

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE PEER REVIEW ORGANIZATIONS
AND STATE MEDICAL BOARDS:
A VITAL LINK**

A MANAGEMENT ADVISORY REPORT



APRIL 1993

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Department of Health and Human Services

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APRIL 1993 OEI-01-92-00530

EXECUTIVE SUMMARY

PURPOSE

To review the status of Peer Review Organization (PRO) efforts to provide State medical boards with information about physicians responsible for substandard medical care.

BACKGROUND

The PROs identify physicians responsible for serious quality-of-care problems, but they seldom inform State medical boards about these physicians. In prior reports, we have expressed concern that this lack of information sharing inhibits the boards' effectiveness in protecting Medicare and Medicaid beneficiaries and other citizens of their States.

Most recently, in a 1990 report entitled "State Medical Boards and Medical Discipline," we urged the passage of legislation that would require PROs to share case information with boards when they send a first sanction notice to a physician. Congress passed such legislation in 1990.

FINDING

The 1990 legislation has had little if any effect.

The 1990 legislation included a provision that the case 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 share little information with the boards.

RECOMMENDATION

The Health Care Financing Administration should propose legislation mandating that PROs provide case information to State medical boards when they have confirmed, after medical review, that a physician is responsible for medical mismanagement resulting in significant adverse effects on the patient.

This approach would provide increased protection to Medicare beneficiaries and rests on a solid overall rationale:

- ▶ *It limits referrals to serious quality-of-care cases.*
- ▶ *It is clear-cut and workable.*
- ▶ *It would be fair to physicians.*
- ▶ *It would provide valuable information to boards.*

COMMENTS

We received comments on the draft report from the Health Care Financing Administration (HCFA), Public Health Service (PHS), and Assistant Secretary for Planning and Evaluation (ASPE) within the Department. The American Medical Association (AMA), American Medical Peer Review Association (AMPRA), and American Association of Retired Persons (AARP) also provided comments. The full text of each comment appears in appendix A.

The HCFA, ASPE, and the AMA disagree with our recommendation. The HCFA believes that our recommendation for legislation would not solve the problem because of "the confusion created by the two current amendments." The HCFA, ASPE, and the AMA believe that the pending fourth scope of work, and its efforts to foster a more cooperative relationship between PROs and physicians, will move toward achieving this goal.

The PHS, AMPRA, and AARP concur with our recommendation to HCFA. The PHS notes that a report from the PROs would be consistent with the requirements for reporting other types of peer review activity to the National Practitioner Data Bank (NPDB) and should provide useful information for the State medical boards.

We have retained our recommendation as presented in the draft report.

TABLE OF CONTENTS

Executive Summary

Introduction 1

 PROs and State Medical Boards

 A Review of Recent History

Finding 3

Recommendation 5

Comments on the Draft Report 7

Appendices

 A. Detailed Comments on the Draft Report A-1

 B. Endnotes B-1

INTRODUCTION

PURPOSE

To review the status of Peer Review Organization (PRO) efforts to provide State medical boards with information about physicians responsible for substandard medical care.

BACKGROUND

PROs and State Medical Boards

The PROs are organizations funded by the U.S. Department of Health and Human Services (HHS) to determine the appropriateness and quality of medical care provided to Medicare beneficiaries. They do this primarily by reviewing samples of inpatient medical records against standards of established medical practice. Once they confirm¹ that a physician is responsible for a quality-of-care problem, their response depends on the seriousness of the problem. Even in the most serious cases, however, their response is almost always educational.² In fiscal year 1992, the PROs took the punitive approach of recommending that HHS exclude a physician from further participation in the Medicare and Medicaid programs only 14 times.³

The State medical boards license and discipline physicians. Since 1965, when the Medicare and Medicaid programs were established, the Federal government has relied upon them to determine when physicians are legally authorized to participate in these programs and, when necessary, to discipline physicians. Most boards initiate investigations of physicians primarily on the basis of complaints or referrals made to them. The violations they identify sometimes involve quality-of-care problems, but more often they concern drug and alcohol abuse, sexual misconduct, and criminal behavior. Their response ranges from a license revocation to a letter of warning. In 1991, the boards took 2,804 prejudicial actions against physicians, of which 959 involved a loss of license or license privileges and 1,110 involved a restriction of license or license privileges.⁴

A Review of Recent History

From the beginning of the PRO program in 1984-86, we have been concerned that PROs seldom provide the boards with information about physicians whom they find to be responsible for serious quality-of-care problems. We have held that this lack of information sharing inhibits the boards' effectiveness in protecting the citizens of their States. Boards, we have pointed out, may not even know the identity of physicians whom the PROs, after extensive medical review, have found responsible for substandard or unnecessary medical care in one or more incidents.

