

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Managed Care Organization
Nonreporting to the
National Practitioner Data Bank**

A Signal for Broader Concern



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EXECUTIVE SUMMARY

PURPOSE

In this study we examine the extent to which managed care organizations are reporting adverse actions they take against health care practitioners to the National Practitioner Data Bank and the factors that influence their level of reporting.

DATA BANK AND MANAGED CARE ORGANIZATIONS

The basic aim of the Data Bank is to help protect patients from poorly performing health care practitioners, mainly physicians and dentists. It contains information on practitioners who have had medical malpractice payments made on their behalf and/or adverse actions taken against them by a licensure board, professional society, or health care entity, such as a hospital or managed care organization. Health care organizations and licensure boards use this information to help them in their reviews of practitioners.

EXTENT OF REPORTING

Managed care organizations rarely submit adverse action reports to the Data Bank.

- C From September 1, 1990 to September 30, 1999, they reported only 715 adverse actions.
- C Eighty-four percent of the managed care organizations (1,176 out of 1,401) never reported an adverse action.

EXPLANATIONS

With close to 100 million individuals enrolled in these organizations and hundreds of thousands of physicians and dentists associated with them, fewer than 1,000 adverse action reports over nearly a decade serves for all practical purposes as “nonreporting.” Among the possible explanations we identified are: the level of reporting may be appropriate; managed care organizations may not be submitting reportable actions (perhaps because of some misunderstanding about their reporting responsibility); they may be responding to poorly performing practitioners in ways that do not require reporting to the Data Bank; and they may lack sufficient access to information to determine if an adverse action is warranted.

While each of the above factors deserves attention as part of a fuller examination of factors influencing reporting to the Data Bank, two explanations stood out as especially convincing as we reviewed the information obtained from our interviews and the literature.

The two most likely explanations for the low level of reporting:

Limited focus on clinical oversight

Some managed care organizations devote considerable attention to the quality of care being provided to their enrollees. But we learned that in a health care marketplace that has been changing rapidly, many managed care organizations devote little attention to clinical oversight. The following factors help explain this limited focus:

- Ⓒ Heavy reliance on contracted panels of physicians rather than salaried physicians;
- Ⓒ Marketplace emphasis on price; and
- Ⓒ Consumer emphasis on access to physicians.

Reliance on downstream entities--hospitals, physician practice groups, and State licensure boards--to conduct quality monitoring of practitioners

Managed care officials emphasized to us that they rely upon these entities to protect patients from poor performers. They explained that these entities are more directly concerned with the delivery of care and therefore in a better position to take actions that would call for reporting. They added that as an ongoing check on the competency of practitioners, they rely heavily on the staff privileging functions of hospitals.

A BROADER CONCERN

Limitations of downstream entities that managed care organizations rely upon

Managed care organizations' considerable reliance on these entities accentuates the importance of their efforts to identify and take appropriate action against those few practitioners who pose harm to patients. In this study, we did not examine the performance of the downstream entities. But our prior studies and the health care literature offer considerable basis for questioning the patient protections they afford.

Hospitals find it difficult to hold individual practitioners responsible for poor care.

State licensure boards struggle with quality-of-care cases.

Physician practice groups are similarly constrained.

ISSUES WARRANTING ATTENTION

Recently, the Institute of Medicine has drawn national attention to the widespread phenomenon of medical errors. In its call for action, it emphasized that most errors are attributable to error-prone systems rather than individuals. But it also made clear that the public needs protection from "unsafe practitioners" who present danger to patients.

Our observations about the limitations of the downstream entities leads us to target seven issues that call for greater attention if patients are to be adequately protected. These issues, listed below, can be addressed by individual researchers, research organizations, and component agencies with the U.S. Department of Health and Human Services (HHS).

- Ⓒ Dealing with unsafe practitioners as part of patient safety efforts.
- Ⓒ Patient protection role of managed care organizations.
- Ⓒ Patient protection role of physician practice groups.
- Ⓒ Effectiveness of hospital privileging practices.
- Ⓒ Performance of licensure boards in quality-of-care cases.
- Ⓒ Managed care organizations' understanding of their reporting responsibilities.
- Ⓒ Managed care organizations' compliance in reporting adverse actions.

COMMENTS

Within the Department of Health and Human Services, we received comments from the Health Resources and Services Administration (HRSA), the Agency for Healthcare Research and Quality (AHRQ), and the Health Care Financing Administration (HCFA). We also solicited and received comments from the American Association of Health Plans (AAHP). Based on these comments, we made a number of changes that are reflected in this final report.

The HHS agencies expressed support for the thrust of our report. We draw particular attention to HRSA's readiness to join AHRQ in convening a conference, as we suggest, to address practitioner monitoring roles and responsibilities of physician practice groups and managed care organizations; to AHRQ's commitment to consider our findings when implementing its patient safety agenda; and to HCFA's intention to examine its bi-annual, on-site monitoring of Medicare+Choice organizations to see what changes might be warranted.

In its written response to our draft report and in follow-up interactions, AAHP emphasized two points that we have addressed in this final report. One is that some managed care organizations devote much more attention to clinical oversight than we indicated in our draft report. We recognize that and have made that clear in this report. The second point is that to some degree the low level of managed care organization reporting to the Data Bank may be attributable to misunderstandings about their responsibility to report directly to the Data Bank rather than to State licensure boards. We find this explanation plausible and, accordingly, have urged HRSA to conduct outreach to managed care organizations to clear up any such misunderstandings.

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INTRODUCTION

PURPOSE

In this study we started out with the intention of: (1) determining the extent to which managed care organizations are reporting adverse actions they take against health care practitioners to the National Practitioner Data Bank and (2) identifying the factors that influence their level of reporting. As we became more aware of the explanations for a low level of reporting, we developed a broader concern that goes beyond our initial intent. That concern centers on the limitations of the entities that managed care organizations increasingly rely upon to protect patients from poorly performing practitioners.¹ In the report, we elaborate on that concern and review ways in which it might be addressed.

BACKGROUND

National Practitioner Data Bank

In 1986, prompted by reports that physicians who lost their licenses to practice in one State were continuing their practice in another, Congress established the National Practitioner Data Bank (Data Bank). As set forth in the enabling legislation, the Data Bank serves as a national repository that State licensure boards and health care entities can draw upon to help them make more informed decisions concerning the licensing, credentialing, and, where necessary, the disciplining of physicians and other health care practitioners.² Its fundamental aim is to help protect patients from poorly performing practitioners.

Toward that end, Congress mandated that certain types of information be reported to the Data Bank. This information is the essential raw material of the Data Bank. It includes (1) medical malpractice payments made by insurers on behalf of physicians and dentists and (2) adverse actions taken by State medical or dental boards, professional societies, and health care organizations, such as hospitals and managed care organizations (MCOs). For these organizations, reportable actions encompass all professional review determinations that affect a physician's or dentist's clinical privileges for more than 30 days and voluntary surrenders or restrictions by physicians or dentists when they are under investigation for possible professional incompetence or improper conduct.

Practitioner-specific information in the Data Bank is not available to the general public. But the statute stipulates that the information can be made available, upon request, to licensure boards and health care entities (including MCOs) that perform peer review functions. Further, it mandates that hospitals query the Data Bank as part of the application process for practitioners seeking clinical privileges and every 2 years for those having such privileges. The Data Bank,

administered under the direction of the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services, has been operating since September 1990.

