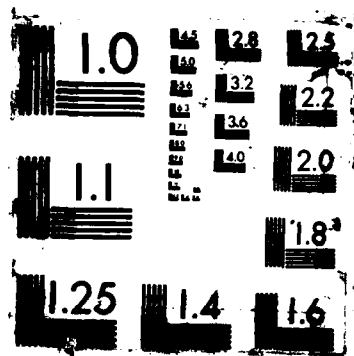


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ORGANIZATIONS' EVALUATIONS(U) GENERAL ACCOUNTING OFFICE
WASHINGTON DC HUMAN RESOURCES DIV OCT 87 GAO/HRD-88-13
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GAO

United States General Accounting Office

Report to the Subcommittee on Health,
Committee on Finance, U.S. Senate

AD-A187 585

October 1987

MEDICARE

Better Controls Needed for Peer Review Organizations' Evaluations



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General Accounting Office
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Human Resources Division

B-229169

October 8, 1987

The Honorable George J. Mitchell
Chairman, Subcommittee on Health
Committee on Finance
United States Senate

The Honorable Dave Durenberger
Ranking Minority Member
Subcommittee on Health
Committee on Finance
United States Senate

This report, issued at the Subcommittee's request, discusses the Health Care Financing Administration's (HCFA's) evaluation of Peer Review Organizations' performance during the 1984-86 contract period. It also discusses HCFA's process for determining program funding for the 1986-88 contract period. The report contains recommendations to the Secretary of Health and Human Services.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Health and Human Services; the Administrator of the Health Care Financing Administration; and interested congressional committees.

Edward A. Hensmore

for Richard L. Fogel
Assistant Comptroller General

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Executive Summary

Purpose

Professional Review Organizations (PROs) contract with the Medicare program to review the necessity, appropriateness, and quality of inpatient hospital services received by the program's beneficiaries. From February through July 1986, the Department of Health and Human Services' (HHS's) Health Care Financing Administration (HCFA) evaluated the PROs' performance under their contracts to determine whether the contracts, awarded for a 2-year period, should be renewed on a noncompetitive basis or whether a competition should be held. As a result of the evaluations, HCFA was requiring competition for about half of the PRO contracts.

Based on a concern that the high nonrenewal rate indicated problems either with some PROs or with HCFA's management of the program, the Chairman and Ranking Minority Member of the Subcommittee on Health, Senate Committee on Finance, requested that GAO assess (1) HCFA's PRO evaluation methodology and (2) the adequacy of HCFA's routine monitoring of the PROs for identifying performance problems. In addition, GAO was asked to determine how HCFA decided on the funding level for the new contracts.

Background

The Tax Equity and Fiscal Responsibility Act of 1982 replaced Medicare's utilization review program with the PRO program. While the predecessor review organizations were funded through annual grants, PROs operate under fixed-price 2-year contracts that can be renewed at HCFA's option for additional 2-year periods.

The Social Security Amendments of 1983 established Medicare's prospective payment system (PPS) and required each hospital, as a condition for Medicare payment, to have an agreement with the PRO covering its area to review the quality, necessity, and appropriateness of care provided to Medicare beneficiaries. This law also included specific requirements for PRO review that were designed to assure provision of quality care and protect Medicare from paying for unnecessary care. PRO contracts included quality and cost control provisions required by law.

To decide whether to renew individual contracts, HCFA evaluated the PRO's performance against the contract requirements. HCFA asked PROs to complete a detailed report covering their performance during the first 15 to 17 months of their contracts, and HCFA's regional offices reviewed these reports for accuracy. Data from these reports, as well as from HCFA's ongoing PRO monitoring and from a contract for monitoring PROs (the so-called SuperPRO contract), were used by evaluation panels to

assess PRO performance. The panels evaluated 16 elements combined into three areas. To earn a panel recommendation for noncompetitive renewal, the PRO had to pass all three areas.

GAO reviewed selected aspects of the 50 PRO evaluations. GAO also reviewed six evaluations in detail, including those of two PROs that were noncompetitively renewed and four PROs that had to compete for renewal. GAO's review included an assessment of the internal controls HCFA used for assuring that the evaluations were consistent, fair, and accurate.

Results in Brief

The evaluation process had instructions that were inconsistent, incorrect, or not properly implemented by the panels, and documentation of the panels' and HCFA's decisions was not always adequate. HCFA's controls over the process were not sufficient to identify and correct these problems. Although GAO did not identify any instance where a clearly wrong renewal decision resulted, the potential for erroneous decisions existed because of the absence of appropriate controls. HCFA needs to establish a better system of internal controls over its future evaluations of PRO contracts.

The substantial number of PROs that failed the evaluations and HCFA's unawareness of the extent of the problems identified through the evaluation process showed that HCFA's routine monitoring had not identified and corrected PRO performance problems. This, in turn, meant that Medicare and its beneficiaries may not have been receiving all of the protection intended under the program. HCFA recognized this monitoring problem during the evaluation process and acted to strengthen routine monitoring of the new PRO contracts. Monitoring could be further strengthened by giving monitoring personnel more specific criteria for measuring PRO performance.

HCFA designed the scope of work to keep the cost of the program at the minimum funding level permitted by law. GAO believes that HCFA should design the scope of work to provide reasonable assurance that Medicare is not paying for unnecessary care and that Medicare beneficiaries are receiving good quality care and then determine the appropriate costs. Also, GAO found many uncertainties in HCFA's methodology for estimating costs to individual PROs in carrying out the work required by their contracts. As a result, GAO could not determine whether individual PROs were appropriately funded.

GAO's Analysis

Inadequate Internal Controls Over Evaluations

In several instances, HCFA's internal control procedures were inadequate to prevent (1) inconsistencies in the evaluation process, (2) improper application of the instructions by the panels, and (3) inadequate documentation of evaluation results. For example, the instructions to the panels regarding the scoring of the element relating to sanctions were incorrect. Although HCFA officials were aware of this problem, their internal controls were inadequate to prevent one of the six panels reviewed from using the incorrect instructions and as a result recommending competitive contract renewal. This error was not found and corrected by HCFA until the PRO appealed HCFA's decision to open its contract to competition. HCFA's internal controls were also inadequate to prevent 15 panels from assigning scores inconsistent with instructions for one or more evaluation elements.

In two instances, HCFA's internal controls were inadequate to assure that the results of evaluations were adequately documented. In one case, there was no documentation of a decision by HCFA officials to offer a PRO noncompetitive contract renewal when the panel had not recommended this action.

HCFA Monitoring Inadequate

Five out of the six PROs whose evaluations GAO examined in detail had performance problems not detected by HCFA program monitors until the renewal evaluation, which took place about 18 months into the 24-month contract period. These problems included data-system inadequacies, failure to implement interventions for admissions and quality objectives in a timely manner, and failure to act on all detected quality issues.

HCFA officials have improved their methodology for routine monitoring of PRO performance for the new contracts. However, this methodology lacks clear criteria defining what constitutes unacceptable performance in several areas. For example, although HCFA monitoring personnel are asked to judge if the PRO has satisfactory working relationships with providers and other Medicare contractors, the methodology provides no criteria defining what constitutes a satisfactory relationship.

PRO Program Funded at Legal Minimum

The PRO program is funded directly from the Medicare Trust Funds, and there is a statutorily set minimum level of funding. HCFA adopted this minimum funding level as the basis for its design of the scope of the program for the 1986-88 contract period. GAO found that HCFA's methodology for estimating the cost of individual PRO contracts contained so many uncertainties that GAO could not determine whether these estimates were reasonable estimates of the costs to the PROs of carrying out the contracts. However, the fact that virtually all contract awards differed from estimated costs suggests that the contract negotiation process may have compensated in part for these uncertainties.

Recommendations

GAO recommends that the Secretary of HHS direct the Administrator of HCFA to

- assure that in future PRO evaluations, the evaluation process has sufficient internal controls to assure that evaluations are consistently applied and that decisions resulting from the evaluations are adequately documented;
- provide criteria to enable HCFA personnel to differentiate between acceptable and unacceptable performance in routine monitoring of PRO activities;
- determine the scope of review needed to adequately meet the program's intent and use this as the starting point for determining the program's funding level; and
- collect and use adequate cost and performance data to set each PRO's contract funding at a level sufficient to provide the coverage determined to be necessary.

Agency Comments

In commenting on a draft of this report, HHS and the American Medical Peer Review Association generally agreed with GAO's recommendations. HHS said it had taken and will continue to take actions to improve the PRO evaluation and funding processes.

GAO's discussions of these comments are included in the relevant chapters, and copies of the comments are included as appendixes III and IV.

Contents

Executive Summary		2
Chapter 1		8
Introduction	Medicare and Its Utilization and Quality Review Policies	8
	The PRO Evaluations	9
	The Evaluation Process	10
	The Evaluation Scoring System	12
	Objectives, Scope, and Methodology	13
Chapter 2		16
Insufficient Internal Controls Over the Renewal Evaluation Process	HCFA Lacks Documented Internal Controls Over the Evaluation Process	16
	Inconsistencies in Instructions for Evaluating PRO Performance on Quality Objectives	17
	Inconsistency in Instructions on Profiling	18
	Error in Panel Instructions	19
	Incorrect Scoring of PROs by Panels	20
	Inadequate Documentation of Evaluation Results	21
	Conclusions	24
	Recommendation	25
	Agency Comments and Our Evaluation	25
Chapter 3		26
Routine PRO Monitoring Could Be Improved to Detect and Correct Poor Performance	HCFA Monitoring Did Not Always Detect Poor PRO Performance	26
	PROMPTS Did Not Adequately Cover Many Evaluation Elements	28
	PROMPTS-2 Covers Most Weak Areas in PROMPTS but Sometimes Lacks Criteria	30
	Conclusions	32
	Recommendation	32
	Agency Comments and Our Evaluation	32
Chapter 4		34
HCFA Funds PRO Program at the Legal Minimum	PRO Funding for 1986-88 Contracts Based on Minimum Required by Law	34
	Scope of Work Designed to Keep Program Funding Within Minimum	35
	Conclusions	39
	Recommendations	39

Contents

	Agency Comments and Our Evaluation	40
Appendixes		
	Appendix I: PRO Report Worksheets and Related Activities	42
	Appendix II: PRO Evaluation Scores, Panel Recommendations, and Final Decisions	43
	Appendix III: Comments From the Department of Health and Human Services	45
	Appendix IV: Comments From the American Medical Peer Review Association	50
Tables		
	Table 1.1: PRO Evaluation Scoring	13
	Table 4.1: Percentage of Total Admissions to Be Reviewed, by Category	36

Abbreviations

AMPRA	American Medical Peer Review Association
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
PPS	prospective payment system
PRO	Peer Review Organization
PSRO	Professional Standards Review Organization
PROMPTS	Peer Review Organization Monitoring Protocol and Tracking System

Introduction

On June 4, 1986, the Chairman and Ranking Minority Member, Subcommittee on Health, Senate Committee on Finance, concerned that the high contract nonrenewal rate indicated problems either with some Peer Review Organizations (PROs) or with the Health Care Financing Administration's (HCFA's) program management, requested that we review HCFA's evaluations of PROs' performance. The evaluations were made to decide whether to renew PRO contracts without competition or to require competition. The Chairman and Ranking Minority Member were concerned that the review of PRO performance be based on objective, fair, and verifiable measures of success in meeting the program's mission. In later discussions, the Subcommittee also asked us to determine how HCFA decided the level at which it would fund the new PRO contracts.