We first addressed this issue in a 1986 report entitled "Medical Licensure and Discipline: An Overview" (P-01-86-00064). We addressed it again, more forcefully, in a 1990 report entitled "State Medical Boards and Medical Discipline" (OEI-01-89-00560). In that report and in testimony before Congress,⁵ we called for legislation mandating that the PROs share case information with the boards when the first sanction notice is sent to a physician. Such a notice rarely leads to an actual sanction referral to the Federal government, but it does reflect a PRO's considered judgment about the quality of medical care rendered to a patient.⁶ This recommendation for a statutory amendment, which had considerable support, would have addressed PROs' concerns about how the sharing of case information could violate confidentiality requirements under existing law.⁷

In 1990, Congress passed legislation calling for the PROs to share case information with the boards. The legislation was passed in response to concerns raised by us, the Federation of State Medical Boards, and others about the lack of information sharing between PROs and boards.

FINDING

► *The 1990 legislation has had little if any effect.*

Upon passage of the legislation, the Health Care Financing Administration (HCFA), which funds and oversees the PROs, followed up by amending the PROs' scope of work to require that they inform boards of physicians to whom they have sent a first sanction notice. Subsequently, however, HCFA rescinded this requirement in response to concerns that it was not in accordance with the congressional stipulation that the PROs must grant physicians "notice and hearing" before sending information about them to the boards. The New York regional office of HCFA characterized the legislation as follows:

The statutory provisions added by section 4205(d) of OBRA '90 about PRO responsibility to notify licensing bodies concerning certain PRO actions are inherently inconsistent. These provisions do not provide clear authority for the disclosure of information other than sanction reports submitted to the Secretary pursuant to section 1156 (b)(1) of the Act.⁸

The actual sharing of case information still appears to be minimal, even for the most serious cases. This was the clear message of a March 1992 report of the Citizen Advocacy Center (CAC) funded by the American Association of Retired Persons (AARP).⁹ In that report, the CAC reviewed the recent experiences of 10 States where the PROs and medical boards had shown an interest in more active information sharing. Among those States, it found that only the Ohio PRO was sending much information to the medical board.¹⁰

The CAC extended its survey to all 50 States. In a November 1992 report, it confirmed that little information exchange is taking place nationwide. In addition to Ohio, CAC found that only in Mississippi, New York, and to a lesser extent Texas, are much data flowing from PROs to medical boards concerning physicians who might be candidates for disciplinary action.¹¹

Ohio's endeavor illustrates the potential for such an information exchange. From May 1990 until April 1992, the Ohio PRO has referred 75 cases to the Ohio medical board. Of these, the board has dismissed 13 without any active investigation and another 37 after conducting some investigation. The remaining 25 are in various stages of review, with 8 of them at an advanced stage involving the initiation of a formal action against a physician.¹²

The table on the next page summarizes the key actions from 1986 to 1991 related to PROs sharing information with medical boards.