Prior Inquiry on Hospital Reporting

In 1995, we examined the extent of hospital reporting to the Data Bank. We found that from September 1, 1990 to December 31, 1993, about 75 percent of hospitals in the United States had never reported an adverse action to the Data Bank. Our report also cited four issues that warranted further analysis to determine whether this level of reporting constituted a problem that must be addressed:

- C There may be few practitioners with serious performance problems;
- C Some hospitals may be responding to poorly performing practitioners in ways that do not require reporting to the Data Bank;
- C Some hospitals may be de-emphasizing or even avoiding adverse actions against poorly performing physicians; and
- C Some reportable hospital actions may not, in fact, be reported to the Data Bank.³

In response to our recommendations, HRSA convened a national conference examining the minimal reporting and funded a study that examined hospital reporting in more depth.⁴ But by the end of the decade, the situation was not much different: 60 percent of the hospitals still had not reported a single adverse event to the Data Bank.⁵

This Inquiry

In this inquiry, conducted at the request of HRSA's Division of Quality Assurance, we focus on MCO reporting of adverse actions to the Data Bank. Like hospitals, they must report to the Data Bank any actions they take against affiliated practitioners that affect their clinical privileges for more than 30 days. Their cooperation in carrying out this reporting requirement is important because MCOs have come to represent a significant potential source of information for the Data Bank. Enrollment in MCOs increased from 34 million in 1990 to 81 million in 1999. During the same period, Medicare enrollment in MCOs increased from 1.6 million to 6 million; Medicaid from 1.4 million to 11 million.⁶

Our quantitative analysis in this report drew on data in the Data Bank for the period from September 1, 1990 to September 30, 1999.⁷ In assembling the data on MCO reporting to the Data Bank, we used an inclusive definition of MCOs, one that includes Health Maintenance Organizations and Preferred Provider Organizations.⁸

Our qualitative analysis aimed to offer some understanding of factors influencing MCO reporting to the Data bank. We held telephone discussions with medical and/or executive leadership of six MCOs located in different parts of the country; in four of these instances, the MCO officials represented nationally based organizations (and therefore were relevant to hundreds of subsidiary health plans and many thousands of enrollees and affiliated practitioners). After the issuance of

our draft report, we held a focus group session with officials from the American Association of Health Plans and with medical directors and other officials from five additional MCOs.

We held other discussions with two consumer advocates, two knowledgeable experts on the credentialing process, a health care attorney whose clients include MCOs, and two senior officials at a national managed care accrediting organization. We conducted a literature review, focusing on literature that helped to explain the role of MCOs in monitoring the performance of practitioners. And, finally, we drew on more than 15 years of our own work concerning quality assurance (see appendix B for a complete list of our reports on quality assurance).

We begin our presentation by presenting data on MCO reporting to the Data Bank. We then turn to a discussion of possible explanations and to an elaboration of the broader concern that emerged from our review. We close by offering a number of issues calling for further analysis.

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

EXTENT OF REPORTING

For health care entities seeking to protect patients from poor care, adverse action reports serve as an important signal. They identify practitioners who have been disciplined because of peer concerns about their competence and/or conduct. These practitioners have been found responsible for actions that adversely affect or could adversely affect the health or welfare of patients. It is the responsibility of entities that hire or affiliate with physicians or dentists to consider carefully such reports and determine whether or under what conditions they should allow practitioners identified in these adverse action reports to treat patients. It is also the responsibility of these entities to regularly review the performance of their own practitioners and, when called for, to take adverse actions and report them to the Data Bank.

As the Data Bank became institutionalized in the 1990s, health care organizations have come to rely upon it as a significant tool in their credentialing processes.⁹ Hospitals, which are mandated to query the Data Bank, have long since become accustomed to using it. Managed care organizations, even though not required to query the Data Bank, have regularly been doing so and now account for about one-half of all queries. From September 1, 1990 to December 31, 1999, they queried the Data Bank more than 8 million times.¹⁰ At an average cost of about \$4 a query, this amounts to more than \$30 million they spent during the 1990s to query the Data Bank.

Yet, as the data below reveal, the MCOs provide little input to the Data bank. They do little to contribute to its usefulness as a credentialing resource either for themselves or for others who look to the Data Bank as a patient protection tool.

Managed care organizations rarely submit adverse action reports to the Data Bank.

From September 1, 1990 to September 30, 1999, they reported only 715 adverse actions to the Data Bank.

During a period when enrollment in managed care grew to account for over 100 million Americans, MCOs took reportable actions against fewer than 1,000 practitioners. The rate of reporting increased slightly over the past decade. In 1991, the Data bank received 32 reports; by 1998, the Data Bank received 116 reports.

Eighty-four percent of the managed care organizations currently registered with the Data Bank (1,176 out of 1,401) never reported an adverse action to the Data Bank.

Among the 225 that reported an adverse action, almost half did so only once. At the other end, three reported more than 20 adverse actions; they are located in Arizona, Florida, and Ohio.¹¹

EXPLANATIONS

We recognize that no clear basis exists for how much MCO reporting to the Data Bank should occur. However, given that managed care has become the dominant form of health care, that close to 100 million individuals are enrolled in MCOs, and that hundreds of thousands of physicians and dentists are associated with them, less than 1,000 adverse action reports during the 1990s appears to be low. At the least, this low level of reporting calls for some explanation.

Among the possible explanations we identified that deserve consideration are the following:

- *The level of reporting may be appropriate.* It appears unlikely to us, but we must recognize this explanation as one possibility. Supporting it is the contention, as we will address shortly, that MCOs look to other bodies to take the kind of actions that are reportable to the Data Bank.
- *MCOs may not be submitting reportable actions.* This possibility was underscored during our focus group session, when some MCO officials offered their understanding that direct MCO reporting to the Data Bank is not required. They indicated that they submit reports to the State medical board, not the Data Bank.¹² In any case, we have no basis for knowing how often reportable actions are not reported.¹³
- *MCOs may be responding to poorly performing practitioners in ways that do not require reporting to the Data Bank.* These might involve adverse actions that are below the threshold of a reportable action. They might also involve educational efforts that are not punitive in nature and that are in accord with quality improvement precepts that seek to establish safe environments for acknowledging errors and/or correcting deficiencies. From this vantage point, a report to the Data Bank can be seen as a policing action that undermines improvement efforts and that ought to be avoided except in the most extreme circumstances.
- *MCOs may lack sufficient access to information to determine if an adverse action is warranted against a practitioner.* Because of concerns about legal liability and other reasons, hospitals, physician practice groups, and even MCOs themselves are reluctant to share information they have about the performance of individual practitioners and to divulge peer review information that has traditionally been regarded as confidential.¹⁴ Furthermore, the patient information that is needed to make such informed judgments about performance tends to be scattered among many settings, such as a physician's office, a hospital, an ambulatory surgical center, and a laboratory.¹⁵ Thus, even those MCOs that may be inclined to carefully monitor the performance of individual practitioners are likely to have a difficult time doing so with a high level of confidence.

Each of these explanations deserves attention as part of any complete examination of the factors influencing MCO reporting to the Data Bank. But as we synthesized the information we obtained through our interviews and literature review, two explanations stood out as being especially convincing. They are concerned with basic characteristics of the health care marketplace as it has evolved in recent years. These explanations suggest that MCOs rarely consider adverse actions against practitioners, let alone take actions and then not report them to the Data Bank.

The two most likely explanations for low level of reporting

Limited focus on clinical oversight

Some MCOs devote considerable attention to the quality of care provided to their enrollees. They issue practice guidelines, collect and review indicators of physician performance, monitor adverse events, and, as needed, conduct peer review.¹⁶ But the clear thrust of our interviews and review of literature is that evolving conditions in the health care marketplace have contributed to a more limited focus on clinical oversight by MCOs. To a considerable degree, as some managed care officials themselves emphasized to us, their organizations are functioning more as insurance companies than as clinical entities. They described their organizations more as administrative entities than as integrated health care delivery systems that coordinate, monitor, and assure the quality of care that individual practitioners provide.

Many physicians, it seems, share this assessment. One MCO medical director told us about focus group sessions that her organization had conducted with physicians in its network. According to the focus groups, only a few physicians considered the MCO as a clinical organization. The majority viewed it as nothing more than a “bill paying organization.”

Below, we identify three characteristics of the current managed care environment that buttress the observation that MCOs tend to play a limited role in conducting clinical oversight of their practitioners:

Heavy reliance on contracted panels of physicians rather than salaried physicians. The managed care organizations of today rarely function as staff model health maintenance organizations with salaried physicians.¹⁷ Instead, they tend to be loose networks that contract with individual physicians. These physicians, in turn, typically are aligned with multiple MCOs.¹⁸ Managed care officials reported that while both staff and contracted physicians go through a rigorous process of credentialing, the ongoing quality review of contracted physicians is distinctly less than has been the case for staff physicians.

Marketplace emphasis on price. In recent years much national attention has focused on health care quality. But the clear experience of the health care marketplace is that purchasers and consumers have emphasized price in selecting health plans. This has been well documented in recent studies. It means that MCOs often have little incentive to devote many resources to quality assessment and improvement.¹⁹ One managed care

executive, whose organization had taken a number of important quality initiatives, including some aimed at poorly performing practitioners, expressed his frustration over how minimally these initiatives were rewarded by the marketplace.

