

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE MEDICARE PEER REVIEW
ORGANIZATIONS' ROLE
IN IDENTIFYING AND RESPONDING
TO POOR PERFORMERS**



**JUNE GIBBS BROWN
Inspector General**

**DECEMBER 1995
OEI-01-93-00251**

OFFICE OF INSPECTOR GENERAL

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BOSTON

Joyce M. Greenleaf, *Project Leader*
Elizabeth A. Robboy

HEADQUARTERS

Barbara Tedesco, *Technical Support Staff*

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EXECUTIVE SUMMARY

PURPOSE

To assess the ability of the Medicare Peer Review Organizations to identify and respond to poorly performing physicians and hospitals at a time when their primary mission is to improve the overall quality of medical care.

BACKGROUND

In carrying out their mission to protect Medicare beneficiaries, the Peer Review Organizations (PROs) perform two basic functions. One is to contribute to improving the overall practice of medicine by working collegially with the medical community in analyzing patterns of care and outcomes. Their focus is on the systems of care rather than individual caregivers. The other function is to identify and respond to poorly performing physicians or hospitals by reviewing individual instances of questionable care and by taking follow-up actions they deem appropriate. The former function, which aims to improve care overall, dominates. The latter function, to identify and deal effectively with poor performers, has always faced major constraints, many of which have been highlighted in prior Office of Inspector General (OIG) reports.

This report draws on data from surveys of 22 PROs representing 72 percent of the beneficiary population in the country, on aggregate data from HCFA reflecting all the PROs' record review workload under the fourth contract, on telephone calls with officials from 10 State medical boards, and on information from our previous PRO inquiries.

FINDINGS

As the PRO Program becomes increasingly committed to improving the overall practice of medicine, its ability to find and take action on poorly performing physicians and hospitals is questionable.

- ▶ **Limited Leads.** The PROs find themselves with very limited leads to identify poorly performing physicians or hospitals. The PROs rely on beneficiary complaints, referrals from the medical community, and newer approaches to identify poor performers. However, the beneficiary complaint process, as we indicated in a recent report, has significant flaws; the referrals from the medical community remain minimal; and the new approaches have identified few leads.
- ▶ **Limited Analysis.** Once the PROs become aware of an instance of questionable care, they are unlikely under their current contracts to determine if it is an isolated event or part of a pattern of such care. The PROs do have the authority to collect and analyze such data. Their priorities, however, are elsewhere.

- ▶ **Limited Follow-Up.** During their current contracts with HCFA, 10 of the 22 PROs in our sample had not initiated any improvement plans that compel individual physicians or hospitals to address the quality-of-care problems. The other 12 initiated improvement plans in response to 146 quality-of-care problems. One PRO identified half of those problems.
- ▶ **Moribund Sanction Recommendations.** The PROs' sanction recommendations to the Office of Inspector General have dwindled from a high of 72 in FY 1987 to 12, 14, 13 and 13 in FYs 1991 through 1994.
- ▶ **Minimal Referrals to State Medical Boards.** In 1993, Congress passed legislation requiring PROs to share information with medical boards on physicians found to be responsible for serious quality-of-care problems. The legislation appears to have had little, if any, impact on the level of such sharing.

The PROs themselves find much that is positive about the current direction of the Program. But some express reservations about its impact on protecting Medicare beneficiaries from poor performers.

- ▶ **Compatible Functions.** Seventeen of the 22 PROs (77 percent) in our sample indicated that the two basic PRO functions--improving the mainstream of care and dealing with poor performers--are compatible.
- ▶ **Weakened Protections.** Yet, when questioned further, 11 of 22 PROs (50 percent) concluded that beneficiary protections have become weaker. This compares to 5 (23 percent) that concluded protections have become stronger, 4 (18 percent) that concluded protections have remained about the same, and 2 (9 percent) that did not know.

RECOMMENDATION

Our inquiry does not question the PRO Program's focus on improving the mainstream of care; nor does it reflect a desire to return to an emphasis on random medical record reviews. We recognize that the random reviews were labor-intensive, generated much discord with the medical community, and identified few quality-of-care problems relative to the numbers of records reviewed. We also understand that the premise of the PRO Program's current direction holds promise for improving the overall practice of medicine. This is of great importance to Medicare beneficiaries and others.

Yet, we find sufficient basis to question the responsiveness of the PRO Program to its other traditional function: identifying and responding to physicians and hospitals that fail to meet minimally acceptable standards of care. We direct our recommendation to this vulnerability.

We recommend that HCFA reconsider the PROs' function to identify and respond effectively to poorly performing physicians and hospitals.

There needs to be a public discussion on what existing or potential processes could deal effectively with poor performers. To further that public discussion, we offer two options for HCFA to consider based on the premise that the PROs' emphasis on improving care overall will remain dominant:

OPTION 1

► *The HCFA should proceed toward directing the PROs to focus exclusively on improving the mainstream of care. To help deal with poor performers, it should consider ways in which the Federal government might support other bodies, such as State medical boards and ombudsmen, that are more focused on addressing individual cases of poor medical care.*

Pros: Could clarify the PROs' mission and thereby contribute to improved performance. Could make PROs' mission consistent with their funded and operational priorities. Could contribute to more effective performance by other bodies focussing on poor performers.

Cons: Could undermine improvement efforts by removing what some regard as a complementary function of the PROs. Could weaken the PROs' authority with the medical community. Could endanger beneficiaries if others fail to deal effectively with poor performers.

OPTION 2

► *The HCFA should devote further inquiry to determine: (1) if the two functions of improving the mainstream of care and identifying and dealing effectively with poor performers can reasonably be performed by one organization, and (2) how PROs can carry out both simultaneously. Toward this end, it could support research efforts, demonstration projects by individual PROs, and conferences.*

Pros: Could lead to a better understanding of the two functions' compatibility. Could identify benchmark practices among the PROs. Could lead to innovation in how PROs achieve both functions.

Cons: Could delay inevitable decisions about the direction and role of the PRO Program. Could call for additional resources or siphon resources away from improvement projects. Could restrict PROs from effectively performing either function.

COMMENTS ON THE DRAFT REPORT

We solicited and received comments on the draft report from the Health Care Financing Administration (HCFA), the American Medical Peer Review Association (AMPRA), the American Medical Association (AMA), the American Association of Retired Persons (AARP), the Public Citizen Health Research Group (hereafter referred to as Public

Citizen), and the Coalition for Consumer Protection and Quality in Health Care Reform (hereafter referred to as the Coalition). We include the complete text of the detailed comments in appendix E. Below we summarize the major comments of the respondents and then, in italics, offer our responses. In the report, we made minor edits in response to comments.

The HCFA concurred with our recommendation, found merit in both options, and asked us to call for a public discussion on the issues. It also expressed concerns about our discussion of the PROs' limited efforts in identifying patterns of poor care and our presentation of the survey data on weakened protections. The AMPRA supported option 2, believing it is premature to focus PRO activity exclusively on improving the mainstream. The AMPRA believes the two functions are compatible and that the quality improvement approach holds promise for dealing with poor performers, giving several examples of successful projects. The AMA indicated that it had no firm position on either option and noted that the primary focus of the PRO program should be improving the mainstream of care. The AARP disagreed with option 1 because of its strong belief that PROs retain their responsibility to identify and respond to poor performers. Public Citizen also disagreed with option 1, noting that while continuous quality improvement is a welcome addition to beneficiary protections, it cannot replace detecting poor performers. Public Citizen supported further study as outlined under option 2. The Coalition, while reserving final judgment on the options, indicated it has concerns about the PROs' ability to provide adequate beneficiary protections given the dominance of their function to improve the overall practice of medicine.

We appreciate HCFA's support for our recommendation and have added language calling for a public discussion. With respect to HCFA's concern about our discussion of limited efforts, we have edited our text to reflect that PROs have the authority to collect and analyze data. With respect to its concern about our presentation of the survey data on weakened protections, we have attempted to provide appropriate context for interpreting the survey data. We agree with AMPRA that continuous quality improvement holds promise for the overall practice of medicine. Our concern, however, is that with the PROs' focus on such systems-oriented approaches Medicare beneficiaries remain vulnerable to harm from individual poor performers. We appreciate all the comments on our draft report and urge continued discussion on the roles PROs can play in protecting Medicare beneficiaries from poorly performing physicians and hospitals.

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INTRODUCTION

PURPOSE

To assess the ability of the Medicare Peer Review Organizations to identify and respond to poorly performing physicians and hospitals at a time when their primary mission is to improve the overall quality of medical care.

BACKGROUND

In April 1993, the Medicare Peer Review Organizations (PROs) began implementing their fourth contracts with the Health Care Financing Administration (HCFA). These contracts marked major changes in the PROs' aims and operations. The PROs now aim to improve the overall practice of medicine. They do this by working collegially with the medical community in analyzing patterns of care and outcomes and by sharing their insights with that community. Their focus is now on the performance of systems of care rather than on individual caregivers.

The HCFA refers to this initiative as the Health Care Quality Improvement Program (HCQIP). The HCQIP rests heavily on the precepts of continuous quality improvement, which hold that it is far more important to improve the overall performance levels even slightly than it is to identify and address poor performers at the margin. This emphasis reflects the kind of redirection called for by the Institute of Medicine in its comprehensive assessment of Medicare quality assurance efforts.¹

Prior to the fourth contracts, the PROs sought to ensure the necessity, quality, and appropriateness of care rendered to Medicare beneficiaries by identifying and addressing individual clinical problems. They did this by reviewing individual instances of questionable care that they had identified through random medical record reviews or beneficiary complaints. At times, the PROs' reviews represented as much as 15 percent of Medicare hospital discharges. Once they confirmed a quality-of-care problem, they addressed it by taking follow-up actions they deemed appropriate. At the extreme, such actions could involve recommending a sanction to the Office of Inspector General (OIG).