**TABLE I
KEY ACTIONS CONCERNING
THE PRO-STATE MEDICAL BOARD LINKAGE**

DATE	ACTION
June 1986	An OIG report, "Medical Licensure and Discipline: An Overview," concludes that PROs are an unproductive source of cases for boards; recommends that PRO regulations be amended "to require more extensive and timely information" to boards.
March 1988	The HCFA issues draft regulation stating that PROs "may without a request, and must, upon a request, disclose" to boards "confidential information relating to a specific case (or) a possible pattern of substandard care."
October 1988	The HCFA, in third scope of work, calls for PROs to "consider" sharing confidential case information with boards when serious quality-of-care problems are found under the quality intervention plan. This serves to operationalize the regulation first issued in draft in March 1988.
May 1989	Missouri PRO indicates that 55 percent of the 38 PROs responding to a national survey regarded their relationship with the board to be good or excellent, but that about two-thirds of the PROs still had not reported any physicians to boards during the past 12 months.
December 1989	The AARP convenes workshop to identify ways of achieving closer ties between PROs and boards. The workshop included representatives of PROs and boards from 10 States. Participants stressed need for clearer legislative or regulatory direction on what information can be shared.
August 1990	An OIG report, "State Medical Boards and Medical Discipline," finds that PROs still refer few cases to boards. In 8 sample States, only 1 of 188 disciplinary actions taken by the boards is found to originate from a PRO referral. OIG recommends legislation mandating that PROs share case information with boards when the first sanction notice is sent to a physician.
December 1990	Congress, in Omnibus Budget Reconciliation Act, requires that PROs notify boards of physicians whom they have found responsible for serious quality-of-care problems. Congress stipulates, however, that notification is not to occur until after "notice and hearing" are granted to the physicians involved.
February 1991	The HCFA adds a provision to an early draft of the fourth scope of work stipulating that once the PRO issues a first sanction notice to a physician, it must notify the board of its findings and decisions.
November 1991	The HCFA, in response to concerns expressed that the above-noted provision does not reflect the intent of the 1990 legislation, removed the provision from that early draft fourth scope of work.
March 1992	The Citizen Advocacy Center, sponsored by the AARP, releases a report providing results of a survey of the 10 States that had participated in the December 1989 AARP conference on PRO-board relationships. The report concludes that, except in Ohio, very little information is being exchanged.
November 1992	The CAC publishes findings from a nationwide survey. The report concludes that, in addition to Ohio, only in Mississippi, New York, and to a lesser extent Texas, is much data flowing from the PRO to the board.

RECOMMENDATION

The Health Care Financing Administration should propose legislation mandating that PROs provide case information to State medical boards when they have confirmed, after medical review, that a physician is responsible for medical mismanagement resulting in significant adverse effects on the patient.

There is considerable agreement that PROs should limit their referrals to the State medical boards to cases involving serious quality-of-care problems. The problem is in defining at what point in the PRO review process the referral should be made.

In our last report, we identified the first sanction notice as the best point of referral. Such cases clearly are serious and would have involved at most a few hundred referrals a year in the entire country. Congress took the same approach, but in drafting the legislation added a hearing requirement that in effect has precluded HCFA from requiring that information be shared at the point of the first sanction notice. In fact, at least one major State medical society has argued that the legislation allows for a PRO to refer a case to a board only when it makes a *final* sanction recommendation after all due process procedures are carried out.¹³ As we noted earlier, there were only 14 such referrals made in FY 1992.

We now recommend that the PROs share case information with the boards at the point when they have confirmed, after medical review, that a physician is responsible for medical mismanagement resulting in significant adverse effects on the patient. The HCFA would need to specify what the case information would include, but it could include not only demographic information on the physicians but also information on the type of quality-of-care problems involved and even the locations at which the problems occurred.

If our recommendation were enacted, information sharing between PROs and boards would involve a limited number of cases. Based on the recent efforts of the PROs, enactment of our recommendation would result in perhaps 1,000 to 1,500 referrals for the entire nation.¹⁴ This is more than the few hundred expected if our prior recommendation had been enacted as we intended, but it is still quite modest in view of the more than 400,000 patient-care physicians in the United States. This approach would provide increased protection to Medicare beneficiaries and rests on a solid overall rationale as indicated below.

It limits referrals to serious quality-of-care cases. It is clearly a serious case when PRO physician consultants have determined that a physician is responsible for care contributing to significant patient harm.¹⁵ Although it does not necessarily follow that such a physician is incompetent or should be investigated or disciplined by the State medical board, it certainly is reasonable to send a report on him or her to the State board responsible for protecting the public from substandard medical care.

It is clear-cut in intent and workable. Making a judgment on whether a physician is responsible for medical mismanagement resulting in patient harm is clearly a part of the PROs' responsibilities. Under our recommendation, the PRO would automatically inform the board once it confirmed and documented patient mismanagement resulting in significant adverse effects on the patient.¹⁶

It would be fair to the physicians. The PROs' determinations in these cases are made only after PRO physicians have reviewed the relevant case information and after the physicians under review have been granted an opportunity to explain the medical care being questioned. If a State medical board then decides to pursue the case, the physician is, of course, entitled to the full range of due process and appeal rights granted under State law.

It would provide valuable information to the boards. From the boards' perspective, the PRO referrals would facilitate reviews of quality-of-care cases because they are based on prior medical judgments of physician reviewers. Even when such cases did not result in a disciplinary action, they would provide information that boards could incorporate in a computer data base to develop a profile of at-risk physicians. Such information could provide valuable markers on the kind of preventive efforts boards could take to avert the need for disciplinary action.

