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IMPLEMENTATION OF PRO'S FOR MEDICARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

FEBRUARY 1, 1984

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IMPLEMENTATION OF THE PRO'S FOR MEDICARE

WEDNESDAY, FEBRUARY 1, 1984

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:02 a.m., in room SD-215, Dirksen Senate Office Building, the Honorable David Durenberger (chairman) presiding.

Present: Senators Durenberger and Bradley.

[The press releases announcing the hearing and statements of Senators Durenberger and Dole follow:]

[Press Release No. 84-101, January 3, 1984]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SCHEDULES HEARING ON IMPLEMENTATION OF PEER REVIEW ORGANIZATIONS FOR MEDICARE

Senator Dave Durenberger (R., Minn.), Chairman of the Subcommittee on Health of the Senate Committee on Finance announced today, that the Subcommittee will hold a hearing on the implementation of the Peer Review Organizations (PRO's) required by the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248.

The hearing will be held on Monday, January 30, 1984, beginning at 1:30 p.m. in Room SD-215 of the Dirksen Senate Office Building.

In announcing the hearing, Senator Durenberger stated that "PRO's are essential to insuring the provision of quality care under the prospective payment system adopted for medicare inpatient hospital services. While strengthening the existing program of peer review, PRO's also provide safeguards against inappropriate utilization and "gaming" of the prospective payment system. The timetable set for PRO implementation, however, will not be met if the administration continues to delay the publication of PRO regulations and withholds issuance of requests for proposals from organizations eligible to provide peer review on a contract basis."

Senator Durenberger noted that the Subcommittee is interested in hearing from the administration on how it expects to meet its responsibility for establishing fully operational PRO's on a timely basis. The Subcommittee is also interested in hearing from peer review organizations as to how an orderly transition from current operations to the new PRO's can be assured.

[Press Release 84-101, Revised, January 23, 1984]

FINANCE HEALTH SUBCOMMITTEE ANNOUNCES CHANGE OF DATE AND TIME FOR HEARING ON IMPLEMENTATION OF PEER REVIEW ORGANIZATIONS FOR MEDICARE

Senator Dave Durenberger (R., Minn.), Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today, time and date changes for the hearing on the Peer Review Program, scheduled for Monday, January 30, 1984.

The hearing will begin at 10:00 a.m. on Wednesday, February 1 in Room SD-215 of the Dirksen Senate Office Building.

OPENING STATEMENT OF SENATOR DAVE DURENBERGER

We're here today to talk about the medicare peer review program. This program was passed on August 17, 1982. The President signed it on September 8, 1982. Now, 17 months later, we're still waiting for the program to be implemented. Final regulations are 4 months overdue, with no indication when they will be forthcoming. Today? Tomorrow? A year from now?

These delays are irresponsible and unacceptable. They threaten the effectiveness of the DRG system which needs peer review to function smoothly. And DRG's have been in place for 4 months. The delays threaten public confidence, too. It's no wonder the Federal Government gets a bad rap when we get this kind of response. Today, I intend to find out why.

Times are changing dramatically for American medicine. The high cost of health care has forced us all to pay more attention to price. Government has responded. With the passage of the medicare prospective payment system, hospitals are, for the first time, being rewarded for cost-effective management strategies. Every day I hear about how we are beginning to get rid of some of the inefficiencies in the medicare program.

Increased attention to price in health care has also increased the demand for accountability. The demand for accountability will be made by the purchasers of health care—by business, by Government, and by patients. The new PRO program is designed to meet this need. The PRO program will be based on performance contracts. If objective goals are not met, contracts will be terminated. The incentives for quality performance in PRO's are set in place.

The importance of quality in the provision of cost-effective health care cannot be overlooked. It is for this reason I insisted on physician involvement in the PRO program. Who else but physicians can assess the quality and quantity of medical care? Would you trust an insurance company employee to tell you how long your mother needs to stay in the hospital? Or whether she needs to be admitted to the hospital for her fever?

And the alternative to peer review? Review by fiscal intermediaries. At best, fiscal intermediaries would be able to monitor cost and utilization patterns. Only physicians can assure that quality standards of practice are maintained. The new peer review legislation provides the last opportunity for independent PRO's to play a significant role in medical review. It is important to assure that this opportunity is guaranteed.

Each day of delay in the publication of the PRO regulations is threatening physician involvement in utilization review—threatening peer review. According to the law, PRO's are to be in place by October 1. As the October deadline approaches, the time potential bidders to negotiate contracts becomes strictly limited. The entire peer review system is jeopardized by this delay.

I am looking forward to finding out the reasons for the delay. I hope we will be able to address the issues raised and get on with implementation of the PRO system as quickly as possible.

OPENING STATEMENT OF SENATOR BOB DOLE

The prospective payment system we adopted for medicare creates an environment where hospitals are encouraged to provide care in the most efficient manner possible. At the same time, however, we also want to ensure that quality is maintained.

The Department of Health and Human Services is responsible for implementing a program of utilization and quality control peer review which we, in the Congress, created to safeguard against any decline in the quality of care available to our Nation's elderly. Whether that program can be implemented in a timely manner is being questioned. I would hope that it can, not only to meet the October deadline imposed on hospitals for participation in the medicare program but, more importantly, to take advantage of the resources available in the existing PSRO program before that program expires.

There are a great many reasons for concern about the timetable for PRO implementation including those related to the ability of organizations to prepare their applications for participation. I am anxious to hear from the Department on where we stand on implementation of a program which is essential to maintaining quality care.

Senator DURENBERGER. The hearing will come to order.

We are here today to talk about the medicare peer review program. The program was passed into law on August 17, 1982; the

President signed it on September 3, 1982; 17 months later, today, we are still waiting for the program to be implemented. Final regulations are 4 months overdue, and there is no indication that they will be forthcoming today, tomorrow, or 1 year from now.

These delays are irresponsible, and they are unacceptable. They threaten the effectiveness of the DRG system which was passed into law 11 months ago and which needs peer review in order to function smoothly. DRG's, as a prospective payment system for medicare, have been in place in this country for 4 months. The delays in peer review threaten public confidence in the system. It is no wonder that the Federal Government gets a bum rap when we get this kind of a response, and today we intend to find out why.

Times are changing dramatically for American medicine and for the health-care delivery system. The high cost of health care has forced each of us to pay more attention to the price of our health, and government has responded on behalf of those who pay into the trust fund for medicare each day, on behalf of the eligible beneficiaries of medicare who are frightened of the prospect of its potential bankruptcy and of the apparent unwillingness of workers in America to pay any more to fund the system. Government had to respond. With the passage of the medicare prospective payment system, hospitals in this country, for the first time, have an incentive or have a reward for cost-effective health-management strategies. Every day I hear about how we are beginning to get rid of some of the inefficiencies in the medicare program and to save money for beneficiaries and for the trust fund.

Increased attention to price and health care has also increased the demand for accountability. The demand for accountability will be made by purchasers of health care—the businesses, the workers in those businesses, government, and by patients. The new PRO program has been designed to meet this need. The PRO program is based on performance contracts. If objective goals are not met, contracts will be terminated. The incentives for quality performance in peer review are set in place.

The importance of quality in the provision of cost-effective health care cannot be overlooked. It is for this reason we insisted on physician involvement in the peer review program. Who else but physicians can assess the quality as well as quantity of medical care? Would you trust an insurance company employee to tell you how long your mother needs to stay in the hospital, or whether she needs to be admitted to the hospital for a fever?

And the alternative to peer review? Review by fiscal intermediaries. At best, fiscal intermediaries would be able to monitor costs and utilization patterns. But only physicians can assure that quality standards of practice are maintained.

The new peer review legislation provides the last opportunity for independent peer review organizations to play a significant role in medical review. It is important to assure that this opportunity is guaranteed. Each day of delay in the publication of the PRO regulations is threatening physician involvement in utilization review and threatening peer review. Each day threatens the success of the prospective payments system. Each day threatens our efforts to

provide affordable access, to high-quality health care for everyone in this country.

According to the law, peer review organizations are supposed to be in place on October 1, 1984. As that deadline approaches, the time for potential bidders to negotiate contracts becomes strictly limited. The entire peer review system is jeopardized by this delay, and I would say the future of medicare is jeopardized as well.

So I am looking forward to finding out the reasons for all of this delay. I hope we will be able to address the issues raised and get on with the implementation of the peer review system as quickly as possible.

Having said that, we will turn to one of the responsible parties. We will pick on Jim Scott. [Laughter.]

Who finds himself in the position, as Associate Administrator for Operations of the Health Care Financing Administration in the U.S. Department of Health and Human Services, of having to respond for this administration to the problems that at least one Senator perceives, as I have just articulated.

Jim, welcome. I appreciate your being here and look forward to your statement.

STATEMENT OF JAMES L. SCOTT, ASSOCIATE ADMINISTRATOR FOR OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Mr. SCOTT. Senator, we have a full statement that we would like to submit for the record, and at this time I would like to read just an abbreviated version of that.

Senator DURENBERGER. Your full statement will be made part of the record.

Mr. SCOTT. Thank you, sir.

I am pleased to be here today to discuss the efforts the Health Care Financing Administration is taking to implement the peer review organization [PRO] program. We share your interest in assuring that the recently enacted prospective-payment system, which was initiated both by the Congress and the administration, has in place an appropriate mechanism to assure that high-quality medical care in hospitals continues to be delivered in this country and that payments continue to be appropriate. We believe that the peer review organization program will accomplish that goal.

Let me emphasize at the outset that the complexity of the new payment system itself and its accompanying medical-review requirement do present an enormous challenge to our Department. However, the Health Care Financing Administration continues to plan on implementing the PRO program by the October 1 date mandated in the statute.

In addition, I am pleased to announce that the administration has in its 1985 budget, which will be released today, full funding for the PRO program for the next fiscal year. We anticipate that the PRO's will provide a significant improvement in medical review when compared to the previous PSRO program.

In addition, Senator, we believe that by close, timely, and forceful administration of the PRO contracts we will be able to identify

and address quickly any evidence of problems or obstacles in meeting agreed-upon objectives.

As you indicated, the prospective-payment plan has very much changed the incentives involved in the provision of hospital care to medicare beneficiaries. We have also changed our emphasis on medical review. Until PRO's are implemented, our professional standards review organizations PSRO's, and fiscal intermediaries in parts of the country not covered by PSRO's will perform medical review.

We believe that the PRO program will redirect, simplify, and enhance the cost effectiveness of peer review in medicare. The intent of the new provisions and our regulations under various stages of development is to direct review activities toward those areas most likely to have quality and utilization issues related to the new prospective-payment system.

In implementing the PRO program, we continue to depend upon the medical community for support and help to provide the protection necessary against what I believe are some unique temptations under prospective payments for gaming the system. Recognizing these unique temptations, the Congress itself specified that PROs address the validity of DRG assignments, the appropriateness of admissions and readmissions, the provision of outlier care, and the maintenance of quality of care.