Consumer emphasis on access to physicians. Consumers have sent a strong and clear message to MCOs and to employers that they want wide access to individual physicians.²⁰ Many States have passed laws facilitating such choice and most MCOs have developed product lines offering consumers less restrictive health plan arrangements that afford them extensive choice of physicians. In this environment, MCOs find that any removal of individual physicians from their panels, even for quality reasons, can be unpopular with enrollees because it diminishes choice. In the current marketplace, MCO officials tell us that assuring widespread patient access to physicians has much more drawing power in attracting or retaining enrollees than does rigorous quality assurance that, to some extent, could restrict access.

Reliance on downstream entities--hospitals, physician practice groups, and State licensure boards--to conduct quality monitoring of practitioners

Given their own limited role in protecting patients from poorly performing practitioners, MCO officials emphasized to us that they rely on the aforementioned entities to perform that critical patient protection function. They explained that hospitals, physician practice groups, and licensure boards are more directly concerned with the delivery of care (compared with the upstream MCOs) and are therefore in a better position to identify questionable performers and to take actions that could call for reporting to the Data Bank.²¹

As an ongoing check on the competency of practitioners, MCO executives told us that they rely heavily on the privileging functions of hospitals.²² This is especially true for physician specialists. Some MCOs, in fact, use their contracts as ways of fostering such links--for example, requiring practitioners to notify the MCO of any changes in their hospital privileging status or requiring a hospital to notify the MCO of any change in such status.

A BROADER CONCERN

Limitations of the downstream entities that MCOs rely upon

The heavy reliance that MCOs place on hospitals, physician practice groups, and State licensure boards accentuates the importance of these bodies' efforts to identify and deal with poorly performing practitioners. For patients, these bodies serve as a vital front line of protection. In this study, we did not examine the performance of these downstream entities, but we know from our prior studies and from the health care literature that there is ample basis for questioning how well they protect patients from those few practitioners who can be dangerous.

Hospitals find it difficult to hold individual practitioners responsible for poor care and to undertake system reforms that foster patient safety.

MCO representatives told us that they rely on hospital privileging and quality review actions to make certain that practitioners provide safe care of high quality. But hospitals are hard-pressed to provide these expected safeguards. We have already noted in this report that 60 percent of the hospitals in the U.S. have never reported an adverse action to the Data Bank. Our prior work has shown that hospital privileging actions can be cursory and that neither the process of accrediting nor certifying hospitals is likely to detect substandard patterns of care or individual practitioners with questionable skills.²³ And the extensive literature on medical errors documents many of the factors that inhibit hospitals and other health care providers from taking preventive actions to reduce the likelihood of harm caused by the treatment process.

These shortcomings in hospital quality review are especially alarming given that hospitals are places where inappropriate care can lead to unnecessary harm. This evidence is documented in the professional literature and is frequently described in the media.^{24,25}

Physician practice groups appear to be similarly constrained.

Thousand of practice groups of various kinds exist across the country. The collaboration and peer review that exist within them certainly serve as an important ongoing force for high quality health care. Yet, we know little about how and how rigorously these physician practice groups protect the public from those few poorly performing practitioners who may pose a danger.²⁶

There is, we believe, reason to have some concern on this matter. From September 1, 1990 to September 30, 1999, group practices reported only 60 actions to the Data Bank. We know from our reviews of State licensure boards and from regular discussions with licensure board officials that these groups rarely report one of their colleagues to a licensure

board for investigation.²⁷ In some cases, groups that find a colleague to be practicing substandard care may merely let that colleague go rather than report him or her to the licensure board. That action helps protect patients relying on the particular physician group, but it leaves the physician free to practice in another setting and perhaps expose patients to harm elsewhere. Indeed, if the group practice took no official action against the physician, the next organization that credentials the physician will likely remain uninformed about the prior performance problems.

State licensure boards struggle with quality-of-care cases.

Quality-of-care cases are complex, time-consuming, and costly to pursue. In our studies over the years, we have given particular attention to State medical licensure boards and to the significant constraints they face in seeking to ensure the public that licensees meet minimum standards of care. These constraints include significant resource shortages, minimal referrals from health care providers (such as hospitals and MCOs), limited authority to collect evidence that can reveal a pattern of poor performance, and a fragmented investigatory process.²⁸ In recent years, these boards appear to have become more attentive to quality-of-care cases and to have strengthened their capacity to address such cases. But numerous inquiries indicate that they still function with significant limitations.²⁹

ISSUES WARRANTING ATTENTION

Recently, the Institute of Medicine (IOM) has drawn national attention to the widespread phenomenon of medical errors and to the kind of measures that can be taken to increase patient safety.³⁰ In its call for action, the IOM emphasized that most errors are attributable to error-prone systems rather than individuals. Accordingly, it urged reform efforts that focus on a redesign of such systems. But the IOM also made clear that as part of an overall effort to promote patient safety, it is important to give attention to the existence of “unsafe practitioners” who present danger to patients. It recognized that some individuals may be “incompetent, impaired, uncaring, or may even have criminal intent.”³¹ “The public,” it added, “needs defensible assurance that such individuals will be dealt with effectively and prevented from harming patients.”³² An important part of system reform, it made clear, is to ensure that adequate systems exist to identify and deal with poorly performing practitioners.

Our observations about the limitations of downstream entities that MCOs rely upon to foster patient safety suggest that greater attention needs to be paid to providing the assurance that the IOM calls for. Below we identify seven key issues that we believe warrant greater attention if patients are to be provided improved protection against “unsafe practitioners.” These are issues that can be addressed by individual researchers, research organizations such as the Institute of Medicine, and by component agencies of the Department of Health and Human Services--most especially the Agency for Healthcare Research and Quality (AHRQ), the Health Resources and Services Administration (HRSA), and the Health Care Financing Administration (HCFA).

Dealing with unsafe practitioners as part of patient safety efforts

How can this best be accomplished? What kind of initiatives appear to be most promising and why? The IOM report suggests that these are important questions worth addressing. Within HHS, AHRQ serves as a focal point for promoting patient safety. Through its research, demonstration, and public education efforts, it could play a valuable role in helping MCOs, hospitals, physician practice groups, and other health care providers determine how identifying and responding to poor performers could be integrated into system reform efforts intended to promote patient safety. In this regard, AHRQ could devote particular attention to the kind of educational and remedial efforts that could be directed to practitioners who have been experiencing performance problems. Given that an implicit aim of the Data Bank is to help protect the public from harm caused by such practitioners, HRSA’s Division of Quality Assurance, which operates the Data Bank, could play a helpful collaborative role in determining how best to deal with unsafe practitioners.³³

Patient protection role of MCOs

Our limited inquiry suggests that the primary patient protection role carried out directly by MCOs rests in their practitioner credentialing efforts. A fuller inquiry could examine the

degree to which that is, in fact, the case and the level of protections actually afforded by these credentialing efforts. Are some more effective than others? If so, why? For the Medicare and Medicaid programs, it is especially important for HCFA and State Medicaid agencies, which serve as purchasers of care on behalf of their beneficiaries, to examine the kind of practitioner monitoring actions they expect of MCOs and how fully they hold them responsible for those actions.³⁴ To the extent that MCOs are not held responsible for protecting patients from unsafe practitioners, then increased scrutiny must be directed to the downstream entities seen to have that responsibility.

Patient protection role of physician practice groups

Given the dependence that MCO representatives say they place on the quality monitoring efforts of physician practice groups, it becomes increasingly important to understand the extent and nature of these efforts. With so many of these groups and with so many different arrangements under which they function, this can be a difficult undertaking. But it appears to us that it is one that warrants attention. How can we explain that in the 1990s these groups reported only about 60 adverse actions to the Data Bank, or that they rarely make referrals to State medical boards? How do they deal with their own colleagues who are not performing adequately? Are there promising quality monitoring approaches being undertaken by some of these groups? Better understanding of these questions can be helpful in improving the protections afforded in nonhospital settings. It would be helpful for some HHS component to convene a conference that addresses the practitioner monitoring roles and responsibilities of physician practice groups and MCOs.

Effectiveness of hospital privileging practices

In our prior review addressing the external review of hospital quality, we recommended that HCFA give greater attention to the oversight of hospital privileging practices. This study adds a measure of urgency to that recommendation because senior MCO officials emphasized to us that they rely heavily on hospital privileging practices as a quality assurance check. This privileging function is a vital patient safeguard, one that goes beyond the credentialing function and one that can continually assess a practitioner's competency. It warrants greater scrutiny. We expect to look more fully at this issue as we continue to monitor the adequacy of the external review of hospital quality.

