HEALTH CARE

Most Community and Migrant Health Center Physicians Have Hospital Privileges

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Health Care:
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The Honorable Dan Rostenkowski, Chairman
The Honorable Bill Archer
Ranking Minority Member
Committee on Ways and Means
House of Representatives

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The Honorable Norman F. Lent
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508, Section 4161(a)(7)) requires that we determine whether community and migrant health center (C/MHC) physicians are able to obtain admitting privileges at local hospitals. Specifically, the act requires that we identify

- how many physicians practicing in centers are without admitting privileges or have been denied privileges at area hospitals,
- hospitals' criteria for granting admitting privileges, and
- whether these criteria are significant barriers to health center physicians acquiring hospital privileges.

This report contains our response to these questions. Our findings are primarily based on the results of a questionnaire we sent to 497 C/MHCs in the United States that employ physicians and have hospitals in their local areas. We received a 90-percent response rate to our questionnaire on C/MHCs' current experience with physician privileging. (See app. I for our scope and methodology.)

Background

Admitting privileges authorize a physician to admit patients to a particular hospital and perform specific medical procedures there. The privileges are authorized for a maximum period of 2 years at which time the hospital must consider their renewal. A physician may admit and treat patients only within the scope of the privileges granted. Both the Health Care Financing Administration and the Joint Commission on Accreditation of Healthcare Organizations have explicit privileging requirements that must be adhered to by hospitals serving Medicare patients[1] and/or seeking Commission

[1]The Health Care Financing Administration's regulations governing hospitals' participation in the federal Medicare reimbursement program (42 CFR Part 482) specify standards that a hospital must follow in granting physician privileges.

accreditation. These criteria are intended to ensure that physicians who are granted privileges are qualified and able to provide quality care. They include consideration of individual character, competence, training, experience, judgment, and evidence of adequate malpractice insurance coverage.

Sections 329 and 330 of the Public Health Service Act authorize the Department of Health and Human Services (HHS) to make grants to C/MHCs to provide primary health care for people unable to fully pay for or otherwise gain access to medical care. The centers are required to provide primary care, including physician, diagnostic, and preventive health services, regardless of patients' ability to fully pay for that care. The centers may also arrange for hospital and other supplemental services needed to support their primary care role. While HHS can award grant funds to pay for hospital and supplemental services, current policy is not to do so. The Congress appropriated $529.9 million to support health center operations in fiscal year 1991.

In June 1991, there were 539 C/MHCs[2] in the United States and its territories. The centers' physician staffs vary in size from 1 part-time physician to 83 full- and part-time physicians. A small number of C/MHCs are staffed only by physician assistants, nurses, outreach workers, and/or contract medical personnel.[3] The centers serve about 5.8 million people and have more than 24 million patient visits annually. More than 3,200[4] full- and part-time physicians staff the centers. (See app. II for additional information on C/MHCs' staffing.)

Physicians' services are provided primarily through the direct employment of doctors. However, some services are also provided by the Public Health Service's National Health Service Corps physicians, health care providers who contract for specific services, and volunteer physicians. Nonvolunteer full- and part-time C/MHC physicians are expected to have admitting privileges at local hospitals, where feasible. In those situations where physicians are unable to obtain such privileges, the Public Health Service expects centers to have referral arrangements with local providers to ensure that patients have access to the type of care needed.

[2]These 539 C/MHCs support about 1,400 clinics where services are provided.

[3]Eleven C/MHCs informed us that they do not employ physicians on either a full- or part-time basis.

[4]The number of staff employed in the 446 C/MHCs that responded to our questionnaire.

Results in Brief

Most C/MHC physicians (82 percent) have admitting privileges at area hospitals. According to C/MHC officials, those that do not, often have not applied for privileges because (1) physicians prefer not to have an inpatient practice, (2) they do not meet a hospital's professional criteria, and/or (3) the distance from the center's physician's residence/practice to the hospital where services are to be provided is often too far to allow for effective physician coverage of their patients. Furthermore, 29 C/MHCs have no physicians with privileges. But, the lack of physician admitting privileges at a local hospital does not prevent C/MHC patients from gaining access to inpatient care. Alternative means, such as referral to non-C/MHC physicians with hospital privileges and to publicly funded hospitals, are used by C/MHCs to help ensure that their patients have access to hospital services.