Medicare and Its Utilization and Quality Review Policies

Medicare, administered by HCFA within the Department of Health and Human Services (HHS), is a health insurance program that covers almost all Americans age 65 and over and certain individuals under 65 who are disabled or have chronic kidney disease. The program, authorized under title XVIII of the Social Security Act, provides protection under two parts. Part A, the hospital insurance program, covers services of institutional providers of health care, primarily hospitals. Part B, the supplementary medical insurance program, covers many noninstitutional health services, with most payments for physician services. In 1986, Medicare paid out \$48.8 billion under part A and \$25.3 billion under part B for health care services and had about 31 million beneficiaries enrolled.

To assure that Medicare beneficiaries receive only medically necessary and appropriate inpatient hospital services of high quality, the Congress, as part of the Social Security Amendments of 1972, established the Professional Standards Review Organization (PSRO) program. To improve the effectiveness of that program, the Congress, in the Tax Equity and Fiscal Responsibility Act of 1982, redirected it and changed its designation to the Utilization and Quality Control Peer Review Organization program. PROs took over responsibility for reviewing the necessity, appropriateness, and quality of hospital services provided Medicare beneficiaries from their predecessor PSROs in 1984.

Unlike the PSROs, which were mostly funded by annual grants, the act required that PROs be administered and funded under 2-year contracts. These contracts were required to be renewable for additional 2-year terms at HHS's option. The act specifically required that the contracts

contain "negotiated objectives against which the organization's performance will be judged" and also explicitly gave HHS the authority to evaluate the effectiveness of the PROs in carrying out their contracts. HCFA administers the PRO program.

The Tax Equity and Fiscal Responsibility Act of 1982, which established the PRO program, provided that it be funded directly from the Medicare Trust Funds. This act did not specifically address funding levels for PROs. The Social Security Amendments of 1983 set a minimum funding level based on the costs of the PSRO program in fiscal year 1982, adjusted for inflation. This minimum funding level was modified by the Consolidated Omnibus Budget Reconciliation Act of 1985 to set minimum funding at fiscal year 1986 program costs, adjusted for inflation.

In the Social Security Amendments of 1983, the Congress modified the way the Medicare Program pays most hospitals for inpatient hospital care by creating the prospective payment system (PPS). As part of this law, it also required that each hospital, as a condition of payment by the Medicare program, have an agreement with the PRO covering its area to review the quality, necessity, and appropriateness of care provided to Medicare beneficiaries. This law also specifically required that the PRO review

- The validity of diagnostic information provided by the hospital, which forms the basis for most payments under the new system;
- The completeness, adequacy, and quality of care provided;
- The appropriateness of admissions and discharges; and
- The appropriateness of care provided to beneficiaries for whom payments are sought under the outlier provisions of the act.

The PRO contracts included provisions related to the quality and cost control provisions of the PRO and PPS acts.

A PRO contract is in effect for the Washington, D.C., metropolitan area, Puerto Rico, the Virgin Islands, Pacific island territories and every state.

The PRO Evaluations

To facilitate monitoring of PROs' success in meeting the requirements of their contracts, HCFA created the PRO Monitoring Protocol and Tracking System, or PROMPTS. PROMPTS consisted of a series of questions in 13 areas of PRO operations that were to be answered by HCFA monitoring

personnel during quarterly site visits.¹ In addition, medical review teams re-reviewed medical records as a check on the PRO's ability to apply review criteria and identify quality and utilization problems. The entire PROMPTS was to be completed on the first visit, but only those sections that needed to be updated or changed, such as those on medical review and objectives, were to be completed on subsequent visits. In addition, areas found unsatisfactory were to be reviewed during subsequent visits.

HCFA also contracted with Systemetrics, a research consulting firm specializing in health care data analysis, to act as the so-called SuperPRO. Under this contract Systemetrics re-reviewed for each PRO a sample of cases to evaluate how well the PRO was carrying out its contractual responsibilities to conduct medical reviews.

In addition, HCFA decided to conduct a special evaluation of PROs' performance for the purpose of deciding whether to exercise the option to renew the contracts without competition. This evaluation process was designed to use the results of PROMPTS and the Systemetrics review, as well as information supplied directly by the PROs. This report is primarily concerned with HCFA's special evaluation.

The Evaluation Process

The principal document used in the evaluation process was the PRO Evaluation Protocol. It consisted of three major segments:

- The PRO self-evaluation report, prepared by the PRO together with instructions for its verification by HCFA regional office personnel.
- An independent analysis, prepared by HCFA regional office personnel, summarizing significant issues arising from regional office monitoring of the PRO.
- The evaluation methodology, consisting of a single page listing the 16 elements of the evaluation along with the maximum point value for each element (see p. 13).

¹The areas were implementation, management, reconsiderations, objectives, confidentiality and disclosure, medical review, sanctions, denials, specialty hospital review, fraud and abuse, data, the timeliness and acceptability of reports PROs were required to submit, and waiver of liability of reviews. The last area relates to PRO determinations of whether hospitals should have known that the care the PRO denied was not covered by Medicare. If the hospital could not reasonably have been expected to know the care was not covered, it can receive payment for it under Medicare's waiver of liability program.

The first step in the PRO evaluation process was preparation of the PRO self-evaluation report.² The PRO was asked to complete 31 worksheets, 30 of which covered the specific activities PROs were required by their contracts to perform. These 30 worksheets covered such things as success in meeting targets for admission and quality objectives, performance of admission and preadmission reviews, production and use of profiles, identification and correction of utilization and quality-of-care issues not covered by objectives, and the PRO's internal control process. The remaining worksheet was designed to permit the PRO to cite any achievements not specifically required by its contract. (See app. I for a complete list of activities covered by the worksheets.) The worksheets required the PROs to provide detailed data from the first 15 to 17 months of their contracts substantiating their achievements.

The second step in the process was a review of the PRO's self-evaluation by the HCFA regional office staff responsible for monitoring the PRO contract. Regional office staff validated the PROs' data using the PROs' files and the routine reports they had provided to HCFA. Regional staff also did some analysis of the data (see pp. 18-19). The PROs were given the opportunity to rebut the findings of the regional staff.

Regional office staff also completed the independent analysis section of HCFA's evaluation instrument. This section was designed to permit the regional office staff to give the evaluation panels the benefit of their detailed experience with each PRO.

The third step in the contract renewal evaluation process involved designating an evaluation panel for each PRO, which normally consisted of five persons drawn from HCFA's central office, the regional office responsible for the PRO, and one other regional office. Each panel member was given a copy of the completed evaluation package, as well as the most recently completed PROMPTS evaluation, the latest report from the SuperPRO, and a set of scoring instructions. Each panel member was to read over these materials and independently evaluate the PRO on the basis of the scoring instructions. The panel then met to prepare a consensus score and a recommendation for either noncompetitive renewal of the PRO's contract or competition for a new contract.

The panel discussed its recommendation with an official in the HCFA central office, usually by telephone. During this discussion, the official was

²Although the self-evaluation was optional, all but one of the PROs prepared one.

to assure that the panel's recommendation was supported by the evidence. If not satisfied, the official would ask the panel to reconsider. If the panel scored the PRO at the "Minimally Met" level in any of the three sections, the instructions specified that the central office would have the final decision about whether to have competition for the contract. An unsatisfactory score in any of the three sections meant that the panel should recommend competition.

Finally, the documentation of the panel's deliberations was sent to HCFA's central office. If central office officials had questions or concerns about a panel's recommendation, they would review the panel documentation. Program officials then prepared letters to the evaluated PRO informing it of the decision. PROs were permitted to appeal an unfavorable decision and offer additional supporting data. All but 3 of the 26 PROs that received unfavorable decisions appealed. However, only one appeal, that of the Arizona PRO, was successful in changing a decision.

Of the 50 PROs evaluated,³ 26 failed the evaluation and their contracts were opened for competition, while 24 were offered noncompetitive renewal. In two cases, the final decision on competition differed from the recommendation of the evaluation panel (see app. II), and in another case it was not clear what the panel had recommended (see pp. 21-22).

The Evaluation Scoring System

For purposes of scoring the evaluation, the 16 evaluation elements were divided into three sections (see table 1.1). The instructions to the evaluation panels required that the PRO achieve a satisfactory score in all three sections for a recommendation for noncompetitive contract renewal.

³Four PRO contracts were terminated during the 1984-86 contract period and were, therefore, not included in the evaluation.

Table 1.1: PRO Evaluation Scoring

Element name	Score	
	Maximum	Minimum satisfactory
Section 1—Meeting Objectives		
Admission objectives	200	130
Quality objectives	200	130
Admission objectives interventions	50	33
Quality objectives interventions	50	33
Total	500	326
Section 2—Required Review Activities		
Review types required by contract	100	65
Profiling	25	17
Waiver activity	25	17
Intensified review	25	17
Total	175	116
Section 3—PRO Management		
Abuse referrals	25	17
Sanctions	75	49
Reconsiderations	25	17
Utilization problems	50	33
Quality-of-care issues	50	33
Private review	25	17
Internal controls	25	17
Impact outside objectives	50	50
Total	325	224

Because the number of points in each section were not equal and because the PRO had to achieve a score of satisfactory for each section to receive a recommendation of noncompetitive contract renewal, the number of points in a given element did not represent its relative importance to the total evaluation.

Objectives, Scope, and Methodology

As requested by the Chairman and Ranking Minority Member of the Subcommittee on Health, Senate Committee on Finance, our review objectives were to determine (1) how HCFA monitored PROs' performance in meeting the requirements of their contracts, (2) the methodology HCFA used in deciding whether to renew PRO contracts without competition, and (3) how HCFA decided on the funding level of the new PRO contracts.

We were also requested to determine how the factors used in the renewal evaluation process compared to the PROS' contractual requirements. We found that with one exception, all elements in the evaluation could be traced to a contractual requirement. The exception was the element on impact outside objectives. HCFA officials told us that this element had been included to give the PROS a way to gain credit for accomplishments in reducing utilization or improving quality of care that were not specifically covered by contractual requirements. Because we found no problems, we do not discuss this area in the remainder of the report.

Finally, we were asked whether HCFA had clearly indicated to the PROS the type of documentation required by the evaluation process. On October 9, 1985, about 5 weeks before the evaluation began for the first group of PROS, HCFA gave the draft evaluation protocol to the PROS and to the American Medical Peer Review Association (AMPRA), the PRO trade organization, for comment. This action gave the PROS advance notice of the documentation requirements of the evaluation. Those PROS with whom we discussed the question thought that they had received adequate advance notice of the evaluation.

As part of our assessment of the methodology HCFA used to decide whether to renew PRO contracts without competition, we also considered HCFA's internal controls over the evaluation development and implementation. Internal controls are the combination of policies and procedures used by managers to help assure that their programs are effectively and consistently managed. We assessed whether HCFA's internal controls provided reasonable assurance that the renewal evaluation methodology was consistent with the PRO contracts and fairly and consistently applied to evaluate PROS.