Performance of licensure boards in quality-of-care cases

These boards provide a vital front line of protection for patients.³⁵ In its report on medical errors, the IOM recognized the key role that they play in fostering patient safety and indicated that "existing licensing and accreditation should be strengthened to ensure that all health care professionals are assessed periodically on both skills and knowledge for practice."³⁶ Within HRSA, the Division of Medicine in the Bureau of Health Professions has a long association with State licensure boards. It is well-positioned to work with these boards (and their associations) to find ways in which they can improve their capacity to identify and act on quality-of-care cases

and be held appropriately accountable for their performance in this area.³⁷ This is an area that the Office of Inspector General reviewed extensively a number of years ago and intends to revisit soon.³⁸

Managed care organizations' understanding of their reporting responsibility

The fact that at least some MCOs do not recognize that they are expected to submit adverse action reports directly to the Data Bank, rather than through a State medical board, is an important insight that emerges from our inquiry. We do not know the extent of this misunderstanding, but it is possible that it could explain to some degree the small number of MCO adverse action reports to the Data Bank. Accordingly, to clear up any possible misunderstanding, we urge HRSA to conduct outreach to inform MCOs of their reporting responsibilities.

Managed care organizations' compliance in reporting adverse actions.

Finally, it is important to know more about compliance efforts being taken to ensure that MCOs and other entities are, in fact, reporting adverse actions to the Data Bank. We urge HRSA to follow through with the request for proposal it is considering in this regard. We also suggest that further attention be given to how, and how thoroughly, accrediting bodies ensure that reporting responsibilities are carried out.

COMMENTS ON THE DRAFT REPORT

Within the Department of Health and Human Services, we received comments on the draft report from the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, and the Health Care Financing Administration. In addition, we received comments from the American Association of Health Plans. Based on these comments, we made some changes that are reflected in this final report. Below, we summarize the comments of the respondents and offer our responses in italics. Appendix A contains the full text of each set of comments

Health Resources and Services and Administration

HRSA expressed its readiness to work with other HHS components, particularly AHRQ, to sponsor a conference, as we suggest, that would address practitioner monitoring roles and responsibilities of physician practice groups and MCOs. The agency underscored the importance of MCOs developing accountability systems directed to unsafe practitioners. In reviewing our possible explanations for the low level of MCO reporting to the Data Bank, it suggested that we could provide greater emphasis on our explanation that MCOs “may be responding to poorly performing practitioners in ways that do not require reporting to the Data Bank.” It based that statement on comments it has heard that when MCOs wish to get rid of poorly performing physicians, they frequently “terminate without cause,” and thereby free themselves of any reporting responsibility. In addition, it suggested two technical changes that we reflected in the final report.

We urge HRSA and AHRQ to follow through with the proposed conference; it could contribute significantly to understandings about the clinical oversight being undertaken in managed care settings. We understand HRSA’s concern about the possibility of MCOs evading reporting responsibilities by avoiding the peer review process and terminating physicians without cause. But we have no basis for knowing if, in fact, that is happening, and, if so, how often. However, on the basis of the focus group discussion we held with a number of MCO representatives after the draft report was issued, we did become aware that misunderstandings about reporting responsibilities may be contributing to some degree to the low level of MCO reporting. Accordingly, in the final report, we added a suggestion that HRSA conduct outreach to help managed care organizations understand their responsibility for submitting adverse action reports to the Data Bank.

Agency for Healthcare Research and Quality

As with the other Departmental components, we had considerable interaction with AHRQ on our working draft report and incorporated a number of their suggestions in the draft report. In its comments on the draft report, the agency agreed that research is needed along the lines we suggested. It indicated that it would consider the report’s findings when implementing its patient safety agenda during the fiscal year.

We look forward to working with AHRQ to assist in this process and underscore the importance of incorporating within patient safety efforts a component that helps identify effective ways of dealing with substandard practitioners.

Health Care Financing Administration

HCFA, after summarizing relevant laws that concern MCO reporting, emphasized that Medicare+Choice organizations with which it contracts are expected to adhere to all applicable non-Medicare laws. It indicated that during its biannual on-site monitoring visits of these organizations, it reviews credentialing files. It added that it will consider whether any changes or additions to its regulations are warranted. This comment addresses our suggestion that HCFA examine the obligations that it and the States impose on MCOs that enroll Medicare or Medicaid beneficiaries.

HCFA noted that we made substantive changes responsive to its comments on our working draft report. But it noted that we did not provide documentation on our assertions that staff model HMOs have better control over quality than MCOs that contract with physicians and that MCOs have little incentive to devote many resources to quality assurance.

On the first point above, our observation was that MCOs' quality review of contracted physicians was less than that of staff physicians. It is based on our interviews and reflects the lesser leverage that MCOs tend to have over contracted physicians who often are associated with multiple MCOs. On the second point, we omitted the reference about incentives, but continue to stress the marketplace emphasis on price rather than quality.

American Association of Health Plans

A central point of AAHP's comments and our subsequent focus group meeting with AAHP officials and medical directors convened by them was that managed care organizations play a more active role in addressing quality of care issues than we indicated in our draft report.

As a result of that meeting and further conversations with MCO officials, our discussion in the final report is more nuanced on MCO's quality assurance role. We recognize the significant attention they give to practitioner credentialing and acknowledge that some MCOs give considerable attention to the quality of care provided to their enrollees. But drawing on the bulk of our interviews and the health care literature, we still conclude that marketplace conditions contribute to what in the main is a limited MCO focus on clinical oversight.

Another important point that emerged as a result of our interactions with AAHP is that some MCOs have misunderstood their responsibility to report adverse actions directly to the Data Bank rather than to State licensure boards. *We found this explanation for the low level of reporting to be important enough to integrate into our possible explanations of the low level of reporting and to urge HRSA to conduct outreach to MCOs to clear up any such misunderstandings. It is possible that such outreach could result in a significant increase in the number of MCO reports submitted to the Data Bank.*

Comments on the Draft Report

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

MAR 2 2001

TO: Deputy Inspector General for Audit Services, OS

FROM: Deputy Administrator

SUBJECT: HRSA Comments on OIG Draft report: "Managed Care Organization
Nonreporting to the National Practitioner Data Bank: A Signal for Broader
Concern" OEI-01-99-00690

Thank you for the opportunity to provide comments on the subject draft report. Attached please find HRSA's comments.

Staff questions may be referred to John Gallicchio on (301) 443-3099.

A handwritten signature in black ink, appearing to read "Tom Morford".

Thomas G. Morford

Attachment

**COMMENTS OF THE HEALTH RESOURCES AND SERVICES ADMINISTRATION ON THE
OFFICE OF THE INSPECTOR GENERAL'S DRAFT REPORT: "MANAGED CARE
ORGANIZATION NONREPORTING TO THE NATIONAL PRACTITIONER DATA BANK: A
SIGNAL FOR BROADER CONCERN"**
OEI-01-99-00690

General Comments

We appreciate the OIG undertaking this inquiry and providing us with the opportunity to review the draft report. Our response to this report includes general comments and specific responses to the four recommendations contained in the resultant report.

Concern at many levels of the Department of Health and Human Services over the low number of clinical privileges adverse action reports that Managed Care Organizations (MCOs) submit to the National Practitioner Data Bank (NPDB) led to the interest and initiative to conduct the assessment which resulted in this report. However, the final report's focus is not only on conclusions about factors contributing to the relatively low number of reports MCOs submitted to the NPDB but on the locus of MCO management levels responsible for performing clinical oversight and submitting adverse clinical action reports to NPDB. The report concludes that the most likely reason there is little MCO reporting to the NPDB is that MCOs accept only limited responsibility for clinical oversight and that MCOs rely on "downstream" entities (hospitals, physician practice groups, and State licensure boards) to conduct quality monitoring. In any event, we can conclude from the OIG's report that the low levels of MCO reporting to the NPDB is part of a more general managed care system quality oversight issue.