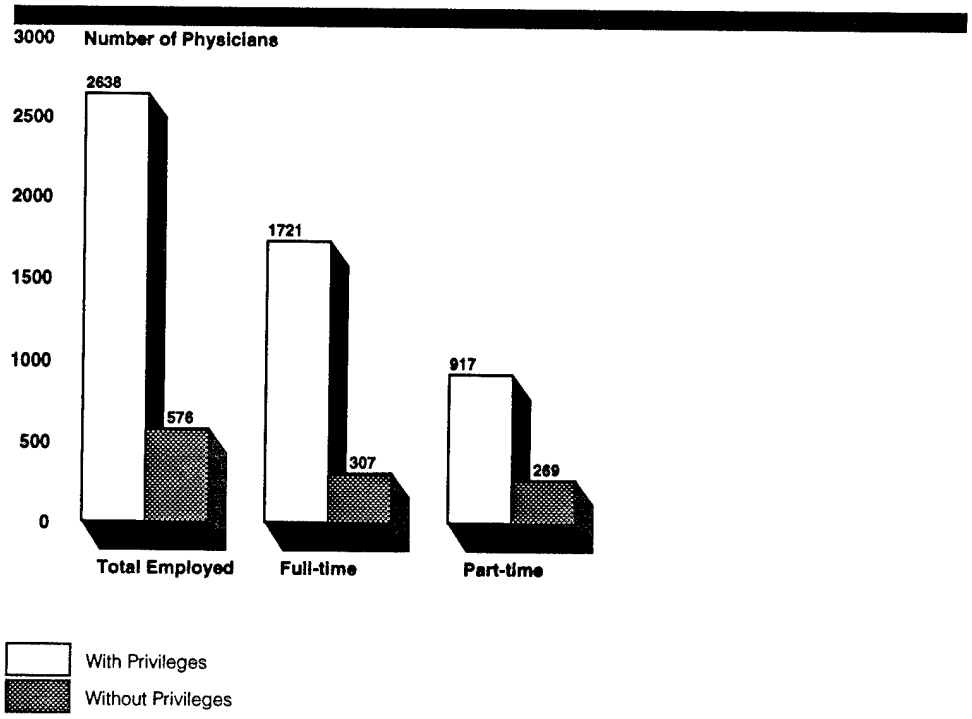
Few C/MHC physicians have been denied hospital admitting privileges because they failed to meet hospitals' criteria. However, 42 C/MHCs indicated that they employ one or more physicians who have not applied for privileges because they do not believe that they meet professional or other hospital criteria.

Most C/MHC Physicians Have Hospital Admitting Privileges

Eighty-two percent of the 3,227 physicians (2,030 full-time and 1,197 part-time) employed in the C/MHCs that responded to our survey questionnaire have patient admitting privileges at local hospitals. Further, 93 percent of these C/MHCs have at least one staff physician who has hospital admitting privileges. Only 29 of the 446 survey respondents stated that none of their full- and part-time physicians have hospital admitting privileges.[5] Figure 1 shows the extent to which C/MHC physicians in full- and part-time positions hold hospital privileges.

[5]Three of the 29 said that they discourage their physicians from obtaining privileges, either because the C/MHC has an alternative arrangement to access hospital care or because the nearest hospital is too far for effective patient coverage. In addition, 13 said that they neither encourage nor discourage physician privileges.