To examine the renewal evaluation process in detail, we judgmentally selected 6 of the 41 PROS whose evaluations had been completed as of June 12, 1986. They were selected to cover examples of evaluations resulting in satisfactory scores (2) and unsatisfactory scores (4). In making the selections we considered information supplied by AMPRA about evaluations it believed might have had problems. We selected

- Medical Review of North Carolina, Inc. (North Carolina);
- Mississippi Foundation for Medical Care, Inc. (Mississippi);
- Kentucky Peer Review Organization (Kentucky);
- Peer Review Systems, Inc. (Ohio);
- Utah Professional Standards Review Organization (Utah); and

- Indiana Peer Review Organization (Indiana).

During our work we noted that the evaluation panel had not recommended noncompetitive renewal of the Professional Foundation for Health Care (Florida), but this PRO was noncompetitively renewed. Therefore, we reviewed those aspects of the evaluation of this PRO related to the decision for noncompetitive renewal.

In addition, we analyzed the scoring of 46 evaluations for inconsistencies with the instructions,⁴ and observed the contract negotiation between HCFA and the California PRO.

We interviewed HCFA and PRO officials, as well as other interested parties; examined documents; analyzed cost information supplied by HCFA; and compared relevant laws, regulations, and manual instructions with the evaluation instruments. We also compared the methodology of HCFA's routine monitoring of PROs with the methodology for renewal evaluation.

Our fieldwork was done from June 1986 through March 1987 in accordance with generally accepted government auditing standards.

⁴Detailed scores were unavailable for 4 evaluations.

Insufficient Internal Controls Over the Renewal Evaluation Process

Our review of the development and implementation of the PRO renewal evaluation process showed that instructions were inconsistent, incorrect, or not properly implemented by the evaluation panels and that documentation of the evaluation results was not adequate. These problems resulted in incorrect scores for individual elements of the evaluation and an undocumented decision to offer noncompetitive contract renewal to a PRO that had not been recommended for renewal by its evaluation panel. The documentation available to us for the seven evaluations we examined was insufficient to enable us to determine that these problems led to a clearly inappropriate renewal or nonrenewal decision.

HCFA PRO program managers generally acknowledged that the problems we identified existed, and attributed them to inadequate time and staff to implement and manage the program. HCFA will need to make contract renewal decisions every 2 years, and we believe that HCFA should assure that adequate internal controls are established so that in future evaluations of PRO performance, (1) the process is internally consistent, (2) the evaluation instructions are clear and consistently applied to all PROs, and (3) evaluation results are adequately documented.

HCFA Lacks Documented Internal Controls Over the Evaluation Process

HCFA did not have an internal control system to assure the systematic documentation of all phases of the development and implementation of the process used to evaluate contractor performance to decide whether to renew a contract without competition. Such documentation is necessary to support the organization's position in event of a challenge to an individual evaluation or to the evaluation process as a whole.

A HCFA official told us that the evaluation document and the panel instructions were developed by a task force that included the two officials most directly responsible for the implementation of the evaluation process. This task force appears to have been the principal internal control for assuring that all portions of the evaluation document and instructions were consistent with one another. However, according to this official, the task force did not document its decisions.

The main internal control process for assuring that the evaluation panels implemented the evaluation consistently and had sufficient evidence to support their recommendations centered on a requirement that the panels discuss, usually by telephone, their finding with one of the two central office officials responsible for implementing the evaluation, who also participated in the evaluation development task force. However, this process was not documented. Except for the requirement that

letters to the PROs informing them of the evaluation outcome be initialed by a responsible official, HCFA officials had no documented process for assuring that the panels had complied with their instructions and for assuring that the evaluation decision was approved by responsible officials after the panels sent their recommendations and supporting documentation to HCFA's central office.

Inconsistencies in Instructions for Evaluating PRO Performance on Quality Objectives

There were inconsistencies between the instructions to the regional offices for verifying the quality objectives information supplied in the Evaluation Protocol and the instructions to the panel for scoring the quality objectives element. The verification instructions gave a less stringent standard for what constituted acceptable performance in this area, while the instructions to the evaluation panel did not address a contractually required severity index intended to weight the objectives for the severity of the problem addressed.

The instructions to HCFA regional office personnel for verifying and analyzing the quality objectives information supplied by the PROs in the self-evaluation stated that these elements were to be considered satisfactory if the difference between total expected and actual quality impact was not more than 5 percent and four of five objectives were found satisfactory.

This instruction required HCFA regional office monitoring personnel to calculate a severity-weighted measure of the total impact of the quality improvements effected by the PRO through its contracted quality objectives. The PRO contract contained severity index numbers that were assigned to each quality objective to indicate the severity of the problem addressed by the quality objective. A severity-weighted difference between the actual and expected impacts was computed for each quality objective, as well as for the total of all quality objectives. By defining acceptable performance in this manner, a PRO could have performed acceptably in the overall element even if it had failed to achieve its target for one quality objective.

However, the standards for acceptable performance on quality objectives in the instructions given to the panels were somewhat more stringent. These instructions define minimally acceptable performance as the PRO meeting all contracted targets, unless failure to meet them was "not because of the lack of action by the PRO." While the instruction to the panel was stricter than that to HCFA regional office personnel, it did not

use the severity index in evaluating the PRO's performance despite its inclusion in the contract.

Inconsistent instructions caused HCFA regional office monitoring personnel and the evaluation panel to come to different conclusions regarding the acceptability of the Utah PRO's performance on its quality objectives. The Utah PRO failed to achieve one of its quality objectives by a large margin. However, it achieved its other quality objectives by large margins. Its overall performance, when calculated by the methodology given the HCFA regional office personnel, was considerably better than that required to have performed satisfactorily in this element under the criteria in the verification instructions. HCFA monitoring personnel therefore rated the PRO satisfactory in the quality objectives area. However, the evaluation panel, as called for in its instructions, rated the PRO unsatisfactory in the evaluation's quality objectives element because it had failed to achieve one objective.

When we discussed this inconsistency of instructions with program officials, they agreed that it existed, and noted that they had not had the time or staff resources to coordinate all phases of the development of the evaluation process as they would have wished to.

Inconsistency in Instructions on Profiling

There was also an inconsistency between the instructions to the panel and the verification instructions to regional office personnel for the profiling element. The PRO contract scope of work required that the PRO have the capability of developing profiles for patients, physicians, and other providers within 45 days after the contract went into effect. The instructions to the evaluation panel for this element state that to receive any credit for this element, the PRO must have at a minimum fulfilled the requirements of the contract after acceptance of a corrective action plan by the regional office.

However, the instructions to regional office personnel for verification of the data supplied by the PRO in the PRO report state that the PRO is to be found deficient if

- it was unable to receive and process data from the intermediary within 45 days of the effective date of its contract or
- the first profile run was not processed for use by the PRO within 6 months from the effective date of the contract

This seems to be more stringent in one respect and less stringent in another than contract requirements. As noted above, the contract requires that the PRO have the capability to run profiles within 45 days of the effective date of the contract, which seems stricter than the standard to be able to receive and process data within 45 days in the verification instructions to regional office personnel. On the other hand, the contracts do not mention requiring the PROs to run a profile for use within 6 months or any other time frame.

Although we did not identify any instance where this inconsistency affected the outcome of an evaluation, such an inconsistency raises the possibility of inconsistent evaluations of PROs since three out of five members of the evaluation panels were usually regional office monitoring personnel.

Error in Panel Instructions

There was an error in the instructions to the evaluation panel for the sanctions element. Although HCFA officials were aware of this error, the panel instructions were not revised. Instead, HCFA program officials attempted to insure that panels did not follow the erroneous instruction through their procedures for reviewing the panel's decision. However, in one case, a PRO failed the PRO management section of the evaluation because the panel used the incorrect instructions, and based on this, competitive contract renewal was recommended. The error was not corrected until the PRO appealed the decision to compete.

The 1984 contract required that PROs initiate sanction proceedings against health care practitioners whom they found rendering services that do not meet professionally recognized standards of health care. HCFA's instructions to the evaluation panels required that for the PRO to be scored as "fully met" in this element, it had to have a sanction case in process. In order to receive the full 75 points for this element, defined as "exceeded met," the PRO was required to have submitted a sanction case to HHS's Office of the Inspector General for adjudication.

HCFA officials told us that in light of the possibility that a PRO might not have found any sanctionable cases, it was unreasonable to hold PROs to this standard. They said that they had discovered this problem with the instructions to the panel when the first group of PROs was being evaluated. HCFA decided that PROs had to be given a fully met score for sanctions if no sanctionable problems had been found by the PRO, the SuperPRO, or HCFA regional office personnel, or if a problem had been identified and the PRO had taken some action toward attempting to

resolve it. Although the written instructions were not modified, HCFA officials said that they had attempted to assure that the stricter standard was not enforced when the panels discussed their recommendations with one of two central office officials. Where the panels had applied the more stringent standard in reviewing the first group, central office officials told us that they had attempted to assure that this was not the sole reason for the PRO's failing the evaluation.

However, in the case of the Utah PRO, which was among the first group of PROs evaluated, the panel gave the PRO a zero score in this element even though no sanctionable problems had been identified. Had the panel given the PRO a minimally passing score for this element, it would have achieved a passing score on all three sections of the evaluation. Nevertheless, HCFA central office officials accepted the panel's recommendation to require competition for the contract. However, when the PRO appealed the decision, HCFA central office officials accepted the PRO's rebuttal of this point. Despite this reversal on the sanctions issue, HCFA did not overturn the panel's recommendation because new information submitted by the PRO showed that it had found several quality-of-care problems that it had not intervened to correct.

Incorrect Scoring of PROs by Panels

In addition, in some instances, panels gave PROs individual element scores that were inconsistent with the instructions. In 13 of 16 evaluation elements,¹ the instructions to the panel indicated that specific scores were to be given for each of three defined levels of performance. For example, for the profiling element, the score for "fully met" was set as 25 points, the "minimally met" score as 17 points, and the "unsatisfactory" score as 0 points. Thus, only these three scores should have been given for this element.

However, in 45 instances spread over 15 evaluations, panels had given element scores other than the scores required by the instructions, e.g., 20 points for the profiling element. HCFA program officials told us that such scores were not permitted by the instructions, and a senior official who received many of the telephone calls from the evaluation panels told us that if they had come to his attention during the evaluation process, he would have asked the panels to correct them.

¹For the other three elements, the instructions explicitly permitted a range of scores for a defined level of performance.

We found no instance where errors of this type affected the outcome of the evaluation. However, the fact that such errors occurred so often, and that they occurred within every group of PROs evaluated, indicates to us that the instructions to the panel on this point were unclear. It also shows that HCFA's measures for monitoring the evaluation process—having the panel officials telephone a HCFA central office official to discuss decisions and supporting evidence—were not adequate to prevent the panels from assigning incorrect scores. A stronger internal control, such as a requirement that all panel decisions and supporting documentation be reviewed and approved in writing by central office officials, could have alerted them to this problem.