COMMENTS ON THE DRAFT REPORT

We received comments on the draft report from the Health Care Financing Administration (HCFA), Public Health Service (PHS), and Assistant Secretary for Planning and Evaluation (ASPE) within the Department. The American Medical Association (AMA), American Medical Peer Review Association (AMPRA), and American Association of Retired Persons (AARP) also provided comments. The full text of each comment appears in appendix A.

Health Care Financing Administration

The HCFA disagrees with our recommendation for three reasons. First, it believes that our proposal for legislation would not solve the problem because of "the confusion created by the two current amendments." Second, it does not believe that every initial violation or proposed action against a physician should be reported to State medical boards. Third, it is concerned that such a requirement could damage the cooperative relationship between PROs and physicians that HCFA is seeking to foster under the fourth scope of work.

With regard to the first point, if the language we propose is insufficient, we offer to work with HCFA to draft legislative language that would alleviate the problem.

With regard to the second point, we agree that actions brought against a physician that are resolved on the basis of evidence presented to the PRO should not be reported to the State medical board. We recommend that PROs share case information with medical boards only for those cases that are judged to have significant adverse impacts on patients. This referral would take place after a physician has interacted with PRO physicians and after PRO physicians have determined that this is a serious quality-of-care problem that requires attention, but before a formal sanction recommendation to the OIG. The boards already receive information on malpractice claims and hospital adverse actions against physicians. It clearly makes sense for the boards to receive information from the PROs when they confirm serious quality-of-care problems after medical review.

With regard to the third point, we recognize that the fourth scope of work contains substantial changes in the role of the PROs. We have included revisions in our endnotes to reflect the final request for proposals that HCFA issued for this contract. The fourth scope will focus on pattern analysis and information sharing as a way of improving overall patient outcomes and the quality of care. We applaud broad-based efforts to improve the quality of care for Medicare beneficiaries and for the population at large. Notwithstanding HCFA's new approach, the PROs continue to have a critical responsibility to protect the health of Medicare beneficiaries. This responsibility may call for taking action against individual physicians who have significant deficiencies in their medical knowledge and/or practice skills, and it may mean that the PRO needs to share information about these practitioners with the medical board.

Public Health Service

The PHS concurs with our recommendation to HCFA. The PHS notes that a report from the PROs would be consistent with the requirements for reporting other types of peer review activity to the National Practitioner Data Bank (NPDB) and should provide useful information for the State medical boards.

We appreciate the PHS' positive response. We also wish to note that the types of cases we recommend be reported to State medical boards--cases that result in significant adverse effects on a patient--are more serious than many of the malpractice actions required to be filed with the NPDB.

Assistant Secretary for Planning and Evaluation

The ASPE does not support our recommendation. It believes that memoranda of agreement between PROs and State medical boards, required under the fourth scope of work, will address the problem. The ASPE also questions whether our recommendation would lead to exchange of information at a stage that is too early in the process.

We believe that it is important to have in place memoranda of agreement between PROs and State medical boards regarding the exchange of information. Unless they require the exchange of meaningful and useful information, such memoranda, in and of themselves, may do little to address physicians with quality-of-care problems. Without the legislative change we recommend, the information exchanged may have no more impact than it does at present.

We disagree with ASPE that our recommendation would lead to exchange of information too early in the process. Information on these cases will be shared with the State medical boards only after they have been confirmed through medical review involving the physician and the PRO physicians.

We also are concerned that ASPE's comments may reflect some misunderstanding. We wish to clarify that this report refers strictly to the role of State medical boards, not to State medical societies.

American Medical Association

The American Medical Association supports, in principle, efforts to improve the sharing of case information between PROs and State medical boards. The AMA, however, disagrees with our recommendation. It believes that existing law and the pending fourth scope of work are adequate to achieve this goal.

We disagree that existing law is adequate to improve this information exchange. The 1990 legislation has had little effect, and the actual sharing of case information continues to be minimal. We are concerned that the PROs, during the fourth scope of work with its focus

on improving the mainstream of care through pattern analysis, may neglect to address serious quality-of-care problems that require disciplinary action against individual physicians.

American Medical Peer Review Association

The American Medical Peer Review Association supports our recommendation and a "a legislative 'fix' to OBRA 90 that would correct the drafting errors and render the language implementable."