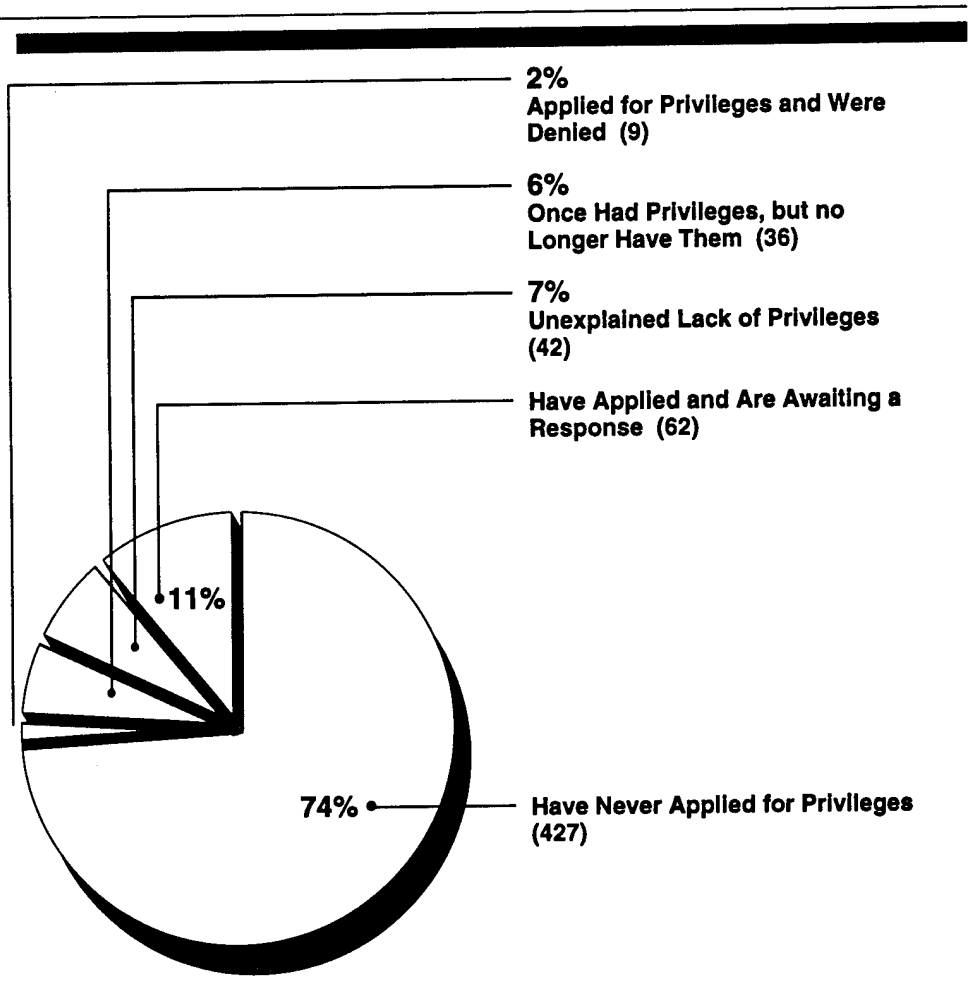
Figure 1: Extent to Which C/MHC Physicians Hold Hospital Privileges



Note: C/MHCs employ 3,227 physicians. Totals shown in bar graph differ from actual number of physicians employed because C/MHCs did not report the status of 2 full-time and 11 part-time physicians (about 1 percent).

Of the 576 C/MHC physicians (307 full-time and 269 part-time) who do not have hospital admitting privileges, 427 have not applied for them. The remaining physicians (1) have applications for privileges pending, (2) had privileges at one time, but no longer do, or (3) applied for privileges and were denied. Figure 2 shows the reasons C/MHCs gave for their physicians not having privileges.

Figure 2: Status of C/MHC Physicians Who Do Not Have Hospital Admitting Privileges



Note: 576 C/MHC physicians do not have admitting privileges.

