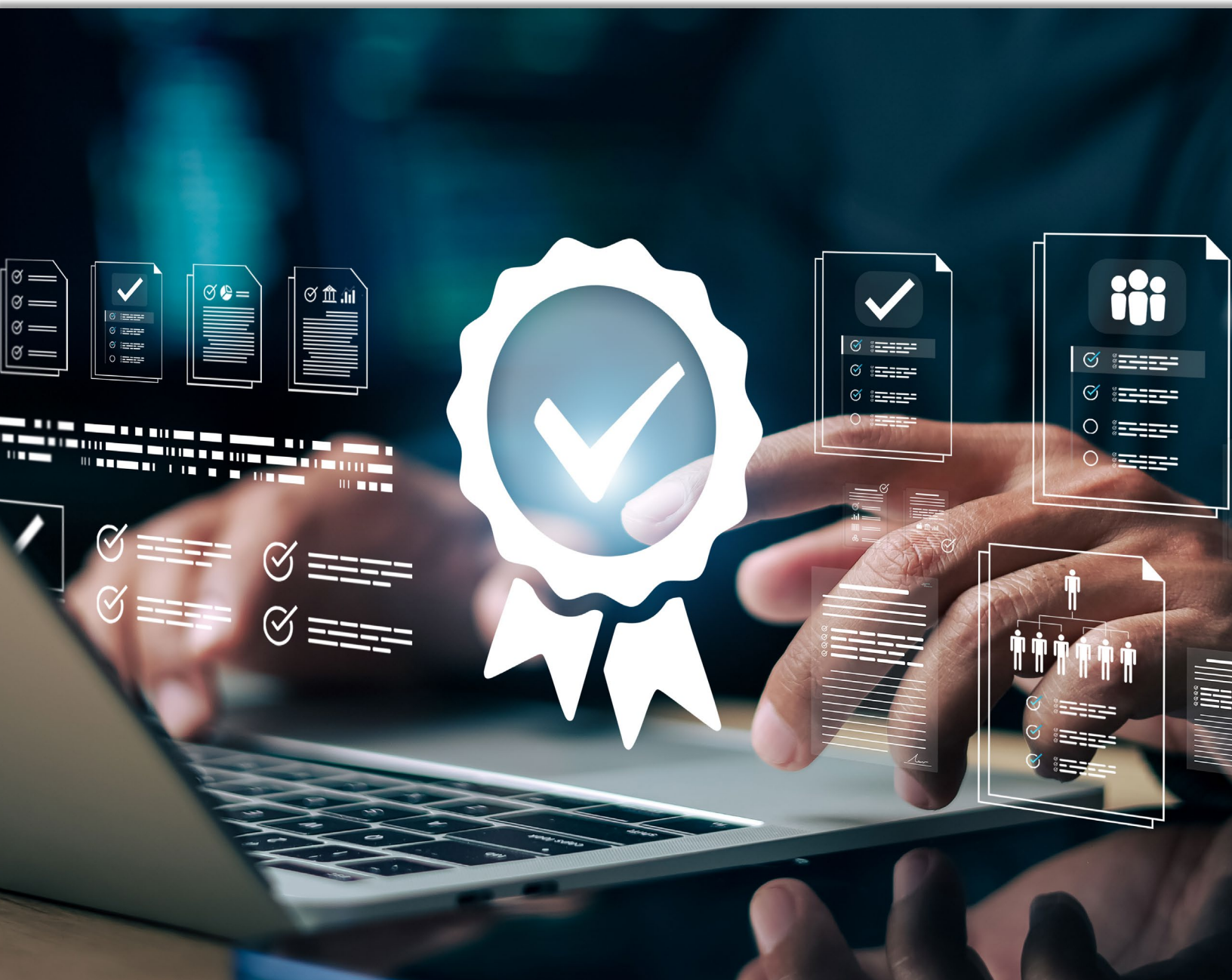
Cancer
UT MD Anderson

Internal Audit
CONNECTED

Provider Credentialing Review

June 1, 2026



Executive Summary

UT MD Anderson Medical Staff & Credentialing Services (MSCS) is responsible for ensuring that all practicing providers are properly qualified, licensed, competent, and authorized to deliver patient care in accordance with MD Anderson's standards and regulatory requirements. Between September 2024 and January 2026, MSCS processed 346 new applications and completed the recredentialing of 2,118 billing providers. Internal Audit conducted this review to assess whether effective controls and processes were in place to support patient safety and maintain compliance with regulatory requirements.

