Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FEDERAL INITIATIVES TO IMPROVE STATE MEDICAL BOARDS' PERFORMANCE

FEBRUARY 1993

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program and management problems and recommends courses to correct them.

OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in these inspection reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

This report was prepared under the direction of Mark R. Yessian, Ph.D., the Regional Inspector General, and Martha B. Kvaal, Deputy Regional Inspector General, Boston Region, Office of Evaluation and Inspections. Participating in this project were the following people:

Boston Region
David Veroff, *Project Leader*

Headquarters
Alan Levine

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FEDERAL INITIATIVES TO IMPROVE STATE MEDICAL BOARDS' PERFORMANCE

FEBRUARY 1993 OEI-01-93-00020

INTRODUCTION

PURPOSE

To review proposed and recommended Federal initiatives to improve State medical boards' disciplinary, licensure, and other quality assurance efforts.

BACKGROUND

State medical boards provide a vital front line of protection for the millions of people who receive medical care including those in the Medicare and Medicaid programs. They determine whether or not a physician meets the minimum necessary qualifications to practice medicine. And through their enforcement of State medical practice acts, they identify and take action against physicians responsible for poor quality care, unprofessional behavior, and other violations of these acts.

In the past decade, State medical boards have steadily advanced their efforts in the areas of licensure and discipline. Boards have come up with significant new approaches, authorities, and resources to safeguard the public. Important efforts include: widespread use of national licensure exams, strict mandatory reporting laws, efforts to assist impaired physicians, re-education efforts, and aggressive prosecution of physicians who abuse or exploit patients. In addition, as we highlight in our report entitled "State Medical Boards and Quality-of-Care Cases: Promising Approaches," States have begun a number of innovative and important efforts to address incompetent physicians and substandard care.[1]

The boards, however, still have many problems. Their capacity to be effective is often hampered by lack of resources. Funding for boards is not always a high priority for State legislatures. While boards often raise substantial amounts of money through licensure and registration fees, in many States large proportions of these funds go into general revenues rather than the boards' own budgets. Budget crises in many States in recent years have not helped this situation. Because of this and other limitations, boards have not been at the forefront of quality assurance efforts.

The Office of Inspector General has a longstanding interest in the quality assurance efforts of State medical boards. Recent and upcoming reports include:

- "State Medical Boards and Medical Discipline," August 1990 (OEI-01-89-00560),
- "State Medical Boards and Medical Discipline: A State-By-State Review," August 1990 (OEI-01-89-00562),
- "Quality Assurance Activities of Medical Licensure Authorities in the United States and Canada," February 1991 (OEI-01-89-00561),

- "Performance Indicators, Annual Reports, and State Medical Discipline: A State-By-State Review," July 1991 (OEI-01-89-00563),

- "The Peer Review Organizations and State Medical Boards: A Vital Link (Draft)," August 1992 (OEI-01-92-00530), and

- "National Practitioner Data Bank: Usefulness and Impact of Reports to State Licensing Boards (Draft)," October 1992 (OEI-01-90-00523).

These reports have highlighted efforts States can take to protect the public from poor medical care. They have also identified a number of initiatives the Federal government could undertake to foster improvement in the boards.

Several other proposals and reports have outlined new efforts the Federal government might undertake to improve the quality assurance efforts of State medical boards. The initiatives come from Congress, the Department of Health and Human Services, the Department of Justice and interagency task forces. Our cataloging of initiatives highlights significant proposals that have received widespread attention.

This report is timed so as to provide the new Administration and Congress with a brief overview of potential Federal action to assist States' quality assurance efforts focused at physicians. By presenting several crucial issues State medical boards face (summarized from our reports' findings) and describing a number of Federal initiatives that we and others have recommended to address the problems, we hope to inform Congressional and executive office decision makers. We do not implicitly or explicitly either endorse or reject any of the other organizations' proposed initiatives.