We welcome AMPRA's support and find it significant that the organization representing the PROs regards the mandated referral to State boards of serious quality-of-care cases to be consistent with their mission. Such a mandate need not preclude PROs from stressing the educational objectives called for under the fourth scope of work.

American Association of Retired Persons

The American Association of Retired Persons supports our recommendation. It suggests that we call for HCFA to either pursue the legislative amendment we identify, or use its rulemaking authority to achieve the desired result.

We appreciate the AARP's positive response. In its response to our recommendation, HCFA cites "confusion created by the existing OBRA 90 amendments," indicating that regulatory redress of this provision will not solve the problem. Legislative change would make it absolutely clear that the type of information exchange we call for is required.


APPENDIX A

DETAILED COMMENTS ON THE DRAFT REPORT

In this appendix we present the full comments on the draft report. The comments presented in this appendix are from:

	Page
The Health Care Financing Administration	A-2
The Public Health Service	A-6
The Assistant Secretary for Planning and Evaluation	A-9
The American Medical Association	A-13
The American Medical Peer Review Association	A-15
The American Association of Retired Persons	A-18

Memorandum



Date JAN 15 1992
From William Toby, Jr.
Acting Administrator

Subject Office of Inspector General (OIG) Draft Management Advisory Report: "The Peer Review Organizations (PRO) and State Medical Boards: A Vital Link." OEI-01-92-00530

To Bryan B. Mitchell
Principal Deputy Inspector General

We have reviewed the subject draft management advisory report which concerns the status of PRO efforts to provide State medical boards with information about physicians responsible for substandard medical care. The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) mandates that PROs share information with State medical boards.

OIG found that the 1990 legislation mandating this information sharing has had little, if any, effect on improving the release of information from PROs to State medical boards. OIG believes that PROs share little information with the boards because the boards are uncertain about the meaning of the "notice and hearing" provision included in OBRA 90.

In response to the passage of OBRA 90, the Health Care Financing Administration (HCFA) amended the PROs' scope of work to require that they inform State Medical boards about physicians to whom they have sent a first sanction notice. However, HCFA later rescinded the requirement in response to concerns that the procedure was not in accordance with the Congressional stipulation that PROs must grant physicians "notice and hearing" before sending information about them to the boards.

OIG recommends that HCFA propose legislation mandating that PROs provide case information to State medical boards when they have confirmed, after medical review, that a physician is responsible for medical mismanagement resulting in significant adverse effects on the patient. HCFA does not concur with the recommendation. We believe the proposed legislation would not correct the confusion created by the existing OBRA 90 amendments related to this issue. Our specific comments are attached for your consideration.

Thank you for the opportunity to review and comment on this draft management advisory report. Please advise us whether you agree with our position on the report's recommendation at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on the Office of Inspector General (OIG) Draft Management
Advisory Report: "The Peer Review Organizations And State
Medical Boards: A Vital Link." OEI-01-92-00530

OIG Recommendation

HCFA should propose legislation mandating that peer review organizations (PROs) provide case information to State medical boards when they have confirmed, after medical review, that a physician is responsible for medical mismanagement resulting in significant adverse effects on the patient.

HCFA Response

HCFA does not concur with the recommendation. Although we do agree that the provision in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) relating to this issue has had little impact, we do not believe OIG's recommendation would solve this problem.

The proposed legislation does not address, and would not correct, the confusion created by the two current amendments. Any proposed correction should, at a minimum, remove the phrase "after notice and hearing" from section 1154(a)(9)(B) of the Social Security Act (the Act), and clearly state that the PRO is required to report to State medical boards only when it makes a recommendation to OIG for sanctions.

We do not believe that an expansion of the reporting requirement to require PROs to report every initial violation or even every proposed action against a physician should be considered. Many violations are not actionable by themselves, and many actions brought against physicians on the basis of evidence initially available to the PRO are resolved upon presentation of additional evidence in the informal discussion or reconsideration by the PRO. In these cases, since the physician was found in compliance with the provisions of section 1154 of the Act, there is no basis for any report to the State medical board, and any earlier report would have to be corrected. Therefore, we do not believe that PROs should report physicians to State medical boards until PROs are referring a recommended sanction to OIG.