Clearly, the overwhelming majority of hospitals and physicians in this country provide high-quality medical care. We expect that they will continue to do so and that any disallowances under the new review programs underway will be the exception, not the rule. However, there are some specific areas that we feel must be addressed under prospective payment, because we have a major responsibility to not only the patients but also to the taxpayers to assure that funds are being expended appropriately. These areas are: the question of unnecessary admissions, unnecessary patient transfers that might take place to maximize reimbursement, premature patient discharge, and service underutilization.

Senator, I would now like to discuss some of the regulations that you mentioned that will compose the structural framework for PRO implementation.

The most important of these is the area designation and eligible organizations regulation. On August 15, 1983, we issued a proposed rule in the Federal Register that would lead to the establishment of the necessary preconditions for PRO implementation. We received over 200 comments in response to that draft regulations from not only the major associations interested in medical review but also from many individual physicians and hospitals. This draft regulation now being finalized has been revised, to incorporate a number of the comments received in response to the August 15 notice.

I can report that the final regulation is in the final stages of review within the administration, and we expect it to be published in the very near future.

Senator DURENBERGER. What does that mean? What does "within the administration" mean?

Mr. SCOTT. We have a review process, Senator, that involves clearance within the agency, which has been completed, clearance

within the Department, and then final review by the Executive Office of the President. And they have completed departmental clearance, sir.

In addition to the area designation and eligible organizations regulation, there are a number of other regulations that are in the process of being developed. These, briefly, relate to the conduct of review, the relationship of PRO's with the medicaid agencies, reconsiderations and appeals, confidentiality, and, finally, a proposed rule that will define the process for PRO's to initiate sanctions. Each of these regulations has been drafted, and is currently under departmental review. We expect them to be published shortly as "Notices of Proposed Rulemaking" for public comment.

Immediately after the final regulation concerning PRO area designations and eligible organizations is published, we expect to release the request for proposals for PRO contracts in all areas.

On August 29, we published a notice in the Federal Register inviting comments on the proposed scope of work. We have analyzed these comments and revised accordingly the scope of work. I should mention, Senator, that many of the people who are going to be testifying here later participated in the discussions with us and provided a number of very useful, very helpful suggestions for improvements to the scope of work.

The scope of work contains the following major provisions:

Under quality objectives, we will ask PRO's to reduce unnecessary hospital readmissions that result from poor care during a prior admission; to assure the completeness of treatment; to reduce unnecessary surgery; and to reduce avoidable postoperative complications. Specifically, many of the people who reviewed our initial draft on the scope of work in the fall of last year commented that the quality objectives needed to be greatly strengthened. I can report at this time that the draft scope of work that will be a part of the RFP has greatly enhanced and strengthened quality objectives.

In addition, the scope of work will also include certain mandated admission objectives: To reduce inappropriate readmissions, to reduce the number of admissions for services usually performed on an outpatient basis, and to reduce the number of inappropriate transfers to exempt units—that is, units that are not covered by the prospective-payment system. The scope of work will also include admission pattern monitoring, which is one of the monitoring devices we have developed.

In addition, we expect the scope of work will require the selective use of preadmission or preprocedure review as techniques for meeting contract objectives. We believe these approaches will be applied by PROs in those situations where the greatest potential for inappropriate admissions or the provision of unnecessary or incorrect care exists.

As you indicated, the contracts will be awarded on a performance basis so that the Health Care Financing Administration will know up front what to expect in the cost of review. Conversely, the PRO's will also know up front what performance standards they will be expected to meet in exchange for the funds that they will receive.

I should note that we will scrutinize all proposals carefully for responsiveness to the scope of work and the capacity to actually accomplish the review function.

We do not plan to make an award unless we are convinced that such an award would be in the best interests of the medicare program.

In conclusion, Mr. Chairman, we recognize that in creating the prospective-payment system, the Congress and the administration made a long-term commitment to changing incentives in the health-care sector to reward cost effective behavior.

In addition, in order to assure that high quality patient care continues to be provided, the Congress mandated a strong quality control mechanism. We believe that the vast majority of physicians and hospitals will continue to provide high quality and appropriate care. However, it is our responsibility to assure that this is the case. Each PRO will be obligated to conduct meaningful quality review and achieve significant impact on the quality of care furnished in its area.

Clearly, there is much to learn as experience with prospective payment and the attending medical review activity grows, and we fully expect the program to be flexible and improve over time. But this I can assure you: The Health Care Financing Administration has set a high priority on developing and implementing an effective medical review system which will examine both the cost and quality of care.

I trust that you found these comments useful, and I will try to answer any questions you might have, sir.

Senator DURENBERGER. Thank you very much for your statement.

[Mr. Scott's prepared statement follows:]

STATEMENT OF

JAMES L. SCOTT

ASSOCIATE ADMINISTRATOR FOR OPERATIONS

HEALTH CARE FINANCING ADMINISTRATION

INTRODUCTION

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM PLEASED TO BE HERE TODAY TO DISCUSS THE EFFORTS THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) IS TAKING TO IMPLEMENT THE PEER REVIEW ORGANIZATION (PRO) PROGRAM. WE SHARE THE INTEREST OF THIS SUBCOMMITTEE IN ASSURING THAT THE RECENTLY ENACTED PROSPECTIVE PAYMENT SYSTEM (PPS), WHICH WAS INITIATED BY THE CONGRESS AND THE ADMINISTRATION, HAS IN PLACE A MECHANISM TO ENSURE THAT HIGH QUALITY MEDICAL CARE IN HOSPITALS CONTINUES TO BE DELIVERED IN THIS COUNTRY AND THAT PAYMENTS CONTINUE TO BE APPROPRIATE. THE PRO PROGRAM WILL DO THAT.

HIGH QUALITY MEDICAL CARE HAS A LONG-STANDING TRADITION IN THIS NATION, AND THIS SUBCOMMITTEE HAS BEEN IN THE VANGUARD OF EFFORTS TO MAINTAIN THIS STANDARD. WE BELIEVE THAT THE NEW PROSPECTIVE PAYMENT SYSTEM BUILDS UPON THAT TRADITION AND WILL ENABLE US TO CONTINUE OUR COMMITMENT TO ASSURING HIGH QUALITY MEDICAL CARE.

LET ME EMPHASIZE AT THE ONSET THAT THE COMPLEXITY OF THE NEW PAYMENT SYSTEM AND ITS ACCOMPANYING MEDICAL REVIEW REQUIREMENT PRESENT AN ENORMOUS CHALLENGE TO OUR DEPARTMENT. HOWEVER, HCFA CONTINUES TO PLAN ON IMPLEMENTING THE PRO PROGRAM BY THE OCTOBER 1 DATE MANDATED IN THE STATUTE.

IN ADDITION, I AM PLEASED TO ANNOUNCE THAT THE ADMINISTRATION EXPECTS TO FULLY FUND THE PRO PROGRAM DURING THE NEXT FISCAL YEAR. MOST OF ALL, LET ME ASSURE YOU THAT THIS ADMINISTRATION -- AND MOST ASSUREDLY HCFA -- SHARES IN YOUR CONCERN AND CONSIDERS IMPLEMENTATION OF THE PRO PROGRAM ONE OF ITS HIGHEST PRIORITIES. WE HAVE LEARNED FROM THE PSRO EXPERIENCE AND, AS A RESULT, EXPECT A MORE VIGOROUS AND ACCOUNTABLE PROGRAM. THROUGH AGGRESSIVE MANAGEMENT OF THE CONTRACT PROCESS, TAILORED TO THE UNIQUE FEATURES OF THIS PROGRAM, WE ANTICIPATE SIGNIFICANT IMPROVEMENT IN RESULTS WHEN COMPARED TO THE PSRO PROGRAM. ADDITIONALLY, BY CLOSE, TIMELY AND FORCEFUL ADMINISTRATION OF THE CONTRACT, WE WILL BE ABLE TO IDENTIFY AND ADDRESS QUICKLY ANY EVIDENCE OF PROBLEMS OR OBSTACLES IN MEETING AGREED-UPON OBJECTIVES. THE PRO LEGISLATION, AS DRAFTED BY YOUR SUBCOMMITTEE AND PASSED BY THE CONGRESS, PROVIDES US WITH THE OPPORTUNITY TO CREATE A MORE EFFICIENT AND STONGER PROGRAM. WE EXPECT TO DO SO AND I LOOK FORWARD TO EXCHANGING VIEWS WITH YOU ON THIS IMPORTANT TOPIC.

INITIATION OF PROSPECTIVE PAYMENT

AS YOU KNOW, THE SOCIAL SECURITY AMENDMENTS OF 1983 (P.L. 98-21) CHANGED THE METHOD OF PAYMENT FOR MEDICARE INPATIENT HOSPITAL SERVICES FROM A COST-BASED, RETROSPECTIVE REIMBURSEMENT SYSTEM TO A PROSPECTIVE PAYMENT SYSTEM BASED ON DIAGNOSIS

RELATED GROUPS (DRGs). THE AMENDMENTS ALSO MANDATED THAT BY OCTOBER 1, 1984, AS A CONDITION FOR CONTINUED MEDICARE REIMBURSEMENT, ALL HOSPITALS UNDER THE PPS MUST HAVE AGREEMENTS WITH UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATIONS TO PERFORM MEDICAL REVIEW. PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSROs), ALONG WITH OUR PROGRAM INTERMEDIARIES, WILL CONTINUE TO PERFORM MEDICAL REVIEW UNTIL A PRO CONTRACT IS AWARDED FOR THE AREAS WHICH THEY COVER. THE PRO PROGRAM WILL REDIRECT, SIMPLIFY, AND ENHANCE THE COST-EFFECTIVENESS OF PEER REVIEW UNDER MEDICARE. THE INTENT OF THE NEW PROVISIONS, AND OUR REGULATIONS UNDER VARIOUS STAGES OF DEVELOPMENT, IS TO DIRECT REVIEW ACTIVITIES TOWARD THOSE AREAS MOST LIKELY TO HAVE QUALITY AND UTILIZATION ISSUES RELATED TO THE NEW PPS. IN DEFINING THE PRO REVIEW SYSTEM, WE BEGAN WITH THE REQUIREMENTS SPECIFIED IN THE STATUTE WHICH INCLUDE REVIEW OF:

- THE VALIDITY OF DIAGNOSTIC AND PROCEDURAL INFORMATION PROVIDED BY HOSPITALS;

- THE COMPLETENESS, ADEQUACY, AND QUALITY OF CARE PROVIDED;

- THE APPROPRIATENESS OF ADMISSIONS AND DISCHARGES; AND

- THE APPROPRIATENESS OF CARE FOR WHICH OUTLIER PAYMENTS ARE MADE.

LATER IN MY STATEMENT I WILL DISCUSS IN MORE DETAIL THE SPECIFIC PRO REVIEW OBLIGATIONS WHICH WILL BE INCLUDED IN CONTRACTS BETWEEN HCFA AND PROS. THESE CONTRACTS WILL SPECIFY THE ACTIVITIES TO BE UNDERTAKEN AND ACHIEVED BY PROS. HOWEVER, I WOULD LIKE TO NOTE AT THIS POINT ONE SPECIAL OR OCCASIONAL CONTRACTUAL ACTIVITY FOR PROS THAT WE BELIEVE IS PARTICULARLY IMPORTANT FOR OUR OVERALL PROGRAM SAFEGUARDS. WHEN ASKED BY THE DEPARTMENT, A PRO WILL BE REQUIRED TO PARTICIPATE IN STUDIES OR INVESTIGATIONS OF ABUSIVE PRACTICES BY PROVIDERS IN THE MEDICARE PROGRAM. WE BELIEVE THE EXPERTISE A PRO WILL HAVE TO OFFER CAN BE PARTICULARLY HELPFUL IN THIS AREA.