We conducted our review in accordance with the *Interim Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

PURSUIT OF QUALITY-OF-CARE CASES

ISSUE: **States have much difficulty pursuing quality-of-care cases. These cases are time-consuming and complex and require legal and medical expertise. States often have problems identifying significant cases and investigating them. Some States have medical practice acts that make pursuing these cases even more difficult.**

OIG RECOMMENDATIONS:

REQUIRE MEDICARE PEER REVIEW ORGANIZATIONS (PROs) TO REPORT CERTAIN CASES: One of the difficulties boards have is that they do not receive complete and accurate information from complainants. The PROs could provide detailed and significant case information about poor-quality physicians. In our August 1992 draft report entitled "The Peer Review Organizations and State Medical Boards: A Vital Link," we recommended that the Health Care Financing Administration (HCFA) propose legislation mandating that PROs provide case information to State medical boards when they have confirmed, after medical review, that a physician is responsible for medical mismanagement resulting in significant adverse effects on the patient.[2] An interagency task force on fraud, abuse, and waste echoed our recommendation.[3] *The HCFA did not concur with our recommendation. They expressed concern that disclosure of this information would damage the cooperative relationship between the PROs and physicians that they are trying to foster.*

ALLOW STATE MEDICAID PROGRAMS TO SHARE CASE INFORMATION: Similarly, Medicaid agencies have information about quality problems. In our August 1990 report entitled "State Medical Boards and Medical Discipline,"[a] we recommended that HCFA amend Medicaid regulations or propose legislation to allow State Medicaid agencies to share with the medical boards case information on physicians against whom they have taken adverse action. *In response to the recommendation, HCFA argued that action on the Medicaid reporting was unnecessary since the HHS Office of General Counsel had made clear that State law determines whether this information is reportable. However, the Omnibus Budget Reconciliation Act of 1990 requires State Medicaid agencies to notify their State's medical board when a physician is terminated, suspended, or otherwise sanctioned. The HCFA has not published regulations to implement this provision.*

PROMOTE IDENTIFICATION OF QUALITY PROBLEMS IN NURSING HOMES: In our "Boards and Discipline" report, we recommended the Administration on Aging (AoA) and HCFA assure that the Long Term Care Ombudsman Program and the

[a]Hereafter referred to as "Boards and Discipline."

States' survey and certification agencies provide assistance to State medical boards in identifying instances of improper medical care provided to nursing home residents. *While AoA fully concurred with our report and sent copies of the report to Ombudsman program administrators, HCFA asked for further clarification. We provided further explanation in our final report.*

ENCOURAGE BOARDS TO USE PROs TO ASSIST ON QUALITY-OF-CARE CASES: Some boards have difficulty getting access to medical opinions on quality-of-care cases. In our "Boards and Discipline" report, we recommended that PHS in collaboration with HCFA determine ways to encourage and assist boards to contract with PROs to conduct reviews of quality-of-care cases. *The PHS concurred with our recommendation, but felt it was HCFA's role to provide encouragement and assistance to States on this issue. The HCFA also concurred with our recommendation, but has not provided any encouragement or assistance.*

PROVIDE ASSISTANCE TO STATES TO IMPROVE INVESTIGATIVE EFFORTS: In our "Boards and Discipline" report, we recommended PHS provide financial support for technical assistance intended to improve boards' investigative efforts. We also recommended that PHS, through its Agency for Health Care Policy and Research, provide demonstration funding concerning the use of practice standards and guidelines to guide investigative efforts in quality-of-care cases. *The PHS concurred with both recommendations and has begun discussing the use of practice standards and guidelines with States.*

OTHER PROPOSED FEDERAL INITIATIVES:

PROVIDE ASSISTANCE TO STATES TO EVALUATE MEDICAL PRACTICE ACTS: Some States' medical practice acts could be improved to allow boards and their staff more authority to investigate and prosecute incompetent or unprofessional physicians. A report from an HHS task force recommended the Department provide technical assistance to States for educating legislators on evaluations of their medical practice acts.[4] *The Public Health Service has, in the past, awarded grants to the Federation of State Medical Boards to provide technical assistance to States to improve their practice acts and to develop a model medical practice act. There is no such effort currently.*