Thus, with the start of the fourth contract, the PROs began to perform two basic functions. The dominant function, however, is the function aimed at improving the overall practice of medicine. During the past 2 years, the HCFA has increasingly stressed it. At the same time, HCFA continues to rely on the PROs to safeguard Medicare beneficiaries by identifying and dealing effectively with individual poor performers. This function has always faced major constraints, many of which have been highlighted in prior reports by the Office of Inspector General.² In fact, in our prior report, *The Beneficiary Complaint Process of Medicare Peer Review Organizations*, we assess the beneficiary complaint process--a key safety valve for beneficiaries. In that report, we found that while the complaint process represented an important source of information on poor

performers, it has some flaws that undermine its effectiveness. We offered recommendations to HCFA for improving the process as a near-term solution.

In this report, we use the term poor performers to refer to physicians whose medical knowledge and/or practice skills are below minimally acceptable standards (as determined by the medical community) and who, therefore, pose a continuing threat to the safety of their patients. With respect to hospitals, we refer to those institutions having insufficient internal systems to ensure that patients are receiving minimally acceptable standards of care.

In this report, we look more broadly at the effectiveness of the PROs in addressing individual poor performers at a time when their focus stresses dealing with system improvements. We conclude with a recommendation that supports long-term strategies for dealing with poorly performing physicians and hospitals that fail to meet minimally acceptable standards of care.

METHODOLOGY

We relied on 4 sources of information: (1) surveys of 22 PROs representing 72 percent of the beneficiary population in the country, (2) aggregate data from HCFA reflecting all PROs' medical record reviews completed under the fourth contract and through June 30, 1994, (3) telephone calls with officials from 10 State medical boards, and (4) cumulative information gathered through our previous inquiries on the PROs. (See appendix A for a more detailed discussion of our methodology.)

Unless noted, the data presented are based on the PROs' experiences under their fourth contract with HCFA.

Hereafter, we use the term quality-of-care problem to refer to a problem identified by a PRO through any source for which (1) the PRO gave the physician or hospital responsible an opportunity to discuss and/or give additional information about the care in question and (2) the PRO's physician reviewer(s) reviewed the record and confirmed that a problem had occurred.

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

FINDINGS

As the PRO Program becomes increasingly committed to improving the overall practice of medicine, its ability to find and take action on poorly performing physicians and hospitals is questionable.

- ▶ **Limited Leads.** The PROs find themselves with very limited leads to identify poorly performing physicians or hospitals. With the phasing out of the random sample medical record review, which has been the primary source for identifying poor performers, PROs still have other sources for identifying poor performers. These include beneficiary complaints, referrals from the medical community, and newer approaches developed under HCQIP. However, the beneficiary complaint process, as we indicated in a recent report, has significant flaws; the referrals from the medical community remain minimal; and the new approaches have identified few leads.

The 53 PROs identified 6,010 cases with quality-of-care problems for reviews completed between April 1993 and June 1994.³ The majority of these (71 percent) came from the 5 percent inpatient random sample medical record review. Yet the random sample has been, at best, an inefficient source for identifying leads, as less than 1 percent of all random sample reviews led to quality-of-care problems.⁴ By October 1995, that random sample will be completely phased out.⁵ In our recent survey of 22 PROs, 17 (77 percent) judged this reduction in record review as a major barrier to identifying individual quality-of-care problems.

The PROs will continue to review those records mandated by law, such as those for quality-related beneficiary complaints.⁶ Of the 6,010 quality-of-care problems identified by PROs, 9 percent came from the mandatory reviews overall and 2 percent from beneficiary complaints (see appendix B). In our prior report, we found that complaints can, in fact, be an important source for identifying quality-of-care problems. But our inspection also revealed that many beneficiaries were unaware of the opportunities to complain to PROs about the quality of their medical care and that PROs received too few complaints to identify meaningful patterns of poor care.⁷

Further, the PROs have received few referrals from the medical community. In our survey of 22 PROs, 6 reported they had received referrals from their State medical boards; none of these referrals led to quality-of-care problems.⁸ Eight PROs reported they had received referrals from hospitals and 13 from physicians; these referrals led to quality-of-care problems in 5 PROs.⁹ For those 5 PROs, though, the referrals accounted for less than 2 percent of all the PROs' quality-of-care problems. At the time of our survey, none of the 22 PROs had written policies encouraging referrals from physicians, hospitals, or medical boards.

Finally, the PROs have identified few leads through their activities begun under the Health Care Quality Improvement Program (HCQIP), including the cooperative projects aimed at

improving overall care. Four of the 22 PROs in our sample identified quality-of-care problems through such projects and their related data collection, even though these projects were not designed to identify poor performers. For those 4 PROs, though, the problems identified through cooperative projects accounted for less than 2 percent of all the PROs' quality-of-care problems. The other 18 PROs identified no leads through such projects.

- ▶ **Limited Analysis.** Once the PROs become aware of an instance of questionable care, they are unlikely under their current contracts to determine if it is an isolated event or part of a pattern of such care. The PROs have little medical data to draw upon to assess an individual physician's or hospital's prior performance. The PROs do have the authority to collect and analyze such data. However, with HCFA's emphasis on cooperative projects that aim to improve the mainstream of care, PROs are unlikely to devote resources to tracking a questionable provider's future performance.

It is one thing to obtain a possible lead on a possible poor performer. It is quite another to conduct the analysis to determine if: (1) a pattern exists that exposes Medicare beneficiaries to undue danger and (2) some kind of follow-up action should be taken. Making such a determination is a resource-intensive and often adversarial process that runs counter to the tenets of continuous quality improvement. It is an allowable activity for expenditure of PRO program funds, but is clearly not a priority under HCFA's current contracts with the PROs.

Through our survey, the PROs cited limitations in conducting the analysis necessary to distinguish patterns of poor performance from isolated incidents of poor care. In fact, officials from 16 of the 22 PROs we surveyed judged difficulties in establishing patterns of poor care as a major barrier to establishing improvement plans with individual physicians or hospitals. They must rely primarily on their historical data bases that include past PRO reviews. But with the reduced medical record review, these data bases are losing relevance.¹⁰ And PROs reported that they rarely initiated projects under the HCQIP to determine whether problems were isolated or part of patterns. None of the 22 PROs reported routinely conducting special data collection to determine if the problems were isolated.

- ▶ **Limited Follow-Up.** Currently, once PROs confirm (through medical record review) that physicians or hospitals are responsible for quality-of-care problems, they rarely do anything more than inform those responsible of the nature of the problem. During their current contracts with HCFA, 10 of the 22 PROs in our sample had not initiated any improvement plans that compel individual physicians or hospitals to address the quality-of-care problems. The other 12 initiated improvement plans in response to 146 quality-of-care problems. One PRO identified half of those problems.

The 22 PROs in our sample responded to all the quality-of-care problems they confirmed. For 99 percent of those problems, the PROs responded with a letter confirming, after

medical record review, that a quality-of-care problem occurred.¹¹ In only 1 percent of the problems did the PROs respond with more than a letter. These involved 146 problems and 12 of the 22 PROs in our sample. The PROs responded to these problems with improvement plans designed to prevent the recurrence of the problem.¹² These plans compelled those involved to take some action, such as attend a course (for a physician) or conduct inservice training (for a hospital).

The number of quality-of-care problems the 12 PROs responded to with improvement plans ranged from 1 to 73, with a median of 6.5. Six PROs responded to 5 or fewer problems with improvement plans, 2 PROs responded to between 6 and 10 problems with plans, and 3 PROs responded to between 11 and 15 problems with plans. One PRO responded to 73 problems with improvement plans, accounting for half of the responses in our sample.

Of the 146 problems the 12 PROs responded to with improvement plans, 77 involved plans directed to physicians and 69 to hospitals. Based on our review of 53 of these improvement plans, we found that most of those directed to hospitals involved a systemic intervention such as a review of or change in the hospital's policies. Most of those directed to physicians included an educational component such as continuing medical education or inservice training (see appendix C).

The extent to which physicians are subject to any corrective or disciplinary actions by hospital quality assurance bodies is unclear. However, given that such actions run counter to the collegial and self-improvement precepts of continuous quality improvement, it is likely to be minimal. In fact, another Office of Inspector General inspection raises important questions about the extent to which hospitals themselves have taken adverse actions directed to physicians.¹³ In that inspection, we found that 75 percent of the hospitals in the United States reported no adverse actions to the National Practitioner Data Bank from September 1, 1990 to December 31, 1993.¹⁴

- ▶ **Moribund Sanction Recommendations.** The sanction referral authority has continued in the moribund state we reported on in 1993. The PROs' sanction recommendations to the Office of Inspector General have dwindled from a high of 72 in FY 1987 to 12, 14, 13 and 13 in FYs 1991 through 1994. By contrast, State medical boards have become much more active in disciplining poorly performing physicians. From CY 1991 to CY 1994, annual board actions increased from 2,804 to 3,571.

From FY 1986 through 1994, the OIG sanctions have shown a similar decline: from a high of 50 in FY 1987 to a low of 6 in FY 1992, 10 in FY 1993, and 7 in FY 1994. In this period, 159 physicians have been sanctioned compared to 3 hospitals (see appendix D).

As we reported in 1993, the drop in PRO sanction recommendations can be explained by three factors: (1) the statutory requirement that prevents sanction unless providers have demonstrated an "unwillingness or lack of ability" to comply with their Medicare

obligations; (2) the PROs' cumulative experience with the costly, complex, and contentious referral process; and (3) their increasing emphasis on educational rather than punitive responses to poor care.¹⁵ The OIG's high rate of rejections also helps explain the decline. From FY 1986 through FY 1994, the OIG rejected 41 percent of the PROs' sanction recommendations based on either willingness and ability, failure to follow the regulatory requirements, or lack of medical evidence (see appendix D).

Like PROs, State medical boards have a responsibility for ensuring quality of medical care. But, unlike PROs, State boards deal with care provided by licensees to all their patients, not just those covered by Medicare. The HCFA requires that, as a condition of participating in Medicare, physicians be licensed by their States. And as PRO sanction recommendations have dropped, medical board actions to discipline physicians have increased. Unlike OIG sanctions, which bar participation in Medicare and Medicaid but do not affect licensure, medical board actions can affect a physician's license to practice. For example, in CY 1994, State boards took 3,571 actions of which 1,498 (42 percent) involved the loss of license, including revocation, suspension, surrender, or mandatory retirement. Another 1,256 of those actions (35 percent) involved some restriction to the license, such as probation or limitation. The remaining actions involved modifications to the licenses that resulted in some penalty or reprimand to the physicians.¹⁶

- ▶ **Minimal Referrals to State Medical Boards.** In 1993, Congress passed legislation requiring PROs to share information with medical boards on physicians found to be responsible for serious quality-of-care problems. The legislation appears to have had little, if any, impact on the level of such sharing.