THE IMPORTANCE OF MEDICAL REVIEW

PHYSICIANS HAVE MADE A TREMENDOUS CONTRIBUTION TO THE MEDICARE PROGRAM IN PROVIDING HIGH QUALITY CARE TO OUR BENEFICIARIES. BUT, MORE THAN EVER BEFORE, PHYSICIANS MUST RECOGNIZE THAT THEY MUST PRACTICE IN AN ENVIRONMENT OF LIMITED RESOURCES.

THE MEDICAL COMMUNITY, OVER THE PAST 60 YEARS, HAS PIONEERED THE CONCEPT OF REVIEWING HEALTH CARE PRACTICES TO DETERMINE THE QUALITY OF CARE AND THE APPROPRIATENESS OF SERVICES PROVIDED. WE EXPECT TO BUILD ON THIS COMMENDABLE TRADITION AND BELIEVE THAT RIGOROUS PEER REVIEW NEED NOT BE VIEWED AS A BURDEN. IN FACT, THE PPS LEGISLATION PROVIDES AN OPPORTUNITY FOR PHYSICIANS TO CONTINUE TO HAVE A SIGNIFICANT ROLE IN MEDICAL REVIEW. WE ARE DEPENDING ON THE MEDICAL COMMUNITY TO ASSIST US IN SUCCESSFULLY IMPLEMENTING THE PROGRAM AND HELP TO PROVIDE PROTECTION AGAINST THE UNIQUE TEMPTATIONS UNDER PPS FOR "GAMING" THE SYSTEM. RECOGNIZING THESE UNIQUE TEMPTATIONS, CONGRESS SPECIFIED THAT PROS ADDRESS THE VALIDITY OF DRG ASSIGNMENTS, THE APPROPRIATENESS OF ADMISSIONS AND READMISSIONS, OUTLIERS, AND MAINTENANCE OF QUALITY OF CARE.

CLEARLY, THE OVERWHELMING MAJORITY OF HOSPITALS AND PHYSICIANS PROVIDE HIGH QUALITY MEDICAL CARE. WE EXPECT THAT THEY WILL CONTINUE TO DO SO AND THAT ANY DISALLOWANCES UNDER THE NEW REVIEW PROGRAM WILL BE THE EXCEPTION, NOT THE RULE. HOWEVER, THERE ARE FIVE SPECIFIC AREAS THAT MUST BE ADDRESSED UNDER THE PROSPECTIVE PAYMENT SYSTEM BECAUSE OF OUR RESPONSIBILITY TO BOTH PATIENTS AND TAXPAYERS TO ASSURE THAT EFFICIENT AND HIGH QUALITY CARE IS PROVIDED. THEY ARE:

- UNNECESSARY ADMISSIONS;
- CASE OVERCOMPLICATION;
- UNNECESSARY PATIENT TRANSFERS;
- PREMATURE PATIENT DISCHARGE; AND
- SERVICE UNDERUTILIZATION.

THESE CONCERNS REPRESENT HCFA'S IMPLEMENTATION STRATEGY FOR THE NEW MEDICAL REVIEW SYSTEM TO ASSURE THAT ADEQUATE PAYMENT SAFEGUARDS ARE INCLUDED IN PPS. I WOULD NOW LIKE TO DISCUSS SOME OF THE REGULATIONS WHICH WILL COMPOSE THE STRUCTURAL FRAMEWORK FOR PRO IMPLEMENTATION.

AREA DESIGNATION AND ELIGIBLE ORGANIZATIONS

ON AUGUST 15, 1983, WE ISSUED A PROPOSED RULE IN THE FEDERAL REGISTER THAT WOULD LEAD TO THE ESTABLISHMENT OF THE NECESSARY PRECONDITIONS FOR PRO IMPLEMENTATION. FIRST, THE PRO PROVISION REQUIRES THE SECRETARY TO CONSOLIDATE EXISITING PSRO AREAS SO THAT EACH STATE IS GENERALLY DESIGNATED AS A STATEWIDE PRO AREA.

SECOND, THE PROVISION REQUIRES THAT ORGANIZATIONS, IN ORDER TO BE ELIGIBLE TO BECOME PROS, MUST BE EITHER "PHYSICIAN-SPONSORED" OR "PHYSICIAN-ACCESS." PHYSICIAN-SPONSORED ORGANIZATIONS MUST BE COMPOSED OF A "SUBSTANTIAL" NUMBER OF THE COMBINED POPULATION OF LICENSED DOCTORS OF MEDICINE AND OSTEOPATHY PRACTICING IN THE REVIEW AREA AND BE "REPRESENTATIVE" OF THESE PHYSICIANS. PHYSICIAN-ACCESS ORGANIZATIONS MUST HAVE AVAILABLE TO THEM A SUFFICIENT NUMBER OF LICENSED PRACTICING PHYSICIANS IN THE REVIEW AREA.

PHYSICIAN-ACCESS ORGANIZATIONS WOULD MEET THE "AVAILABILITY" TEST BY DEMONSTRATING THAT THE NUMBER AND TYPES OF PHYSICIANS AVAILABLE TO THEM IS ADEQUATE TO CARRY OUT THE REVIEW PLAN WHICH THEY PROPOSE. THE PROPOSED RULE REQUIRES THAT, AT A MINIMUM, THE ORGANIZATION HAVE AVAILABLE TO IT AT LEAST ONE SPECIALIST IN EVERY GENERALLY RECOGNIZED SPECIALTY PRACTICED IN THE AREA.

THE STATUTE AND THE PROPOSED RULE PROHIBIT CONTRACTING WITH A HEALTH CARE FACILITY OR AN ASSOCIATION OF FACILITIES WHICH PROVIDES SERVICES IN THE AREA THAT THE PRO WOULD REVIEW. IN ADDITION, WE WOULD PRECLUDE CONTRACTING WITH AN ORGANIZATION THAT IS AFFILIATED WITH, THROUGH MANAGEMENT, OWNERSHIP, OR CONTROL, A HEALTH CARE FACILITY, OR ASSOCIATION OF FACILITIES IN THAT AREA.

FINALLY, IN OPENING PRO ELIGIBILITY TO ORGANIZATIONS WITH ACCESS TO PHYSICIAN SERVICES, THE CONGRESS RECOGNIZED THE UTILITY OF HEALTH CARE FACILITIES OR INSURANCE ORGANIZATIONS (SOME OF WHICH ALREADY HAVE FISCAL INTERMEDIARY CONTRACTS UNDER MEDICARE) BECOMING PROS. HOWEVER, WHILE ELIGIBILITY FOR PRO CONTRACTS WAS EXPANDED, THE AMENDMENTS INCLUDE CERTAIN EXCEPTIONS AND PRIORITIES. FOR EXAMPLE, A PAYOR ORGANIZATION CAN BE A PRO IN THE AREA IT SERVICES ONLY AFTER OCTOBER 1, 1984.

THESE DRAFT REGULATIONS ARE NOW BEING PREPARED AS A FINAL RULE AND HAVE BEEN REVISED TO INCORPORATE A NUMBER OF THE COMMENTS ON THE AUGUST 15 NOTICE. THEY ARE IN THE FINAL STAGE OF REVIEW AND WE EXPECT THAT THEY WILL BE PUBLISHED IN THE NEAR FUTURE.

I WOULD NOW LIKE TO IDENTIFY THE OTHER RULES WE HAVE UNDER DEVELOPMENT TO FURTHER GUIDE THE PRO PROGRAM. THESE DRAFT REGULATIONS ARE ON A FAST TRACK IN OUR AGENCY BECAUSE OF THE NEED FOR QUICK IMPLEMENTATION. HOWEVER, WE WANT THESE REGULATIONS TO BE THE BEST POSSIBLE AND WE WILL PROVIDE AN OPPORTUNITY FOR PUBLIC COMMENT WHEN THEY ARE ISSUED. IT SHOULD ALSO BE NOTED THAT THE PROGRAM CAN BE IMPLEMENTED

EVEN IF THESE REGULATIONS ARE NOT FINALIZED, THEY ARE AS FOLLOWS:

- A PROPOSED RULE ON CONDUCT OF REVIEW WILL OUTLINE THE RELATIONSHIP WHICH WILL EXIST AMONG PROS, FISCAL INTERMEDIARIES, PROVIDERS, AND BENEFICIARIES WHEN PROS ASSUME RESPONSIBILITY FOR REVIEW. IT WILL ALSO OUTLINE PRO UTILIZATION AND QUALITY REVIEW FUNCTIONS.

- ANOTHER PROPOSED RULE WILL DESCRIBE THE MEDICAID PROGRAM'S RELATIONSHIP WITH PROS WHICH IS, BY STATUTE, THE SAME AS THAT WHICH EXISTS BETWEEN MEDICAID STATE AGENCIES AND PSROS TODAY. STATES MAY, AT THEIR OPTION, CONTRACT WITH PROS TO PERFORM REVIEW OF MEDICAID SERVICES. IF THEY DO SO, THE STATE WILL BE ELIGIBLE FOR 75 PERCENT FEDERAL FINANCIAL PARTICIPATION (FFP) FOR THE COSTS OF SUCH REVIEW, AS LONG AS THE REVIEW IS NOT INCONSISTENT WITH THE REVIEW THE PRO IS CONDUCTING UNDER MEDICARE.

- A PROPOSED RULE ON RECONSIDERATIONS AND APPEALS WILL SET FORTH POLICIES AND PROCESSES BY WHICH DETERMINATIONS OF PROS WILL BE SUBJECT TO RECONSIDERATION AND FURTHER APPEALS. THE BASIC POLICY IS THAT A BENEFICIARY, PRACTITIONER, OR PROVIDER DISSATISFIED WITH A PRO'S INITIAL ADVERSE DETERMINATION, I.E., DENIAL, IS ENTITLED TO A RECONSIDERATION

FROM THE PRO. ADDITIONALLY, IN ACCORDANCE WITH SPECIFIC STATUTORY DIRECTIVES, THE PROPOSED RULE WILL SPECIFY THAT THE BENEFICIARY HAVE FURTHER APPEAL RIGHTS, INCLUDING AN ADMINISTRATIVE HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE WHERE THE RECONSIDERATION DETERMINATION IS ADVERSE AND THE AMOUNT IN CONTROVERSY IS AT LEAST $200, AND APPEALS COUNCIL OR JUDICIAL REVIEW WHERE THE AMOUNT IN CONTROVERSY IS AT LEAST $2,000.