In our opinion, the report could provide greater emphasis on one of the report's four possible explanations for the current level of MCO reporting. This explanation states that MCOs "may be responding to poorly performing practitioners in ways that do not require reporting to the Data Bank." Staff of HRSA's Bureau of Health Professions, Division of Quality Assurance (DQA) have been told by administrative staff of one of the Nation's largest health care insurer plans that when MCOs wish to get rid of poorly performing practitioners, they often "terminate without cause." This means they do not assess the practitioner's clinical actions through the peer review process. It is NPDB policy that reportable adverse clinical actions must be determined through a peer review process. Unfortunately, the consequences of taking an administrative dismissal action such as this means the action is not reportable to the NPDB. This could also be one reason for the low number of MCO reports submitted to the NPDB. We believe this issue needs to be more fully explored.

The report provides four specific references of particular relevance to the Division of Quality Assurance (DQA):

- On page 10, the report suggests that DQA should play a collaborative role in determining how best to deal with problem practitioners. The report notes that the Agency for Healthcare Research and Quality (AHRQ) has the lead within the

Department in this area. DQA has been in the past, and continues to be receptive to working with AHRQ in addition to conducting its own work in this area, as acknowledged by a footnote in the report.

- On page 11, the report states "it would be helpful for some HHS component to convene a conference that addresses the practitioner monitoring roles and responsibilities of physician practice groups and MCOs." DQA would be pleased to work with other HHS agencies, particularly AHRQ, to sponsor such a conference.
- On page 12, the report endorses the current DQA effort to contract for a reporting compliance study. In fact, DQA is presently working with the OIG to award such a contract.

Also on page 12, the report says "that further attention be given to how, and how thoroughly, accrediting bodies ensure that reporting responsibilities are carried out." DQA has made several efforts in this regard in the past. We were recently pleased when the Joint Commission on Accreditation of Health Care Organizations (JCAHO) agreed to meet with us to discuss this issue. If JCAHO were to include an NPDB reporting requirement as part of their accreditation surveys, we believe that significant improvements could be realized. In terms of MCO accreditation, DQA has had a collaborative relationship with the National Committee for Quality Assurance (NCQA). For example, NCQA includes staff from DQA in its NCQA's Quarterly Educational Seminar "Effective Credentialing." We hope that NCQA will be willing to take a proactive role in ensuring that MCO's carry out their NPDB reporting requirements; NCQA's interest in these and similar issues has been appreciated.

We suggest that the broader patient protection role of MCOs is related to the responsibilities of MCOs to assure quality as stipulated for Medicare and Medicaid. These requirements suggest the need for the MCO to develop accountability systems related to unsafe practitioners. While the MCOs are primarily insurers, the fact that they enter into contractual relationships with practitioners suggests that they have a vehicle for holding practitioners accountable for unsafe practices.

OIG's methodology and data analysis

The MCO, hospital, and group practice reporting data presented in the report are limited. The importance of the data on the level of MCO reporting (i.e., the 715 reports) would be better understood if it were presented in the context of overall clinical privileges reporting to the NPDB. The 715 MCO reports cited in the report represent 8.7 percent of all the NPDB's 8,243 clinical privilege reports during the period examined. Since there was no other reporting data to which to compare the level of MCO reporting to the NPDB, the report relied on informal interview or "focus group" type data to reach its conclusions concerning why only 715 MCO clinical privileges reports were included in the NPDB. More information on how the OIG conducted discussions and the extent of the discussions would be helpful to readers in understanding the significance of the conclusions reached in the report.

Technical Comments

The authors state that during the period of 9/1/90 to 10/31/99 MCOs reported "only 715 actions" to the NPDB. The date of 10/31/99 should be 9/30/99, according to DQA records.

We thank the OIG for undertaking this study and would be happy to further discuss the issues raised in the report and this response.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Agency for Healthcare
Research and Quality
2101 East Jefferson Street
Rockville MD 20852

February 12, 2001

Department of Health and Human Services
Office of Inspector General
Wilbur J. Cohen Building
330 Independence Avenue, SW
Room 5250
Washington, DC 20201

Attention: Inspector General

Subject: OIG Draft Report: "Managed Care Organization Nonreporting to the National
Practitioner Data Bank: A Signal for Broader Concern," OEI-01-99-00690

The Agency for Healthcare Research and Quality (AHRQ) has reviewed the subject report. Agency representatives had met on several occasions with OIG and NPDB staff to provide input while the report was being drafted. The results presented in the report are not surprising and it is clear that research is needed to see what impact the NPDB has on MCO's. Other areas where research is needed include MCO reporting issues, barriers, and models, for both staff and IPA plans. AHRQ will consider the report findings, as appropriate, when implementing and executing our patient safety agenda this fiscal year.

Thank you for the opportunity to comment on the report. If you have any questions regarding our comments, please contact me on (301) 594-1669.

Sincerely,

Willard B. Evans, Jr.
Director, Office of Management



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: MAR - 5 2001

TO: Michael F. Mangano
Acting Inspector General

FROM: Michael McMullan *Michael McMullan*
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report, "Managed Care Organization Nonreporting to the National Practitioner Data Bank: A Signal For Broader Concern," (OEI-01-99-00690)

Thank you for the opportunity to comment on the above subject OIG draft audit report. The Health Care Financing Administration's (HCFA's) comments are outlined below.

The National Practitioner Data Bank (NPDB), which was established through Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, has been operating since September 1, 1990. The intent of the legislation establishing the NPDB is to improve the quality of health care by providing hospitals, State licensing boards, professional societies, and other health care entities with more complete information on physicians and dentists who engage in unprofessional behavior. PL 99-660 protects the public by restricting the ability of incompetent practitioners to move between States without disclosure or discovery of previous damaging or incompetent performance.

NPDB information is an important supplement to comprehensive and careful review of a practitioner's professional credentials. The data bank provides information on specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, and record of adverse actions on clinic privileges. Information obtained by the NPDB is intended to supplement, not replace, traditional forms of credentials review and, therefore, should serve to alert State licensing authorities and health care entities that there may be a problem with a particular practitioner's professional competence or conduct.

State licensed managed care organizations (MCOs) are required to register with, and report to, the data bank under Federal law. The law is not a Medicare-specific law; it applies to all health care entities. The governing regulation states: "Health care entity means: ... (b) An entity that provides health care services, and engages in professional review activity through a formal peer review process for the purpose of furthering quality health care, or a committee of that entity," 45 CFR 60.3. Further on, the regulation states, "For purposes of paragraph (b) of this definition, an entity includes: a health maintenance organization which is licensed by a State or determined to be qualified as such by the Department of Health and Human Services; and any group or prepaid medical or dental practice which meets the criteria of paragraph (b)." Id.

Page 2 - Michael Mangano

OIG's inspection revealed that from 1990 to 1999, 84 percent of MCOs have not reported an adverse event to the NPDB. At the same time, MCOs have reported less than 1,000 practitioners to the NPDB. According to the OIG report, two explanations for this finding were identified: (1) MCOs are assuming limited responsibility for clinical oversight; and (2) MCOs are relying on downstream entities to conduct quality monitoring of physicians.

We have reviewed the regulatory and policy requirements for Medicare+Choice (M+C) organizations reporting to data banks in cases of poor quality practitioners. While neither the Social Security Act provisions nor the Medicare regulations applicable to M+C organizations specifically reference reporting to the NPDB, 42 CFR 422.502(h) does require, as a contract requirement, that M+C organizations adhere to all applicable non-Medicare laws. Moreover, 42 CFR 422.202 requires reporting to licensing, disciplinary bodies or other appropriate authorities in cases of physician contract termination or suspension due to quality deficiencies. We have also reviewed credentialing requirements for M+C organizations. M+C regulations include credentialing requirements at 42 CFR 422.204, while 42 CFR 422.502(i) requires M+C organizations to provide oversight of credentialing in contracting and subcontracting entities. These requirements are included in the Quality Improvement System for Managed Care (QISMC) Standards and Guidelines. The credentialing requirements in QISMC require M+C organizations to query the NPDB and are considered to be a part of primary source verification.

The HCFA currently conducts biannual on-site monitoring visits of M+C organizations. During the monitoring visits, credentialing files are reviewed and credentialing staff is interviewed regarding applicable laws, regulations and guidelines. We will consider further whether any changes or additions to regulations or other policies are warranted or desirable.

Technical Comments

OIG made some substantive changes from the working draft based upon concerns voiced by HCFA during the exit conference; however, the writers did not include the following comments:

- No documentation was provided to support OIG's assertions that staff model MCOs have better control over quality of care than MCOs that contract directly with physicians.
- No documentation was provided for OIG's statement that "MCOs have little incentive to devote many resources to quality assurance."