Inadequate Documentation of Evaluation Results

During our review, we found that the decisions to noncompetitively renew the Florida and Indiana PROs' contracts were inadequately documented. Although these do not appear to have affected the outcome of the evaluations, lack of documentation indicates inadequate management oversight and control over the evaluation process. Senior PRO program staff acknowledged these documentation problems and attributed them to inadequate internal controls over the process.

Decision to Renew Florida PRO Not Documented

The evaluation results for the Florida PRO were poorly documented for both the panel and postpanel phases of the evaluation. The evaluation panel did not recommend noncompetitive renewal of the Florida contract. The contract was noncompetitively renewed, and we could find no evidence that responsible program officials had explicitly decided to renew the Florida PRO noncompetitively. However, we were unable to determine whether contract renewal was the appropriate action.

Evaluation panel documentation showed that the Florida PRO had failed section 2 (Required Review Activities) of the evaluation. Discussions with the chairman and senior central office member of the Florida PRO evaluation panel showed that the panel was deeply divided over whether the Florida PRO should be offered noncompetitive renewal or the contract recompeted. Initially, the panel had arrived at a tentative recommendation for competition. However, when panel members called a senior official in the central office to discuss the panel's findings, that official questioned the panel's basis for this recommendation. According to these two members of the panel, they had the impression that they were being ordered to pass the Florida PRO. They also said they were instructed by this official to review the Florida PRO's technical proposal for the new contract. Normally, review of the technical proposal would

be done only if a recommendation for noncompetitive renewal had been made.

Although it is clear that the panel did not recommend that the Florida PRO be renewed noncompetitively, the available evidence is ambiguous on whether the panel recommended competition for this contract or whether it returned no recommendation. The Florida evaluation panel documentation contained two panel recommendation sheets. The first, dated March 17, 1987, indicated that the panel's decision was for contract recompetition, but it was not signed by the panel members. The second, dated March 18, 1987, was signed, but no recommendation was indicated. The panel chairman told us that he was unable to recall if the panel had reached a final decision about what recommendation to make after the phone call to the central office official. However, the senior central office member of the panel told us that the panel had decided not to change its mind about its recommendation for recompetition of the contract.

Although the panel had not recommended noncompetitive renewal, HCFA renewed the Florida PRO's contract without competition. We were unable to find any documentation of this decision except the letter to the Florida PRO offering it noncompetitive renewal. Furthermore, neither of the two HCFA officials most directly in charge of the evaluation could recall having made the decision to offer noncompetitive renewal to the PRO. However, one of them told us that he believed that the PRO should have passed the evaluation and been noncompetitively renewed. He said that many of the PRO's difficulties could be traced to the fact that it was unable to obtain data from the intermediaries in Florida for several months, a problem for which HCFA was responsible. In addition, he noted that the PRO had performed review despite this lack of data, which was not required by the contract. He said that he would have recommended noncompetitive contract renewal for the PRO to his superiors had the question ever come up.

The only documentation we found for the decision to offer noncompetitive renewal to the Florida PRO was a draft of the letter to the PRO, initialed by this HCFA official. From our discussions with him, it does not appear that he realized at the time that his approval of this draft letter was in effect a decision to offer noncompetitive renewal to the Florida PRO despite the fact that the evaluation panel had not recommended this. However, he said that he believed that noncompetitive renewal was the proper outcome.

The HCFA official who actually drafted the letter to the PRO offering it noncompetitive renewal could not remember who, if anyone, had told her to draft this letter. However, she said that she had received the results of the panel's review of the Florida PRO's technical proposal for the new contract, which she normally got only in cases when the PRO had passed the evaluation. She said that she did not always see the panel's renewal evaluation documentation. Although the official could not recall all the details, it appears that she assumed that the panel review of the technical proposal meant that the panel had recommended noncompetitive renewal and drafted the letter accordingly.

We were unable to determine whether the decision to renew the Florida PRO noncompetitively was reasonable. The rationale advanced by one HCFA official that the PRO should have been renewed because its problems were due to a lack of good data from the Florida intermediaries seems reasonable. On the other hand, other PROs that were not renewed also had problems obtaining data from intermediaries. In any case, as nearly as we can determine, neither the panel nor central office officials explicitly made a renewal decision. In effect, the decision was implicitly made when a central office official initialed the draft of the letter to the PRO offering it noncompetitive renewal of its contract.

The confusion surrounding the evaluation for this PRO suggests to us that management controls over that part of the evaluation process occurring after the panels had returned their decisions were not adequate. Specifically, HCFA had not established a formal process, including appropriate documentation, requiring key central office officials to review and approve each evaluation decision.

Modification to Indiana Evaluation Score Poorly Documented

Another type of documentation problem occurred in the evaluation process for the Indiana PRO. The evaluation panel's documentation indicated that the PRO had failed section 1 of the evaluation by a substantial margin, in part because of a poor score in the quality objectives element. The PRO passed sections 2 and 3. Despite apparently failing section 1, which according to the panel instructions should have resulted in a recommendation for competition, the panel recommended that the contract be renewed noncompetitively. The reasons for this decision were not documented, nor were we able to clarify the situation through discussions with panel members.

We did identify a document, not part of the official panel documentation, which indicated that the score for section 1 had been raised to the

passing level. The original score for this element, 66 points, had been crossed out and 174 points substituted. This change was annotated "per conference] call 3/21." A change of this amount would have increased the score for section 1 from failing to minimally met and caused the PRO to pass all three sections of the evaluation.

The HCFA regional office official who had been responsible for monitoring this PRO told us that this document was an informal working document used by the panel to record its findings during its deliberations. He told us that the score had been changed as a result of a conference call made from the Chicago Regional Office after the panel had disbanded. He said that the participants in that call had been he, his immediate supervisor in HCFA's Chicago Regional Office, and the director, Division of Program Operations, within HCFA's Health Standards and Quality Bureau, the division responsible for PRO program management. However, neither of the other two officials could recall the conference call. Furthermore, one member of the panel we talked to had no knowledge of this change, nor did the other central office official who was responsible for directing the evaluation process. In addition, we did not find any other documentation of a change in score for the Indiana PRO.

In spite of this, HCFA officials believe the change in score was appropriate and said that the panel documentation should have been corrected to reflect the change. In any case, it could have had no effect on the panel recommendation, because the panel had disbanded before the conversation during which the modification was discussed, and one panel member we talked to was unaware of it. The panel had already recommended that the PRO's contract be renewed noncompetitively despite the fact that it had failed section 1. The central office reviewed the recommendation and accepted it. This possible change in score had no ascertainable effect on the outcome of the evaluation. However, as in the case of Florida, the failure of program officials to adequately document their actions suggests that HCFA's internal controls over the evaluation process were inadequate.

Conclusions

The PRO evaluation process was internally inconsistent, had errors, and was inconsistently applied, and evaluation decisions were not adequately documented. We believe this occurred because of inadequate internal controls over the evaluation process, which did not include (1) a documented central office review of each panel's decision and its supporting documentation and (2) an approval process involving key central office officials. Although we were unable to document any instances

where these problems led to an inappropriate decision to offer or withhold noncompetitive contract renewal, the potential for such errors existed.

HCFA program officials generally agreed that the matters we found were problems and attributed them to inadequate resources to implement and manage the program. We believe that HCFA management should assure that future evaluations of PROs are designed with sufficient internal control mechanisms to assure consistent, adequately documented evaluations.

Recommendation

We recommend that the Secretary of HHS instruct the Administrator of HCFA to assure that in future PRO evaluations, the evaluation process has sufficient internal controls to assure that evaluations are consistently applied and that decisions resulting from them are adequately documented.

Agency Comments and Our Evaluation

In a letter dated September 4, 1987, the HHS inspector general stated that HHS agreed with our recommendation and that steps have been taken to improve the evaluation internal controls based on HCFA's experience during the first contract evaluation process (see app. III). As an example of improvement, HHS said that the summary sheets prepared by the review panels will be controlled to document the nature of the decision-making process. HHS also said that it will continue to improve internal controls.

In an August 30, 1987, letter, the executive vice president of AMPRA agreed with our findings and recommendation (see app. IV).

Routine PRO Monitoring Could Be Improved to Detect and Correct Poor Performance

HCFA had not identified, and therefore had not required PROs to correct, many performance problems before the contract renewal evaluations. These evaluations took place about 18 months into the 24-month contract period. This failure to detect and correct performance problems was due in part to inadequacies in HCFA's measures for routine monitoring of PRO performance, which did not evaluate PRO performance in important areas covered by the contract evaluation, and may have diminished the program's ability to protect Medicare and its beneficiaries.

HCFA officials became aware of the deficiencies in PRO monitoring when it became apparent that about half of the PROs were failing the renewal evaluations. They told us that they were attempting to improve the routine monitoring of the PROs by revising and improving the main instrument for monitoring PRO performance—PROMPTS—and by increasing the amount of data that the PROs were required to report. The new PROMPTS—called PROMPTS-2—was completed on February 27, 1987, about 7 months into the new contract cycle for some PROs. PROMPTS-2 is designed to monitor PRO performance in the important areas covered by the contract evaluation. However, in some cases it lacks criteria to help HCFA regional office monitoring personnel differentiate between acceptable and unacceptable performance.

HCFA Monitoring Did Not Always Detect Poor PRO Performance

All but one of the six PROs whose evaluations we examined had performance problems that were not detected by HCFA's quarterly monitoring visits, and remained undetected until the renewal evaluation. Problems not detected included data-system inadequacies, failure to implement interventions for admissions and quality objectives in a timely manner, inadequate internal control measures to check on the performance of nurse-reviewers and physicians, and failure to act on detected quality issues not included in objectives.

For example, HCFA regional office monitoring personnel failed to detect serious problems with the data system of one of the six before the renewal evaluation. When verifying the data supplied by this PRO on the self-evaluation section of the evaluation document, HCFA regional office personnel discovered that the PRO's data system did not include data from its two review subcontractors. As a result, HCFA regional office personnel were unable to verify the accuracy of the numbers supplied by the PRO, including those it reported for its admission and quality objectives. Furthermore, the data system was so inadequate that the PRO had

to do its profiling manually, a task that HCFA officials considered virtually impossible in a large state. Although this inadequate data system had been the source of the reports that the PRO was required to provide HCFA, we could find no indication, in either PROMPTS or the regional office correspondence files with this PRO, that HCFA monitoring personnel had previously noticed this problem.

Under their contracts PROs were required to take actions—called interventions—to correct problem areas identified in the contract. For example, one PRO we reviewed contracted to reduce avoidable postoperative or other complications. As part of this objective, it agreed in its contract to take specific actions intended to achieve this objective at specific times. For instance, the PRO agreed that in October 1984, it would begin to review all cases of providers with excessive numbers of patients who had complications resulting from hospitalization. However, the PRO did not begin this activity until September 1985. In another instance, the PRO agreed to require providers that had not corrected their problems by December 1984 to begin education programs. However, it had not yet begun this activity at the time the PRO prepared its self-evaluation in January 1986. The PRO received a score of zero in the quality objectives interventions element of its evaluation.

PROs for five of the six states whose evaluations we reviewed performed poorly in the area of interventions for their quality or admissions objectives. In general, this occurred because the PRO did not intervene until well after the times required under the contract. Although PROMPTS did include questions on the timeliness of interventions, this had not been identified as a significant problem with four of these PROs.