- A PROPOSED RULE ON CONFIDENTIALITY WILL APPLY TO ALL INFORMATION OBTAINED OR DEVELOPED BY A PRO AND WILL SET THE RULES GOVERNING PROTECTION AND DISCLOSURE OF INFORMATION GENERATED BY A PRO. IT WILL ALSO COVER ACCESS TO THE INFORMATION BY OTHERS. THE PROPOSED RULE WILL CLASSIFY PRO INFORMATION AS EITHER "CONFIDENTIAL" OR "NON-CONFIDENTIAL" AND APPLY DIFFERENT REQUIREMENTS FOR EACH.

- FINALLY, A PROPOSED RULE WILL DEFINE THE PROCESS FOR PROS TO INITIATE SANCTIONS ON THOSE PROVIDERS AND PRACTITIONERS IDENTIFIED AS PROVIDING IMPROPER CARE TO BENEFICIARIES. STRINGENT ACTION GENERALLY WOULD BE INITIATED AFTER EFFORTS TO CORRECT THE BEHAVIOR IN QUESTION HAVE FAILED. PENALTIES CAN RANGE FROM A FINE TO EXCLUSION FROM THE MEDICARE PROGRAM.

ISSUANCE OF REQUEST FOR PROPOSAL (RFP)

IMMEDIATELY AFTER THE FINAL REGULATIONS CONCERNING PRO AREA DESIGNATIONS AND ELIGIBLE ORGANIZATIONS ARE PUBLISHED, WE EXPECT TO RELEASE THE RFPS FOR THE PRO CONTRACTS IN ALL AREAS. THIS ISSUANCE WILL DESCRIBE THE SPECIFIC PRO OBJECTIVES AND REQUIRED REVIEW ACTIVITIES RELATING TO ADMISSIONS, UTILIZATION, AND QUALITY OF CARE, AS WELL AS THE TECHNICAL APPROACH FOR ACCOMPLISHING OTHER REQUIRED ACTIVITIES.

ON AUGUST 29, WE ISSUED A NOTICE IN THE FEDERAL REGISTER INVITING COMMENTS ON THE PROPOSED SCOPE OF WORK. OVER 60 SETS OF COMMENTS WERE RECEIVED, INCLUDING THOSE FROM THE AMERICAN MEDICAL ASSOCIATION, AMERICAN HOSPITAL ASSOCIATION, AMERICAN ASSOCIATION FOR RETIRED PERSONS, AND AMERICAN MEDICAL PEER REVIEW ASSOCIATION. WE HAVE ANALYZED THESE COMMENTS AND HAVE REVISED ACCORDINGLY THE SCOPE OF WORK. THE SCOPE OF WORK CONTAINS THE FOLLOWING MAJOR PROVISIONS.

- o QUALITY OBJECTIVES -- SIGNIFICANT OUTCOME-ORIENTED IMPROVEMENT MUST BE ACHIEVED IN THE FOLLOWING AREAS:

  - + REDUCING UNNECESSARY HOSPITAL READMISSIONS RESULTING FROM POOR CARE DURING PRIOR ADMISSIONS;

- + ASSURING COMPLETENESS OF TREATMENT;
- + REDUCING UNNECESSARY SURGERY OR OTHER INVASIVE PROCEDURES; AND
- + REDUCING AVOIDABLE POSTOPERATIVE COMPLICATIONS.

o ADMISSION OBJECTIVES -- ALL PROs MUST INCLUDE CERTAIN MANDATED OBJECTIVES IN THEIR PLAN FOR:

- + REDUCING INAPPROPRIATE READMISSIONS;
- + REDUCING THE NUMBER OF ADMISSIONS FOR SERVICES USUALLY PERFORMED ON AN OUTPATIENT BASIS;
- + REDUCING THE NUMBER OF ADMISSIONS FOR UNNECESSARY INVASIVE PROCEDURES;
- + REDUCING THE NUMBER OF INAPPROPRIATE TRANSFERS TO PPS-EXEMPT PSYCHIATRIC, REHABILITATION HOSPITALS OR UNITS, AND SWING-BEDS; AND
- + PERFORMING ADMISSION PATTERN MONITORING IN ACCORDANCE WITH HCFA INSTRUCTIONS.

OTHER PRO-SPECIFIC OBJECTIVES IN THE SCOPE OF WORK PLAN INCLUDE:

+ REDUCING INAPPROPRIATE ADMISSIONS FOR SPECIFIC DIAGNOSTIC RELATED GROUPS;

+ REDUCING ADMISSIONS FOR SPECIFIC PRACTITIONERS AND PROVIDERS; AND

+ OTHER AGREED-UPON ADMISSION OBJECTIVES.

THE CONTRACT WILL MANDATE THE SELECTIVE USE OF PREADMISSION AND PRE-PROCEDURE REVIEW AS ESSENTIAL APPROACHES TO MEETING CONTRACT OBJECTIVES. THESE APPROACHES WILL BE APPLIED BY PROS IN THOSE SITUATIONS WHERE THE GREATEST POTENTIAL FOR INAPPROPRIATE ADMISSIONS OR THE PROVISION OF UNNECESSARY OR INCORRECT CARE EXISTS. ADDITIONALLY, THESE TECHNIQUES CAN BE APPLIED TO PARTICULAR PRACTITIONERS OR PROVIDERS WHERE CONCERNS HAVE BEEN IDENTIFIED.

THE CONTRACT PROCESS, SUBJECT TO THE ELIGIBILITY LIMITATIONS SPECIFIED IN THE STATUTE, WILL BE OPEN TO COMPETITIVE PROPOSALS. THE DEFINITIVE SCHEDULE IS DEPENDENT UPON PUBLICATION OF

THE FINAL REGULATION ON AREA DESIGNATIONS/ELIGIBLE ORGANIZATIONS. PERFORMANCE CONTRACTS WILL BE AWARDED ON A FIXED-PRICE BASIS SO THAT HCFA WILL KNOW "UP FRONT" THE COSTS OF REVIEW. CONVERSELY, PROS WILL ALSO KNOW "UP FRONT" WHAT PERFORMANCE STANDARDS THEY WILL BE EXPECTED TO MEET IN EXCHANGE FOR THE FUNDS THEY WILL RECEIVE.

WE WILL SCRUTINZE ALL PROPOSALS CAREFULLY FOR RESPONSIVENESS TO THE SCOPE OF WORK AND CAPACITY TO ACTUALLY DO THE JOB. WE WILL NOT MAKE AN AWARD THAT IS NOT IN THE BEST INTEREST OF THE PROGRAM.

PROGRAM MONITORING AND EVALUATION

AS I MENTIONED AT THE BEGINNING OF MY TESTIMONY, WE WILL BE CONDUCTING OUR OVERSIGHT IN A FAIR BUT FIRM MANNER. FOR EXAMPLE, PROS WILL RECEIVE THEIR FUNDING ON A MONTHLY BASIS, WHICH WILL BE INTEGRATED WITH OUR MONITORING RESULTS. PROS PERFORMING POORLY WILL BE SUBJECT TO REDUCED OR INTERRUPTED CASH FLOWS UNTIL PERFORMANCE IS BACK ON TRACK.

IN ADDITION, WE WILL EVALUATE PROS USING THREE RETROSPECTIVE MEASURES WHICH WILL IDENTIFY THE DOLLAR SAVINGS ACHIEVED

BY MEETING PREDETERMINED OBJECTIVES IN ADMISSION REVIEW, OUTLIER REVIEW, AND DRG VALIDATION. THE PRO'S ABILITY TO INFLUENCE THE OVERALL ADMISSIONS IN ITS AREA WILL ALSO BE A SIGNIFICANT FACTOR IN OUR EVALUATION. IN THIS REGARD, WE WILL USE TARGET RATES WHICH WILL COMPARE THE ACTUAL PRO PERFORMANCE WITH THE RATE AGREED UPON IN ADVANCE. FINALLY, WE WILL LOOK AT OTHER ACTIVITIES WHICH HAVE NO DIRECT MONETARY MEASURE, I.E., QUALITY REVIEW, AND FRAUD AND ABUSE ACTIONS.

CONCLUSION

MR. CHAIRMAN, IN CREATING THE PROSPECTIVE PAYMENT SYSTEM, CONGRESS AND THE ADMINISTRATION MADE A LONG-TERM COMMITMENT TO CHANGING INCENTIVES IN THE HEALTH CARE SECTOR TO REWARD EFFICIENCY AND COST CONTAINMENT. IN ADDITION, IN ORDER TO ASSURE THAT HIGH QUALITY PATIENT CARE CONTINUES TO BE PROVIDED, THE CONGRESS PUT A STRONG MECHANISM IN PLACE TO ASSURE THAT QUALITY IS MAINTAINED. WE BELIEVE THAT THE VAST MAJORITY OF PHYSICIANS AND HOSPITALS WILL CONTINUE TO PROVIDE HIGH QUALITY AND APPROPRIATE CARE. HOWEVER, IT IS OUR RESPONSIBILITY TO ASSURE THAT THIS IS THE CASE. EACH PRO WILL BE OBLIGATED TO CONDUCT MEANINGFUL QUALITY REVIEW AND ACHIEVE SIGNIFICANT IMPACT ON THE QUALITY OF CARE FURNISHED TO MEDICARE BENEFICIARIES IN ITS AREA.

WE BELIEVE THAT THE PROs CAN MEET THIS CHALLENGE AND BECOME AN INTEGRAL PART OF THE TOTAL HEALTH CARE SYSTEM.

CLEARLY, THERE IS MUCH TO LEARN AS EXPERIENCE WITH PROSPECTIVE PAYMENT AND MEDICAL REVIEW GROWS, AND WE EXPECT THE PROGRAM TO IMPROVE WITH TIME. BUT THIS I ASSURE YOU: THE HEALTH CARE FINANCING ADMINISTRATION HAS SET A HIGH PRIORITY ON DEVELOPING AND IMPLEMENTING AN EFFECTIVE MEDICAL REVIEW SYSTEM WHICH WILL EXAMINE BOTH THE COST AND QUALITY OF CARE.

I HOPE YOU HAVE FOUND MY COMMENTARY USEFUL IN UNDERSTANDING HOW WE ARE APPROACHING QUALITY ASSURANCE ISSUES IN THE CONTEXT OF IMPLEMENTING MEDICAL REVIEW UNDER THE NEW PPS. I WILL BE PLEASED TO ANSWER ANY QUESTIONS YOU MIGHT HAVE.

Senator DURENBERGER. Let me try to take some of these issues, not all of them, one at a time, just so everybody here understands how this system operates. Let me say I don't.

Let's start with the proposed rule on area designation and eligible organizations. Can you tell us when the proposed rule left HCFA on its way toward some other part of the approval process?

Mr. SCOTT. Are you talking about the current draft of the final regulation, sir?

Senator DURENBERGER. Right.

Mr. SCOTT. We completed our review within HCFA in the early part of December, I believe.

Senator DURENBERGER. Early December 1983?

Mr. SCOTT. Right. We published it as a proposed notice, as I indicated, and we received about 200 comments. Those comments were excellent, and quite frankly it took some time to digest some of them. As you would expect, the comments on the same issue varied considerably. While we would like to have been quicker—but quite frankly our feeling was, as you indicated in your opening remark, that this may be the the last chance for medical review—we wanted to make sure on some of the more complicated issues that we in fact had sorted them through as well as we could.

Senator DURENBERGER. Very good.