American Association of
HEALTH PLANS®

February 11, 2001

Mr. Michael Mangano
Acting Inspector General
Office of Inspector General
Department of Health and Human Services
Cohen Building, Room 5246
Washington, DC 20201

Dear Mr. Mangano:

The American Association of Health Plans (AAHP) appreciates the opportunity to comment on the report titled, "Managed Care Organization Nonreporting to the National Practitioner Databank: A Signal for Broader Concern." While we agree with some of the observations and conclusions included in the draft report, we have identified a series of important operational and environmental issues that are not discussed.

In addition, the OIG has drawn conclusions regarding health plan reporting to the NPDB from a very small sample of the industry (six health plans). We believe that an evaluation of a larger sample of health plans would help the OIG better understand the role of health plans in quality monitoring and we request a meeting to further discuss these issues.

Our specific comments appear below.

Comments

* **Submission of adverse action reports to the National Practitioner Data Bank by Managed Care Organizations**

We believe that the draft underestimates the reporting of practitioners who are participating in MCO networks and that key factors related to determining the extent of reporting are not discussed. In addition, the draft omits discussion of infrastructure issues that affect ongoing efforts to address patient safety concerns and the limitations of MCO influence on provider behavior. We urge you to take these issues into consideration as the draft is finalized. Specifically:

- + **Reporting on practitioners affiliated with MCOs --** Health plans do identify quality problems and take action with providers. Many of these actions require short-term interventions or changes in provider practice or

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systems. In many instances, the plans identify potential quality concerns that need further evaluation including a broader review of the physician's practice patterns than the health plans enrolled population. This requires that the plan enlist medical groups, hospitals, and/or the board of medical review.

Once a quality concern is reported to these other organizations, the review process falls under the peer review protection of the investigating organization. Hospitals and medical groups will not release the results of their investigations and frequently will not provide the information needed by plans to complete their own review while the hospital or medical group review is in process. In cases where the review was initiated by the health plan and where reportable actions are taken, these actions are reported by the investigating entity to the databank. Thus the health plan may have initiated the potential quality concern, but would not be the accountable reporting entity.

In states where reporting is required to the board of medical review, the board reviews each case and may undertake their own investigation. The board of medical review then reports to the databank but often not to the health plan.

- + **Infrastructure Issues** - - Evidence suggests that most physicians practice competently, and many patient safety concerns are not due to provider error. The recent report of the Institute of Medicine (*To Err is Human, Building a Safer Health System*) notes that the greatest threat to patient safety is that key elements of the infrastructure necessary to support quality do not exist. The best example of the types of infrastructure development critical to a quality health care environment are systems that prevent drug errors through the identification of drug dosing errors, handwriting errors, and drug interactions. None of these errors require actions that result in reporting to the databank. Health plans have invested in infrastructures that prevent these errors, and they work with providers to improve their systems.
- + **MCOs Select Providers that Meet Credentialing Requirements** - - Health plans do not contract with all physicians for all services. Many health plans contract with physicians for a specific scope of practice. Plans do not contract with all physicians for colonoscopy, for example, but only with those with training and experience appropriate to perform the procedure. This credentialing and contracting process may limit the number of patient safety problems that occur or that health plans can identify.

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- + **Health plans have limited information with which to evaluate the quality of providers-** -The majority of managed care members are now covered by health plans that contract with large number of providers and any given provider has a small percentage of their patient panel with one health plan. This means that plans may not see patterns of poor quality that are visible to hospitals, where physicians admit all of their patients, or group practices, whose physicians and managers see the full range of the provider's performance.
- + **Health plans are committed to quality improvement -** -Health plans concur with the recent Institute of Medicine report, *To Err is Human*, that most threats to patient safety are due to systems errors and deficiencies that are amenable to improvement. Health plans have active internal quality improvement programs designed to enhance systems that support the delivery of care. Health plans also work directly with physicians to reduce deficiencies and improve care in a variety of ways. In most cases, physicians are able in a timely manner to eliminate the deficiencies that may have caused errors and therefore reporting to the NPDB is not necessary. In cases where there are immediate threats to patient safety or plans of correction are not successful, health plans take appropriate action and report those actions to the databank.

- **Explanations for Current Level of Reporting**

While the explanations identified in the draft for the low incidence of reporting directly attributable to MCOs identify legitimate issues, there is an important dimension of the reporting process that is not discussed. One of the major barriers to investigation and sharing of information is the current liability environment. The report of the White House Advisory Commission on Consumer Protection and Quality in the Health Care System clearly states that "...the most significant deterrent to the identification and reduction of errors is the threat of costly, adversarial malpractice litigation". The concern of medical liability was again raised in the Institute of Medicine report, *To Err is Human*. All health care entities move immediately to protect any investigation under a peer review process. Any information shared with organizations outside that process is assumed subject to discovery in the case of malpractice suits. The Health Care Quality Improvement Act of 1986 provided due process protection for providers that were subject to some type of adverse action through the peer review process. The Act requires the proceedings of the peer review process to remain confidential. Therefore, the Act does not allow for the sharing of information among entities that conduct peer review. The lack of identification of quality concerns and reporting to the National Practitioner Databank is a health system issue - not just a health plan issue.

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If you have questions about the issues raised by AAHP or are interested in additional information or data related to these issues, please contact either of us at (202) 778-3222. We would be glad to discuss our comments with you and identify member plan representatives who are knowledgeable about these issues and can provide additional information.

Sincerely,

Chuck Cutler, MD

Charles M. Cutler, MD, MS
Chief Medical Officer

Carmella Bocchino

Carmella Bocchino, RN, MBA
Vice President, Medical Affairs

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Endnotes

1. We use the term “poorly performing practitioners” to refer to those whose knowledge and/or skills are below professionally accepted standards in one or more areas of their practice. We recognize that there are complex factors that can be responsible, and that the condition can be temporary in nature. Whatever the causes or duration, however, patients face unnecessary risk when practitioners are performing below acceptable standards. Our intent in this report is not to urge that practitioners be punished for their poor performance, but to encourage adequate attention to protecting patients from harm. Interventions directed to these practitioners could well be educational or remedial in nature as long as adequate attention is given to the safety of patients during the educational/remedial process.
2. The Data Bank refers to other health care professionals as licensed health care practitioners. It defines them as individuals (other than physicians) who are licensed or otherwise authorized by the State to provide health care. According to the Data Bank, medical malpractice payments comprised 75 percent of reports submitted to the Data Bank from 1990 through 1999,.
3. Department of Health and Human Services, Office of Inspector, General *Hospital Reporting to the National Practitioner Data Bank*, OEI-01-94-00050, February, 1995
4. Laura-Mae Baldwin et al., “Hospital Peer Review and the National Practitioner Data Bank: Clinical Privileges Report,” *Journal of the American Medical Association* 282 (July 28, 1999): 4: 349-355.
5. Department of Health and Human Services, Health Resources and Services Administration, *1999 National Practitioner Data Bank Annual Report*, May 2000, p.22.
6. Including preferred provider organization with 80 to 100 million enrollees, over 150 million Americans are enrolled in some form of managed care plan. The enrollment data for Medicaid managed care are from 1991 through 1999. Interstudy Publications Press Release for HMO Industry Report 10.1, April 26, 2000 [<http://www.hmodata.com/>, accessed July, 2000.]
7. In our analysis of reporting levels of clinical privileging actions, we used the year the action was originally reported to the Data Bank. The variable is called ORIGYEAR in the Reports Research Files. We did not analyze data from the last 3 months of 1999. Because HRSA is reclassifying action codes for its web-based reporting system, the data were inconsistent with data from the previous 9 years. We excluded the last 3 months of 1999 because of these inconsistencies.
8. The Data Bank originally used variables named HMO and PPO. But because many different forms of managed care plans started to emerge, the Data Bank has gone to an all-encompassing variable called MCO to designate all of these different types of managed care plans.
9. In a report summarizing the deliberations of a meeting of the Federal Credentialing Program, the following definition of credentialing was offered: “Credentialing is employed to ensure the delivery of high quality health care by appropriately qualified professionals. Credentialing includes the verification

of education and training; the currency of state or jurisdictional licenses; registrations or certifications; proper authorization to dispense drugs; and the status of hospital privileges. It also includes a review for malpractice claims, criminal history and past adverse actions against a license.” See Health Resources and Services Administration, Center for Health Professions, *Proceedings of Demonstration Project Working Meeting of the Federal Credentialing Program*, Albuquerque, New Mexico, July 11-14, 1999, p.8.

