Medicaid programs. The HHS OIG "Cumulative Sanctions Report" of exclusion information includes the health care provider's name, date of birth, medical specialty, address at the time of sanction, sanction, and date of sanction. The sanctions are referenced to the specific section of the Act, which identifies the reason for the exclusion.

A cumulative alphabetical list, with over 8,500 excluded individuals, is available by writing: Mr. William Libercci; Director, Health Care Administrative Sanctions Staff; Office of Inspector General; Room N2-01-26; 7500 Security Boulevard; Baltimore, MD 21244-1850. Additional information on an excluded individual can also be obtained by writing the above address.

Requests that include a formatted, high density disk in an self-addressed pre-paid return mailer, will be returned with a DOS file that can be manipulated in a data base program. In addition, if the exclusion status of providers is desired on an ongoing basis, written requests containing no more than 10 queries (include the providers name, social security number and date of birth) will be responded to as soon as possible.

The Cumulative Sanctions Report is also available on the Internet. It is posted on the Ignet Web Site in a format which: (1) appears on-screen like the printed version; (2) is searchable; and (3) is selectively printable (e.g., the user may print one or more pages).

To view the report, Internet users *must* download a *free* copy of Adobe™ Acrobat™ Reader. A link to Adobe's™ home page for software and directions is co-located with the report positing. Using Acrobat™, Internet users may either view the report while connected to the Internet or download the report for later use.

The report is located on the HHS IG "subpage" of the Ignet Home Page in the sections entitled, "Investigations/Civil Fraud and Administrative Adjudication."

To access the Ignet Home Page, point to:

http://www.sbaonline.sba.gov/ignet

To access HHS' OIG page directly, point to:

http://www.sbaonline.sba.gov/ignet/internal/hhs/hhs.html

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

OCT 18 1996

TO: Deputy Inspector General
for Audit Services
Office of Inspector General

FROM: Director

SUBJECT: Review of the Report on Policies and Procedures for Medical Personnel Credentialing and Privileging at the Indian Health Service, National Institutes of Health, and Health Resources and Services Administration (A-15-94-00006)

I am responding to your August 23 memorandum asking for comments on the draft Report on Policies and Procedures for the Credentialing and Privileging of Medical Personnel at the Indian Health Service, National Institutes of Health, and Health Resources and Services Administration (A-15-94-00006). My staff provided input to the report throughout its writing, reviewed the draft report, and have no further comments to submit.

I am pleased that your review found the IHS credentialing and privileging policies to be adequate for our direct care facilities. My staff and I will continue to advocate for the use of comprehensive credentialing and privileging procedures in the tribally operated facilities.

Thank you for the opportunity to provide comments on this report.

Michael H. Trujillo, M.D., M.P.H.
Assistant Surgeon General

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

OCT 16 1996

TO: Inspector General

FROM: Associate Director
Office of Administration and Management

SUBJECT: Office of Inspector General Draft Report, "Review of the Policies and Procedures for Medical Personnel Credentialing and Privileging at the Indian Health Service, National Institutes of Health, and Health Resources and Services Administration" - (A-15-94-00006)

The following are the Indian Health Service (IHS) comments on the subject report:

- OIG Comment (page 12, paragraph 2, line 5) - The statement is made that the IHS has not continued the procedure to run checks on new employees (physicians and nurses) through the Federation of State Medical Boards (physicians) and the National Council of State Boards of Nursing (nurses) since the Office of the Assistant Secretary for Health (OASH) ceased performing this service.

  IHS Response - This is definitely not the case. The IHS Health Professions Support Branch has been performing this service for the IHS since January of this year and will continue to do so until the Clinical Support Center takes over the verification of the physicians' credentialing sometime this year. We will continue with the verification of the nurses' credentialing.

If you have any questions regarding this memorandum, please call Mr. Charles Miller, Chief, Management Control Branch, Division of Management Policy, on 443-9597.

Luke McIntosh

cc: Chief, Health Professions Support Branch

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

NOV 4 1996

TO: Deputy Inspector General for Audit Services, OS, DHHS

FROM: Deputy Administrator

SUBJECT: Office of Inspector General Draft Report "Review of the Policies and Procedures for Medical Personnel Credentialing and Privileging at the Indian Health Service, National Institutes of Health, and Health Resources and Services Administration" A-15-94-00006

Attached, in accordance with your August 23, 1996 request, are HRSA's comments to the subject draft report.