That is the agency level. Then where does it go—to the Department?

Mr. SCOTT. It goes to departmental clearance, yes, sir, where the Assistant Secretaries in the Department, the staff offices, and the other operating divisions within the Department review what we have done.

Senator DURENBERGER. All right. Is it out of the Department?

Mr. SCOTT. Yes, sir.

Senator DURENBERGER. When did it leave the Department?

Mr. SCOTT. Yesterday.

Senator DURENBERGER. Yesterday. [Laughter.]

January 31, 1984. What do they do in the Department that you don't do in the Agency that would take almost 2 months?

Mr. SCOTT. There are additional kinds of reviews. Not trying to be facetious, I guess it is the old "you can't see the forest for the trees" routine sometimes, Senator. For people like myself and those who work on a daily basis with the program, we see it in one perspective. There clearly are other perspectives, and I think it is a good process that the Department goes through.

Senator DURENBERGER. Well, what is the process? Do you know?

Mr. SCOTT. Yes, sir.

Senator DURENBERGER. I mean, what is the Department process?

Mr. SCOTT. Once a regulation has been signed off by our Administrator, it goes to the Department for departmental circulation. I hate to sound bureaucratic, but it is sort of a bureaucratic process.

Senator DURENBERGER. No, go ahead. We all need to understand how this large bureaucracy works, and you are going to help us understand it.

Mr. SCOTT. If I do that, I will get a gold star, because a lot of people in the Department don't understand it. [Laughter.]

Senator DURENBERGER. You are allegedly describing the third largest government in the world, or whatever it is, at HHS, so help us.

Mr. SCOTT. We have an organizational chart you can't even print.

The Assistant Secretaries look at it, and they bring some unique perspective, Senator, to the discussions. The staff in the Office of Management and Budget is very interested in paperwork reduction kinds of issues; they are very interested in budget implications. The staff of the Office of the Assistant Secretary for Legislation takes a long look at what we are doing and challenge us to make sure that in their minds we are following appropriately the direction that the Congress has set out. The Office of the General Counsel takes a very careful review of the regulations, again to insure that we have dotted our "i's" and have crossed our "t's" and that in fact the policies we are articulating are consistent with the statute and the committee reports. The Assistant Secretary for Planning and Evaluation takes a look at it to make sure, I think, that we are dealing consistently within the philosophical framework that this administration has set forward on issues such as competition.

That is the kind of review that takes place, and I think it is a healthy review. Sometimes it takes longer than any of us would like, but if it results in an improved quality product and a more rational regulation, I think it is worth it.

Senator DURENBERGER. All right. Then what happened to it at the end of the day yesterday? Where is this document now?

Mr. SCOTT. The Department staff completed their review and they made a recommendation to the Secretary—these are in fact the Secretary's regulations. She has had an opportunity in the last few days to review them, and what happened yesterday is that she did sign the regulation, Senator.

Senator DURENBERGER. So she signed it. Is it still sitting on her desk?

Mr. SCOTT. I don't know the answer to that, sir.

Senator DURENBERGER. If it is not sitting on her desk, where does it go?

Mr. SCOTT. The process is that, once the regulation has cleared the Department, it goes on to the Executive Office of the President to Executive OMB, for final review.

Senator DURENBERGER. All right. Do you know what happens to it after that?

Mr. SCOTT. After we reach an agreement with Executive OMB on any outstanding issues, it goes to the Federal Register.

Senator DURENBERGER. Why don't you describe to us what happens to it when it gets to OMB. [Laughter.]

Not the end result; I want to know the process.

Mr. SCOTT. The process, again, is one, Senator, where people in the Office of the President—people representing the President's viewpoint—have an opportunity to again review what the Department has done. They look for consistency with basic administration policies, and make sure that the direction that we appear to be moving in is consistent with their understanding of the directions that the President himself would like to move in. They of course have some concern at OMB about matters such as the budget, con-

cerns that I think you yourself indicated this morning that we are all concerned about, the trust fund. So they will undertake that kind of review.

Senator DURENBERGER. So there is some philosophy, and there is budget, and you mentioned earlier they have a strong concern in the Executive Office of the President for paperwork reduction, which I think is a concern we passed out of the Congress and sent over to them, although I am sure they had it before we did that.

Mr. SCOTT. Yes, sir.

Senator DURENBERGER. Can you give us some idea, with regard to area designation and eligible organizations, how long that process should take?

Mr. SCOTT. Senator, quite honestly, I do not expect that it will take very long by the fact that the statement that I have presented here today is a statement representing the administration's position and has been cleared not only by the Department but by the folks in Executive OMB; we have in the budget for 1985 full funding for Peer Review Organizations: over the last month there have been extensive discussions with E-OMB staff on some of the issues involved in peer review and the scope of work. Quite frankly—and this is just my personal opinion—I am optimistic that we will see the regulations very soon.

Senator DURENBERGER. You say "before we see" them, you, and me. I will see them after you see them, I suppose. But the Executive Office of the President, in terms of a signoff so that they become visible to the rest of the world, I take it is Dave Stockman, is that correct? The Director of the Office of Management and Budget? Does he have to sign off on them?

Mr. SCOTT. Senator, you are talking about a part of the Government that I don't work that closely with. I don't know who over there would do what as far as signoff, which person would actually have to do that.

Senator DURENBERGER. Well, presuming that he does signoff, or somebody in authority has to signoff, what then is the rest of the process?

Mr. SCOTT. The rest of the process, then, is very simply a mechanical one. The regs are returned to the Department. We, at that point in time, notify the Federal Register, and the race is ready to begin.

Senator DURENBERGER. All right. Is there a time delay there? What is the nature of the timing, once it is back to the Department, before it would appear in the Federal Register?

Mr. SCOTT. It is a matter of 1, or 2, or 3 days, something like that. You know, it takes time for the Federal Register to set the printing and develop the schedules, and things like that.

Senator DURENBERGER. To a maximum of 3 days?

Mr. SCOTT. Three days. Yes, sir.

Senator DURENBERGER. All right. Then what does the law require in terms of the date of publication in the Federal Register? Is it effective as soon as it is published, or is there some time period after that?

Mr. SCOTT. It is a final rule. It would be effective at that time.

Senator DURENBERGER. All right.

So, conceivably—I don't want to put dates in your mouth here, but you are the only one testifying for the administration today, as far as I can tell—we ought to be able to see a publication in the Federal Register by the end of February? Is that conceivable? I am trying to be optimistic.

Mr. SCOTT. I would consider the end of February to be pessimistic.

Senator DURENBERGER. Oh; now, that depends on what I mean by "optimism." [Laughter.]

How about February 15?

Mr. SCOTT. I would consider the end of February to be pessimistic. I think we have a very good opportunity, sir, to move quickly on these rules. I certainly don't want to indicate that there will not be issues raised. Just as there were issues raised in the public comment period, we expect that there will be considerable discussion; continuing discussion, on many of those issues, and there may be new issues raised. But clearly, the ethic at work within the administration is to do this as quickly as possible.

Senator DURENBERGER. But assuming that you and I are both on the same side of this issue, and I understand that we are, pessimism then means that we are not able to achieve our objective quite as quickly as we want to.

Now, let me try March 15 on you. Would you get a little more optimistic about March 15?

Mr. SCOTT. No. Let me go back. You thought the end of February would be optimistic. I guess what I am trying to say is that I think we should be through much quicker than that.

Senator DURENBERGER. Thank you. That is a very good answer. [Laughter.]

Let us take the next one—and I am just going through your testimony here.

"There are other rules under development to further guide the PRO program. These draft regulations are on a fast track in our agency because of the need for quick implementation." One of those is the proposed rule on "conduct of review, outlining the relationship among PRO's, fiscal intermediaries, providers, and beneficiaries, when PRO's assume responsibility for review." Where is that proposed rule in the process?

Mr. SCOTT. That is in the Department. It is going through that Assistant Secretary clearance process that I described earlier.

Senator DURENBERGER. And is there a reason to believe that there should be a 2-month time line on that, or might that one be a little shorter than 2 months in the Department?

Mr. SCOTT. Once we get to the point of the area designation regulation coming out in final, my expectation is that the conduct of review regulation, the relationships with medicaid, and the other regulations should move expeditiously through the process. They are much less controversial, in many ways, than what the other one would be.

Senator DURENBERGER. Did conduct review and the relationship with medicaid, and the reconsiderations and appeals rule—let's stop with those three—are they all out of the agency and in the Department now?

Mr. SCOTT. All of them are except for the appeals rule, Senator. We have been engaged within the Agency—and there has been some discussion with our Office of General Counsel—on some of those issues. I think you can understand the necessity on questions of appeals—that our legal procedure be absolutely perfect. However, that one is on my desk back in Baltimore, so it may move this afternoon.

Senator DURENBERGER. On the money issue, which is certainly welcome news if I understand it, does that contemplate a request for a supplemental appropriation for financing peer review? You said "fully funded."

Mr. SCOTT. That is for the PRO's for the 1985 budget.

Senator DURENBERGER. That is for 1985.

Mr. SCOTT. I assume your question, then, is will we need a supplemental for transitions in 1985, a subject of some considerable discussion within the Agency.

We do not believe that, given our expectations for an early publication of the area designation rule, that we will in fact need a supplemental appropriation for the year. We think we can make the money that we have stretch. I am not going to try to fool anybody; it will be a tight stretch. But we think that if we are successful in bringing the PRO's up on a timely basis, in middle to late summer, we have got enough money to cover our current medical review requirements.

Senator DURENBERGER. I am told, and I don't know whether we will hear it or not, that we are going to hear some testimony later in the day saying that some of the existing peer review organizations, if they are going to stay in business to be competitive for these contracts, are going to have to dip into their termination funds, in order to stay in business. Are you aware of that problem?

Mr. SCOTT. Senator, we have some PSRO's whose funding expires on May 31. And we have the capacity within our management of that budget to reallocate some funds to some of those particular projects to insure that in fact they don't run out of money.

We recognize the importance of continuity. We have a $40 billion a year program out there. And with medical review as our primary safeguard, we are not at all interested in having any lapse of effort. We will make whatever modifications we need to within our own budget authorities to cover it.

Senator DURENBERGER. All right.

Can I take you now to the request for proposal, or the RFP, as you all call it? It says here, "We expect to release the RFP's for the PRO contracts in all areas immediately after the final regulations concerning PRO area designations and eligible organizations are published." Does that mean, then, that we may be looking at some time before the end of February for the issuance of RFP's?

Mr. SCOTT. We are looking, literally, at a statement within hours of the time that we have the final regulations. We will be prepared, whether it is 24 or 48 hours, in a very quick timeframe, to put the RFP's on the street.

Senator DURENBERGER. How long will interested parties be given to prepare responses?

Mr. SCOTT. If things work as we are planning, our desire and hope—and I want people to understand I am using those two terms

right now—based on the optimistic projection on the area designation regulation—is that people should have approximately 60 days to respond.

Senator DURENBERGER. How long will it then take to evaluate the proposals and negotiate contracts?

Mr. SCOTT. We would be allowing ourselves approximately another 60 days to accomplish that, sir.

Senator DURENBERGER. So that is a total of 4 months, then, approximately.