10. Two factors help explain the large numbers of MCO queries. One is that accreditation standards set forth by the National Commission for Quality Assurance call for MCOs to query the Data Bank when credentialing and recredentialing physicians in their networks. The other is that many physicians are associated with multiple MCOs and thus are subjected to multiple queries. For example, a physician affiliated with five MCOs could well be the focus of ten or more queries every 2 years as a routine part of the credentialing and recredentialing process.

11. It is important to note that these numbers are for individual MCOs, whether or not they are part of a larger corporation. In the Data Bank’s registration system, each MCO is listed separately, whether or not it is part of a larger corporation including other MCOs.

12. Before the Data Bank allowed for electronic reporting of adverse events, MCOs, hospitals, and other entities that provided adverse event reports to the Data Bank did so through the State licensure board. They sent a paper copy of the report to the licensure board, which then sent it on to the Data Bank. This earlier practice may contribute to an explanation for why some MCOs (and perhaps hospitals and other entities) do not assume they are responsible for directly reporting to the Data Bank.

13. We do not know how fully, if at all, the accrediting bodies conduct compliance checks as part of their accreditation process. We do know that the Department of Health and Human Services conducts little such compliance checking of its own. However, within HHS, the Health Resources and Services Administration is planning to issue a request for proposals that would develop a methodology for reviewing compliance and conducting tests of the methodology in selected sites.

14. Hospitals, as well as physician practice groups, are not inclined to share peer review information with MCOs. While various factors may help explain this lack of feedback, two appear most fundamental. One is that peer review has traditionally been regarded as confidential information. Many fear that opening it up will undermine the sense of collegiality upon which it is built and therefore discourage peer review. The other factor is concern for legal liability--that whatever legal liability protections are afforded in the statute, the entities and individuals engaged in peer review could be subjecting themselves to costly and lengthy lawsuits.

15. Some MCOs have developed databases that incorporate information from patient encounters and from patient satisfaction surveys, and have used this information as a monitoring tool, sometimes disclosing it to payers and the public. But the message we received from our interviews was that even in these cases, the data collection is seldom regarded as a tool for identifying and taking action against practitioners who provide substandard care.

16. Some MCO officials explained these processes to us in considerable detail.

17. For further discussion on the changing managed care marketplace, see Jon Gabel, “Ten Ways HMOs have Changed During the 1990s,” *Health Affairs* 16 (May/June 1997) 3: 134-145. See also Bruce E. Landon et al., “A Conceptual Model of the Effects on the Quality of Medical Care,” *Journal of the American Medical Association* 279 (May 6, 1998) 17: 1377-1382, and James C. Robinson and Lawrence P. Casalino, “Vertical Integration and Organizational Networks in Health Care,” *Health Affairs* 15 (Spring 1996) 1: 7-22.

18. This is especially true for Independent Practice Associations (IPAs), which have become the dominant form of physician practice group. Some MCOs, especially those in California, have been looking to IPAs to conduct utilization review, credential physicians, and undertake other quality improvement initiatives. For further discussion on IPAs, see Thomas Bodenheimer, “The American Health Care System: Physicians and the Changing Marketplace,” *The New England Journal of Medicine* 340 (February 18, 1999) 7: 584-588; Kevin Grumbach et al., “Independent Practice Association Physician Groups in California,” *Health Affairs* 17 (May/June 1998) 3: 227-237; and James C. Robinson, “Blended Payment Methods in Physician Organizations Under Managed Care,” *Journal of the American Medical Association* 282 (October 6, 1999) 13: 1258-1263.

19. For further discussion on the preference for price over quality, see Robert H. Brook, “Managed Care is not the Problem, Quality is,” *Journal of the American Medical Association* 278 (November 19, 1997): 1612-1614; M.E. Chernew and D.P. Scanlon, “Health Plan Report Cards and Insurance Choice,” *Inquiry* 35 (1998) 1: 9-22; Commonwealth Fund, “Employers Underutilize HEDIS Data,” *Commonwealth Fund Quarterly* (Summer 1998): 1-2; Judith H. Hibbard and Jacquelyn J. Jewitt, “Will Quality Report Cards Help Consumers?” *Health Affairs* 16 (May/June 1997) 3: 218-228; Martin Marshall et al., “The Public Release of Public Data: What do we Expect to Gain? A Review of the Evidence,” *Journal of the American Medical Association* 283 (April 12, 2000) 14: 1866-1874; J. Meyer et al., “Theory and Practice of Value - Based Purchasing: Lessons from the Pioneers,” (Rockville, MD.: Agency for Health Care Policy and Research, 1997); Eric C. Schneider and Arnold M. Epstein, “Use of Performance Reports: A Survey of Patients Undergoing Cardiac Surgery,” *Journal of the American Medical Association* 279 (May 27, 1998) 20: 1638-1642; Anne Tumison et al., “Choosing a Health Plan: What Information will Consumers Use?” 16 (May/June) 3: 229-238; Commonwealth Fund, “Employers Underutilize HEDIS Data,” *Commonwealth Fund Quarterly* (Summer 1998): 1-2; and R.A. Berenson, “Beyond Competition,” *Health Affairs* (March/April):171-180.

20. For further discussion on the preference for access to physicians, see Catherine G. McLaughlin and Paul B. Ginsburg, “Competition, Quality of Care, and the Role of the Consumer,” *The Milbank Quarterly* 76 (November 4, 1998) 4: 737-743; J.D. Reshovsky et al., “Does Type of Health Insurance affect Health Care Use and Assessment of Care among the Privately Insured?,” *Health Services Research* 35 (April 2000); and Ralph Ullman et al., “Satisfaction and Choice: A View from the Plans,” *Health Affairs* 16 (May/June 1997) 3: 209-217.

21. The reference here is to all boards responsible for the licensure and discipline of health professionals, but in particular to medical licensure boards. Accordingly, our attention in this report focuses on these State medical boards.

22. Privileging, in contrast to credentialing, focuses on the substance of a practitioner's allowable scope of practice for an organization. Here is the definition of privileging provided in the Federal Credentialing Program report mentioned earlier: "Based upon the data collected in the credentialing process, a hospital, through its medical staff section, or health plan through its membership process determines the appropriate extent to professional practice to be granted to an individual health care provider." See *Proceedings of Demonstration Project*, p.9.

23. The following elaboration is from our report, "*The External Review of Hospital Quality: The Role of Accreditation*," OEI-01-97-00051, July 1999, pp. 16-17:

"A standard part of an accreditation survey is a review of hospitals' own processes in ensuring competence of their practitioners. But that review of credentialing and privileging offers, at best, a preliminary and superficial assessment. It generally last 45 to 60 minutes, during which the surveyor both interviews the medical staff leadership and reviews files (in some cases, the hospital's staff also reviews files).

While the hospitals generally choose the files for review in the credentials session, they do so at the direction of the surveyors, ensuring different privileges (active, courtesy, consulting, and temporary, for example) and specialties are represented. But time is too short for any in-depth review of these files. For example, in one hospital with over 500 active staff, the surveyor reviewed three practitioners' credentials and privileges. Even though he found a problem with one of the three (a podiatrist who was performing surgery for which he is not privileged), the surveyor reviewed no additional files.

The credentials session falls short in other ways, as well. While the surveyors do ask important questions about the hospitals' process for matching privileges to competencies and verifying licences, we observed no surveyor ask how the hospital identified or dealt with physicians whose knowledge or practice skills were marginal. Even though Federal law requires hospitals to report any practitioner they have disciplined to the National Practitioner Data Bank, it is unlikely that surveyors will make any determination about hospitals' compliance with the law: Joint Commission standards do not currently reference the law for reporting to the Data Bank, and the likelihood is low that surveyors will choose a file of a disciplined physician randomly."

24. The most comprehensive study to date is the Harvard medical practice study that involved the review of about 30,000 randomly selected records of patients hospitalized in New York State during 1984. The study found that 1 percent of the hospitalizations involved adverse events caused by negligence. The study team estimated that during 1984 negligent care provided in New York State hospitals was responsible for 27,179 injuries, including 6,895 deaths and 877 instances of "permanent and total disability." See Troyen A. Brennan et al., "Incidence of Adverse Events and Negligence in

Hospitalized Patients,” *The New England Journal of Medicine* 324 (February 7, 1991) 6: 370-376.