In April 1993, we reported that the PROs' sharing of case information, even for the most serious cases, was minimal.¹⁷ The Citizen Advocacy Center also reported on the minimal level of sharing based on its 2 surveys in 1992, one that reviewed the experiences of 10 States where PROs and medical boards both had shown an interest in sharing and a second, more extensive survey of all 50 States.¹⁸ Between its two surveys, the Center found that in only Ohio, Mississippi, New York, and to a lesser extent Texas, was much information being sent to the medical boards.

To assess the current level of sharing, we called the medical boards in the 10 States identified by the Center with boards and PROs committed to sharing information.¹⁹ We found that sharing remains minimal. No board official reported an increase in the level of sharing. Officials from 3 of those 10 States--including Ohio and Mississippi--reported that the level of sharing was less than what they had reported to the Center in 1992. Five reported the level of sharing was about the same. Two were unable to answer due to a lack of data.

The PROs themselves find much that is positive about the current direction of the Program. But some express reservations about its impact on protecting Medicare beneficiaries from poor performers.

- ▶ **Compatible Functions.** Seventeen of the 22 PROs (77 percent) in our sample indicated that the two basic PRO functions--improving the mainstream of care and dealing with poor performers--are compatible.
- ▶ **Weakened Protections.** Yet, when questioned further, 11 of 22 PROs (50 percent) concluded that beneficiary protections have become weaker. This compares to 5 (23 percent) that concluded protections have become stronger, 4 (18 percent) that concluded protections have remained about the same, and 2 (9 percent) that did not know.

Several PRO officials explained the functions' compatibility by noting that improving care overall also improves the poor performers. They pointed out that problems they identify with poor performers become opportunities for cooperative projects aimed at overall improvement. Indeed, according to some officials with whom we spoke, it is the PROs' clout as the entities that deal with poor performers that can convince reluctant hospitals to participate in improvement projects. Others noted that compatibility means not pursuing minor problems while reserving resources for those outlier physicians and hospitals that pose significant threat to do great harm. In fact, some said that hospital officials welcome the PROs and rely on them for help in identifying and dealing with poor performers.

Yet, while the PROs reflect strong support for the compatibility of the two functions, they also point to weakened protections for the beneficiary. Twice as many PRO officials concluded protections have weakened since the third contract than concluded they have strengthened. Many in the PRO community with whom we spoke tied the weakened protections directly to their lessened ability to conduct medical record reviews. They reported that without funding and authority for some minimal level of record review, instances and patterns of poor care have gone undetected and therefore unaddressed. And although its value was never definitively documented, some PROs questioned if the sentinel effect--whereby the mere knowledge of ongoing medical record reviews creates an incentive to improve care with the medical community--will exist as record review declines.

RECOMMENDATION

Our inquiry does not question the PRO Program's focus on improving the mainstream of care; nor does it reflect a desire to return to an emphasis on random medical record reviews. We recognize that the random reviews were labor-intensive, generated much discord with the medical community, and identified few quality-of-care problems relative to the numbers of records reviewed. We also understand that the premise of the PRO Program's current direction holds promise for improving the overall practice of medicine.²⁰ This is of great importance to Medicare beneficiaries and others.

Yet, we find sufficient basis to question the responsiveness of the PRO Program to its other traditional function: identifying and responding to physicians and hospitals that fail to meet minimally acceptable standards of care. We direct our recommendation to this vulnerability.

We recommend that HCFA reconsider the PROs' function to identify and respond effectively to poorly performing physicians and hospitals.

There needs to be a public discussion on what existing or potential processes could deal effectively with poor performers. To further that public discussion, we offer two options for HCFA to consider based on the premise that the PROs' emphasis on improving care overall will remain dominant:

OPTION 1

► *The HCFA should proceed toward directing the PROs to focus exclusively on improving the mainstream of care. To help deal with poor performers, it should consider ways in which the Federal government might support other bodies, such as State medical boards and ombudsmen, that are more focused on addressing individual cases of poor medical care.*

Pros: Could clarify the PROs' mission and thereby contribute to improved performance. Could make PROs' mission consistent with their funded and operational priorities. Could contribute to more effective performance by other bodies focussing on poor performers.

Cons: Could undermine improvement efforts by removing what some regard as a complementary function of the PROs. Could weaken the PROs' authority with the medical community. Could endanger beneficiaries if others fail to deal effectively with poor performers.

OPTION 2

► *The HCFA should devote further inquiry to determine: (1) if the two functions of improving the mainstream of care and identifying and dealing effectively with poor*

performers can reasonably be performed by one organization, and (2) how PROs can carry out both simultaneously. Toward this end, it could support research efforts, demonstration projects by individual PROs, and conferences.

Pros: Could lead to a better understanding of the two functions' compatibility. Could identify benchmark practices among the PROs. Could lead to innovation in how PROs achieve both functions.

Cons: Could delay inevitable decisions about the direction and role of the PRO Program. Could call for additional resources or siphon resources away from improvement projects. Could restrict PROs from effectively performing either functions.

COMMENTS ON THE DRAFT REPORT

We solicited and received comments on the draft report from the Health Care Financing Administration (HCFA), the American Medical Peer Review Association (AMPRA), the American Medical Association (AMA), the American Association of Retired Persons (AARP), the Public Citizen Health Research Group (hereafter referred to as Public Citizen), and the Coalition for Consumer Protection and Quality in Health Care Reform (hereafter referred to as the Coalition). We include the complete text of the detailed comments in appendix E. Below we summarize the major comments of the respondents and then, in italics, offer our responses. In the report, we made minor edits in response to comments.

The HCFA concurred with our recommendation to reconsider the PROs' function to identify and respond to poor performers. It found merit in both options and asked that we call for a public discussion on these issues. It expressed concerns about our discussion of the PROs' limited efforts in identifying patterns of poor care, pointing out that PROs have the authority and opportunity to perform primary data collection if they find an instance of questionable care. The HCFA also expressed concerns that our presentation of the survey data on weakened protections would lead other readers to conclude we advocate a return to case review, although it understood that we did not.

We appreciate HCFA's support for our recommendation. Based on HCFA's suggestion, we added language calling for a public discussion in introducing the two options. With respect to HCFA's concerns about our discussion of the PROs' limited efforts concerning problem analysis, we point out that our text specifies such analysis is an eligible program expense. We have edited that text to make clear that PROs in fact have the authority to conduct such analysis. With respect to HCFA's concerns about our presentation of the survey data on weakened protections, we have attempted to provide the appropriate context so that it is clear to readers that we do not advocate a return to case review.

The AMPRA supported option 2, believing it is premature to focus PRO activity exclusively on improving the mainstream. The AMPRA believes the two functions are compatible and that the quality improvement approach holds promise for dealing with poor performers, giving several examples of successful improvement projects. The AMPRA also called for strengthened PRO interactions with medical boards, ombudsmen, licensing agencies, and accrediting bodies.

We agree with AMPRA that continuous quality improvement holds promise for the overall practice of medicine, as in the systems-oriented examples AMPRA cites. Our concern, however, is that with the PROs' focus on such systems-oriented approaches, Medicare beneficiaries remain vulnerable to harm from those individuals whose medical knowledge and/or practice skills are below minimally acceptable standards.

The AMA indicated that it had no firm position on either option and noted that the primary focus of the PRO program should be improving the mainstream of care. The

AARP disagreed with option 1 because of its strong belief that PROs retain their responsibility to identify and respond to poor performers. Public Citizen also disagreed with option 1, noting that while continuous quality improvement is a welcome addition to beneficiary protections, it cannot replace detecting poor performers. Public Citizen also noted that while it supports further study as outlined under option 2, recommendations made in previous OIG studies should be vigorously implemented. The Coalition, while reserving final judgment on the options, indicated it has concerns about the PROs' ability to provide adequate beneficiary protections given the dominance of their function to improve the overall practice of medicine.

We appreciate these comments on our draft report and urge continued discussion on roles PROs can play in protecting Medicare beneficiaries from poorly performing physicians and hospitals.

APPENDIX A

METHODOLOGY

Mail and Telephone Surveys of 22 PROs

We conducted mail and telephone surveys with 22 PROs in January 1995. We chose these PROs through a stratified sample in which we arrayed PROs according to the number of Medicare beneficiaries in each State (high and low beneficiary population). We chose all 17 of the PROs for States in the high-population stratum¹ and a random sample of 5 PROs for States in the low-population stratum.² The PROs in our sample represent 72 percent of the Medicare beneficiary population in the country. The response rate for both the telephone interviews and the mail survey was 100 percent.

We sent out a mail survey to all 22 PROs in which we asked PROs for specific data under the fourth contract. The data included sources for confirmed quality-of-care problems and how many such problems led to improvement plans, among others.

We supplemented the mail survey with more in-depth telephone interviews. For the interviews, we designed and pretested a discussion guide with questions about identifying quality-of-care problems, the complaint process, barriers to identifying individual quality-of-care problems, responding to confirmed quality-of-care problems, and barriers to responding to confirmed quality-of-care problems, among others.

Aggregate Data from HCFA

We also drew on data from HCFA's PROD3 data base (which includes the results of all inpatient record reviews) and PROD5 data base (which includes the results of all physician reviews). Through these we obtained data on the number and sources of confirmed physician and hospital quality-of-care problems for all PROs for reviews completed under the fourth contract through June 30, 1994.³ Our tests of the data revealed that 10 PROs reported no beneficiary complaints when, in fact, they had received such complaints.

¹ These included the following States (listed in descending order of beneficiary population): California, New York, Florida, Pennsylvania, Texas, Ohio, Illinois, Michigan, New Jersey, North Carolina, Massachusetts, Missouri, Indiana, Georgia, Virginia, Wisconsin, and Tennessee.