Mr. SCOTT. We would be targeting, hopefully, some of the peer review organizations to actually be able to begin work in the Summer.

Senator DURENBERGER. Against what baseline will reductions in unnecessary admissions, inappropriate readmissions, and unnecessary surgery be measured? Does the Department know how much of such inappropriate care is now being provided?

Mr. SCOTT. Senator, I don't think we have a number where we can say x percent of this or y percent of that was wrong. As you indicated in your opening remarks, we will be negotiating performance contracts, and we will be evaluating projects based upon the achievement of their own negotiated objectives. So that is one of the reasons that the process for awarding the contract is very complicated. There will in fact be some negotiation as to what those objectives will be, and then we will try, in our evaluation of each individual PRO, to compare its actual performance and its actual impact on these areas compared to what was laid out in its objectives.

Senator DURENBERGER. Will the Department prohibit fiscal intermediary participation until 12 months after the first contract is let; that is, beyond October 1984?

Mr. SCOTT. We fully expect, Senator, and are very hopeful, in fact, that in the first granting of contracts, we will be able to make awards to the organizations that are physician-sponsored or are physician-access organizations. If in fact something goes wrong and we do not receive a proposal, or we do not receive a proposal that even after negotiations becomes an acceptable proposal, it is our hope to fall back on an interim basis on our fiscal intermediary as a PRO of last resort. So, with that as a fall-back position for us, we do not believe that a prohibition on their availability would be wise.

Senator DURENBERGER. Well, you see my problem here.

Mr. SCOTT. Yes, sir.

Senator DURENBERGER. I don't have Dave Stockman sitting where you are sitting, and I assume that for a variety of reasons he still thinks fiscal intermediaries can do this job. I sure hope I am wrong, he has told me I am wrong, but I haven't seen a lot of evidence of it. If you are right and all of this stuff is now scoped out to move very quickly, I have fewer concerns, because I like the way within the agency you are going about this, and I don't have a great deal of fear. But if I have to be concerned about delays and the promulgation of rules or the inadequacy of financing, then I am left with your statement, which says, "Well, if somebody isn't ready or we don't have the right kind of contract in place, then we are going to use fiscal intermediaries." I would like Dave Stockman

to hear from you that under no circumstances will you use fiscal intermediaries.

Mr. SCOTT. Our ability to use fiscal intermediaries, Senator, works, to our advantage in a number of ways. For one thing, it imposes some discipline on the prospective offerers. There may be areas in which we might only have one project preparing a bid. And if in fact it think it is the only choice that we have, it could make the negotiations somewhat more troublesome.

Our feeling is, as I indicated earlier, given the fact that we have $40 billion at risk, for us to have a fallback position will provide some discipline in the bidding process and help us negotiate in some of those circumstances.

Senator DURENBERGER. I can't argue that.

Let me ask you one other question that occurred to me over the weekend, having spent a day in Kansas and a day in Minnesota listening to both medicare beneficiaries and providers talk about the first 4 months of DRGS. It wasn't covered in your statement, which is why I am asking the question.

Do you see a role for the peer review organization or something related to it in providing consumers with information on quality, this whole issue of quality, versus effeciency, or some role in the potential alternative of monitoring hospital communications with consumers? Now, I ask that because in both of these States, in just a matter of hours, I heard an awful lot of people say, "Hospitals are dumping and they are blaming DRG's, so write your Senator and your Congressman and tell them they are off on the wrong track, they are invading the quality of health care for senior citizens in America with this efficiency business of theirs."

So, it strikes me, and maybe we overlooked it in the legislation, that there ought to be some appropriate role in reaching over the providers to the consumers so that they better understand, particularly the issues in peer review between quality and the so-called "efficiency." Maybe you might want to respond in a general way to that inquiry.

Mr. SCOTT. I think, Senator, it is a good concept. I we are to be successful in bringing about the efficiencies desired under prospective payment, it has got to be a success that comes about not only because hospitals and doctors are fully informed of the system but also because the consumers, as you have indicated, are knowledgeable about what is going on and are making wise choices.

Through our regulations on information disclosure later on which will be published soon, we hope to be able to outline some policies so that the consumers will have access to certain information that will be useful to them.

In addition, Senator, I report that in other regulations that we are working on, especially the hospital conditions of participation, the issue that you have just brought up is one that is under active discussion. Many of the people representing outside organizations—the hospital associations and some of the senior citizens groups—have made that a point to us and have made some suggestions that we are looking at under the hospital condition regulation.

Senator DURENBERGER. Are there any questions you expected me to ask you that I didn't? [Laughter.]

Mr. SCOTT. I am not going to touch that one at all. [Laughter.]

Senator DURENBERGER. All right.

Thank you very much, Jim. We appreciate your testimony and your effort.

Mr. SCOTT. Thank you, Senator.

Senator DURENBERGER. Our next witness is Dr. Thomas G. Dehn, vice president of the American Medical Peer Review Association, from Milwaukee, Wis.

Thank you very much for being here. You probably know the rules around here. Your full statement will be made a part of the record. You may comment on it in anyway, and if you want to, in your comments, react in anyway to the HCFA testimony we have just heard, feel free to do so.

Let me, on a personal note, welcome you here. I spoke with my mother earlier, and she told me about a year ago that I ought to get to know you. I hate to do it under these circumstances, but I appreciate you being here.

Dr. DEHN. This is not the worst way to reacquaint an old friendship.

STATEMENT OF THOMAS G. DEHN, M.D., VICE PRESIDENT OF AMERICAN MEDICAL PEER REVIEW ASSOCIATION, MILWAUKEE, WIS.

Dr. DEHN. Thank you, Senator. I appreciated your introductory comments and your allusion to your mother. I can guarantee you that your concerns are justified. Since your mother and my mother are friends, I can assure you that neither of them would like a fiscal intermediary to determine the cost and quality of their hospitalization.

As you mentioned, we have submitted a written statement, and we would appreciate the opportunity to enter that into the record.

Senator DURENBERGER. It will be made a part of the record.

Dr. DEHN. In the introduction you indicated, and I will reiterate, I am a physician, a radiologist, in the full-time practice of medicine. Not everybody believes that any radiologist is in the full-time practice of medicine, but I am trying, in the city of Milwaukee.

I am currently the president of a 20,000-member HMO-IPA, as well as vice president of the American Medical Peer Review Association. Perhaps the legitimizing reason why I am here is because I also chaired a private sector task force on the implementation of what is now colloquially known as The Durenberger Amendment, and we have a specific reason, obviously, in implementing that.

I am going to confine my remarks this morning to issues related specifically to the delayed implementation of same, and I do not share Mr. Scott's optimism about the timely implementation. We are already a year late on the implementation, and I have some serious concerns.

In my verbal presentation I will provide examples of both cost and quality compromises that I believe require adequate and timely physician review that may be disrupted by virtue of the delay that we have noticed and is the reason for our presence here. As I conclude my remarks, if I have time, I would like to make some comments about the private sector interrelationship to this.

Senator DURENBERGER. Go right ahead. In fact, we will leave the light off.

Dr. DEHN. I am concerned, as others are, that there has been a conscious effort by the administration to delay the orderly transition from the PSRO program to the PRO program. I am not parochial enough to suggest that all PSRO's should automatically become PRO's, and I welcome the competitive aspects that were elucidated by Mr. Scott earlier.

My problem is, the current funding in conjunction with the delay of implementation of PRO will leave us without a physician-based review system in the interim. This is a serious problem, and one that I believe can be remedied by at least sufficient interim funding of the program currently in existence.

Mr. Scott indicated that there was $4 million available for termination costs. My understanding of that $4 million is, first of all, it simply isn't enough, and, second, that there are some legislative and/or regulatory constraints on using termination money to perform review.

The bottom line, Senator, is that your mother, who I understand is now living in Florida, and my mother in Minnesota, and Senator Baucus's relatives in Montana will be without a medically based review system after May 31—with a little luck, after June 30—by virtue of the fact that we are being strangled under the current review process from lack of funds.

Currently operational review organizations have been asked by health care financing to perform outlier review and admission certification, under the current prospective system. We are doing that, but the labor intensity necessary to perform that kind of review is virtually impossible under a 27-percent reduction in funding, which we are presently facing.

What I am seeing, in sort of a nefarious way, and I hope my paranoia is not too pervasive, is a conscious effort to posture the fiscal intermediaries to successfully bid for the PRO contracts by dooming the current system of medically based review to failure. A couple of examples:

Like some others, I thought that the quality issue was a nonissue, and that we as physicians and institutional providers were hiding behind it. I had the opportunity recently to perform some utilization review on a private basis for a nursing home. I simply asked the nursing home administrator if he noticed an increase in the intensity of illness in patients being discharged from the hospital—essentially, dumping. He was uncontrollable. I said, "Well, give me an example. I have to testify in front of Senator Durenberger."

I am holding an actual medical record—confidentiality prevents me from giving you either the name of the patient or the hospital. The date is December 29, 1983, and the discharge diagnosis from a respected facility in Milwaukee is "Resolved pneumonia"—"resolved." The patient should be well. From the same day I have an X-ray report indicating an "infiltrate"—which is pneumonia—"bilaterally"—both sides—consistent with congestive heart failure in superimposed pneumonia. Well, that patient was dumped from that hospital, I presume in response to inversion of the fiscal incentives.

The worse part, and it does get worse, occurs upon the arrival of the patient at the nursing home. This patient was evaluated at the nursing home, found to be in cardiac failure as well as pneumonia, and an attempt was made to get the patient back into the acute care facility, who, for some bureaucratic reasons, delayed the admission, and the patient died.

I mentioned to the administrator that the case was a bit extreme. "Do you have any more?" He said he had five more that he could easily recall, not ending in death but some ending in stroke, permanent disability, and in improper care.

Now, that is the kind of compromise of quality that I think a physician review organization is in the best position to identify, to review, and hopefully to prevent. I don't think a fiscal intermediary can do that.

The second example, one related to cost, involves a case also in southeastern Wisconsin. It was a cost outlier that was brought to the attention of the foundation for medical care evaluation, our local PSRO, involving a bottom-line figure of $17,000. This required review by three physicians for at least 2 hours apiece, and it resulted in a denial. If there are skeptics in this room that don't think that prospective payment has the attention of hospital administrators, I have news for them. When we notified the hospital of a $17,000 denial, we needed physicians, nurses, and lawyers to back us up from here to Baltimore. That level of review requires courage and dedication and it's present in existing review organizations, but I am afraid the morale is deteriorating by virtue of strangulation of funds.

I don't think the fiscal intermediary has the equipment or has the medical expertise to make decisions on the basis of the two examples that I just gave you, and I would appreciate your attention to that problem.

The case that I am trying to build is, not that you guarantee that PSRO's become PRO's, but give us the money to get through the interim until the folks that have delayed implementation get on the ball or medicare recipients will be hospitalized without any, or with incompetent, review.

The May 31 termination problem for many PSRO's, in addition to a deterioration of review will result in increased startup costs for the new PRO's. It simply doesn't make a lot of sense to me.

I will conclude by indicating that we have a report from the private sector task force on implementation of your legislation which speaks to the issue, of quality review and risk management. I would like to make a subtle distinction between quality assurance and risk management.