Overall, we determined that providers were appropriately licensed and credentialed as required. However, we identified the following opportunities for MSCS to further strengthen its processes and system access. Specifically, management should:

- Ensure the accuracy of reports utilized for approval of credentialed providers (*Governing Body report*),
- Implement a user access review process,
- Establish performance metrics, and
- Review provider files to ensure accuracy.

Addressing these opportunities will help limit the risk of inaccurate reporting, incomplete documentation, or potential delays in the credentialing process issues that could affect operational efficiency, compliance, and institutional credibility. Additionally, MSCS anticipates a September 2026 implementation of MD Staff Credentialing Software to support these efforts.

As part of our review, we gained an understanding of key elements which impact timeliness of the onboarding and credentialing process. As a result, we connected with the Provider Integration Oversight Council (PIOC), which has been charged with initiatives to:

- Establish onboarding timeliness targets,
- Implement accountability measures to track performance,
- Identify and address bottlenecks, and
- Ensure compliance.

The PIOC has determined that the process takes an average of about 139 days from a provider's signed offer letter to provider's first billing service date (see **Appendix B** for additional timeliness analysis).

Management Summary Response:
Management agrees with the observations and recommendations and has developed action plans to be implemented on or before 12/31/2026.

Appendix A outlines the objective, scope and methodology for the engagement.

The courtesy and cooperation extended by Medical Staff and Credentialing Services, Patient Billing Services (PBS), and Faculty Academic Life (FAL) sincerely appreciated.

Further details are outlined in the Detailed Observations section below. Less significant issues were communicated to management separately.

Ann Lovelady, CIA, CHIAP, CFE, CRMA, CCSA
AVP and Chief Audit Officer Ad Interim
June 1, 2026

DETAILED OBSERVATIONS

High

1.0 Ensure the Accuracy of the Governing Body Report

The Credentialing Committee of Medical Staff (CCMS) and the Executive Committee of Medical Staff (ECMS) regularly review reports (agendas) relating to newly credentialed providers. These reports are included as part of the Governing Body report for final approval. During our review, we noted that the department does not have a review process to ensure the information included in the Governing Body report is accurate, or a formal process for resolution when errors have been identified. Specifically:

- **Inaccurate Governing Body report**: Two providers were erroneously included on the December 2025 Governing Body report when they should have been included on the January 2026 report. Per the National Committee for Quality Assurance (NCQA) requirement, providers must have an active medical license prior to initial credentialing; however, these providers' licenses were not active until January 2026. Although our review confirmed that no services were provided in December, accuracy of the Governing Body report is critical because it serves as the institution's official authorization to initiate billing enrollment for new providers. Inaccurate information may impact leadership decision-making.

- **Lack of formal process for error resolution**: After the error was identified by Patient Billing Services, MSCS drafted an addendum to the December 2025 Governing Body report to reflect the corrections. However, this addendum was not reviewed and approved to CCMS, ECMS, or the Governing Body. This increases the risk that senior and executive leadership are not made aware of important revisions that could impact the institutions' operations or reputation.

Recommendation:
Management should establish controls to ensure the Governing Body report is accurate. Additionally, MSCS should establish a formal process so that when errors are identified, any necessary addenda are reviewed and approved by the appropriate committees.

Management Action Plan
Executive Leadership: Jeffrey E Lee, MD
Division/Department Executive: Evelyn Starr-High
Owners: Margaret Foreman, Sandra Tillman
Implementation Date: May 1, 2026

Due to limitations in the current credentialing software, the Governing Body report has historically required a manual process. To reduce the risk of error, the department has implemented additional controls, including mandatory use of a leadership-developed checklist by credentialing coordinators and a new pre-submission audit step before initial faculty applicants are presented to the CCMS. This audit is performed by a coordinator assigned to this quality-control function, which is a newly established role.

Going forward, Governing Body reports will be generated using established criteria within the credentialing software, including confirmation of active Texas licensure. Applications will also move through a virtual committee workflow designed to prevent advancement to committee review unless all required criteria are met. If corrections are identified after submission, the appropriate committee or approval body will be notified to ensure transparency and governance oversight.