² These included the following States (listed in descending order of beneficiary population): New Mexico, Utah, Montana, South Dakota, and Delaware.

³ In analyzing our data on confirmed quality-of-care problems, we report the most conservative interpretations. We chose this approach to avoid double counting complaints that resulted in confirmed problems with both a physician and a hospital.

Nevertheless, when these data are viewed in the context of our telephone interviews and survey data, we believe the findings and recommendation in this report are valid.

Follow-up with 10 State Medical Boards

In April 1995, we called the 10 State medical boards identified by the Citizen Advocacy Center as sharing a commitment for increased sharing with the PROs in their States.⁴ We reviewed their previous level of sharing (as reported to the Center) and then asked them to assess their current level of sharing as more, less, or about the same.

Previous Office of Inspector General Inquiries on PROs

We have an extensive history of reviewing the PRO Program, starting in 1988. The major studies we drew on in this report include: *Peer Review Organizations and State Medical Boards: A Vital Link*, OEI-01-92-00530, April 1993; *The Sanction Referral Authority of Peer Review Organizations*, OEI-01-92-00250, April 1993; and, *The Beneficiary Complaint Process of the Medicare Peer Review Organizations*, Draft Report, OEI-01-93-00250, June 1995.⁵

⁴ The Center identified Alabama, California, Colorado, Iowa, Minnesota, Mississippi, Ohio, Rhode Island, West Virginia, and Wisconsin as States with medical boards and PROs both committed to sharing information. (Citizen Advocacy Center, *Information Exchange Between Peer Review Organizations and Medical Licensing Boards: Update and Report on CAC Survey*, March 1992, and *Information Exchange Between Peer Review Organizations and Medical Licensing Boards: Report on the 50 State Survey*, November 1992.)

⁵ Other OIG reports include: *The Utilization and Quality Control Peer Review Organization Program: Quality Review Activities*, OAI-01-00570, September 1988; *The Utilization and Quality Control Peer Review Organization Program: Sanction Activities*, OAI-01-00571, November 1988; *The Utilization and Quality Control Peer Review Organization Program: An Exploration of Program Effectiveness*, OAI-01-88-00572, February 1989; and, *Educating Physicians Responsible for Poor Medical Care: A Review of the Peer Review Organizations' Efforts*, OEI-01-89-00020, February 1992.

The Office of Inspector General has also issued a number of reports on DRG validation.

APPENDIX B

PROS' SOURCES FOR IDENTIFYING CONFIRMED QUALITY-OF-CARE PROBLEMS UNDER THE FOURTH CONTRACT FOR REVIEWS COMPLETED THROUGH JUNE 30, 1994

TYPE OF REVIEW	Total Quality Problems Identified	As a percentage Of All Quality Problems
RANDOM SAMPLE^a	4261	70.9%
MANDATORY REVIEWS^b	519	8.6%
Medicare Code Editor	15	<1%
Hospital Adjustment	37	<1%
Assistant at Cataract Surgery	0	0%
Fiscal Intermediary (FI) referral	88	<1%
Regional Office (RO) referral	4	<1%
Hospital Issued Notice of Noncoverage	274	4.6%
Beneficiary Complaint	101	1.7%
MISCELLANEOUS REVIEWS^c	1438	23.9%
Other	329	<1%
Intervening Care	29	<1%
Focussed Review Selection	11	<1%
PRO-selected Intensified review	5	<1%
FI/Carrier Pre-payment Reject	3	<1%
Ventilator-Dependent Unit	1	<1%
FI Prepayment Reject	3	<1%
Readmission	527	8.8%
Specialty Hospital	355	5.9%
UCDS	168	2.8%
Hospital Adjustment Previously selected	7	<1%
TOTALS	6218 ^d	103.5%

Notes: N=53 PROs. The number of beneficiary complaints represented here should be considered conservative because of reporting flaws. Ten PROs reported no beneficiary complaints when in fact they received such complaints under the fourth contract. ^a Will be eliminated as of October 1995. ^b Will continue as the main source of record reviews. ^c Of the types of reviews listed here, only the "other" category and the hospital adjustment previously selected are likely to be continued. ^d Of these quality-of-care problems, 208 were selected for more than 1 reason. The PROs identified 6010 confirmed quality-of-care problems through June 31, 1994.

Source: HCFA PROD3 and PROD5 data bases. **Analysis:** HHS Office of Inspector General.

APPENDIX C

INTERVENTIONS INCLUDED IN IMPROVEMENT PLANS

Intervention	Directed to Physicians (n=25)	Directed to Hospitals (n=28)	Total (n=53)
Protocol/Policy Change	5 (20%)	22 (79%)	27 (53%)
Inservice Training	5 (20%)	17 (61%)	22 (42%)
Continuing Medical Education (CME)	8 (32%)	--	8 (15%)
Case Presentation	4 (16%)	8 (29%)	12 (23%)
Hospital Case Monitoring	4 (16%)	12 (43%)	16 (30%)
PRO Case Monitoring	2 (8%)	1 (4%)	3 (6%)
Meeting with the Hospital	5 (20%)	8 (29%)	13 (25%)
Meeting with the PRO	6 (24%)	3 (11%)	9 (17%)
Referral to Hospital Quality Assurance Committee	7 (28%)	10 (36%)	17 (32%)
Required Consultation	3 (12%)	--	3 (6%)
SPEX Exam	1 (4%)	--	1 (2%)
Consideration of Sanction	9 (36%)	4 (14%)	13 (25%)
Telephone Call	2 (8%)	1 (4%)	3 (6%)
Other	3 (12%)	--	3 (6%)
<p>Note: Our analysis was based on those written materials (mostly letters) sent to us by the PROs. Thus, any telephone calls, meetings, or other interventions not documented in these written materials are excluded from this table. These represent 53 of the 146 improvement plans that PROs in our sample initiated under the fourth contract.</p> <p>Source: HHS Office of Inspector General Survey of 22 PROs, January 1995.</p> <p>Analysis: HHS Office of Inspector General.</p>			

TYPOLOGY OF INTERVENTIONS USED IN IMPROVEMENT PLANS

Typology	Interventions directed to Physicians (n=25)	Interventions directed to Hospitals (n=28)
Educational	15 (60%)	17 (60%)
Systemic	5 (20%)	22 (79%)
Punitive	9 (36%)	4 (14%)

Note: These represent 46 of the 146 improvement plans that PROs in our sample initiated under the fourth contract. Our analysis was based on those written materials (mostly letters) sent to us by the PROs. Thus, any telephone calls, meetings, or other interviews not documented in these written materials are excluded from this table.

The number of interventions we identified in any one improvement plan ranged from one to seven. Depending on the interventions within any one improvement plan, it could be characterized as educational, systemic, punitive, or a combination of these. Five of the plans directed to physicians and two directed to hospitals contained no interventions we considered educational, systemic, or punitive.

We considered the following interventions as educational: inservice training, continuing education, and case presentations. We considered interventions as systemic if they involved protocol and policy changes, including the use of new forms and posting of rules. We considered interventions as punitive if they involved consideration of sanction. We excluded interventions such as meetings and monitoring because we were unable to determine whether they were educational or punitive in nature.

Source: HHS Office of Inspector General Survey of 22 PROs, January 1995.

Analysis: HHS Office of Inspector General.

APPENDIX D

OVERVIEW OF SANCTION DATA FROM THE OFFICE OF INSPECTOR GENERAL (OIG)

PRO SANCTION RECOMMENDATIONS TO THE OIG BY TYPE OF PROVIDER

Type of Provider:	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	TOTAL
Physician	60	66	34	21	29	12	13	12	13	260
Hospital	6	6	3	1	0	0	1	0	0	17
Nursing Home	0	0	0	0	0	0	0	1	0	1
Total	66	72	37	22	29	12	14	13	13	278

Source: HHS Office of Inspector General, Office of Investigations.

OIG SANCTIONS BASED ON PRO RECOMMENDATIONS BY TYPE OF SANCTION

Type of Sanction	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	TOTAL
Exclusion	21	34	18	10	13	10	5	7	7	125
Monetary Penalty	9	16	2	0	0	0	1	0	0	28
*Pre-Exclusion Retirement	0	0	2	1	1	2	0	3	0	9
Total	30	50	22	11	14	12	6	10	7	162

Source: HHS Office of Inspector General, Office of Investigations.

*Pre-exclusion retirement results from an agreement among the PRO, the physician, and the OIG that the physician retire from practice rather than be excluded. Because the retirement would not have occurred without the sanction recommendation, the OIG counts these as actions taken.

REFERRALS REJECTED OR CLOSED BY THE OIG WITHOUT SANCTION

Rejection Based on:	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	TOTAL
Unwilling or Unable Requirement	0	19	11	4	4	2	2	1	0	43
Failure to Follow Regulatory Process	4	10	12	6	2	1	0	1	1	37
Lack of Medical Evidence	6	5	0	2	2	5	7	1	1	29
Closed Due to Death or Other	2	0	0	0	0	0	0	0	3	5
Total	12	34	23	12	8	8	9	3	5	114
Source: HHS Office of Inspector General, Office of Investigations.										

APPENDIX E

COMMENTS ON THE DRAFT REPORT

In this appendix, we present in full the comments from the Health Care Financing Administration, the American Medical Peer Review Association, the American Medical Association, the American Association of Retired Persons, the Public Citizen Health Research Group, and the Coalition for Consumer Protection and Quality in Health Care Reform.



DATE: OCT 25 1995

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General Draft Report: "The Medicare Peer Review Organizations' (PROs) Role in Identifying and Responding to Poor Performances," (OEI-01-93-00251)

We reviewed the subject draft report which examines how well the PROs are finding and taking action on poorly performing physicians and hospitals.

Our detailed comments are attached for your consideration.

Thank you for the opportunity to review and comment on this report. Please contact us if you would like to discuss our comments further.

Attachment

Health Care Financing Administration (HCFA) Comments
on Office of Inspector General (OIG) Draft Report:
"The Medicare Peer Review Organizations' (PROs) Role
in Identifying and Responding to Poor
Performers," (OEI-01-93-00251)

OIG Recommendation

HCFA should reconsider the PROs' function to identify and respond effectively to poor performing physicians and hospitals. Two options are offered.