A subsequent study focusing on the care received by 1,047 hospitalized patients from 1989 through 1992 in a large teaching hospital affiliated with a medical school offered an even more disturbing finding. It found that 17.7 percent of the patients received inappropriate care resulting in a serious adverse event--ranging from temporary disability to death. See Lori B. Andrews et al., “An Alternative Strategy for Studying Adverse Events in Medical Care,” *The Lancet* 349 (February 1, 1997) 309-313.

Finally, a study of a sample of admissions in Utah and Colorado in the early 1990s found that 3.7 percent of the patients experienced an adverse event--an injury caused by medical mismanagement. See Helen R. Burstin et al., “Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado,” *Medical Care*: (Spring 2000) 261-271.

25. Accounts about dangerous physicians who have caused considerable harm to patients and have revealed the shortcomings of quality oversight functions regularly appear in television news magazines and in the popular press. Among the press accounts in recent years are the following: Sandra Bondman, “What Can You Find Out About Your Doctor?,” *Washington Post*, (June 8, 1999) [www.washingtonpost.com/wp-sr...ate/1999-06/08/0591-060899-idx.html, last accessed June 1999]; Jennifer Steinhauer, “Brain Surgeon Cited in Bungled ‘95 Case Faces a New Inquiry,” *New York Times* (January 18, 2000); Jennifer Steinhauer, “Surgeon Treated Wrong Side of Two Brains, Albany Says,” *New York Times* (March 1, 2000). Jennifer Steinhauer, “Inquiry Creates Doubt Around State Staten Island Doctor and Hospital,” *New York Times* (March 19, 2000); Jennifer Steinhauer and Edward Wong, “How System Let Doctor Under Inquiry Keep Working After Bizarre Act,” *New York Times*, January 27, 2000; Susan Rubinowitz and Christine Landon, “Probed Doctors Aren’t Feeling Too Much Pain,” *New York Post* (March 5, 2000); Mark McIntire and Jack Dolan, “White Coats Dark Secrets A Special Report: They Have Killed or Injured Thousands of Patients,” *Hartford Courant*, (April 30, 2000) [www.ctnow.com/s...type=article&render=&ck=&ver=hb1.3, last accessed May 2000]; Mike McIntire, “White Coats Dark Secrets A Special Report: Patients Bleed, Practice Thrives,” *Hartford Courant*, (April 30, 2000)[www.ctnow.com/s...type=article&render=&ck=&ver=hb1.3, last accessed May 2000]; Jennifer Steinhauer, “Doctor’s License Suspended Over Faulty Mammograms,” *New York Times* (June 1, 2000); Jennifer Steinhauer, “Suspended Radiologists Have Troubled Professional Histories,” *New York Times* (June 3, 2000); Michael Cooper, “Ex-Doctor is Charged in 3 Patient Deaths,” *New York Times* (July 12, 2000); and Atul Gawande, “When Good Doctors Go Bad,” *New Yorker Magazine*, (August 7, 2000).

26. Some physician practice groups, especially IPAs in California, have begun to implement utilization reviews, physician credentialing, physician profiling, and other quality assurance (QA) initiatives. While physician practice groups do engage in such efforts, there is some question as to the effectiveness of these QA initiatives. For further discussion on the limits of QA in physician practice groups, see Eve A. Kerr et al., “Quality Assurance in Capitated Physician Groups: Where is the Emphasis?,” *Journal of the American Medical Association* 276 (October 16, 1996) 15: 1236-1239; S.R. Weingarten et al.,

“Evaluation of a Pneumonia Practice Guideline in an Interventional Trial,” *American Journal of Respiratory Critical Care Medicine* 153 (1996): 1110-1115; L. M. Lewis, L.C. Lasaster, B.E. Ruoff, “Failure of a Chest Pain Policy to Modify Physician Evaluation and Management,” *Annals of Emergency Medicine* 25 (1995): 9-14; and J.M. Grimshaw and I.T. Russell, “Effect of Clinical Guidelines on Medical Practice: A Systematic Review of Rigorous Evaluations,” *Lancet* 342 (1993): 1317-1322.

27. Recently, at a national meeting of State medical boards, we held a focus group discussion with representatives of numerous State boards. The discussion focused on the boards’ handling of quality-of-care cases.

28. See Office of Inspector General, *Medical Licensure and Discipline: An Overview*, June 1986; *State Medical Boards and Medical Discipline*, OEI-01-89-00560, August 1990; *State Medical Boards and Medical Discipline: A State-by-State Review*, OEI-01-89-00560, August 1990; *Quality Assurance Activities of Medical Licensure Authorities in the United States and Canada*, OEI-01-89-00561, February 1992; *Performance Indicators, Annual Reports, and State Medical Discipline: A State-by-State Review*, OEI-89-00563, July 1991; and *State Medical Boards and Quality-of-Care Cases: Promising Approaches*, OEI-01-92-00050, June 1997.

For further analysis drawing in large measure on the above reports, see also M.R. Yessian, “State Medical Boards and Quality Assurance,” *Federation Bulletin: The Journal of Medical Licensure and Discipline* 79 (1992) 5: 126-135; M.R. Yessian, “How Can State Medical Boards Compete in the Quality Assurance Marketplace?,” *Federation Bulletin* (1994) 2: 102-108; and M.R. Yessian, “From Self-Regulation to Public Protection: Medical Licensure Authorities in an Age of Rising Consumerism,” *Federation Bulletin* 81 (1994) 3: 190-194.

29. See for examples: Timothy S. Jost, “Oversight of the Competence of Healthcare Professionals,” in *Regulation of the Healthcare Professions*, Timothy S. Jost, ed. (Chicago, IL: Health Administration Press, 1997); L.J. Finnochio, C.M. Dower, N.T. Blick, C.M. Gragnola, and the Task Force on Health Care Workforce Regulation, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation* (San Francisco, CA.: Pew Health Professions Commission, 1998); and Carl F. Ameringer, *State Medical Boards and the Politics of Public Protection* (Baltimore, Md.: The Johns Hopkins University Press, 1999).

30. Institute of Medicine, *To Err is Human: Building a Safer Health System* (Washington, DC: National Academy Press, 2000).

31. *Ibid.*, p. 169.

32. *Ibid.*

33. HRSA supported follow-up inquiries to our prior work on hospital reporting. More recently, it funded another promising effort exploring ways to improve the dialogue between health care providers and State licensure boards. Its grant to the Citizen Advocacy Center seeks to foster collaboration

between licensure boards and hospitals in developing remedial, educationally-oriented approaches for helping practitioners who have knowledge and/or practice deficiencies while at the same time ensuring that the patients remain adequately protected.

34. HCFA's Monitoring Review Guide contains language that calls for MCOs contracting with Medicare to monitor physicians who are in their network. HCFA's Quality Improvement System for Managed Care also has provisions that call for Medicare MCOs to "implement a documented process for selection and retention of affiliated providers for physicians, including members of physician groups." [www.medicare.gov/quality/3AHTM, accessed December 3, 2000]

35. These boards, of course, are State entities under the jurisdiction of the laws and governance of their individual States. But, because Medicare and Medicaid statutes require that physicians who are reimbursed under these programs be licensed by the States, the boards also provide an important service to Federal programs. Under Medicare law, doctors of medicine and osteopathy, dentists, podiatrists, chiropractors, and optometrists are the six categories of health care professionals defined as "physicians."

36. *To Err is Human*, p. 135.

37. In prior years, the Division of Medicine has provided some funding support to associations representing State licensing boards to help them improve the performance of the boards. Particularly notable was its support to the Federation of State Medical Boards for developing a self-assessment instrument. The effort resulted in a wide array of measures that boards (and others) could use to assess their performance and to review how they compared with their own performance over time and with similar boards. Unfortunately, we have learned through our inquiries that the use of this instrument, or some version of it, does not appear to have taken hold across the States.

38. It is important to note that the Federation of State Medical Boards established a special committee to address how State boards can do a better job of addressing quality-of-care cases. The committee produced a report with numerous well-considered recommendations of steps that boards (and State governments) can take in this regard. See Federation of State Medical Boards, *Special Committee on Evaluation of Quality of Care and Maintenance of Competence*, 1998.