High

2.0 Implement a User Access Review Process

The MSCS department does not have processes or controls for granting, modifying, reviewing, or removing user access to its credentialing system, or to ensure appropriate segregation of duties among users. This credentialing system, critical to the department's activities, contains sensitive data, including personally identifiable information (PII).

Of the 59 active users, we identified one account belonging to an individual who recently left the institution. In addition, most users have the ability to review, edit and delete information within the system. While management has indicated that this access is necessary, it is advisable to periodically review these permissions to ensure they remain appropriate and not excessive.

The National Institute of Standards in Technology (NIST) principle of Least Privilege states that users should only be granted the minimum, essential access rights necessary to perform their specific tasks, and only for the duration required. Further, per institutional policy, system access is restricted to authorized personnel in accordance with their scope of practice, so it is important to make sure that this access is not excessive since some of this information maintained in EchoCredentialing software (Echo) is considered confidential, such as social security numbers.

Having inappropriate access increases the risk of unauthorized activity, errors, inappropriate modification or deletion of confidential credentialing information leading to potential reputation risk for the institution.

Recommendation:
Management should implement a formal, periodic user access review process, performed at a regular frequency, to ensure that system access remains appropriate and aligns with users' current job responsibilities. Additionally, the Department should maintain documentation of the reviews performed to demonstrate oversight and compliance with access control requirements.

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Implementation Date: December 31, 2026

We understand the importance of this and can assure all individuals with access are provided the access based on their need and their job roles. We concur that when someone leaves, they should be removed. A formally documented user access review will be performed and occur quarterly by the Informatics Analyst. Documentation of the review will be maintained on the Department Common Drive and reported to leadership. As we migrate to a new credentialing system (MD-Staff), more rules will be established along with the development of a Data Governance Committee that will be required to review access as a part of their scope.

Medium

3.0 Establish Performance Metrics

The Department has not established key performance indicators (KPIs) to measure its success related to the credentialing process, or more broadly, its strategic and operational goals. While it collects turnaround time (TAT) data, from receipt of a credentialing application to Governing Body approval, these TATs are not assessed against internal benchmarks or national standards. In addition, limitations and system issues within the legacy Echo software affect the reliability and accuracy of the reported TAT data.

Best practices require clearly defined metrics that align with the Department's mission and objectives that should be regularly monitored. Without such metrics, the Department cannot accurately determine whether its credentialing process is operating efficiently or meeting expectations. Inefficiencies or delays in the credentialing process may go unnoticed or undetected, limiting management's ability to take necessary corrective measures.

Recommendation:
Management should establish key performance indicators/metrics, to align with the Department's mission and objectives. Once established, Management should set performance targets and monitor and report on performance regularly.

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MSCS routinely tracks credentialing turn-around-times (TATs) and reports clinical faculty metrics through the institutional dashboard (clinical faculty recruiting and onboarding dashboard). Credentialing application volumes and progress are reported monthly at staff meetings. In addition, leadership reviews monthly reports reflecting employee responsiveness and the issues identified throughout the process.

While KPIs have been developed and are being tracked, limitations in the current credentialling system and ongoing software issues affect the reliability of these data. To strengthen monitoring, the department has created and filled a new auditing role. Once the new credentialing software is deployed and staff are fully trained, leadership will routinely track, monitor, and report all established KPIs against defined targets. In the interim, management will continue tracking available metrics through existing internal processes.

External credentialing benchmarks have limited applicability to MD Anderson because of its physician employment model and additional institutional review and onboarding requirements. Discussions with UT System institutions and peer cancer centers, including Memorial Sloan Kettering, City of Hope, and Moffitt, indicate that definitions and methodologies vary, making direct comparisons difficult. However, these discussions suggest that MD Anderson's credentialing turnaround times are generally competitive.

Going forward, MSCS will continue to emphasize internally defined standards and operational targets as the most meaningful basis for performance monitoring and improvement. The Provider Oversight Integration Council established a goal for all institutional preboarding (including credentialing) steps be routinely completed within 60 days.