OPTION 1

The HCFA should proceed toward directing the PROs to focus exclusively on improving the mainstream of care. To help deal with poor performers, it should consider ways in which the Federal Government might support other bodies, such as State medical boards and ombudsmen, that are more focused on addressing individual cases of poor medical care.

OPTION 2

The HCFA should devote further inquiry to determine: (1) if the two functions of improving the mainstream of care and identifying and dealing effectively with poor performers can reasonably be performed by one organization, and (2) how PROs can carry out both simultaneously. Toward this end, it could support research efforts, demonstration projects by individual PROs, and conferences.

HCFA Response

HCFA concurs and believes that both options have merit. We will work with our resources and the medical community to explore avenues to determine what processes are best to deal with the types of poor performers mentioned in this report.

Technical/General Comments

1. We suggest that the following language be added to introduce the two options offered in your recommendation: "There needs to be a public discussion on what existing or potential process(es) there could be for dealing with the types of poor performers mentioned in this report. Here are two options."

2. In regard to your discussion of **Limited Analysis** on page 4, we wish to point out that the PROs have the authority and opportunity to perform primary data collection if they find an instance of questionable care. We have asked PROs to take a scientific approach in investigating such cases through the analysis of clinical and operational records associated with the performance at issue.
3. In regard to your discussion on **Weakened Protections**, we question why the emphasis is placed on the 50 percent of PROs that find protections weakened, which apparently argues that the case review approach is better. We do not believe it is the OIG's intention to present an argument for case review; however, a reader could infer this based on the way survey results are discussed in this report.

We thus suggest that the OIG clarify their survey results to ensure that the reader understands that the OIG is not advocating case review. We recommend the following language: "Forty-one percent of the surveyed PROs felt that beneficiary protections are better or equal, 9 percent felt they were neutral, and 50 percent felt that the protections are weaker." At this point the OIG could explain why the case review method was preferred by some PROs and why they felt it offered better beneficiary protection.



AMERICAN MEDICAL PEER REVIEW ASSOCIATION

1140 Connecticut Avenue, NW • Suite 1050 • Washington, D.C. 20036 • 202/331-5790 • FAX: (202) 833-2047

October 15, 1995

June Gibbs Brown
Inspector General
Department of Health & Human Services
Office of Inspector General
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Brown:

On behalf of the American Medical Peer Review Association (AMPRA) -- the national membership association representing the nation's network of peer review organizations -- I appreciate the opportunity to review the draft Inspector General's report, "*The Medicare Peer Review Organization's Role in Identifying and Responding to Poor Performers.*"

AMPRA favors option two:

The HCFA should devote further inquiry to determine: (1) if the two functions of improving the mainstream of care and identifying and dealing effectively with poor performers can reasonably be performed by one organization, and (2) how PROs can carry out both simultaneously. Toward this end, it could support research efforts, demonstration projects by individual PROs, and conference.

It is premature to focus PRO activity exclusively on improving the mainstream of care until we have further evaluated the Health Care Quality Improvement Program's (HCQIP) ability to deal with poor performance. In principle, we believe that the two functions are compatible.

AMPRA maintains that individual case review is not the only means to identify and to respond to poor performers. The innovative HCQIP approach of analysis and feedback of patterns of care, through the comparison of provider performance to scientifically based quality measures, shows promise for evaluating the full range of practice performance including those providers on the tail end of the performance distribution. While the emphasis is on improving the mainstream of care, PROs are also responsible for holding providers accountable for improvement, particularly those providers whose performance show great variance from accepted quality standards and are unwilling or unable to correct identified quality concerns. Without PRO sanction and corrective action authority, there is a real question as to whether all providers will be committed to making quality improvement a priority.

While still early in HCQIP's evolution, there are, nonetheless, many examples which successfully identify and deal with poor performance. For example, unnecessary radical prostate cancer surgery for men over the age of 70 represents poor practice that has been corrected by PROs through feedback of information to doctors on the rates of surgery for older men together with the scientific evidence for non-surgical intervention. Recent guidelines by the American College of Cardiology and the American Heart Association state that routine right heart catheterization is unnecessary. As a result of PRO performance monitoring, feedback, and education, right heart catheterization rates have dropped significantly.

Additionally, in Florida, Medicare beneficiaries were denied cataract surgery because of restrictive criteria employed by Medicare HMOs at variance from accepted Agency for Health Care Policy and Research (AHCPR) guidelines. PRO intervention led the HMOs to adopt the AHCPR guidelines, and beneficiaries now enjoy increased access to necessary care. AMPRA contends that HCQIP's more scientific and systems-oriented approach to identifying and responding to poor performers might prove to be a more effective strategy than the subjective and highly litigious system of individual case review.

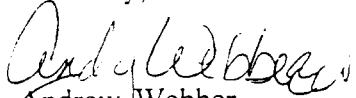
There are other reasons why AMPRA supports option two: 1) PROs are still engaged in individual case review through review of beneficiary complaints and hospital notices of non-coverage; 2) the absence of sanction authority would weaken the PROs' authority with the medical community (as observed in the report); and, 3) removing the sanction authority from PROs would endanger beneficiaries if other mechanisms fail to effectively deal with poor performers.

AMPRA also recommends that PRO interaction and communications with state medical boards, ombudsmen, licensing agencies, and accrediting bodies be strengthened. We urge HCFA to issue regulations that would implement the 1993 statute that requires the sharing of information between PROs and medical licensing boards.

Just recently AMPRA and Joint Commission on the Accreditation of Healthcare Organizations collaborated on a pilot project in the state of Pennsylvania to share PRO and Joint Commission hospital accreditation findings for the purpose of accelerating hospital improvement activities. Voluntary efforts at information sharing such as this should be encouraged.

Again, we thank you for allowing us the opportunity to comment. Please let us know how we can be of further assistance in resolving these important public policy issues.

Sincerely,


Andrew Webber
Executive Vice President

American Medical Association

Physicians dedicated to the health of America



James S. Todd, MD
Executive Vice President

515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464-4184 Fax

October 13, 1995

June Gibbs Brown
Inspector General
Department of Health and Human Services
330 Independence Avenue, S.W. Room 5250
Washington, D.C. 20201

Dear Ms. Brown,

The American Medical Association (AMA) appreciates the opportunity to respond to the recommendations contained in the Office of Inspector General (OIG) report, The Medicare Peer Review Organizations' Role In Identifying and Responding to Poor Performers.

During the past two years, there has been a positive reaction from the medical community in response to the PRO program, specifically the PRO Fourth Scope of Work. The PRO Fourth Scope of Work correctly and appropriately attempts to improve the overall quality of care provided to Medicare patients by analyzing patterns of care and outcomes and by sharing information with the medical community. In placing a greater emphasis on physician and provider education, there has been an increased level of collaboration among PROs, hospitals, and physicians on quality improvement efforts.

We are pleased that the new Fifth Scope of Work, which will continue to define the future direction of the PRO program, builds on the positive changes of the current scope of work by further enhancing these cooperative activities. The AMA remains very supportive of the educational, non-punitive direction of the Medicare PRO program. We continue to believe that the program's emphasis should be on improving the mainstream of care through pattern analysis rather than a punitive approach that addresses individual clinical errors.

Toward this end, we have no firm position on the two specific recommended options for the PRO program as discussed in this report. Given your assumption, with which we wholeheartedly concur, that the PRO program's primary focus should be on improving the mainstream of care, we believe that, if the Health Care Financing Administration (HCFA) determines that identifying and responding to poor performers should remain a function of the PRO program, further study is appropriate to determine the potential effectiveness of PROs in performing both activities. Regardless of the actions taken, HCFA must take great care not to undercut the educational approach of the current PRO program, as well as the improving cooperative relationship between the PROs and the medical community.

Again, thank you for the opportunity to comment on this report. The AMA is strongly committed to the objective of maintaining, and, where needed, improving the quality of care provided to Medicare patients and will continue to play an active role in ensuring that physicians' perspectives are an integral part of the PRO process.

Sincerely,

James S. Todd, MD
James S. Todd, MD



Bringing lifetimes of experience and leadership to serve all generations.

November 21, 1995

June Gibbs Brown
Inspector General
Department of Health and Human Services
Office of the Inspector General
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Inspector General Brown:

The American Association of Retired Persons (AARP) appreciates the opportunity to comment on the important draft report "The Medicare Peer Review Organizations' Role In Identifying and Responding to Poor Performers."

You suggest that HCFA reconsider PROs' function and either direct the PROs to focus exclusively on improving the mainstream of care, or determine through research whether and how quality improvement and patient protection functions can reasonably be performed by one organization.

We do not concur with the first option because AARP believes strongly that PROs should retain the responsibility to identify and respond effectively to poorly performing physicians and hospitals. To do so, the patient protection elements should be strengthened so that they can be effective. In addition, the quality improvement functions PROs have assumed should be evaluated to assess their impact on patient well-being.

Background and OIG Findings

As the latest draft report indicates, the PRO program has undergone a profound transformation during the last several years, from one focused primarily on identifying and addressing individual instances of poor care to one emphasizing the overall improvement of care through cooperative quality improvement projects. The transformation was set in motion by the 1990 Institute of Medicine report on Medicare quality assurance, and has proceeded with the strong support of the health policy and provider communities.

American Association of Retired Persons 601 E Street, N.W., Washington, D.C. 20049 (202) 434-2277
Eugene I. Lehrmann *President* Horace B. Deets *Executive Director*

During the debates that accompanied the transformation, AARP supported incorporation of "Continuous Quality Improvement" (CQI) principles and methodologies into the PRO-hospital-physician interaction. At the same time, however, the Association argued that Medicare patients' interests required retention of PROs' capability to address individual poor performance and poor performers through vigorous intervention.