A lot of folks banter around the fact that the term "quality," is relatively difficult to define. Lawyers however define "quality" in communities across the country every day, in an effort to establish standard practice of care and breaches thereof. We can identify, in a physician review organization, similar standards and compromises of quality. That, in the business industry and in some hospitals, is called risk management. I don't believe that we should be arrogant enough to suggest that implementation of this program will improve quality of care; I think that battle is gone. I think that the best we can do, the best any of us can do, with the inversion of the

incentives in the prospective payment system is to try to prevent against breaches that may occur when the fiscal incentive is to undertreat. That is risk management. If we can identify those breaches and help to plug the gaps, I think we will have done our job with regard to quality assurance and/or, more appropriately, risk management.

I would appreciate the opportunity to enter the private sector task force document into the record.

Finally, it would seem that the intent of your legislation, Senator, was to provide the opportunity for the contracting agencies to be innovative, to offer different kinds of products—preadmission certification, different internal structures within the State. This seems to be thwarted and by my reading of the current draft proposal on the scope of work it is prescriptive. I have read many of your articles and have heard several of your speeches, and you continually allude to the fact that you do not want this program to be prescriptive; you want an opportunity to compete, as I do in my HMO. The regulations that I have seen so far, and I hope Mr. Scott considers this seriously, are so ludicrous as to require 6 months notification of the termination of an executive director. If I have an executive director in my PRO who isn't doing his job, I don't want him around for 6 months; that guy hits the pavement. And that is the kind of prescription that we see in the current draft scope of work that I believe is counterproductive to the intent of your legislation.

Senator, thank you for the opportunity to present this. We would appreciate help on interim funding and also keeping HCFA's feet to the fire on timely implementation of this program.

Senator DURENBERGER. And I thank you a great deal for the comments. I trust that your full statement goes more specifically into some of the other proposed rules that HCFA is working on.

Dr. DEHN. Certainly.

Senator DURENBERGER. I am glad that you brought at least one illustration along of some of the things I was hearing over the weekend.

Obviously I feel a frustration that goes all of the way down to the bottom of my stomach when I hear of a situation as you described, following the testimony about the philosophy of this administration that doubles up on looking at the legal issues, doubles up on the planning, doubles up on the legislative, and after all of that to land someplace in the Executive Office of the President, where somebody who doesn't know a damn thing about health care is again coming along with some theory or philosophy of how you meet the needs of the elderly in America. So, as I say, it did get to me and I appreciate that.

On the cost side—you talked about the $4 million and the 27-percent reduction—does your full statement detail how and where some of the existing PRO's in the country are in trouble and how much time we have to rescue them financially?

Dr. DEHN. Yes, it does, Senator. And we would be happy to provide your staff with additional information about it.

Senator DURENBERGER. OK. I think that would be helpful, particularly in light of whatever we need to do in a supplemental ap-

propriation or to enforce the utilization or transfer of existing funds.

[The information follows:]

PURPOSES/OBJECTIVES

ISSUES

1. What is the purpose of a PRO?
2. What are acceptable PRO objectives?

RECOMMENDATIONS

Purpose

1. To review medical services in both the public and private sector by medical peers relating to medical necessity and appropriateness of care setting.
2. To involve both the public and private sector in the review process to safeguard equitable distribution of medical care costs, review costs and benefits.
3. To contribute to the examination of the medical care delivery system as a whole by skilled data analysis and comparison of varying practice patterns.

Objectives

1. To evaluate the interrelationship between medical care cost and quality recognizing the fact that emerging methods of reimbursement may potentially compromise quality.
2. To achieve a cost benefit ratio measured in terms of volume changes that represents a significant return on investment without adversely affecting the quality of care.
3. To maintain already acceptable volume levels.

RATIONALE

1. With already existing as well as proposed changes in the reimbursement system PROs will be in the unique position of gathering and analyzing information about the effects of these changes on both the use of and quality of medical care services.
2. There are two major factors which contribute to cost of health care: 1) numbers of units of service delivered; and 2) cost per unit. While PROs are intended to affect the first of these, they have no control over the cost per unit. Therefore, measuring effectiveness in terms of reduction in dollars spent is inappropriate. Measurement of changes in volume may include, but are not limited to:

- Days of acute care/thousand enrollees
- Admission rate
- Ancillary service utilization
- Length of stay
- Demonstrated shifts of service delivery to more appropriate care settings

These measurements must be based on accurate and timely data relating to services delivered and definition of eligibles.

If dollar savings are to be calculated, a formula using constant dollars should be used. That is, at that point in time when baseline data is collected for use in the future to measure volume changes, data on cost per unit should also be collected. Measurement of the cost effectiveness would then be based on multiplying the change in volume by the baseline cost data.

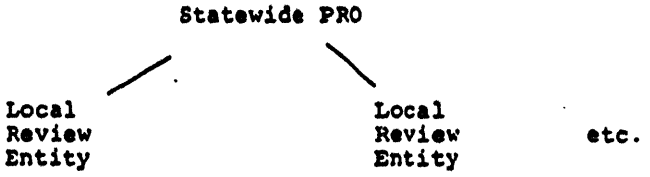
PRO AREA ORGANIZATION

ISSUES

What is the most effective way in which to organize areas for PRO implementation?

RECOMMENDATIONS

1. Statewide areas chosen for PRO implementation should be able to structure itself so that it may rely on already existing local review entities to carry out the day-to-day review activities. The following diagram represents this structure.



   It is essential, therefore, that no restriction be placed on the number of subcontracts into which a PRO could enter.

2. The statewide review agency should receive credit for the review experience provided by the subcontractor/s in their bid for the contract.

RATIONALE

1. Rather than expending resources to restructure review activities, it is more cost efficient and effective to allow a PRO to subcontract with already existing local review entities which have demonstrated the capability to perform well.

2. Private sector groups have stated that they believe it is essential to maintain their flexibility to concentrate their resources in areas where they have primary interest. These areas would differ depending on the location of the private group. Providing a structure that would allow the private sector to contract with a corporate entity at a local level as well as at a statewide level would meet the expressed need of the private sector for maintaining such flexibility.

ORGANIZATIONAL STRUCTURE

ISSUES

1. The Scope of Work document is too restrictive in the specification that only Board certified/eligible physicians can be used for reconsideration examinations.

2. Prohibition of PRO board membership to facility related individuals.

3. Key personnel changes

RECOMMENDATIONS

Issue 1 - Revise page 20 by deleting the reference to "Board certified or board eligible" and replacing it with "physicians or dentists - duly licensed." (Re: Scope of Work)

Issue 2 - Delete (7a) - Prohibitions and restrictions section of proposed rules to allow board membership by managing employees and governing body members of Health care facilities.

Issue 3 - Revise item (4a) of Part II of the Scope of Work entitled KEY PERSONNEL to read KEY PERSONNEL refers only to Executive Directors.

RATIONALE

Issue 1 - In many areas of the country the availability and expenses of locating "board certified or eligible" physicians as described for reconsideration hearings would preclude adequate and timely reconsideration review.

Issue 2 - Experience has shown that facility related board members provide insight and communication to the board not otherwise available if prohibited.

Issue 3 - The requirement to report changes in key personnel sixty days prior to termination other than the Executive Director is too prescriptive and seriously impairs the Executive Director's ability to manage a responsive, autonomous and flexible organization.

ADMISSIONS OBJECTIVES/METHODS OF EVALUATION

ISSUE 1

The PRO Private Sector Task Force recognizes that the PPS introduces incentives which might lead to an increase in "inappropriate" hospital admissions. Consequently, it is reasonable to require PROs to undertake review activities which guard against such inappropriate admissions. The Task Force is concerned, however, that the "Admission factor" proposed by HCFA as the indicator of a PRO's success in addressing this issue may not be a reliable quantitative measure of a PRO's impact on "inappropriate" admissions. The Task Force urges HCFA to acknowledge that the evaluation tool proposed requires substantial refinement and validation prior to being accepted. The Task Force recommends that HCFA:

RECOMMENDATIONS

1) A. Explicitly identify the "Admission factor" as an untested indicator requiring further evaluation and refinement.

B. Create a technical work group composed of HCFA and PRO representatives for the purpose of conducting this validation process, and

C. Not use the measure proposed to evaluate any PRO contractor until the process of validation the evaluation tool has been completed.

ISSUE 2

Modification of Objectives - The PRO Private Sector Task Force is concerned that HCFA might include in PRO contracts language which would make the "Scope of Work" for the contractor open-ended rather than defined. The Task Force understands HCFA's concern with retaining the flexibility to respond to events. Certainly, it will not always be possible to anticipate every task appropriate for a PRO contractor.

RECOMMENDATIONS

It is imperative that if changes/and or additions are to be made in the Scope of Work after the contract has been awarded that such modifications be the result of a renegotiation process, not simply HCFA directives.

QUALITY ASSURANCE

ISSUE

The members of the Private Sector Task Force believe that the quality assurance system outlined in the Scope of Work for PRO contract is too restrictive and limited and lacks the innovation demonstrated in the balance of the document.

RECOMMENDATIONS

A. Objective: We believe that the objective of an effective quality assurance program in a P.P.S. should identify and correct quality compromises that may result from incentives in the system which potentially lead to either undertreatment or withholding of treatment.

B. Method: An effective program must, therefore, be flexible and based on the ability to recognize and correct a broad range of variations from acceptable quality patterns. This requirement necessitates a combination of screening and, where necessary, individual record review.

C. Criteria: Criterion for screening should be generic, that is, applicable to a broad range of medical services and not diagnosis specific. Criteria should be appropriate nationally for comparative purposes but should also include some screening criteria of regional importance. Examples of national criteria include, but are not limited to:

- Admission for adverse results of OPD management.
- Admission for complication or incomplete management of a problem on previous hospital admission.
- Transfer from a general care unit to a special care unit.
- Transfer to another acute care facility.
- Unplanned return to operating room on this admission.
- Myocardial infarction occurring within 48 hours of a surgical procedure on this admission.
- Cardiac or respiratory arrest.
- Death

Examples of regional criteria may relate to specific disease entities or practice patterns noted by either the contractor or contractee. All national criteria should be developed jointly by a technical work group composed of HCFA representatives and PRO representatives. Regional criteria should be agreed upon jointly by HCFA and the PRO contractee.

D. Focus: Cases found in variance from these criteria are not necessarily representative of compromised care but are only identified for specific case review. These cases should be reviewed through the authority of the PRO, either on a delegated or a non-delegated basis. No case should be considered a "problem" until subjected to "peer review" by physician reviewers. Problems identified should be quantified and corrected under the authority of the PRO and facilities or providers unresponsive to this authority should be subject to sanction.

E. Evaluation: Evaluation of this system should be equally innovative. The effectiveness of a quality assurance program does not lend itself to quantifiable evaluation. Any evaluation based on points or percentages is therefore too restrictive and cumbersome to adequately describe success or failure. "Points" given for problem resolution based on "seriousness" perversly rewards areas where care is already compromised and penalizes areas where baseline care is good.