Staff questions may be referred to Paul Clark on (301) 443-5255.

John D. Mahoney

HEALTH RESOURCES AND SERVICES ADMINISTRATION
COMMENTS ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORT "REVIEW OF THE POLICIES AND PROCEDURES FOR MEDICAL PERSONNEL CREDENTIALING AND PRIVILEGING AT THE INDIAN HEALTH SERVICE (IHS), NATIONAL INSTITUTES OF HEALTH (NIH), AND HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)" A-15-94-00006

OIG RECOMMENDATION

The Administrator of HRSA disseminates detailed information on the operation of a comprehensive credentialing and privileging program to community, migrant, homeless, and public housing health center grantees.

HRSA COMMENTS

We concur. The periodic onsite Primary Care Effectiveness Reviews, which evaluate the overall management of the health centers, have shown that most health centers already have in place comprehensive credentialing procedures that meet both program requirements and the deeming process guidelines.

However, HRSA believes it can assist its grantees by providing them with a copy of the IHS Medical Staff Credentialing Resource Handbook (Handbook). The Handbook would provide grantees with supplemental information for use as an excellent guideline in the development and enhancement of their existing credentialing procedures.

HRSA received approval on October 18, 1996, from the IHS to reproduce this document. HRSA will distribute copies to Medical Directors of each community/migrant health center, health care for the homeless, and health services for residents of public housing grantees by November 15, 1996.

OIG RECOMMENDATION

The IHS and HRSA modify their employment or credentialing policies and practices to require, as a routine procedure, a search of the HHS OIG Medicare and Medicaid exclusion list.

HRSA COMMENT

We concur. The HRSA's Office of Human Resources Development has modified its credentialing practices to require a routine search of the HHS OIG Medicare and Medicaid exclusion list before hiring any new providers.

However, current HRSA policy requires initial and periodic querying of the National Practitioner Data Bank (NPDB) on all senior health providers that the agency employs. HRSA's Bureau of Health Professions is negotiating an interagency agreement with the Health Care Financing Administration to include OIG's Medicare/Medicaid Exclusion reports in the NPDB. If this is accomplished, the OIG exclusion list information will be automatically obtained whenever the NPDB is queried. The separate search of the exclusion list will then be superfluous, and will be dropped at that time.

OIG RECOMMENDATION

The Interagency Council revise its credentialing policy to require a search of HHS' OIG Medicare and Medicaid exclusion list.

HRSA COMMENT

As a member of the Interagency Council (Council), HRSA concurs. At its September 18, 1996 meeting, the Council discussed this specific OIG recommendation. Although several Council members indicated their concurrence with it, a formal vote on the matter was not taken. The Council reviews its credentialing

policy biannually. The next review will be sometime in FY98, at which time the Council will review this matter.

Additionally, an Interdepartmental Steering Committee on Federal Health Care Provider Credentialing (Steering Committee) has been established. The Steering Committee has met and is currently drafting an implementation plan for improving access to data to support credentialing and privileging of providers working in military and civilian agencies of the Federal Government.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

OCT 7 1996

TO: Mr. Thomas D. Roslewicz
Deputy Inspector General For Audit Services, DHHS

FROM: Deputy Director for Management, NIH

SUBJECT: NIH Comments on the Draft Report ***Review of the Policies and Procedures for Medical Personnel Credentialing and Privileging at the Indian Health Service (IHS), National Institutes of Health (NIH), and Health Resources and Services Administration (HRSA)*** (A-15-94-00006)

As requested, we have reviewed the above referenced draft report on the adequacy of NIH, IHS, and HRSA policies and procedures for health care professional credential verification and privileging. We do not have any comments on this draft report.

However, we are pleased that (1) the NIH policy on *Credentialing Health Professionals at the Clinical Center* was cited as a model for the other agencies within DHHS, and (2) the report notes that management controls used by NIH appear to be critical in ensuring objectives of credential verification privileging are met.

We appreciate the opportunity to review this draft. Should your staff have any questions, please ask them to call William Gillen, Office of Management Assessment, NIH, at (301) 496-2461.

Anthony L. Itteilag

cc:
Dr. Gallin, CC
Mr. Benowitz, OHRM