OIG's draft report documents the following:

1. With the phasing out of medical record reviews, PRO data bases are losing relevance in terms of detecting instances of poor care. Record review and data collection had been the PRO tool that identified 71 percent of quality problems in the past.
2. The new climate of cooperation with the physician-hospital community engendered by the "CQI" approach, while admirable, appears to have taken some teeth out of the role of PRO as watchdog. First, PROs are identifying very few quality problems. Second, PROs are not following up on the ones they identify; in the OIG survey of 22 PROs, of 146 quality problems identified, 50 percent were handled by one PRO, and PRO action on quality problems for the most part was a letter of caution. Third, there is no evidence that follow up is now being handled by hospitals. Finally, it appears from OIG's findings that PROs are not sharing information on quality of care cases with state licensing boards as required.

AARP Comments

It is important to keep in mind that the PRO statute provides three distinct trigger points for PRO activity on behalf of beneficiaries:

- Establishment of a hospital discharge appeal system that enables patients to request a PRO review of a decision to terminate Medicare coverage of a hospital stay.
- The beneficiary complaint authority, which enables beneficiaries to obtain a PRO review of an allegation of a quality of care problem.
- The overall PRO review authority that was previously implemented through random case review aimed at uncovering quality and utilization concerns, but which now utilizes pattern analysis in the pursuit of mainstream quality improvement.

In responding to the draft report's recommendation, we believe it should be evaluated in the context of all the patient protection functions outlined above.

1. The hospital discharge appeal system

While not the subject of the draft report, the PROs' statutory responsibility to respond to Medicare beneficiaries' requests for review of a hospital discharge notice continues to embody an important patient protection role. Recently, AARP has participated in a task force effort to improve the communication of beneficiaries' discharge appeal rights through a rewriting of the "Important Message from Medicare" and the use of additional methods, such as videos made available to hospitalized patients and their families. HCFA should proceed with implementation of the task force recommendations, and PROs should undertake to aggressively inform patients of their discharge appeal rights. There has not been, and should not be, any conflict between this PRO role and PROs' newer quality improvement functions.

2. The beneficiary complaint authority

OIG's recent companion draft report on the beneficiary complaint authority revealed serious operational deficiencies, which AARP addressed in its comment letter of September 27, 1995. As we stated in that letter, "In light of the elimination of random sample record review the process of investigating and responding to beneficiary complaints assumes even greater importance as a means of protecting beneficiaries from poor quality care."

The OIG reports make clear that complaints have been a productive source of quality of care concerns. Moreover, it is clear that neither HCFA nor the PROs perceive an incompatibility between the complaint authority and the quality improvement strategy; complaint investigation is a prominent feature of the fifth scope of work's patient protection elements. From AARP's perspective, the complaint authority deficiencies should be remedied, patients should be made aware of its existence, and PROs should continue to serve as complaint investigators.

3. The PRO review system

PRO-initiated review activity presents the greatest perceived conflict between a strategy aimed at identifying poor performers, and one aimed at quality improvement. Clearly, the latter strategy has prevailed, and, as the OIG report observes:

"We recognize that the random reviews were labor-intensive, generated much discord with the medical community, and identified few quality-of-care problems relative to the numbers of records reviewed. We also understand that the premise of the PRO Program's current direction holds promise for improving the overall practice of medicine. This is of great importance to Medicare beneficiaries and others."

Inspector General Brown
November 21, 1995
Page 4

It has been the contention of those urging the shift to a CQI review strategy that many more patients will be better protected over time than was true previously, and that egregious individual instances of poor quality will still be addressed through educational or disciplinary responses as required. In this connection, an interesting finding of the OIG study is that 77 percent of the PROs queried (17 out of 22) believe that the two PRO functions are compatible. At the same time, however, half think beneficiary protections have been weakened by the current scope of work.

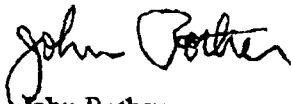
For AARP the jury on the shift in review strategy is still out. The new strategy is a promising one, but remains unevaluated in terms of its real impact on clinical performance. We urge OIG to undertake studies with respect to the nature and results of the Health Care Quality Improvement Program. We also, as stated above, emphasize the importance of viewing PROs' patient protection role in a broader context that includes the discharge appeals and beneficiary complaint elements. Currently, those elements exist largely as "paper" functions, and require extensive publicity and operational improvements to enable them to serve patients adequately.

PROs remain the major national program with authority to intervene on behalf of Medicare beneficiaries and affect their quality of care. As more of those beneficiaries move into new forms of health care delivery, with financial incentives that possibly threaten health care quality, patient protections will become even more critical.

The Office of Inspector General's ongoing efforts to offer remedies for and deficiencies in the PRO program continue to provide a great service to Medicare beneficiaries. We look forward to continuing to work with you and other interested parties to bring about beneficial change.

Thank you again for the opportunity to comment. If you should have any questions, please contact Mary Jo Gibson in AARP's Public Policy Institute at (202) 434-3896 or Cheryl Matheis in Federal Affairs at (202) 434-3774.

Sincerely,



John Rother
Director
Legislation and Public Policy

Public Citizen

Buyers Up • Congress Watch • Critical Mass • Global Trade Watch • Health Research Group • Litigation Group
Joan Claybrook, President

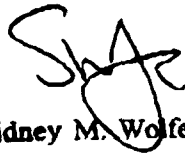
October 16, 1995

June Gibbs Brown
Inspector General
Department of Health and Human Services
Washington, D.C. 20201

Dear Ms. Brown:

Please find enclosed our comments on the OIG's draft report, "The Medicare Peer Review Organizations' Role in Identifying and Responding to Poor Performers." We appreciate the opportunity to review and comment on this report. Please let us know if we can be of further assistance to you or your staff in your studies regarding Peer Review Organizations.

Sincerely,



Sidney M. Wolfe, M.D.
Director



Lauren Dame
Staff Attorney

Enclosure

Ralph Nader, Founder

1600 20th Street NW • Washington, DC 20009-1001 • (202) 588-1000

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**COMMENTS ON "THE MEDICARE PEER REVIEW ORGANIZATIONS'
ROLE IN IDENTIFYING AND RESPONDING TO POOR PERFORMERS"
(OEL-01-93-00251)**

Submitted by Public Citizen's Health Research Group
October 16, 1995

We appreciate this opportunity to comment on this report by the Office of Inspector General ("OIG") of the Department of Health and Human Services ("HHS"). Public Citizen's Health Research Group has been a supporter of the concept of Peer Review Organizations ("PROs") since their inception, and believes that PROs, if strengthened, could serve a vital role in protecting Medicare beneficiaries from poor quality medical care. As the report points out, the main emphasis of PROs has shifted in the past few years from trying to identify and respond to individual physicians and hospitals that are performing poorly, to incorporating the concepts of "continuous quality improvement" and working with the medical community to improve the overall quality of medicine.

We agree with the report that, given this shift in focus, it is important to assess the ability of the PROs to continue to perform their "policing" role. We disagree, however, with the policy options suggested by the report, particularly Option One -- to eliminate the PROs' role in identifying and responding to individual poor performers, and to focus only on improvement in the overall practice of medicine. While "continuous quality improvement" is a welcome addition to the methods of protecting Medicare beneficiaries, it does not, and cannot, replace the necessary task of detecting poor performers. Improving the overall practice of medicine may incidentally identify some poor performers, but such is not its primary goal, and in order to fully protect Medicare beneficiaries, the government must continue to seek out those doctors and hospitals who cause needless suffering because of unnecessary or poor quality medical care. At present, there is no organization or agency that adequately protects Medicare beneficiaries or the broader patient population from poorly performing physicians and hospitals. What protection does exist comes from a variety of groups, such as state medical boards, hospital quality assurance departments, accreditation organizations, and others, which at best offer only a patchwork of protection. Each group has a different mission and focus, and each protects the medical consumer to only a limited degree.

- State medical boards, the first line of defense against poorly performing physicians, have a mixed record in protecting the public. Each year, Public Citizen's Health Research Group compares the performance of the various state medical boards by analyzing the rate at which doctors are disciplined in each state. We have found an enormous variation among the different state licensing boards: in 1994, for example, the Kentucky Medical Board had a rate of 9.62 serious disciplinary actions per 1000 doctors, while the Pennsylvania Medical Board had a rate of only 2.04 serious disciplinary actions per 1000 doctors. Thus, while some state boards may offer reasonable protection to citizens in that state, other boards discipline so few physicians that they offer almost no protection at all.

- Hospital quality assurance departments, another possible line of defense against poor performance, conduct their business behind a shroud of secrecy, making it hard to assess

the success of their efforts. As of December 1993, however, seventy-five percent of the hospitals in this country had not reported to the National Practitioner Data Bank even one adverse action taken against a doctor. Given the very limited number of reports filed by hospitals -- reports mandated by law -- there is reason to question whether hospitals are actively identifying and responding to poor performing doctors, and to be concerned about the level of protection provided to patients.

- **Accrediting organizations that inspect hospitals** -- the most important being the Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO") -- offer little to instill confidence in the public. Like hospital quality assurance departments, the JCAHO maintains the results of its inspections in secrecy, and rarely refuses accreditation to a hospital. Public Citizen's Health Research Group has long been critical of the fact that the JCAHO, a private organization dominated by the industry it is supposed to be regulating, has been given so large a role in "protecting" Medicare beneficiaries from poorly performing hospitals.

Option One in this report includes the suggestion that the Health Care Financing Administration consider ways for the federal government to support the efforts of organizations that are more focused on addressing individual cases of poor care -- this is an idea that we support, but not at the cost of PROs' "policing role." Even with the existence of PROs, the system for identifying and responding to poorly performing physicians and hospitals is hardly a seamless web. Without PROs, there will be even less protection for Medicare beneficiaries.

Option Two suggests studying the PROs to determine whether they can perform both roles at the same time, and if so, how best to do so. While we support further study to determine ways to improve PROs, we would like to point out that most of the problems identified in this report have been identified before in the series of OIG reports cited in Footnote 2. While the PROs' shift in focus may have exacerbated some of their problems in identifying and responding to poor performers, the nature of the problems has not changed. To boost the performance of PROs, therefore, we suggest that some of the recommendations of previous reports be vigorously implemented, in particular:

- **HHS should propose legislation requiring PROs to provide case information to State medical boards when PROs have confirmed that a physician is responsible for poor quality of care resulting in harm to the patient.** The legislation proposed should resolve the confusion caused by OBRA '90, (PL 101-508), which requires "notice and hearing" before PROs share case information.
- **HHS should seek legislative change that would permit PROs to provide and receive data from the National Practitioner Data Bank.** One of the problems identified in the report is the difficulty of a PRO determining whether poor behavior is part of a pattern or merely an isolated incident, and access to other information collected in the National Practitioner Data Bank would assist in such a determination.