HCFA supports an approach which encourages PROs and State medical boards to work cooperatively and share information in a way that helps each of them carry out their complementary functions. The proposed legislative change could damage the cooperative relationship between PROs and physicians that HCFA is attempting to foster under its new Health Care Quality Improvement Initiative.

PRO disclosure of confidential information to State medical boards is currently regulated in the Code of Federal Regulations (CFR). A PRO must disclose information upon request from State or Federal licensing boards, and a PRO may provide such information at its own discretion without a formal request according to

42 CFR 476.138(a)(1 and 2). HCFA is currently considering ways to encourage information sharing between the PROs and medical boards under this regulation.

In this regard, the PRO confidentiality regulations are currently being revised. We will consider including the requirement of mandatory disclosures to the licensing boards without a request and clarification on what information may be disclosed to whom and under what circumstances.

As a requirement of the Fourth Scope of Work (SOW), HCFA is requiring PROs to do the following:

- o Meet with the State medical board, as well as other relevant licensing agencies, near the beginning of their fourth round contracts, to discuss the type of information that would be useful to the board and the PRO;
- o Establish a memorandum of agreement with the board within the first 60 days of the contract to exchange agreed upon information within specific timeframes; and
- o Implement a process for the ongoing, routine exchange of the agreed upon information in conformance with confidentiality and disclosure requirements in the statute and regulations.

Additional Comments

Regarding the OBRA 90 amendment, we note that while the requirements of section 1154(a)(9)(B) of the Act are on hold, a provision included in our proposed regulation, HSQ-135-F, is consistent with section 4205(d) of OBRA 90. This part added a new paragraph (D) to section 1160(b)(1) of the Act requiring PROs to provide notice to the State medical board when the PRO submits a physician sanction recommendation to OIG. The provision that will be implemented in HSQ-135-F requires a PRO to provide relevant portions of any PRO sanction report forwarded to OIG to State/Federal licensing bodies or national accreditation bodies if the report concerns practitioners or facilities that are subject to the licensing or accreditation bodies' jurisdiction.

Page 1 - Background. 1st paragraph. last sentence

Is the number "12" the number of cases that OIG agreed to effectuate the recommended exclusion(s)? Did PROs recommend sanction in more than 12 cases?

Page 3

Page 3 - 1st paragraph, 2d sentence

HCFA rescinded the requirement because the statute was not clear in its intent.

Page 4 - December 1990 Box

There is also a provision for notification when sanction recommendations are sent to OIG.

Page 4 - February 1991 Box

The Fourth SOW requires PROs to develop memorandums of agreement with State licensing boards regarding information to be exchanged. Also, it requires PRO notification to boards when sanction recommendations are made to OIG.

Page 5 - 3rd paragraph, last sentence

Same comment as page 1 - Background.

Page A-1. 6

The following language should be included after the word "violating," "in a gross and flagrant manner or substantially in a substantial number of cases."

Page A-2. 15

The next PRO contracts will include a significantly different approach to quality review. The focus of the quality review will be on: (a) description of the quality concern, (b) outcomes, (c) causality, (d) source, and (e) type of deficiency. We recently established a Quality Review Task Force composed of representatives from the American Medical Association, American Hospital Association, several PROs, and HCFA's central and regional office staffs. The task force is to develop consistent and uniform methods of documenting the quality review process/findings for implementing the SOW requirements.



Memorandum

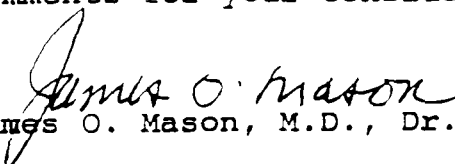
Date • OCT 13 1992

From Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Report "The Peer Review Organizations and State Medical Boards: A Vital Link"

To Acting Inspector General, OS

Attached are the Public Health Services (PHS) comments on the subject report. Although the report contains no recommendations for PHS, we offer general comments and a series of technical comments for your consideration.


James O. Mason, M.D., Dr.P.H.

Attachment

PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF INSPECTOR
GENERAL (OIG) DRAFT REPORT "THE PEER REVIEW ORGANIZATIONS AND
STATE MEDICAL BOARDS: A VITAL LINK," OEI-01-92-00530

General Comments

The single recommendation in this report is not directed to PHS. However, we have reviewed its contents and concur with the recommendation that "the Health Care Financing Administration (HCFA) should propose legislation mandating that Peer Review Organizations (PRO) provide case information to State medical boards when they have confirmed, after medical review, that a physician is responsible for medical mismanagement resulting in significant adverse effects on the patient." Requiring that a report be filed with the State medical board after a medical review is consistent with requirements for reporting other types of peer review activity to the National Practitioner Data Bank (NPDB). Such reports from the PROs, along with NPDB reports, should provide State medical boards with additional useful information for conducting their proceedings.