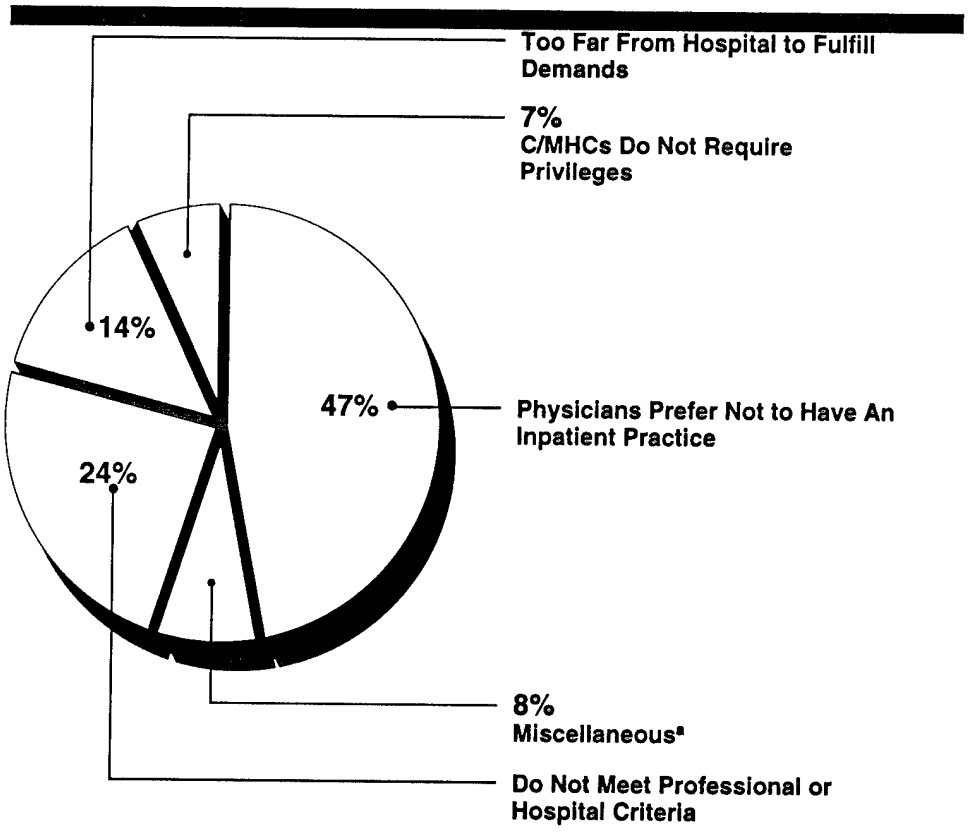
Survey respondents that employ the 427 physicians who have not applied for hospital privileges, cited the following reasons for this situation:

- physicians preferred not to have an inpatient practice,
- physicians are concerned they may not meet hospital or professional criteria,
- some teaching hospitals require that a physician applicant be a member of the hospital's faculty,

- physicians' concern with meeting some hospitals' malpractice insurance coverage requirements,[6]
- the distance between the physician's residence/practice and the hospital is too far to allow effective patient coverage, and
- C/MHC does not require privileges.

Figure 3 shows the reasons most often cited by C/MHCs for their physicians having never applied for admitting privileges.

Figure 3: Reasons C/MHCs Gave for Physicians Having Never Applied for Admitting Privileges



[a]Includes physicians who are not members of teaching hospital faculty and those concerned about meeting hospitals' malpractice coverage requirements.

[6]Several legislative proposals recently considered by the Congress, if adopted, would address C/MHC malpractice insurance coverage issues. They propose either establishing C/MHCs as a self-insured group or amending existing legislation to treat C/MHC medical staff as federal employees, which would allow successful malpractice claims to be paid from the U.S. Treasury.

C/MHCs' policies regarding physician privileges vary. Of the 446 centers responding to our questionnaire, 345 require that all their physicians have privileges, and 88 percent of their physicians have them. The remaining C/MHCs either encourage, but do not require privileges (62 C/MHCs); discourage privileges (3 C/MHCs); are neutral (28 C/MHCs); or did not state a position (8 C/MHCs).