PROACTIVE QUALITY ASSESSMENT AND ASSURANCE

ISSUE: **After initial licensure examinations, State medical boards have little or no role in proactively assessing and assuring quality medical care. All boards respond to complaints and reports about poor-quality care, but few do anything either to independently assess and address individual physician performance or to promote improved quality of care for all physicians.**

OIG RECOMMENDATIONS:

TEST RANDOM PRACTICE AUDITS: In our February 1991 report entitled "Quality Assurance Activities of Medical Licensure Authorities in the United States and Canada,"[b] we recommended that PHS provide demonstration funding to States on the use of random practice audits as preventive, quality assurance measures. This report noted the successful use of random practice audits, particularly with isolated physicians, to assess performance and improve practices. *The PHS concurred with the intent of the recommendation, but believes that medical review criteria and medical outcomes measures must be more fully developed prior to implementation.*

OTHER PROPOSED FEDERAL INITIATIVES:

REQUIRE PERIODIC REEXAMINATION OF PHYSICIANS EITHER THROUGH THE BOARDS OR THROUGH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS): Recently proposed legislation would have required every physician treating Medicare patients to take a recertification examination every seven years.[5] The examination, if administered by a State medical board, would have to be approved by the Secretary of HHS. Otherwise the examination would be provided directly by HHS. This legislation was not voted on in 1991 or 1992.

REQUIRE STATES TO IMPLEMENT QUALITY ASSURANCE PROGRAMS: Recently proposed legislation would have required each State to implement quality assurance programs that, among other things, would establish standards of care in areas where there is a great risk of negligence.[6] This legislation was not voted on in 1992.

[b]Hereafter referred to as "QA Activities."

PERFORMANCE ASSESSMENT

ISSUE: **State medical boards have not been able, over the years, to gauge their performance in relation to other State medical boards. More active assessment of performance would allow States to focus resources and effectively present to the public and to State legislatures their accomplishments and needs.**

OIG RECOMMENDATIONS:

PROVIDE ASSISTANCE FOR DEVELOPMENT OF PERFORMANCE INDICATORS: In "Boards and Discipline," we recommended that PHS provide financial support for the development of performance indicators suitable for widespread use by State medical boards. A Department of Justice task force recommended HHS itself develop indicators of performance. *The PHS has supported the Federation of State Medical Board's efforts to develop a performance assessment program (SAI). Approximately seventy indicators have been developed, but are not currently used widely. A second phase of the project, which would involve implementation, is scheduled for completion by the end of 1993.*

COLLECT, ANALYZE, AND DISSEMINATE STATE-BY-STATE DATA: In "Boards and Discipline," we recommended that PHS collect, analyze, and disseminate State-by-State data on staffing, revenues, expenditures, and caseloads of State medical boards. *The PHS concurred with this recommendation. The SAI may eventually fulfill this need if the information gathered is disseminated.*

OTHER PROPOSED FEDERAL INITIATIVES:

DEVELOP AND REQUIRE BOARDS TO REPORT INFORMATION RELEVANT TO PERFORMANCE CRITERIA: Recently proposed Federal legislation would require the Secretary of Health and Human Services to develop regulations that specify performance criteria for medical boards.[7] The legislation also would require States to collect, analyze, and supply the Secretary with information and data on staffing, revenues, disciplinary actions, expenditures, caseloads, and the use of continuing medical education programs to demonstrate adherence to the criteria. This legislation has not been voted on in 1993.