Technical Comments

Following are several suggested modifications to the text of this draft report.

1. The first paragraph of the Background section in the Executive Summary states that the lack of PRO information reaching State medical boards inhibits the boards' effectiveness in protecting Medicare and Medicaid beneficiaries and other citizens in their States. We would suggest that the report state that the lack of sharing of PRO information probably inhibits the effectiveness of the boards.
2. The report states on page 1, paragraph 3, that "The violations they (State medical boards) identify sometimes involve quality-of-care problems, but more often they concern drug and alcohol abuse, sexual misconduct, and criminal behavior." It may be more appropriate to revise this sentence as follows: "The actions they (boards) take against physicians are more likely to be based on drug and alcohol abuse, sexual misconduct, and criminal behavior since evidence of a legal nature is required and can be obtained and used in such cases." State practice legislation requires legal evidence. Proving incompetence legally is very difficult and thus boards are often less able to take action against an "incompetent" practitioner. Nevertheless, PROs should send appropriate information to the State boards.

3. The same concept as discussed in number 2 above appears on page 3, paragraph 4. Rather than repeating the same wording regarding the boards, we would suggest that the report include a paragraph near the beginning that identifies legal requirements facing State medical boards versus the decision-making of the PROs. Emphasis should be placed on the PROs providing appropriate material to the boards.
4. On page 5, paragraph 4, the report states that HCFA would need to specify what information PROs should send to the boards which "...could include...information on the type of quality-of-care problems involved and even the locations at which the problems occurred." We suggest that the report recommend that PROs be required to provide this information.



TO: Bryan Mitchell
Principal Deputy Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Management Advisory Reports: "The Sanction Referral Authority of Peer Review Organizations" (OEI-01-92-00250) and "The Peer Review Organizations and State Medical Boards: A Vital Link" (OEI-01-92-00530)
-- COMMENTS

I offer the following comments on the two subject draft reports, which I have linked due to the interrelatedness of their recommendations.

In the first report, you reviewed the sanction referral authority of peer review organizations (PROs), of which referral to state medical boards is one element. You recommended several policy options for improvement, including a recommendation requiring that state medical boards be informed whenever a serious quality of care problem is confirmed through medical review; this is a lesser standard than is currently in place. In the second report, you specifically examined the low frequency with which PROs referred cases involving physicians cited for poor quality of care to state medical boards. You reiterated the recommendation concerning PRO-medical board contact contained in the first report.

I agree with the observations made in these reports that the formal sanction referral process is not often used. Nevertheless, I feel that the process is critical and, with improvements, some of which you propose in your reports, I believe it will play an important role in the primarily educational efforts of the PROs under the Fourth Scope of Work (SOW). I have the following comments about the findings, policy options and recommendations of your reports.

- o Repeal or substantially modify the unwilling or unable requirement. (Policy option 1, Report on the Sanction Referral Authority) I agree that the additional evidentiary hurdle for sanction of demonstrating that a physician is either unwilling or unable to comply with a corrective action plan is, at present, vague. The report is written from the perspective of complete repeal, however, and does not identify how the requirement could be meaningfully modified. I suggest that you clarify better why the recent legislative change -- defining a physician's failure to participate in a corrective action plan (CAP) as

demonstrated unwillingness or inability to comply -- is inadequate. Also, I urge you to clarify how due process protections would be preserved in the event that the requirement was modified or repealed.

- Increase the monetary penalty sanction substantially. (Policy option 2, Report on the Sanction Referral Authority) I agree that this is an important policy option, and believe that it would be a desirable alternative for the PROs, where patient safety would not be compromised.
- Eliminate the PROs' sanction referral authority. (Policy option 3, Report on the Sanction Referral Authority) This is a theoretical option only; without the ability to impose sanctions in the face of aberrant or poor quality behavior, PROs would have little clout in certain circumstances to influence physician behavior. I would oppose this proposal.
- Provide sanction authority directly to the PROs. (Policy option 4, Report on the Sanction Referral Authority) There are actually two alternatives to OIG administration of the sanctions process. The first is to decentralize and give the PROs the direct authority to impose sanctions. The second is to move the authority from OIG to HCFA. Decentralization would be undesirable for the reasons cited on page 10 of the Sanction Referral Authority report, with the additional concern that physician exclusion is too serious an outcome to cede without central review to the PROs, who are merely the contractual agents of the Federal Government.