Four of the six PROs performed poorly in the area of correction of quality-of-care problems not covered by the quality objectives. In three of the four cases, there was no indication that this problem had been identified before the renewal evaluation, which could have resulted in inadequate protection of Medicare beneficiaries against poor quality of care because identified quality problems were not corrected.

Two PROs received low scores because they had inadequate internal control systems. These systems are designed to measure and correct deficiencies in the performance of PRO personnel, primarily nurse-reviewers, who perform the initial review of the medical records, and physicians, who decide whether problems referred to them by the nurse-reviewers are significant. Despite the importance of having such a system, there

was no evidence that this deficiency had been identified in these two PROs before the renewal evaluation.

Failure to detect and correct PRO performance deficiencies until the contract renewal evaluation, three-quarters of the way into the contract period, was a serious deficiency in HCFA's management of the program. The contracts were intended to carry out the intent of the PRO program authorizing legislation to protect the Medicare program and beneficiaries against unnecessary utilization and poor quality of care. To the extent that HCFA had not identified PRO performance problems, HCFA had not assured that the program was accomplishing its functions.

HCFA officials were aware of this deficiency when we began our review. They redesigned the PROMPTS system (PROMPTS-2) to correct this problem in the 1986-88 contract period.¹ They also said PROMPTS-2 will form the basis of the contract renewal evaluations to be conducted in 1988. However, PROMPTS-2 was not available until February 27, 1987, about 7 months after the effective date of the first of the current round of contracts. In addition, as of March 31, 1987, HCFA had not decided how information not covered in PROMPTS-2 would be included in the renewal evaluation or how this evaluation would be conducted.

PROMPTS Did Not Adequately Cover Many Evaluation Elements

A major reason for HCFA monitoring personnel not identifying significant PRO problems until the renewal evaluation was that the principal tool used by HCFA regional office personnel for routine monitoring of the PROs—PROMPTS—did not adequately address performance in many elements stressed in the renewal evaluation.

For example, the PRO Evaluation Protocol required that the PRO list each potential sanctionable problem, with the date on which the PRO notified the hospital or physician, and its current status. However, PROMPTS asked only if the PRO was properly implementing its sanction plan and properly reporting its sanction activity to HCFA. PROMPTS did not require the monitoring official to assure that sanctionable issues, once identified, were being promptly resolved.

PROMPTS also did not contain questions on the issue of the adequacy of the PROs' data systems. Nor did it encourage HCFA regional office personnel charged with monitoring the PROs' activities to investigate the accuracy of the data reported by the PROs. Rather, PROMPTS simply asked

¹The contracts cover a 2-year period between roughly mid-1986 through mid-1988.

them to determine whether the reports were received on time and were acceptable. Staff at one regional office we visited told us that as long as the data reports were internally consistent and not obviously erroneous, they would not check the validity of the data behind the reports. While there was no element of the renewal evaluation specifically directed at the adequacy of the PRO's data system, in the case of one PRO, HCFA regional office monitoring personnel discovered that the PRO had the data system problem discussed on pages 26-27 when they found that they were unable to verify much of the data supplied by the PRO in its self-evaluation report.

Quality-of-Care Issues Not Stressed in PROMPTS

Four of the six PROs we visited were found to be deficient in the quality-of-care element because they did not properly follow up on identified quality-of-care problems. Although PRO activities in identifying and correcting quality-of-care problems in areas not covered by their quality objectives were an important element in the renewal evaluation, the PROMPTS document did not contain questions pertaining to the resolution of such problems.

Quality-of-care issues are identified in the course of performing medical review activities. The Medical Review section of PROMPTS contained questions that would have indicated if the PRO was finding quality-of-care problems in the cases it reviewed. However, the Medical Review section did not contain questions addressing the more important issue of what the PRO did to correct the problems identified. SuperPRO reviews also identified quality-of-care issues that the PRO did not find, but did not address the resolution of those problems that the PRO had found. Also, none of the data reports supplied by the PRO contained information on PRO activities in this area.

In contrast, the contract renewal evaluations contained two elements that addressed identification of quality-of-care issues not contained in PRO objectives. One element required the PRO to list each quality-of-care problem it had identified in its medical review activities, the date identified, actions taken to resolve it, and the results or pending actions if it was still unresolved. In addition, the PRO was required to give similar information on cases that had been referred to it by other parties, including Members of Congress, the HHS Office of the Inspector General, and HCFA.

The monitoring system may not have stressed the area of PRO activity in correcting quality-of-care problems outside its quality objectives in part

because of what appears to have been a greater emphasis on utilization control in the early part of the contract period. Neither PROMPTS nor the scope of work for the 1984 contract dealt very extensively with quality of care when compared with the amount of attention given to the issue of detecting and correcting overutilization problems, such as unnecessary admissions. However, by the time of the evaluation, emphasis seems to have shifted toward quality-of-care issues.

Some HCFA officials we talked to acknowledged this shift in emphasis. For example, one HCFA official involved in the development of PROMPTS told us that the differences in emphasis on quality between PROMPTS and the contract evaluations reflected the fact that there were different concerns in 1984, when PROMPTS was developed, and 1986, when the evaluations were performed. Another HCFA official involved in monitoring PRO performance said that there may have been a shift in monitoring emphasis toward quality in the middle of the contract period, although there was no change in the contract requirement to identify and correct quality problems. Another HCFA official involved in PRO monitoring told us that *monitoring PROs in the area of quality* was not emphasized until the second half of the contract period.

While we believe that HCFA's emphasis on assuring that PROs detect and correct quality-of-care problems whether or not they form part of the PRO's objectives is correct, HCFA's apparent increase in emphasis on quality-of-care issues during the contract period did pose a problem for PROs. Because HCFA's monitoring program was deficient in this area, it was less likely that either HCFA or the PROs would be aware that the PROs were performing inadequately in this area before it was revealed by the renewal evaluation.

PROMPTS-2 Covers Most Weak Areas in PROMPTS but Sometimes Lacks Criteria

The new PROMPTS-2 should better focus the attention of HCFA monitoring personnel on those areas of contract performance in which problems remained undetected during the previous contract. However, in our analysis of PROMPTS-2, we found some instances where it lacks clear criteria to assist HCFA monitoring personnel in determining exactly what constitutes acceptable performance.

PROMPTS-2 addresses most areas in which we found the original PROMPTS to be deficient. For example, while PROMPTS required HCFA monitoring personnel to determine if the PRO was producing profiles, it did not raise the issue of how the PRO was using them. PROMPTS-2 requires monitoring personnel to assure that the PRO is using profiles to identify problems

Again, while PROMPTS did not require HCFA monitoring personnel to examine the accuracy of the data reported by the PRO, PROMPTS-2 requires that HCFA monitoring personnel assure themselves that these data are accurate. In the area of quality issues not covered by PRO quality objectives, an area where many PROs had problems identified through the evaluation, PROMPTS had no questions at all. PROMPTS-2, however, requires HCFA monitoring personnel to assure themselves that the PRO acts promptly to resolve quality issues and to prevent their recurrence.

Although PROMPTS-2 represents an improvement over PROMPTS, our analysis found a potential problem. In some areas PROMPTS-2 lacks criteria to help HCFA monitoring personnel determine the difference between acceptable and unacceptable performance. For example, in the area of interventions to correct quality problems, PROMPTS-2 asks the monitor to determine if the PRO has effectively identified areas needing intervention, promptly resolved the problems, and addressed them appropriately. Nowhere does it define what is meant by "effectively," "promptly," or "appropriately." In another instance, the HCFA monitor is asked to determine if the PRO's internal control system is adequate. However, it does not indicate what constitutes an "adequate" internal control system.

The HCFA monitors are also asked to judge if the relationships between the PRO and the intermediary, and between the PRO and providers, are "working effectively." They are asked to list specific problems. The document contains no definition of what constitutes an effective working relationship or what constitutes a problem in working relationships.

In these instances, HCFA is depending on the individual judgment of its monitoring personnel to determine what constitutes acceptable performance. This could lead to inconsistent results when PROMPTS-2 is applied to different PROs.

When we discussed this with HCFA officials, they did not agree that it was significant. They said that in some cases, such criteria are found in other documents. In addition, they argued that HCFA regional office monitoring personnel had sufficient experience with the program, and sufficient knowledge of the history of the individual PROs for which they

²Effective working relationships between PROs and fiscal intermediaries were defined by a series of questions in a draft version of PROMPTS-2.

were responsible, to make accurate judgments regarding what is acceptable and what is not. They noted that HCEA intended to conduct training for monitoring personnel and was reviewing all corrective action plans to assure that decisions made by monitoring personnel were fair and consistent. However, we believe that inconsistent decisions by HCEA monitoring personnel would be less likely and identification of performance problems more assured if criteria were included in PROMPTS-2.

Conclusions

HCEA did not detect and correct many instances of poor PRO performance before the contract renewal evaluation. This meant that many PROs were not adequately carrying out important requirements of their contracts for most of their contract periods and thus the Medicare program and its beneficiaries may not have received all the protection intended.

At the time we began our audit work, HCEA program officials told us that the number of PROs failing the contract renewal evaluation had alerted them to the need to improve their PRO monitoring efforts and that they were taking action to do so. They said they had redesigned PROMPTS to better focus regional office monitoring efforts on important measures of outcome and they intended to use it as the basis for the next renewal evaluation.

We believe that PROMPTS-2 is a significant improvement over PROMPTS. It covers most of the areas in which PROMPTS was deficient. However, in some cases, it may not provide adequate criteria to enable HCEA monitoring personnel to differentiate between acceptable and unacceptable performance. We believe that to assure greater consistency in evaluating PRO performance, such criteria should be included in the document, either directly or by reference if the criteria are contained in other documents.

Recommendation

We recommend that the Secretary of HHS direct the Administrator of HCEA to provide criteria to enable HCEA personnel to differentiate between acceptable and unacceptable performance in the routine monitoring of PROs' activities.

Agency Comments and Our Evaluation

The HHS inspector general stated that HHS generally agreed with this recommendation and indicated that, where appropriate, HCEA would continue to provide criteria to its personnel for differentiating between acceptable and unacceptable performance. He said that HCEA regional

Chapter 3
Routine PRO Monitoring Could Be Improved
to Detect and Correct Poor Performance

office personnel have been given criteria outside of the PROMPTS document because the document is not intended to serve as an instructional device or manual for project officers. He also said that training programs have been held and instructional materials provided. He also said HCEA believes that criteria contained in the individual PRO contracts, PRO instructional issuances, and the PRO monitoring protocols, as well as the training and instructional materials, will result in appropriate monitoring of PRO performance.

We agree that adequate criteria may be available in other documents. However, we continue to believe that incorporating such criteria in the PROMPTS-2 document, either directly or by reference, would help assure that they would be uniformly and consistently applied by HCEA's PRO monitoring personnel.

AMPRA agreed with our findings and this recommendation. AMPRA stated, that deficiencies in PRO operations should be pointed out to the PRO as early in the contract cycle as possible. AMPRA said waiting for the final evaluation before deficiencies are identified is not fair to the PRO, which has assumed HCEA is satisfied with operations until that point, and does not permit time for corrective action.