Among the 345 C/MHCs requiring that physicians have privileges, all 1,026 full-time and 556 part-time physicians in 229 centers met the requirement. The 116 C/MHCs whose physicians did not comply with their requirement to have privileges employ 726 full- and part-time physicians with privileges and 327 without privileges.

Hospitals' Privileging Criteria Are Not Significant Barriers for Most Physician Applicants

C/MHCs' responses to our survey indicate that most of their physicians do not find that local hospital criteria prevent them from obtaining privileges when they apply. Only nine currently employed physicians who have applied for hospital privileges have been denied because they do not meet hospital privileging criteria. Of those nine, four were denied because of unacceptable professional qualifications, one because of the C/MHC physician's distance from the hospital, and one for failure to disclose a malpractice suit. The remaining three C/MHC physicians were denied admitting privileges at local area hospitals because they were not in private practice and the hospital was more than 20 miles from the center. The first criterion is not recognized in Medicare or Joint Commission standards. Distance is recognized in Joint Commission standards as a consideration in granting privileges.

To receive Medicare reimbursement and/or be accredited by the Joint Commission, hospitals must establish and follow certain privileging criteria. To be eligible for Medicare reimbursement, privileging criteria must be based on individual character, competence, training, experience, and judgment. Under no circumstances can the privileges be based solely upon certification or membership in a specialty group. Commission standards include and expand on Medicare requirements. For example, under Commission standards, hospitals can require evidence of adequate malpractice insurance coverage and can consider commuting time from an applicant's residence and work location to the hospital. With respect to teaching facilities, medical staff bylaws can make admitting privileges contingent on medical school faculty membership.

Eighteen, or 4 percent, of the 446 survey respondents believe that hospitals in their local area have, at one time or another, denied center physicians admitting privileges because they practice at the C/MHC. However, the reasons given by the hospitals to these C/MHCs for denial are all consistent with Medicare or the Joint Commission policies. They include inadequate professional qualifications, distance from the hospital, lack of faculty status, and insufficient malpractice insurance coverage. Although the number of physicians who have privileges in the 18 centers is below the 82 percent nationwide, a majority (69 percent) of the centers' physicians do have privileges. At least one physician in 13 of the 18 C/MHCs has privileges. The remaining five centers have no physicians with privileges.

In addition to data obtained through our questionnaire, we contacted seven C/MHCs that employed physicians who experienced problems obtaining hospital privileges, according to the National Association of Community Health Centers, Inc. All seven C/MHCs responded to our questionnaire, but none reported that hospitals declined to accept privileging applications or denied their physicians privileges. Two had indicated that hospitals in their area had taken longer than they thought necessary to approve privileging applications.

Officials in each of the seven centers told us that obtaining hospital privileges is not currently a problem for their physicians. An official at one of the centers that reported privileging delays told us that the problem has been resolved and that the physician involved has been granted privileges. An official at another center that reported delays told us that two of its physicians have applied for privileges at the same hospital three times in the past 3 years and that the hospital has not acted on their applications. But he also stated that neither of the physicians has completed a hospital residency program nor do they meet the hospital's distance criteria. Officials at three C/MHCs told us that they either (1) knew of no privileging problems in the past 3 years (one C/MHC) or (2) were aware of problems that occurred 5 to 8 years ago but no longer exist (two C/MHCs). Administrators from the remaining two C/MHCs did, however, express concern about the appropriateness of teaching hospitals being allowed to use faculty membership as a criterion for granting privileges. None of their physicians have privileges in the local teaching hospitals where many of their uninsured patients must go to receive care. But, most of their physicians have privileges in other local area hospitals.

Centers Have Mechanisms for Obtaining Access to Care When Their Physicians Do Not Have Hospital Privileges

C/MHCs use a variety of methods to obtain hospital care for their patients when their physicians do not have admitting privileges. These include referral of patients to (1) other C/MHC physicians with privileges, (2) non-C/MHC physicians who have privileges, and (3) public hospitals designated for the indigent, where staff physicians decide whether to admit the patient. Of the 29 C/MHCs that have no physicians privileged, 3 centers indicated that it is difficult to have patients admitted for nonemergency care, and 19 centers stated that having physicians on staff with privileges would make their admitting process easier. (See app. III for an analysis of the 29 C/MHCs.)