The second alternative, having HCFA pursue the sanction actions, also may not be desirable, but the report does not provide sufficient information to evaluate whether the OIG has been too conservative in its choice of which cases to pursue, and whether this restraint -- rejecting, for example, 8 of 12 cases referred to it in FY 1991 -- is itself contributing to the dwindling number of cases proposed for sanctions by the PROs. It appears from the statistics in Appendix B that the PROs may be doing a better job at following the proper procedures for developing a solid case. No justification or explanation is provided, however, for the increasing rate of cases rejected by the OIG for lack of medical evidence from FY 1988 to 1991. Why is the OIG rejecting the medical advice of the PRO physicians? The report would be substantially strengthened by an objective evaluation of the cases the OIG rejected, and by the discussion of the second alternative.

- Maintain PROs' sanction referral authority as it exists now, but mandate referrals to State medical boards when PROs

confirm serious quality-of-care problems. (Policy option 5, Report on the Sanction Referral Authority and recommendation of report "The Peer Review Organizations and State Medical Boards: A Vital Link") I do not support this proposal for several reasons. I would agree that the PROs and the State medical boards (and hospital licensure authorities, etc.) should be in closer contact. The most recent versions of the PRO Fourth Scope of Work include requirements that each PRO develop memoranda of agreement (MOAs) with such entities, within 60 days after the effective date of its contract, for the purpose of mutual exchange of information and data. Such mutual exchange is far more likely to contribute to improvement of quality of care than a legislated requirement for unilateral action.

I understand that the provision of the 1990 Omnibus Budget Reconciliation Act requiring PROs to share case information with state medical boards has not been implemented because it is unclear. I understand that a technical correction to require the PROs to inform boards when a sanction recommendation is sent to the OIG has been sought but that it may not have been included among the OBRA technicals in the tax bill that will be sent to the President soon. If no action has been taken on the technical change, it should be advanced again in the next session.

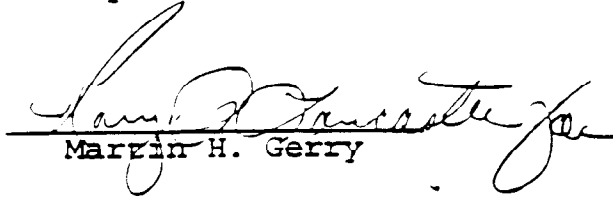
It is not clear how the OIG's proposal would differ from the technical correction being sought by HCFA. It would seem to require involvement of the state medical societies at an earlier stage, prior to issuance of the sanction recommendation to the OIG and prior to the physician having the full opportunity to review and respond to the concerns raised by a PRO. Except for clear instances where patients are in immediate danger, it does not seem fair or appropriate to essentially initiate a parallel investigation by the medical society until there has been confirmation of a problem. This is particularly a problem in those states that require all complaints made to the state medical society to be made public, including reports from the PROs. I do not object to such publicity where the physician has had ample opportunity to respond to the PRO and has been unwilling or unable to cooperate in the development and execution of a meaningful corrective action plan. However, such publicity is probably more useful as a potential sanction than as a context for obtaining physician cooperation for changed behavior.

Furthermore, it is curious that the OIG is calling for mandatory notification of the medical board prior to the issuance of the sanction recommendation to OIG. As noted above, the OIG refused to pursue 5 of 12 cases referred to it in FY 1991 because of inadequate medical

evidence from the PROs. The reports do not explain why it would be productive or appropriate to engage the state medical societies based on information that the OIG itself feels is inadequate to justify a sanction.

Finally, the first three tables of Appendix B of the report on the Sanction Referral Authority (sanctions referred to the OIG, referrals rejected by OIG, sanctions imposed by the OIG) do not agree and should be clarified. For FYs 1987, 1988, 1989 and 1991, the sum of the sanctions imposed and referrals rejected exceeds the sanctions referred (cases are resolved in a later year than they are referred?). Similarly, the totals for all years involved do not agree.

If you have any questions, please call Elise Smith at 690-6870.


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