FUNDING

ISSUE: **Medical boards often are inadequately funded. This lack of funding restricts boards' ability to address disciplinary issues adequately and to be proactive in assuring quality.**

OIG RECOMMENDATIONS:

ENCOURAGE THE SHARING OF INFORMATION ABOUT ADDRESSING RESOURCE LIMITATIONS: In our "Boards and Discipline" report, we recommended that PHS convene a national meeting to focus attention on the importance of the boards' oversight role and to examine how the boards' resource and other limitations should be addressed. We also recommended, and a Department of Justice group concurred,[8] that PHS develop performance standards that would, among other things, compare State medical boards on the basis of licensure revenue and expenditures. *The PHS concurred with our recommendations and has, as mentioned before, helped develop SAI which includes questions about revenue and expenditures.*

PROVIDE FINANCIAL SUPPORT FOR PROACTIVE/INNOVATIVE ACTIVITIES: As mentioned above, in our "Boards and Discipline" report we recommended that PHS provide financial support for a number of important developments. We recommended that PHS provide funds for the development of performance indicators suitable for widespread use by State medical boards, funds for technical assistance efforts intended to improve the boards' investigative efforts, and, through the Agency for Health Care Policy and Research (AHCPR), demonstration funds concerning the use of practice standards and guidelines to guide investigative efforts in quality-of-care cases. As mentioned above, in our "QA Activities" report, we recommended that PHS provide demonstration funding on the use of random practice audits as preventive quality assurance measures. *The PHS concurred with all of these recommendations except the last.*

OTHER PROPOSED FEDERAL INITIATIVES:

REQUIRE THAT THE TOTAL AMOUNT OF FEES PAID BY PHYSICIANS BE ALLOCATED TO BOARD ACTIVITIES: In many States, a large proportion of the licensure and registration fees collected by boards are used to support general activities of the State government, and are not dedicated to the boards' activities. Recently proposed legislation would have required States, in order to receive Federal PHS or Medicaid funding, to certify that they allocate the total amount of fees paid for licensing or certification of health care practitioners to the agencies responsible for disciplinary actions.[9] Neither piece of legislation was voted on in 1992.

CONCLUSION

State medical boards are responsible for assuring the basic competence of all physicians. A medical license allows physicians to practice on patients with almost no restrictions. Since the Federal government has a direct role in assuring that Medicare and Medicaid patients are given adequate medical treatment and has an indirect role in promoting the health and well-being of all Americans, the OIG and others in Federal government have great interest in making sure that State medical boards are doing their jobs in protecting the public.

The Federal government can have a significant role in encouraging, funding, and, in some cases, mandating improvements in medical boards. This does not, however, imply that they have any explicit oversight authority over boards or that States themselves do not have responsibility for boards' performance. All of the initiatives described in this report must supplement active and effective State involvement to assure quality medical care.

APPENDIX A

NOTES

1. "State Medical Boards' Pursuit of Quality-of-Care Cases: Promising Approaches," OEI-01-92-00050, February 1993.

2. We and others have been urging action in this area for years. In a 1986 report, "Medical Licensure and Discipline: An Overview," we recommended that HCFA's regulations be amended to require PROs to report more extensive and timely information to boards. In "Boards and Discipline," we recommended legislation mandating that PROs share case information with boards. In December 1990, Congress, in the Omnibus Budget Reconciliation Act, required that PROs notify boards of physicians whom they have found responsible for serious quality-of-care problems. Congress, in the law, stipulated that notification was not to occur until after notice and hearing are granted to the physicians involved.

3. "Health Care Anti-Fraud, Abuse and Waste Initiative," State/Federal Model Legislation Working Group of the Administration's Task Force on Health Care Anti-Fraud, Abuse, and Waste, September 17, 1992.

4. Otis R. Bowen, M.D., "Report of the Task Force on Medical Liability and Malpractice," Department of Health and Human Services, August 1987, p. 22.

5. "The Medicare Physician Qualification Act of 1990," H.R. 4464, (101st Congress).

6. "Basicare Health Access and Cost Control Act," S. 2346, (102nd Congress).

7. "Health Care Choice and Access Improvement Act of 1993," H.R. 150, (103rd Congress).

8. "Medical Malpractice Reform Paper," Department of Justice, Tort Law Reform Working Group (September 21, 1990).

9. "The American Health Quality Act," S. 1836 in the 102nd Congress linked certain Medicaid funds to this requirement. "The Ensuring Access Through Medical Liability Reform Act of 1991," S. 489 in the same Congress linked PHS funding to States to this requirement.