Even in C/MHCs where physicians have privileges, patients are not necessarily admitted to the local hospitals where privileges are held. For example, physicians in 32 C/MHCs rarely or never admit their uninsured patients for nonemergency purposes to the hospitals where they have privileges. However, none of these centers reported that their uninsured patients do not have access to hospital care. The patients are referred to either a teaching hospital or other public hospital that provides care to indigent patients. For example, one C/MHC's uninsured patients are readily admitted to a local public-teaching facility for both emergency and nonemergency hospital care. None of the C/MHC's eight full- and part-time physicians have privileges at this teaching facility to admit, treat, or follow patients. However, all of the center's physicians have such privileges at local for-profit hospitals.

We obtained oral comments on a draft of this report from Public Health Service and National Association of Community Health Centers, Inc. officials. These officials agreed with the information in the draft report. Where appropriate, we incorporated their comments and suggestions.

We are sending copies of this report to appropriate congressional committees, the Secretary of HHS, and other interested parties. We will also make copies available to others upon request. If you have any questions about this report, please call me at (202) 512-7101. Other major contributors are listed in appendix IV.

David P. Baine

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Director, Federal Health
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Contents

Abbreviations

C/MHC	community and migrant health center
HHS	Department of Health and Human Services

Scope and Methodology

In September 1991, we sent a questionnaire to all 518 community and migrant health centers located in the United States requesting current information on their physicians and their physicians' hospital privileges.[1] Subsequently, we adjusted this universe to 497 C/MHCs by deleting 21 C/MHCs that (1) do not employ physicians, (2) had their only physician slot vacant or (3) do not have hospitals in their local area. As of December 16, 1991, we had received responses from 446 of the 497 C/MHCs, representing a 90-percent response rate.

We analyzed each questionnaire response and developed information on the total number of physicians: (1) practicing in health centers, (2) with and without hospital admitting privileges, and (3) who have been denied admitting privileges. By reviewing Medicare and Joint Commission requirements we identified the criteria that hospitals use to grant physicians admitting privileges. From the questionnaire we determined the reasons hospitals had given for denying C/MHC physicians privileges, and assessed the reasons' acceptability as criteria according to the general standards identified. We did not examine the quality of primary or hospital care being provided to C/MHC patients nor did we confirm with hospitals, centers' perceptions as to why physician privileges were denied.

To identify issues that influence whether C/MHC physicians obtain admitting privileges at local hospitals, we interviewed officials at nine C/MHCs and four hospitals in Texas and Oregon. Table I.1 identifies the centers and hospitals we visited.

[1]We did not include 21 additional C/MHCs located in U.S. territories.

Table I.1: C/MHCs and Hospitals Visited

HHS regional office	
Dallas, TX (Region VI)	
C/MHCs	Los Barrios Unidos Community Clinic Dallas, TX
	Martin Luther King, Jr. Family Clinic, Inc. Dallas, TX
	Barrio Comprehensive Family Health Care Center, Inc. San Antonio, TX
	Centro del Barrio, Inc. San Antonio, TX
	Ella Austin Health Center San Antonio, TX
	Uvalde County Clinic Uvalde, TX
Hospitals	Parkland Memorial Hospital Dallas, TX
Seattle, WA (Region X)	
C/MHCs	Multnomah County Health Division Portland, OR
	Virginia Garcia Memorial Health Center Cornelius, OR
	La Clinica del Carino Hood River, OR
Hospitals	Emmanual Hospital Health Center Portland, OR
	Providence Medical Center Portland, OR
	Hood River Memorial Hospital Hood River, OR

At the nine C/MHCs, we met with officials and medical staff directors to discuss (1) how centers admit patients to hospitals when inpatient care is required, (2) the role physician admitting privileges play in gaining patient admission, and (3) whether the centers can gain access to nonemergency hospital care when the need arises, regardless of whether their physicians

have admitting privileges. We met with officials at the four hospitals visited to discuss the role of C/MHCs in the medical community and document the policies and procedures these hospitals use in granting center physicians admitting privileges.