- HHS should seek legislative change to increase the amount of monetary penalties permitted in order to make them a more meaningful sanction. Current law limits monetary penalties to the amount of the medically unnecessary or improper service -- an amount too small to serve as an adequate sanction or deterrent.

- HHS should seek legislation to repeal the requirement that physicians or hospitals which have violated Medicare obligations may be sanctioned only if they demonstrate an "unwillingness or inability" to comply with Medicare obligations. OIG reports since at least 1988 have identified this "unwilling or unable" requirement as a major impediment to PROs exercising their sanction referral authority, and have recommended deletion of this requirement.

- HHS should increase educational and outreach efforts to inform Medicare beneficiaries of the existence and functions of PROs. Beneficiary complaints will become an even more important source of leads for PROs as the random sample medical record review is phased out.

PROs can serve a vital role in protecting Medicare beneficiaries from poor quality medical care, but they have not yet lived up to their potential. Over the past years, PROs' use of their sanction authority has dwindled, and now with the shift in focus to "continuous quality improvement" and education, we fear that PROs will become less effective unless the recommendations made in previous OIG reports, and repeated here in our comments, are implemented.

We are not unmindful of the difficulties PROs may have as their resources are shifted more and more towards enforcing their mandate to improve the general practice of medicine. This focus, however, cannot replace the necessary task of identifying individual poor performers -- both physicians and hospitals -- in the medical field. The two approaches deal with different aspects of quality problems, and no matter how much "continuous quality improvement" is able to raise general standards of medical care, there will always be poor performers who injure individual patients and who must be detected and sanctioned. PROs, in order to fully protect Medicare beneficiaries, must be strengthened to perform this service.

Coalition for Consumer Protection and Quality in Health Care Reform

1275 K Street, N.W., Suite 900 Washington, DC 20005

(202)789-3606 Fax (202)842-1150

November 6, 1995

Ms. June Gibbs Brown
Inspector General
Department of Health and Human Services
Cohen Building, Room 5250
330 Independence Ave., S.W.
Washington, D.C. 20201

Dear Ms. Brown:

Thank you for asking the Coalition for Consumer Protection and Quality in Health Care Reform to comment on your draft report, "The Medicare Peer Review Organizations' Role in Identifying and Responding to Poor Performers."

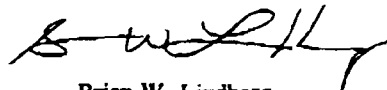
The Coalition is composed of more than thirty organizations with the common goal of a health care system that offers good consumer information, meaningful choice, quality assurance, and public accountability. When we receive a request for comment such as yours, we circulate the document to our membership asking for their comments. Depending on the issue, we may receive one or more comments. For example, in your previous report, dealing with complaint handling, four of our member organizations responded. We always pass on the unedited comments of our members, as we did with the above-mentioned report.

On some issues, the Coalition as a whole takes a position. The nature of our Coalition is such that when we do take a Coalition position, each member does not necessarily subscribe to every specific recommendation, but rather supports what we say as generally on target.

When only one or two of our members respond to a call for comments, we do not usually take a formal position as a Coalition. In the case of your current draft report on identifying and responding to poor performers, we received only one comment -- from the Citizen Advocacy Center (CAC). The comment is enclosed. While I cannot state that CAC's comments represent the Coalition's position (since so few of our members chose to express a view), I can say that they are quite knowledgeable about this program and may generally represent the views of most Coalition members.

Thank you for the opportunity to comment.

Sincerely,



Brian W. Lindberg
Executive Director

[c:\igcom2.wps]

COMMENTS
on the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
DRAFT REPORT

**"The Medicare Peer Review Organizations' Role
in Identifying and Responding to Poor Performers"
August, 1995**

Introduction

The Citizen Advocacy Center (CAC) is a unique support program for the thousands of public members who serve on health care regulatory boards and governing bodies as representatives of the consumer interest. Whether appointed by governors to serve on regulatory or other health policy boards or selected by private sector institutions and agencies to serve on boards or advisory panels, public members are typically in the minority and are usually without the resources and technical support available to their counterparts from professional and business communities. CAC is a not-for-profit 501(c)(3) organization created to serve the public interest by providing research, training, technical support, and networking opportunities to help public members make their contributions informed, effective, and significant.

One of CAC's networks (called "PRONET") is composed of the beneficiary members of the Boards of Directors of the Medicare Peer Review Organizations which are the subject of this draft report. From time to time, PRONET takes positions on matters of particular interest to Medicare beneficiaries, which include OIG reports dealing with the performance of PROs. In this instance, *PRONET has not yet spoken on the draft report that is the subject of these comments.* At its most recent annual meeting in September, 1995 in Salt Lake City, Utah, PRONET members adopted a resolution calling on CAC to convene a forum where PRONET members would have an opportunity to review and debate the direction of the Medicare quality oversight program and to develop a "White Paper" on the subject for presentation at the 1996 annual

meeting.¹ Thus, PRONET's comments on the findings and recommendations in the OIG's draft report will be contained in that future document. The comments presented here reflect the views of CAC.

Summary of the OIG Findings and Recommendations

The OIG presents two major findings:

1) As the PRO Program becomes increasingly committed to improving the overall practice of medicine, its ability to find and take action on poorly performing physicians and hospitals is questionable.

2) The PROs themselves find much that is positive about the current direction of the Program. But some express reservations about its impact on protecting Medicare beneficiaries from poor performers.

In arriving at finding #1, the OIG concluded that PROs:

- find themselves with very limited leads to identify poorly performing physicians or hospitals;
- are unlikely to determine whether incidents that are brought to their attention are isolated events, or parts of a pattern of questionable care;
- rarely do more than inform those responsible of the nature of a quality of care problem when one is confirmed;
- submit virtually no sanction recommendations to the OIG (the number of sanction recommendations has declined from a high of 72 in 1987 to only 13 in 1994);
- refer very few cases to state boards of medicine, even though 1993 federal legislation requires them to do so.

In arriving at finding #2, the OIG concluded that while 17 of 22 PROs (77%) believe that the two basic PRO functions -- improving the mainstream of care and dealing with poor performers -- are compatible, 50% of these same PROs have concluded that beneficiary protections have become weaker.

Having made these two findings, the OIG suggested to the Health Care Financing Administration (HCFA) that it has two options for the future. These are:

¹ The full resolution as adopted by PRONET is attached to this comment.

OPTION 1: The HCFA should proceed toward directing the PROs to focus exclusively on improving the mainstream of care. To help deal with poor performers, it should consider ways in which the Federal government might support other bodies, such as State Medical boards and ombudsmen, that are more focused on addressing individual cases of poor medical care.

OPTION 2: The HCFA should devote further inquiry to determine: (1) if the two functions of improving the mainstream of care and identifying and dealing effectively with poor performers can reasonably be performed by one organization, and (2) how PROs can carry out both simultaneously. Toward that end, it could support research efforts, demonstration projects by individual PROs, and conferences.

CAC Comments

Beginning with the Fourth Scope of Work in 1993, HCFA dramatically changed the primary function of the PROs. The PROs' new assignment was to analyze patterns of care and outcomes, and share this information with the medical community. PROs moved away from individual chart review designed to identify poor performers, effectively ending their role as policemen, one with which most PROs never seemed comfortable. Organized medicine and the provider community reacted favorably to this change in direction.

Even during the years when PROs devoted most of their energy to chart review, they were regularly criticized for doing a poor job of policing poor performers. They sent very few sanction recommendations to the OIG. They failed to develop cooperative relationships with boards of medicine, which have more disciplinary authority and broader powers to supplement PRO sanction authority. Very few quality of care cases have been referred by PROs to state medical boards. PROs tended to prefer educational interventions over sanctions. Even so, as an earlier OIG report revealed, PRO educational interventions generally consisted of notifying a provider of a confirmed quality problem and asking the provider to do something about it.

While their operations have now changed under the Fourth and Fifth Scopes of Work, PROs still retain the legal authority and the duty to identify and deal with poor performers. PROs continue to receive complaints from beneficiaries and have the responsibility for addressing any quality problems revealed in these complaints.

CAC believes that the OIG draft report accurately states the options presently before HCFA -- 1) to relieve PROs of responsibility for dealing with poor performers, or 2) to find a way to reconcile the apparent conflict between this

responsibility and the PROs' pattern analysis quality improvement activities.

CAC reserves final judgment until PRONET has had an opportunity to examine and debate the PROs' quality protection role. Nevertheless, we will say that we think a lot of convincing is needed to justify continuing to rely on PROs to police poor performers. Given that PROs did an inadequate job of dealing with poor performers when this was one of their major responsibilities, what is the evidence that PROs will do a more dependable job of policing quality problems now that this has become a lesser responsibility in the PRO Scope of Work? It would be misleading for PROs to hold themselves out as part of a safety net but fail to provide meaningful protection.

PRONET RESOLUTIONS passed at the Citizen Advocacy Center "PRONET" Annual Meeting, September 28, 1995.