AMPRA also said that PROMPTS-2 is an improvement over earlier evaluation instruments. AMPRA expressed its concern, however, that PROMPTS-2 lacks specific criteria to measure acceptable and unacceptable performance and that without defined criteria, the subjective judgments of different HCEA personnel will continue to influence final evaluations of PROs.

HCFA Funds PRO Program at the Legal Minimum

HCFA designed the scope of the 1986-88 PRO contracts around the minimum level of funding permitted by law. Furthermore, because of uncertainties in the methodology HCFA used to determine the funding level for each PRO contract, we do not know whether the PROs are appropriately funded to perform the level of effort included in the contracts. We believe that HCFA should initially determine the scope of the PRO contracts needed to protect the Medicare program and its beneficiaries and use this as the starting point for determining the program's funding level.

PRO Funding for 1986-88 Contracts Based on Minimum Required by Law

The funding for individual PRO contracts for the current 2-year contracts is based on the minimum program funding permitted by law. In the Social Security Amendments of 1983, the Congress required that the PRO program be funded directly from the Hospital Insurance Trust Fund and set a minimum funding level. It required that Medicare inpatient hospital review by PROs be funded at an amount not less than the cost per review set in fiscal year 1982, and not less in the aggregate than the amount expended in fiscal year 1982 for the PSRO program, when adjusted for inflation. Under this provision, HCFA based the cost of the program on the cost per admission in 1982, as adjusted for inflation. After HCFA established the budget target for the PRO program, the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) modified the floor so that funding cannot be less than the amount expended in fiscal year 1986, adjusted for inflation.

HCFA essentially considered the 1983 act's budgetary "floor" to be the "ceiling" as well, and all budget estimates for the contracts awarded in 1986 were made based on the minimum budget allowed by law. According to a HCFA official, these estimates were made before the scope of work was developed and were revised during the budgeting process because of changes in the actuarial estimates of the number of Medicare hospital admissions during the contract period. Initially, the HCFA actuaries had assumed that the numbers of admissions would continue to increase under PPS as they had under cost reimbursement. However, as data about Medicare admissions under PPS began to come in, HCFA realized that admissions were not increasing as expected. HCFA officials, therefore, decided to base the budget estimates on the assumption that the numbers of admissions would remain constant at the 1984 level. This process resulted in a final budget estimate for fiscal years 1987 and 1988, essentially the contract period for those contracts signed in 1986, of about \$357 million for inpatient hospital reviews.

According to a HCFA official involved in the PRO budgeting process, HCFA aimed at an initial contract figure of about \$320 million, leaving a reserve of \$37 million, or more than 10 percent of the total amount, to pay for unexpected expenses, such as contract terminations, and for PROs' activities in preparing sanction cases, which are separately funded through contract modifications. However, we estimate the total funding for the 1986-88 contract cycle at about \$293 million. Thus, HCFA has a program reserve of about \$64 million, or almost 18 percent, rather than the target 10 percent.

This raises the possibility that HCFA may not be able to spend up to the legislative budgetary floor during this 2-year contract cycle. We asked a HCFA official responsible for PRO budgeting if this was a possibility. He responded that underspending the floor amount was unlikely, because the floor had been changed to the 1986 program costs, updated for inflation. According to the figures contained in the President's 1988 budget, the program cost \$151 million in 1986, which corresponds to a spending floor for 1986-88 of about \$318 million, using the most recent inflation estimates.

Scope of Work Designed to Keep Program Funding Within Minimum

The scope of work for the 1986-88 contracts was designed to keep the cost of the program at the legal minimum. In addition, there were so many uncertainties in the methodologies HCFA used to estimate the cost of performing the scope of work that was established that we cannot be certain that HCFA's funding estimates for individual PROs reflect the actual costs of performing that work. HCFA program officials generally agreed with our findings and told us that these estimates were intended as general guides to the contract officers in negotiating the prices of the contracts.

Scope of Work Designed Around Minimum Funding

HCFA officials, when designing the scope of work for the 1986 contracts, decided that they would have to work within a similar amount of money as in the previous contract cycle. However, based on their experience during the first contracts, HCFA decided to increase the intensity of case reviews, primarily to review more cases for quality problems. This would have the effect of increasing the average cost per review. Because HCFA was attempting to keep the cost of the program constant, the increased review costs had to be offset by reducing the number of cases reviewed.

According to HCFA officials, the scope of work for the first contract cycle was designed so that PROs would review about 30 percent of Medicare inpatient admissions. (In fact, overall, PROs reviewed 40 percent or more.) In preparing the scope of work for the 1986 contract cycle, HCFA reduced the estimated percentage of admissions to be reviewed to about 26 percent. Table 4.1 gives the breakdown of this percentage into categories.

Table 4.1: Percentage of Total Admissions to Be Reviewed, by Category

Review category	Percentage of total admissions
All cases with specified diagnosis codes	0.066
Hospital notices of noncoverage	0.456
Day or cost outliers	1.500
Transfers to other hospitals or to PPS exempt units	1.135
Readmissions of patients within 15 days of discharge ^a	3.000
Validation of PPS payment category assigned to admission	2.960
Preadmission reviews	2.500
Specialty hospitals	1.000
Random sample (includes intensified review when problems found)	9.890
Validation of contracted objectives	0.310
Contracted objectives	3.000
Total	25.817

^aThe Omnibus Budget Reconciliation Act of 1986 requires HCFA to require PROs to review at least a sample of all hospital readmissions within 31 days of a prior discharge. However, this provision is effective only for contracts entered into or renewed on or after January 1, 1987. All of the contracts for the current 2-year period were effective before this date.

Uncertainties in Scope of Work

According to a HCFA official who helped develop this estimate, the actual percentage of cases that each PRO will have to review within each of the individual components varies. The 3-percent random sample¹ of all cases was set by HCFA. Some others, such as those for outliers and validation of PPS payment category, were based on historical data from Medicare's statistical information systems and are, therefore, relatively reliable. Others are based on less "hard" information. For example, this official pointed out that the estimate for readmissions is subject to uncertainty because of the need to apply judgment in determining which readmissions were related to the medical conditions of a prior admission. In addition, he said that the 3-percent estimate for contract objectives is

¹The 9.89 percent in table 4.1 includes an additional estimated 6.89 percent for intensified review stemming from errors found in the 3-percent random sample.

uncertain because PROs have contracted for different objectives. Furthermore, according to this official, all of these estimates were national in scope, and individual PROs could differ from the estimates because of local differences.

Uncertainties in HCFA's Contract Price Estimates

HCFA used several assumptions to develop its initial cost estimates for PRO contracts that result in a degree of uncertainty about these estimates. HCFA officials told us that the estimates were intended to be no more than a general guide for contract negotiators. We found that the actual percentages of cases reviewed and costs per case in awarded contracts varied significantly from those estimated.

As part of their preparation for negotiating the 1986 round of contracts, HCFA prepared state-by-state estimates of what it should cost to perform each review category shown in table 4.1. According to the HCFA official responsible for preparing these estimates, HCFA staff began by developing direct labor costs for each review category. To do this, they developed estimates of the time that would be required to perform each type of review by registered nurses and other specialists using HCFA personnel in these professions. They then estimated wage rates for nurse reviewers from Bureau of Labor Statistics hourly wage rates for the specific areas, adjusted for inflation. Wage rates for accredited medical records technicians were developed based on a 1983 American Medical Records Association survey of its membership. The percentage of cases requiring physician involvement and the amount of physician time per review was estimated based on the experience of HCFA's in-house physicians. For physician wage rates, HCFA used a national rate of \$54 per hour. According to this official, HCFA did not attempt to use actual PRO experience in estimating nurse or physician cost per review because it did not have reliable PRO cost information.

Using a model based on the actual experience of a random sample of 21 PROs, HCFA used these direct labor costs as the basis for estimating the other costs of a PRO, such as salaries of administrative personnel, fringe benefits, overhead, and subcontracting costs. In addition, if a PRO had one or more contracts to perform review for other governmental or non-governmental entities, HCFA reduced its estimate by prorating the PRO's overhead costs between the PRO's other business and its Medicare contract.

This calculation gave HCFA an estimated cost per case for performing each type of review. Overall costs for each PRO were then computed by

multiplying this figure times the number of reviews of each type for each state. The latter figure was obtained by multiplying the nationally estimated percentage of reviews of each type times the estimated total number of admissions for each state. This latter number was in turn developed by combining actual experience data by state for an earlier year with national actuarial estimates. According to a HCFA official, this was done because HCFA did not have the numbers of admissions per state on a current basis.

This HCFA official stated that these estimates were only intended to be used as a starting point for negotiations with the PRO by the contracting officer. They did not take into account differences in patterns of health care among the states, which could cause the actual level of effort needed by PROs to differ considerably. Thus, it was expected that the actual amounts awarded to a PRO might differ significantly from the estimate developed using the model.

The national actuarial estimates of admissions, which as noted above had already been revised once to assume no increase in Medicare admissions, were again revised downward to assume a decreasing number of Medicare admissions. According to the HCFA official in charge of the PRO budgeting process, this reduction in the estimated number of admissions was not used to recalculate the total amount available for the PRO program. However, HCFA required all but a few PROs with the earliest awarded contracts to base their offered price estimates on the revised, lower admission estimates. In the instance where we observed a negotiation, the PRO, which had been instructed to use the earlier admission estimates as the basis for its offer, was told that it would have to base its offer on the later, lower estimates when it arrived for the negotiating session.

HCFA officials told us that they were prepared to give PROs additional funding if they could show that they would do additional reviews above the estimated percentages. In fact, for most of the contracts for the 1986-88 contract cycle, the negotiated percentage of admissions to be reviewed was above the 25.8-percent HCFA national estimate and led to increases in contract prices. In the instance where we observed the contract negotiation process, HCFA negotiators increased the price by about \$2 million when the PRO was able to document that it would be doing more reviews in certain categories (for a total of 27.6 percent of all admissions) than had been estimated (25.8 percent).

Furthermore, for most PROs the contract cost per case reviewed differed significantly from the original HCFA estimates. However, in contrast to the percentage of reviews, nearly as many final contract prices were below the estimated cost as were above it, and the overall average cost per review was less than 2 percent above the estimated cost.

Conclusions

HCFA designed the scope of work of the 1986-88 contracts to keep the cost of the program close to the legislatively mandated minimum funding level. If this funding level is inadequate, the Medicare program and its beneficiaries would not receive the degree of protection from unnecessary and poor quality hospital care the Congress intended the PRO program to provide.

There were many uncertainties in the methodology that HCFA used to estimate the costs to individual PROs in carrying out the scope of work of the contract. As a result, we could not determine whether HCFA's cost estimates were reasonable estimates of the costs to the PROs of carrying out the required work. However, the fact that the contract awards differ from the estimated costs in both cost per review and number of reviews suggests that the contract negotiation process may have, at least in part, compensated for these uncertainties.

In the final analysis, if contract prices are too low, HCFA's willingness and ability to make modifications to contract prices will be the determinant of whether PROs receive sufficient funding to carry out the scope of work.