In addition, we contacted seven C/MHCs that had physicians who experienced problems obtaining hospital privileges, according to the National Association of Community Health Centers, Inc. We requested information on the type of problems physicians had experienced, when these problems had occurred, and whether they continue. We did not discuss physician privileging with local hospital officials.

We met with Public Health Service officials within the Department of Health and Human Services, Rockville, Maryland, to (1) determine the role C/MHCs play in providing primary health care to those unable to pay for or otherwise gain access to medical care and (2) discuss policies that govern physician privileging under C/MHC grant provisions. We also researched legislation, analyzed agency regulations and policies, and collected background information on the objectives of the C/MHC program.

We also visited HHS regional offices in Seattle and Dallas, where we interviewed each regional health administrator; director, Division of Health Services Delivery; and director, Office of Grants Management to discuss their experience regarding physician privileging and their implementation of program policies and procedures. We selected these regional offices because they have oversight responsibility for several C/MHCs whose officials believed that hospitals in their areas denied center physicians admitting privileges or whose physicians have been unable to get hospital admitting privileges.

We gave Public Health Service and National Association of Community Health Centers, Inc. officials an opportunity to review and orally comment on a draft copy of this report. We considered their comments in preparing this report.

We performed our work from February through December 1991, in accordance with generally accepted government auditing standards.

Physician Staff Size at 446 C/MHCs Responding to Our Questionnaire

		Physicians on staff (actual)		
Physicians on staff (range)	**C/MHCs**	**Full-time**	**Part-time**	**Total**
1 to 10	361	1,150	569	**1,719**
11 to 20	66	567	351	**918**
21 to 30	11	164	103	**267**
31 and over[a]	8	149	174	**323**
Total	**446**	**2,030**	**1,197**	**3,227**

[a]Only one C/MHC has more than 39 physicians. That C/MHC has 3 full- and 80 part-time physicians.

Patients of C/MHCs That Have No Physicians With Admitting Privileges Have Hospital Access

Of 446 C/MHCs that responded to our questionnaire, 29 reported that none of their physicians have privileges. Table III.1 shows the reasons why this occurred and the impact it has on these centers' ability to gain hospital admission for their patients.

Table III.1: Analysis of 29 C/MHCs That Have No Physicians With Hospital Admitting Privileges

	Total[a]
Full-time physicians	65
Part-time physicians	26
Means used always, almost always, or most of the time to gain access to hospital care:[b]	
Referral to non-C/MHCs physician	15
A public hospital's emergency room	8
A nonpublic hospital's emergency room	4
Referral to volunteer physician	2
A public hospital, other than the emergency room	1
A nonpublic hospital, other than the emergency room	1
Degree of difficulty in gaining access to hospital care:	
Easy/very easy	19
Neither easy nor difficult	7
Difficult/very difficult	3
Effect admitting privileges would have on access to hospital care:	
Much easier	6
Somewhat easier	13
Not at all easier	10
Status of staff physicians:	
Applied for privileges/decision pending	6
Applied for privileges/denied	3
Have not applied for privileges	66
Status not reported	16
Reasons most physicians have not applied for privileges:[b]	
Distance too far from physician's residence/practice to hospital	9
Physician does not want to provide inpatient care	4
Does not believe he/she is medically qualified for privileges	3
C/MHC does not require physicians to have privileges	2
Does not believe he/she meets teaching staff requirements	1
Does not meet requirements for insurance coverage	1
Physician's personal considerations	1

(Table notes on next page)

[a]Total represents centers' responses rather than individual physicians' responses.

[b]Totals may vary because some C/MHCs cited more than one primary factor, while others did not indicate that any single factor was predominant.

Major Contributors to This Report

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