RESOLUTION REGARDING THE PRO BENEFICIARY COMPLAINT PROCESS

WE, THE PRONET BENEFICIARY BOARD MEMBERS ASSEMBLED FOR THE 1995 CITIZEN ADVOCACY CENTER "PRONET" ANNUAL MEETING IN SALT LAKE CITY, UTAH ON SEPTEMBER 28, 1995, ENACT THE FOLLOWING RESOLUTION IN CONCERN THAT A MORE EFFECTIVE AND MORE ACCOUNTABLE QUALITY-RELATED COMPLAINT PROCESS IS NECESSARY TO ADEQUATELY PROTECT MEDICARE BENEFICIARIES:

WHEREAS, the U.S. Department of Health and Human Services Office of the Inspector General (OIG) recently released a draft report assessing the PRO beneficiary complaint process and found such complaints to be a rich source of quality of care problems and critical to the PROs' ability to protect beneficiaries from individual instances of poor care, and

WHEREAS, most beneficiaries are unaware of the PRO complaint process in spite of years of outreach and public education efforts, and

WHEREAS, major barriers to an effective complaint process include the current federal confidentiality requirements and the lengthy investigation process,

THEREFORE, BE IT RESOLVED THAT the PRONET Members attending the 1995 Citizen Advocacy Center "PRONET" Annual Meeting urge HCFA to adopt and implement the OIG's recommendations, including:

- 1. That HCFA work with PROs to identify cost-effective ways to correct the flaws in the complaint process and require PROs to respond substantively to the complainant as suggested by the OIG report.**
- 2. That HCFA work with the Citizen Advocacy Center and AMPRA's Communications Network to identify cost-effective ways to enhance Medicare beneficiaries' awareness of PROs and the complaint process, in addition to the Fifth Scope of Work communications directives that focus on Health Care Quality Improvement initiatives.**
- 3. That HCFA streamline the complaint process in order to expedite the investigation and response processes. To that end, PRONET urges HCFA to work with the Citizen Advocacy Center to collect information about how other health care oversight bodies, such as state licensing boards, conduct complaint investigations.**

RESOLUTION REGARDING A FORUM TO REVIEW AND DEBATE THE DIRECTION OF THE MEDICARE QUALITY OVERSIGHT PROGRAM AND ITS IMPACT ON MEDICARE BENEFICIARIES

WE THE PRONET BENEFICIARY BOARD MEMBERS ASSEMBLED FOR THE 1995 CITIZEN ADVOCACY CENTER "PRONET" ANNUAL MEETING IN SALT LAKE CITY, UTAH ON SEPTEMBER 28, 1995, ENACT THE FOLLOWING RESOLUTION IN CONCERN ABOUT CHANGES IN QUALITY OVERSIGHT BODIES FOR THE MEDICARE PROGRAM:

WHEREAS, there is a question about whether the PRO movement in today's climate of deregulation and major changes in the delivery of health care in the Medicare program (and Medicaid, etc.) has become irrelevant and vestigial, and

WHEREAS, Peer Review as a concept and a strategy for the assurance of quality care for Medicare beneficiaries has been effectively dismantled and the vast machinery of that system of review, oversight and interaction has been disassembled and its value dissipated, and

WHEREAS, there are varying degrees of acceptance of these changes by the medical profession, research community, and Medicare beneficiaries, and

WHEREAS, PRONET has not had the opportunity to date to adequately consider these varying opinions and develop its own collective position on how these changes affect the quality of health care from the Medicare beneficiary's perspective,

THEREFORE, BE IT RESOLVED THAT the PRONET Members attending the 1995 Citizen Advocacy Center "PRONET" Annual Meeting urge CAC to convene a forum where PRONET members would have an opportunity to review and debate the direction of the Medicare quality oversight program.

BE IT FURTHER RESOLVED THAT this recommendation should be given the highest priority so that the PRONET Steering Committee can develop a "White Paper" that reflects the collective thinking of the PRONET membership to be presented during the 1996 Citizen Advocacy Center Annual Meeting.

RESOLUTION REGARDING THE HCFA CONTRACT BIDDING PROCESS

WE, THE PRONET BENEFICIARY BOARD MEMBERS ASSEMBLED FOR THE 1995 CITIZEN ADVOCACY CENTER PRONET ANNUAL MEETING IN SALT LAKE CITY, UTAH ON SEPTEMBER 28, 1995, ENACT THE FOLLOWING RESOLUTION:

BE IT RESOLVED THAT the PRONET Members attending the 1995 Citizen Advocacy Center PRONET Annual Meeting urge the Health Care Financing Administration (HCFA) to reassess its rules governing the PRO contract bidding process for designating a PRO in a given state to assure maximum fairness and equal application

APPENDIX F

NOTES

1. The Institute of Medicine, *Medicare: A Strategy for Quality Assurance* (Washington, D.C.: National Academy Press, 1990).

2. U.S. Department of Health and Human Services, Office of Inspector General, *The Utilization and Quality Control Peer Review Organization Program: Quality Review Activities*, OAI-01-00570, September 1988; *The Utilization and Quality Control Peer Review Organization Program: Sanction Activities*, OAI-01-88-00571, November 1988; *The Utilization and Quality Control Peer Review Organization Program: An Exploration of Program Effectiveness*, OAI-01-88-00572, February 1989; *Educating Physicians Responsible for Poor Medical Care: A Review of the Peer Review Organizations' Efforts*, OEI-01-89-00020, February 1992; *Peer Review Organizations and State Medical Boards: A Vital Link*, OEI-01-92-00530, April 1993; *The Sanction Referral Authority of Peer Review Organizations*, OEI-01-92-00250, April 1993; and *The Beneficiary Complaint Process of the Medicare Peer Review Organizations*, Draft Report, OEI-01-93-00250, June 1995.

The Office of Inspector General has also issued a number of reports on DRG validation.

3. Reflects reviews completed under the fourth contracts. The HCFA staggers the starting dates of the PROs' contracts, thus some PROs began their fourth contract in April 1993, some in July 1993, and some in October 1993.

4. The volume of random sample medical record reviews has historically been so large that even with such a low confirmation rate, the majority of quality-of-care problems stemmed from those reviews.

5. Hebbel and McMullan to Executive Directors, Peer Review Organizations, 20 December 1994, Health Care Financing Administration, Baltimore, MD.

6. Other than beneficiary complaints, PROs are mandated to review the following types of cases: Assistant at Cataract Surgery, Medicare Code Editor, Hospital Adjustment, FI referral, RO referral, and Hospital Issued Notice of Noncoverage (HINN). The PROs will also continue to do some miscellaneous reviews. However, the most fruitful source among the miscellaneous reviews--the readmission reviews, which accounted for 9 percent of the 6,010 confirmed quality-of-care problems that PROs identified--will also be eliminated.

7. *The Beneficiary Complaint Process of the Medicare Peer Review Organizations*.

8. Those who offered an estimate reported having received one or two or a few such referrals.

9. Those who offered an estimate reported having received between one and four referrals from hospitals. Nine of those who offered an estimate on physician referrals reported having received either a small number or between 1 and 4 such referrals; 1 reported having received 6; and 2, 10 or more.
10. We understand that PROs, through their HCQIP cooperative projects with hospitals, could identify instances of poor performance. However, unless the questionable care is so egregious as to prompt a sanction recommendation, it will be excluded from the historical data bases of quality-of-care problems that PROs monitor for patterns to emerge.
11. As required in their contracts, the PROs also profile quarterly all the quality-of-care problems they have identified. This activity does not involve reviewing additional case records on a particular provider but is simply a method for monitoring the PROs' pool of quality-of-care problems to identify patterns of poor care.
12. In determining whether an individual quality-of-care problem would result in an improvement plan, the PROs considered the existence of a pattern of quality-of-care concerns or problems and severity of the problem/harm to the patient. Some PROs reported also having considered whether the problem could be corrected, the receptivity of the physician or hospital involved, and the opinion of the medical director.
13. U.S. Department of Health and Human Services, Office of Inspector General, *Hospital Reporting to the National Practitioner Data Bank*, OEI-01-94-00050, February 1995.
14. The National Practitioner Data Bank, established in the Health Care Quality Improvement Act of 1986, maintains records of medical malpractice and adverse actions taken by hospitals, other health care entities, licensure boards, and professional societies against licensed health care professionals. Hospitals and other health care entities must report to the Data Bank all adverse actions they take that affect a practitioner's clinical privileges for more than 30 days.
15. We reported that the unwilling and unable requirement remained an obstacle despite the Administrative Conference of the United States referring to it as an "inappropriate" burden of proof in 1989 and Congress' attempt to make it more workable in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508).
- The PROs cited the high costs, the complexity of balancing physicians' rights to due process with the beneficiaries' need for quality, and the confusing instructions from HCFA and OIG.
- See *The Sanction Referral Authority of Peer Review Organizations*.
16. Federation of State Medical Boards of the U.S., Inc., *Annual Board Action Statistical Package*, April 5, 1995.

Many medical boards are beginning to devote more attention to quality-of-care cases. But most disciplinary actions taken by boards still focus on other issues, such as drug and alcohol abuse, sexual abuse, and criminal violations.

17. Concerns about violating confidentiality requirements explain, at least in part, why so little sharing has occurred. In 1990, Congress passed legislation calling for the PROs to share information with the boards, but it has had little if any effect. It included a provision that the sharing occur after the PROs' grant physicians "notice and hearing." Because of uncertainty about the meaning of this "notice and hearing" provision, however, PROs still shared little information with the boards. (see *The Peer Review Organizations and State Medical Boards: A Vital Link*)

18. Citizen Advocacy Center, *Information Exchange Between Peer Review Organizations and Medical Licensing Boards: Update and Report on CAC Survey*, March 1992, and *Information Exchange Between Peer Review Organizations and Medical Licensing Boards: Report on the 50 State Survey*, November 1992.

19. The Center identified Alabama, California, Colorado, Iowa, Minnesota, Mississippi, Ohio, Rhode Island, West Virginia, and Wisconsin as States with medical boards and PROs both committed to sharing information.

20. For example, the New York PRO initiated a cooperative project aimed at improving prophylactic antibiotic administration. It collaborated with more than 70 hospitals to conduct this project and, based on the project's feedback, these hospitals are changing their antibiotic administration policies. (from "IPRO Works with Hospitals to Implement Feedback Effort," *IPRO Quality Initiatives*, Winter 1995.)

Another example involves the Alabama PRO's use of data from the large-scale Cooperative Cardiovascular Project. By working with the PRO, one hospital in Alabama increased the proportion of patients receiving beta blockers when indicated from one-third to all. It also increased the post-heart attack administration of aspirin from 70 percent to 95 percent of eligible patients. (from Linda Oberman Prager, "Undoing Case Review," *American Medical News*, June 26, 1995.)