Recommendations

We recommend that the Secretary of HHS direct the Administrator of HCFA to

- determine the scope of review needed to adequately meet the program's intent and use this as the starting point for determining the program's funding level and
- collect and use adequate cost and performance data to set each PRO's contract funding at a level sufficient to provide the coverage determined to be necessary.

Agency Comments and Our Evaluation

The inspector general said that HHS concurred with our recommendation that HCFA should determine the scope of review needed to adequately meet the program's intent and use this as the starting point for determining the program's funding level. He said, however, that this recommendation stemmed from our misunderstanding of how the scope of review was developed. According to the inspector general, the scope of work supporting PRO contracts was developed based upon experience gained from medical review by PSROs and fiscal intermediaries and was designed to address "gaming" of the newly enacted PPS.

When we discussed this comment with HCFA officials, it appeared to us that HCFA did not agree that the funding level had influenced the scope of work. HCFA officials told us that funding levels had not been considered in developing the scope of work for the 1986-88 contracts. In their view, the fact that the cost of the scope of work had come out at about the legally required minimum funding level was evidence that this level was adequate to meet the program's intent. They noted that the Office of Management and Budget did not actually approve the funding level until the scope of work was available and indicated that if HCFA had felt it necessary to ask for additional funding, it would have done so.

Our evidence indicates, and HCFA officials agree, that

- the funding level for the 1986-88 scope of work was developed and sent to the Office of Management and Budget for approval before the scope of work was approved,
- the funding level was at that time justified solely on the basis of the legally required minimum funding level, and
- the funding level remained at the minimum after the development of the scope of work for the 1986-88 contracts.

These circumstances indicate to us that the minimum legally permitted funding level would have had a constraining effect on the development of the scope of work. Regardless of whether the minimum funding level was a constraint on the 1986-88 scope of work, we believe our recommendation is valid for how future scopes of work should be developed, and HHS agreed with this.

The inspector general said that HHS also concurred with our recommendation that HCFA collect and use adequate cost and performance data to set each PRO's contract funding at a level sufficient to provide the coverage determined to be necessary and that HCFA had taken steps to improve the information base on which its estimates are based. As

examples, it noted that PROs are required to report cost data under the current PRO scope of work and that HCFA had initiated plans to conduct studies in several PRO areas to validate the time required to perform various review functions and the associated costs of such efforts.

AMPRA, in its comments, strongly concurred with our findings on PRO funding. AMPRA believes that the PROs have been underfunded for the current round of contracts and that HCFA should renegotiate the PRO contracts. AMPRA also believes that HCFA should develop its future cost estimates on the basis of actual PRO review costs.

PRO Report Worksheets and Related Activities

Worksheet number	Activity covered
1	Admission Objective 1
2	Admission Objective 2
3	Admission Objective 3
4	Admission Objective 4 (not all PROs had a fourth admission objective)
5	Preadmission Review
6	Admission Review
7	Diagnosis Related Group Validation
8	Day and Cost Outlier Denials
9	Quality Objectives (provides for up to six quality objectives)
10	Referrals from HCFA, the inspector general, or Members of Congress and others
11	Sanctions and Reconsiderations
12	Utilization Problems (covers problems not found in the admission objectives)
13	Quality-of-Care Issues (covers quality issues not found in quality objectives)
14	Profiling (covers hospital, physician, DRG/procedure, and patient profiles)
15.1	Interventions for Admission Objective 1
15.2	Interventions for Admission Objective 2
15.3	Interventions for Admission Objective 3
15.4	Interventions for Admission Objective 4 (if applicable)
15.5	Interventions for Quality Objective 1
15.6	Interventions for Quality Objective 2
15.7	Interventions for Quality Objective 3
15.8	Interventions for Quality Objective 4
15.9	Interventions for Quality Objective 5
15.10	Interventions for Quality Objective 6
16	Waiver Activity
17	Intensified Review (covers intensified review for admissions, DRG validation, and day and cost outliers)
18	Private Review
19.1	Internal Quality Control for Review Coordinators
19.2	Internal Quality Control for Physician Advisors
19.3	Internal Quality Control for DRG Validation Staff
20	Impact Outside Objectives (covers PRO achievements in areas not specifically required by the contract)

PRO Evaluation Scores, Panel Recommendations, and Final Decisions^a

State	Scores			Panel recommendation	Final decision
	Section 1 ^b objectives	Section 2 ^c required reviews	Section 3 ^d management		
Alabama	183	34	208	Unsat	Compete
Alaska	359	132	225	Sat	Renew
Amer Samoa/ Guam	99	99	186	Unsat	Compete
Arizona ^e	380	140	206	Sat	Renew
Arkansas	436	157	283	Sat	Renew
California	385	159	295	Sat	Renew
Connecticut	367	140	229	Sat	Renew
Delaware	311	90	199	Unsat	Compete
Dist Columbia	269	99	190	Unsat	Compete
Florida ^f	374	99	240	N/A	Renew
Georgia	319	42	284	Unsat	Compete
Hawaii	189	127	107	Unsat	Compete
Illinois	343	132	233	Sat	Renew
Indiana	219	142	224	Sat	Renew
Iowa	376	132	275	Sat	Renew
Kansas ^g	365	116	246	Sat	Compete
Kentucky	260	50	150	Unsat	Compete
Louisiana	261	24	239	Unsat	Compete
Maine	334	82	222	Unsat	Compete
Maryland	320	116	211	Unsat	Compete
Michigan	372	175	262	Sat	Renew
Minnesota	261	51	159	Unsat	Compete
Mississippi	394	140	292	Sat	Renew
Missouri	287	99	224	Unsat	Compete
Montana	348	132	234	Sat	Renew
Nebraska	231	80	146	Unsat	Compete
Nevada ^h	337	132	292	Sat	Renew
New Hampshire	332	124	272	Sat	Renew
New Jersey	395	134	248	Sat	Renew
New Mexico	132	17	25	Unsat	Compete
New York	343	132	291	Sat	Renew
No Carolina	0	132	162	Unsat	Compete
No Dakota	370	132	238	Sat	Renew
Ohio	252	132	175	Unsat	Compete
Oklahoma	261	132	214	Unsat	Compete
Oregon	227	124	210	Unsat	Compete
Puerto Rico ⁱ	356	200	224	Sat	Renew

(continued)

Appendix II
PRO Evaluation Scores, Panel
Recommendations, and Final Decisions

State	Scores			Panel recommendation	Final decision
	Section 1 ^b objectives	Section 2 ^c required reviews	Section 3 ^d management		
Rhode Island	330	116	224	Sat	Renew
So Dakota	264	140	181	Unsat	Compete
Tennessee	243	159	192	Unsat	Compete
Texas	329	120	237	Sat	Renew
Utah	343	124	175	Unsat	Compete
Vermont ^e	309	124	210	Unsat	Renew
Virgin Islands	0	200	75	Unsat	Compete
Virginia	376	124	268	Sat	Renew
Washington	261	112	103	Unsat	Compete
West Virginia	477	173	276	Sat	Renew
Wisconsin	234	99	196	Unsat	Compete
Wyoming	351	124	269	Sat	Renew

^aIdaho, Massachusetts, Pennsylvania, and South Carolina were not evaluated due to termination of the contract. Colorado scores were not available. Some scores have been rounded to remove decimals.

^bSection I: Total: 500. Minimally Met: 326. Fully Met: 389. Exceeded Met: 448.

^cSection II: Total: 175. Minimally Met: 116. Fully Met: 175.

^dSection III: Total: 325. Minimally Met: 224. Fully Met: 318.

^ePanel recommendation for renewal overruled by HCFA headquarters officials, but PRO successfully appealed decision.

^fActual panel recommendation unclear from available documentation.

^gPanel recommendation overruled by HCFA headquarters officials.

^hContract competed due to inability to negotiate price.

ⁱNon-PPS area with atypical PRO contract.

Comments From the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

SEP 4 1987

Mr. Richard L. Fogel
Assistant Comptroller General
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report, "Medicare: Better Controls Needed for Peer Review Organizations' Evaluations." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "R. Kusserow", written over a light-colored background.

Richard P. Kusserow
Inspector General

Appendix III
Comments From the Department of Health
and Human Services

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Better Controls Needed In Peer Review
Organizations' Evaluations"

Overview

GAO's report was prepared at the request of the Chairman and Ranking Minority Member of the Subcommittee on Health, Senate Committee on Finance. They asked that GAO assess (1) the Health Care Financing Administration's (HCFA's) Peer Review Organization's (PRO's) evaluation methodology and (2) the adequacy of HCFA's routine monitoring of the PROs for identifying performance problems. In addition, GAO was asked to determine how HCFA decided on the funding level for the new contracts.

According to GAO, the evaluation process involved instructions that were inconsistent, incorrect or not properly implemented by the evaluation panels and documentation of the panels' and HCFA's decisions was not always adequate. Additionally, GAO reports that the substantial portion of PROs that failed the evaluations as well as HCFA's lack of awareness of the extent of the problems identified through the evaluation process showed that HCFA's routine monitoring during the contract period had not identified and corrected PRO performance problems.

We would note that GAO's review covered HCFA's monitoring and evaluation efforts for the PRO's first contracting cycle. For the first contracting cycle, HCFA developed a process for ongoing monitoring which utilized a Peer Review Organization Monitoring Protocol and Tracking System (PROMPTS) document as a means of obtaining consistency on a national basis of the monitoring of the 54 individual PROs. The purpose of the final evaluation was to determine whether a PRO's performance was sufficient to merit a noncompetitive renewal of its contract. Those PROs that did not meet contract requirements during the contract period were identified and terminated. During this first contracting cycle this combined, ongoing process resulted in three PROs being terminated and a final determination that 25 PROs did not perform at a high enough level to warrant noncompetitive renewal.

It is noteworthy that GAO's comprehensive review of this process did not reveal a single instance where a flaw in the process resulted in an inappropriate decision to offer or withhold a noncompetitive contract renewal. This tends to confirm the ultimate success of HCFA's monitoring and evaluation programs.

GAO Recommendation

The Secretary, HHS, should instruct the Administrator of HCFA to assure that in future PRO evaluations, the evaluation process has sufficient internal controls to assure that evaluations are consistently applied and that decisions resulting from the evaluation are adequately documented.

Appendix III
Comments From the Department of Health
and Human Services

Page 2

Department Comment

We concur with this recommendation and steps have been taken to improve the internal controls that were in place during the first contracting cycle. For example, as part of the evaluation process, summary sheets are prepared by a review panel comprised of central and regional office personnel to ensure that PRO evaluations are complete and accurate. Such summary sheets will be controlled to document the nature of the decision-making process. Internal controls will continue to be improved on an ongoing basis.

GAO's concern in this area results from findings: that HCFA lacked internal controls over the evaluation process; that there were inconsistencies in the instructions for evaluation and profiling; that panel instructions were incorrect and that evaluation results, in some instances, were not adequately documented. There were two cases where the decision did not appear to be fully documented in the file. In both of these instances the PRO in question was noncompetitively renewed. These two cases did, in fact, slip through the controls in place at that time. While this was inappropriate, it should be noted that due to the number of evaluations being done simultaneously, we put emphasis on contracts proposed for nonrenewal as virtually all of these decisions were appealed. As stated above, HCFA has taken steps to improve the evaluation internal controls based on its experience during the first PRO contracting cycle.