Medium

4.0 Review Provider Files to Ensure Accuracy

MSCS's current review process may not consistently ensure provider files are verified timely, documented accurately, or recorded completely. Specifically:

- **Untimely Primary Source Verifications**: Our review identified that one provider's PSV (see text box) was completed 126 days prior to CCMS review, exceeding the NCQA's timeframe of 120 days prior to committee approval. As a result, this provider was credentialed based on outdated source verifications instead of rerunning current verifications. According to MSCS, when PSVs are not performed within the established timeframe, it is required to restart the credentialing process to ensure the use of current and valid licensure and exclusion.

Primary Source Verifications

As part of MSCS's credentialing process, automated Primary Source Verifications (PSVs) are performed on certain provider qualifications, including screenings through key databases.

- **Inaccurately Recorded Background Check Dates**: 81 of 171 (47%) initial credentialing files tested, contained incorrect PreCheck background report dates recorded in its system of record because staff entered the report receipt date rather than the actual report date. These errors occurred because the staff was unclear about the data-entry expectations. According to MSCS, it has provided additional guidance to staff to clarify expectations.

- **Inconsistent Recording of Key Dates**: 60 of 171 (35%) initial credentialing files and 6 of 60 (10%) recredentialing files were missing key dates in Echo. For example, the EPAF offer received date and/or Department Chair approval date were not consistently recorded in the required system modules. In some cases, supporting documentation was maintained outside of Echo in a shared folder accessible to MSCS staff.

Implementing a secondary review process could help ensure credentialing activities are completed within required timeframes and that critical information is accurately recorded in Echo, its system of record. Without a review process in place, the risks are increased that data accuracy and reliability will be compromised and deadlines will be missed. *This issue was previously communicated to management in a prior engagement.*

Recommendation:
Management should implement controls to ensure provider files are verified timely, documented accurately, and recorded completely, such as, but not limited to, a review process for key information in Echo, enhanced staff training, as well as periodic monitoring.

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Previous staffing levels did not allow for consistent secondary review of provider files. To strengthen controls, MSCS has created and filled an auditor role responsible for reviewing 100% of initial faculty applications for compliance with credentialing requirements. Audit results will be uploaded into the credentialing system, and files will be formally closed once review is complete. MSCS has also implemented revised required checklists and reports to improve consistency, retrained staff on accurate documentation of background check dates and other key credentialing dates and currently reviews timeliness metrics monthly. As this is a new process, tracking and workflow expectations will continue to be refined.

Many of the identified issues relate to manual data entry in the current system. The new credentialing system, MD-Staff, will auto-populate key fields by querying designated external source databases and integrating data from other MD Anderson systems, significantly reducing reliance on manual data entry and the potential for error.

APPENDIX A – Objective, Scope, and Methodology

The objective of the review is to review the controls and processes in place to verify a provider's qualifications, experience, and background during appointments and reappointments. Our review covered processes in place for the period of September 1, 2024, through January 31, 2026, and related periods. Our procedures included, but were not limited to, the following:

- Interviewing key personnel and reviewing relevant organizational policies to understand current processes.
- Reviewing and analyzing initial appointment and reappointment data.
- Examining user access within credentialing systems for appropriate safeguarding of confidential information.

Our internal audit was conducted in accordance with the Global Internal Audit Standards. The internal audit function at UT MD Anderson is independent per the Generally Accepted Government Auditing Standards (GAGAS) requirements for internal auditors.

Audit Team: Courtney Ambres-Wade and Melissa Prompuntagorn-Gwosdz

Number of Priority Findings to be monitored by UT System: *None*

A Priority Finding is defined as "an issue identified by an internal audit that, if not addressed timely, could directly impact achievement of a strategic or important operational objective of a UT institution or the UT System as a whole."

APPENDIX B – Timeliness Analysis

The following information reflects analysis conducted by the Provider Integration Oversight Council (PIOC). According to its charter, the PIOC "provides strategic oversight and guidance on the new medical staff integration process, from recruitment through billing activation. The Council is responsible for evaluating and prioritizing critical process improvements, policy enhancements, and best practices to optimize efficiency, reduce administrative burden, and enhance the overall experience for new providers."

According to PIOC's analysis, the average timeline from the signed offer letter to a provider's first billing date is approximately 139 days. As part of a formal institutional initiative, departments are currently expected to meet a 21-day target for completing **Orientation and Practice Phase** activation. To support this goal, the PIOC has been identifying opportunities to streamline workflows and strengthen coordination across stakeholders to improve compliance with the expected timeline.