GAO Recommendation

That the Secretary of HHS direct the Administrator of HCFA to provide criteria to enable HCFA personnel to differentiate between acceptable and unacceptable performance in the routine monitoring of PROs' activities.

Department Comment

We generally agree with this recommendation and will, where appropriate, continue to provide criteria to HCFA personnel for differentiating between acceptable and unacceptable performance.

This recommendation resulted from GAO's concern that the ongoing PRO monitoring protocol (PROMPTS-2) does not contain adequate criteria to enable HCFA monitoring personnel to differentiate between acceptable and unacceptable performance. The criteria to be used by regional office (RO) monitoring personnel (i.e., project officers) have been given to RO personnel outside of the PROMPTS-2 document. The decision to do so is based on the premise that PROMPTS-2 was never intended to function as an instructional device or manual for project officers. Training programs have been held for regional project officers and medical review personnel, and instructional materials have been provided. HCFA believes criteria

contained in the individual PRO contracts, PRO instructional issuances and the PRO monitoring protocols as well as training and instructional materials specific to PROMPTS will result in appropriate monitoring of PRO performance.

For the finding applicable to this recommendation, GAO also criticized HCFA during the first PRO contracting cycle for not detecting and correcting many instances of poor PRO performance before the contract renewal evaluation. HCFA believes that the monitoring document did enable it to identify poor performers. This is evident by the three PRO contract terminations prior to the evaluation. The evaluation further identified problems that kept a PRO from achieving a level of performance sufficient for noncompetitive renewal, but not poor enough for termination.

GAO acknowledges that the PROMPTS-2 monitoring document alleviates many of its concerns. These improvements were made as a result of HCFA's experience during the first PRO contracting cycle. HCFA will continue to make improvements as experience dictates.

GAO Recommendation

That the Secretary of HHS direct the Administrator of HCFA to:

--determine the scope of review needed to adequately meet the program's intent and use this as the starting point for determining the program's funding level; and

Department Comment

We concur with this recommendation and will continue efforts in this area.

This recommendation apparently resulted from GAO's misunderstanding as to how the scope of review was developed. The scope of work supporting PRO contracts was developed based upon experience gained from medical review by Professional Standards Review Organizations and fiscal intermediaries and was designed to address "gaming" of the newly enacted prospective payment system (PPS). We therefore focused PRO review on identifying and/or preventing unnecessary admissions. Specific review requirements were established to monitor areas most susceptible to "gaming" such as over-utilization, erroneous diagnosis related group classification, transfers, readmissions and outliers. Focusing requirements were also included to ensure that PROs intensified review in identified problem areas.

As we gained experience with PPS and PRO review, we began during the first scope of work to strengthen PRO activities in the area of quality of care assurance and to specifically monitor PRO performance in that area to ensure that PROs identified, assessed, and corrected quality problems.

In addition, the second scope of work provided for an even more intensive review process (requiring quality review of each case, adding mandated quality screens, using HCFA-identified potential quality of care problems to develop objectives, and requiring greater physician participation). As with the first scope of work, it contained provisions for focusing review on problems identified.

GAO Recommendation

—collect and use adequate cost and performance data to set each PRO's contract funding at a level sufficient to provide the coverage determined to be necessary.

Department Comment

We concur with the need for adequate cost and performance data to set each PRO's contract funding level and will continue to improve the base upon which its estimates are predicated. Under the current PRO scope of work, PROs are required to report cost data. In addition, HCFA has initiated plans to conduct engineering studies in several PRO areas which will validate the time required to perform various review functions and the associated cost of such efforts. This information should assist us in establishing individual PRO funding levels and negotiating PRO contracts for the third scope of work.

This recommendation resulted from the finding that HCFA cost estimates were based on a model which reflected significant uncertainties (percent of cases reviewed and cost per case). The national funding model utilized to develop the Government estimates was designed to serve as a tool (not a hard and fast rule) for negotiators to evaluate each PRO's cost proposal and make adjustments for justifiable differences.

As GAO stated, HCFA's funding model was based on data from HCFA's actuary, the Department of Labor, professional medical associations and the individual PROs. It also incorporated professional estimates of the time elements needed to perform required review functions.

HCFA found the funding model extremely valuable in negotiating PRO contracts. The conclusion reached by GAO that the overall average cost contracted per review was less than 2 percent above the cost estimated by the HCFA model is evidence that the HCFA model was indeed effective and appropriate. As emphasized above, HCFA is continuing to seek ways to improve the model upon which PRO estimates are based.



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Figure 1. Schematic representation of the experimental design. The subjects were divided into two groups: the control group and the experimental group. The control group was divided into two subgroups: the control group and the control group. The experimental group was divided into two subgroups: the experimental group and the experimental group.

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97. *Chlorophyll arz* (Chl *arz*)
98. *Chlorophyll asz* (Chl *asz*)
99. *Chlorophyll atz* (Chl *atz*)
100. *Chlorophyll auz* (Chl *auz*)
101. *Chlorophyll avz* (Chl *avz*)
102. *Chlorophyll awz* (Chl *awz*)
103. *Chlorophyll axz* (Chl *axz*)
104. *Chlorophyll ayz* (Chl *ayz*)
105. *Chlorophyll ayz* (Chl *ayz*)
106. *Chlorophyll azz* (Chl *azz*)
107. *Chlorophyll azaa* (Chl *aza*)
108. *Chlorophyll abz* (Chl *abz*)
109. *Chlorophyll acz* (Chl *acz*)
110. *Chlorophyll adz* (Chl *adz*)
111. *Chlorophyll aez* (Chl *aez*)
112. *Chlorophyll afz* (Chl *afz*)
113. *Chlorophyll agz* (Chl *agz*)
114. *Chlorophyll ahz* (Chl *ahz*)
115. *Chlorophyll aiz* (Chl *aiz*)
116. *Chlorophyll ajz* (Chl *ajz*)
117. *Chlorophyll akz* (Chl *akz*)
118. *Chlorophyll alz* (Chl *alz*)
119. *Chlorophyll amz* (Chl *amz*)
120. *Chlorophyll anz* (Chl *anz*)
121. *Chlorophyll aoz* (Chl *aoz*)
122. *Chlorophyll apz* (Chl *apz*)
123. *Chlorophyll aqz* (Chl *aqz*)
124. *Chlorophyll arz* (Chl *arz*)
125. *Chlorophyll asz* (Chl *asz*)
126. *Chlorophyll atz* (Chl *atz*)
127. *Chlorophyll auz* (Chl *auz*)
128. *Chlorophyll avz* (Chl *avz*)
129. *Chlorophyll awz* (Chl *awz*)
130. *Chlorophyll axz* (Chl *axz*)
131. *Chlorophyll ayz* (Chl *ayz*)
132. *Chlorophyll ayz* (Chl *ayz*)
133. *Chlorophyll azz* (Chl *azz*)
134. *Chlorophyll azaa* (Chl *aza*)
135. *Chlorophyll abz* (Chl *abz*)
136. *Chlorophyll acz* (Chl *acz*)
137. *Chlorophyll adz* (Chl *adz*)
138. *Chlorophyll aez* (Chl *aez*)
139. *Chlorophyll afz* (Chl *afz*)
140. *Chlorophyll agz* (Chl *agz*)
141. *Chlorophyll ahz* (Chl *ahz*)
142. *Chlorophyll aiz* (Chl *aiz*)
143. *Chlorophyll ajz* (Chl *ajz*)
144. *Chlorophyll akz* (Chl *akz*)
145. *Chlorophyll alz* (Chl *alz*)
146. *Chlorophyll amz* (Chl

1. *Phragmites australis* (Cav.) Trin. ex Steud.

$\mu = 1$
 $\mu = 1$
 $\mu = 1$

Figure 1

[illegible]

1. *Chlorophyll a* (Chl *a*)

1. We agree that deficiencies in PRO operations should be pointed out to the PRO as early in the contract cycle as possible. Waiting for the final evaluation before deficiencies are uncovered is not fair to the PRO that has assumed HCFA is satisfied with operations until that point. In addition, it does not permit time for corrective action.
2. We agree that PROMPTS-2 is an improvement over earlier evaluation instruments. We strongly share GAO's concern, however, that PROMPTS-2 lacks specific criteria to measure acceptable or unacceptable performance. Without defined criteria, the subjective judgments of different HCFA personnel will continue to influence final evaluations of PROs. AMPRA strongly endorses the recommendation that specific and objective evaluation criteria be developed.

Appendix IV
Comments From the American Medical Peer
Review Association

Page Two
August 30, 1987
Mr. Fogel

3. AMPRA strongly recommends that each PRO, as part of the evaluation process, be able to examine and rebut the "independent analysis" prepared by HCFA regional office personnel. Further, final evaluation panel findings, recommendations and numerical scores should be shared with every PRO. For PROs that are non-renewed, it is particularly important that all evaluation materials be shared so a specific rebuttal to all identified deficiencies can be possible. Non-renewed PROs received a generalized summary of deficiencies in the form of a letter when only a complete set of evaluation materials will permit a thorough response. For renewed PROs, the complete set of evaluation materials can only assist in identifying weaknesses in PRO operations that need improvement.
4. AMPRA remains perplexed by the relationship of SuperPRO to the PRO evaluations. It appears that SuperPRO had little or no influence on final determinations. Furthermore, it has been AMPRA's observation that the SuperPRO efforts to monitor medical review decisions by PROs duplicates regional office medical review team oversight. AMPRA recommends that the role of the SuperPRO be clarified and that a single entity be given responsibility to monitor PRO medical review determinations.
5. AMPRA strongly concurs with the GAO report findings on PRO funding. It has been obvious that HCFA has consistently funded the PRO program at the legal minimum required by law. AMPRA believes that this minimum level is grossly inadequate to fund labor intensive quality reviews and new congressionally mandated review activities. Furthermore, we agree that "HCFA used several assumptions to develop its initial cost estimates for PRO contracts which result in a degree of uncertainty about these estimates". AMPRA believes that HCFA significantly underestimated the time PRO reviewers would take to review cases in the second round of PRO contracts. An AMPRA survey shows that review time has more than doubled and that both physician referrals and the time it takes a physician to review cases has jumped significantly. This increased review "intensity" was not offset by the decrease in volume of review in the second round of contracts. For nearly every PRO, review expenses exceed review costs.

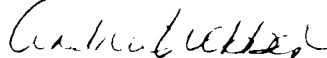
AMPRA recommends that HCFA renegotiate the base contracts in recognition of the fact that their cost estimates and assumptions were "uncertain" and now proved wrong by actual PRO experience. For the future, AMPRA recommends that HCFA cost estimates be developed in recognition of actual PRO review costs and shared with the PRO community.

Appendix IV
Comments From the American Medical Peer
Review Association

Page Three
August 30, 1987
Mr. Fogel

Once again, AMPRA appreciates the opportunity to comment on GAO's report. We sincerely hope that report recommendations will be implemented.

Sincerely,



Andrew H. Webber
Executive Vice President

END

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