Accurate evaluation of the effectiveness of the system should be solely based on the ability of the PRO to demonstrate that care can be delivered under the PPS system without compromise of quality. If that can be demonstrated then that should be sufficient to indicate the effectiveness of the program. Increasing or unresolved occurance rates above national norms, therefore, should be the only pass/fail measure of the adequacy of the PRO quality assurance program.

RATIONALE

The extreme change from the methodology recommended in the Scope of Work document is intended to specifically address quality issues inherent in a prospective payment system. The generic criteria are therefore, specifically designed to screen for possible adverse occurrences directly related to the system. Regional criteria are intended to address local quality issues related to inappropriate care beyond that identified in the generic criteria.

FACILITATION OF PRIVATE REVIEW

ISSUE

The Scope of Work document is relatively silent on the intent of the Durenburger legislation with respect to the facilitation of private review. The ability of prospective PROs to implement private review and the realization of this ability is an important aspect to consider in evaluating PRO proposals. The significant cost and quality review resources being created can be less costly to the government if they are used by other third party payors. Minor changes in the Scope of Work can promote this objective.

RECOMMENDATIONS

A. Rather than simply requiring contractors to "make their facilities available", a plan for implementing or increasing private review would help assure that PROs take an active role in facilitating review in the private sector. This could be accomplished with the following changes to the Scope of Work.

   Section E-1 should read: "The contractor must have a plan for performing review under contract with private and public entities paying for health care in its area."

   Section D-2 c.(3) should read: "Meeting other specified and agreed-upon objectives for which no monetary benefit can be applied, including efforts to implement the plan for private review.

B. Since a plan for private review will be prepared, it is not necessary for the contractor to perform a separate examination of the feasibility of combining private and Medicare data. This could be part of the plan. Therefore, it is recommended that Section C-2 h.(2)(d) should be deleted.

C. It is assumed that in awarding evaluation points for private review experience the length and scope of that experience will be considered. However, the current format appears to award an automatic 25 points for any experience, no matter how brief or insignificant. It is recommended that 3.a.c.(2) carry the following parenthetical addition; "(number of points to be based on length and scope of private experience in the PRO area)".

RATIONALE

The intent of these changes is not to allow the federal government to be in a position of approving private review programs, but rather to indicate the ability and intent of the organization to perform such reviews.

Senator DURENBERGER. One other related question, just because I haven't read your full statement. The other thing that bothers me, of course, is the loss of human resources in some of these programs. Obviously, you have the kind of commitment that you need to stick with the process through thick and thin, but I am assuming that we have already put a fair amount of strain on a lot of dedicated physicians out there across America who hoped that we had our hearts in the right place but now are not so sure, and then there are the economic strains, even among physicians, I'm sure.

Are we, across the country or in certain parts of the country, losing some commitment of human resources to this peer review program?

Dr. DEHN. The answer to that is a clear yes. The morale has deteriorated in the existing organizations. Many on a staff level feel like they are lameducks. On a physician level, it isn't an easy job in the first place; it doesn't win a lot of friends, and to couple that with little backup in terms of dollars and administrative encouragement has been devastating. Clearly, we have lost many physicians from the program throughout the country and that represents a serious loss because whomever wins a PRO contract the cadre of interested physicians is finite.

So, yes, there is a compromise of the human resources that are available. Hopefully, we can get them in the reentry draft into PRO, but I am a little skeptical.

Senator DURENBERGER. I haven't seen what they are coming out with on area designation, but I am assuming that there will be 50 areas or 52, or something like that. Do you anticipate any problem within that with either subcontracting or some other provisions to facilitate the use of subgroups within a geographic area like a State?

Dr. DEHN. I don't see a problem. AMPRA has taken the position that the legislation is fairly clear with regard to sub-State organizations, if those become necessary, and that is up to the discretion of HCFA.

We are pleased with the opportunity to subcontract. There are certainly some sub-State organizations that deserve to be separate entities, at least in some respects, and I think the ability to subcontract will facilitate, for instance, in large States where clearly the population is different—California and New York, Ohio—the ability to form discrete organizations under the umbrella of the PRO. I think that latitude is there, and I encourage that subcontracting.

Senator DURENBERGER. What about Mr. Scott's response to my question about prohibiting fiscal intermediaries? His response was that, "Well, we need some leverage over the physician-based organization." Is that an appropriate concern?

Dr. DEHN. I don't think so. I would like to tell you that physicians who have been annealed in this fire are dedicated. We, certainly, are not in it for the money, and the premise that competition will develop a better organization is highly unlikely. Since as far as physician organizations are concerned we are not financially driven. The better organizations are virtually all in place and ready to go. We are afraid that this conscious effort, frankly thwarts the intent of the legislation, fiscal intermediaries are eligible to compete for these contracts as of October 1, which coinciden-

tally appears to be the timetable for implementation of PRO that we heard Mr. Scott explain.

I don't think that there is a significant benefit to inserting the terror factor in the bidding process. I think, as a matter of fact quite the contrary, it may compromise the development of good review organizations because the cheapest is not always the best.

Senator DURENBERGER. All right. Thank you very much. I appreciate your testimony a great deal.

Dr. DEHN. Thank you.

[Dr. Dehn's prepared statement follows:]

STATEMENT OF THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION, PRESENTED BY THOMAS G. DEHN, M.D., VICE PRESIDENT, AMPRA

EXECUTIVE SUMMARY

- THE IMPLEMENTATION OF THE PRO PROGRAM MUST MOVE FORWARD. Eighteen months have passed since enactment of the PRO law and still initial regulations have not been published in the Federal Register nor Requests for Proposals for PRO contracts released. Medicare prospective payment regulations, in contrast, were generated in six months time. The American Medical Peer Review Association (AMPRA) must question the Administration's commitment to implementing this critical element of PPS.

- THE MOST ORDERLY TRANSITION FROM MEDICAL REVIEW UNDER THE PSRO PROGRAM TO MEDICAL REVIEW UNDER THE PRO PROGRAM HAS BEEN COMPROMISED. Failure of the Administration to support interim funding for PSROs in FY 1984 has limited medical review oversight of PPS. At a time when medical review activities and expenditures should be sharply increasing to protect quality of patient care, maintenance of appropriate utilization and minimization of gaming of the prospective payment system, PSRO budgets have been sharply reduced.

- AMPRA RECOMMENDS THAT THE SENATE FINANCE COMMITTEE GIVE SERIOUS CONSIDERATION TO AMENDING THE SOCIAL SECURITY AMENDMENTS OF 1983 TO ASSURE THAT, IN THE EVENT THAT PROS ARE NOT IMPLEMENTED BY THE CLOSE OF FISCAL YEAR 1984, EXISTING PSROS CONDUCTING MEDICAL REVIEW BE SUPPORTED BY THE HOSPITAL TRUST FUND AS ENVISIONED BY THE PRO FUNDING FORMULA. Such an amendment would assure an orderly transition period and preclude another divisive battle for funding through the appropriations process.

- PHYSICIAN PEER REVIEW AND NOT REVIEW BY FISCAL INTERMEDIARIES REMAINS THE MOST APPROPRIATE VEHICLE TO ADDRESS ISSUES OF MEDICAL QUALITY, NECESSITY AND APPROPRIATENESS. AMPRA questions the contention that fiscal intermediaries can do a better job of medical review. More than ever, it is the expertise embodied in physician based peer review which can furnish the professional oversight to assess the quality and appropriateness of care rendered. Medical review, without appropriate levels of professional judgement and without careful anaylsis and access to patient medical records, can become arbitrary, capricious, economically unfair to provider institutions, and potentially dangerous to patient care.

- PHYSICIAN PEER REVIEW IS NEEDED TO PROTECT QUALITY OF CARE IN AN AGE OF LIMITED RESOURCES. The economic incentives of hospital prospective payment argue for a strong risk management program aimed at assuring the maintanence of the quality of care for Medicare patients. AMPRA believes that the physician peer reiew process can best address these quality of care concerns.

- THE PRIVATE SECTOR SEEKS SWIFT IMPLEMENTATION OF THE PRO PROGRAM. The demands for medical review are intensifying and private purchasers are anxious to work with PROs on utilization management and quality assurance efforts. Further delays in PRO implementation causes medical review uncertainty in the private sector and deprives private purchasers of an important management tool.

AMPRA IS CONCERNED THAT THE GREAT POTENTIAL OF THE PRO PROGRAM WILL BE COMPROMISED BY REGULATORY INFLEXIBILITY AND REDUNDANT OVERSIGHT. The intent of the Durenberger law was clearly to liberate review organizations from obtrusive government regulations and oversight while maintaining accountability through fixed price performance based contracts. It is our hope that this legislative intent will be realized. AMPRA must register its fear, however, after review of the PRO Scope of Work and given recent PSRO experience under PPS, that an overly prescriptive approach will be adopted.

Mr. Chairman, I am Thomas Dehn, M.D., Vice President of the American Medical Peer Review Association (AMPRA) and a practicing physician in Milwaukee, Wisconsin. In addition, I recently chaired a private sector task force on implementation of the PRO program, convened by AMPRA, and including representatives from business, insurance, consumers, hospitals, state government and others interested in and supportive of this vital program. With me is Andrew Webber, Executive Vice President of AMPRA. On behalf of AMPRA and its member Professional Standard Review Organizations (PSROs) I want to express our sincere appreciation for the opportunity to share our views with you and the other members of the Subcommittee.

We are especially pleased, Mr. Chairman, by your continuing interest and support of physician-based peer review programs. These oversight hearings come at an especially critical point in the evolution of medical peer review programs. The purpose of our testimony today is to share with you our experiences and our opinions concerning implementation of the PRO program authorized by TEFRA in August, 1982 and to respond to your request to hear from existing review organizations concerning the transition period from PSRO to PRO.

At the outset we must register disappointment with the lack of progress toward meeting the schedule of implementation called for in the law and announced by the Administration last year. As you and other members of the Subcommittee are aware, no final implementing regulations for the PRO program have been issued. Requests for Proposals for PRO contracts have yet to be released to even a single PRO review area. The October 1, 1984

deadline by which all hospitals must have signed contracts with PROs or risk loss of Medicare reimbursement is rapidly approaching with still much work to be done to implement the program. We cannot over emphasize our belief that these administrative delays should cease and that regulations and the contracting process should be initiated promptly.

It is with growing impatience and frustration that we must observe that, after a year and a half, final regulations for PRO's are not published yet HCFA was able to implement the Medicare prospective payment system (PPS) for hospitals within six months of enactment. Surely, we must ask if the most complex and, indeed, controversial change in the Medicare system can be successfully implemented in six months, are we unreasonable to ask for initial PRO regulations and release of RFPs in 18 months? We believe that this kind of priority should also have been accorded the PRO program which is so critical to the successful implementation and operation of PPS.

Delays are not only frustrating the goals and operations of existing PSROs, but, more importantly, they are also putting the administration of PPS at substantial risk. We expected that implementation of the PRO program would occur in tandem with the initiation of PPS. This new payment system is now in place for well over half of the nation's hospitals, but as yet not a single PRO has been contracted with to perform the monitoring and review functions required under the PPS law.

Meanwhile, the most orderly transition from the existing PSROs to PROs has been compromised. At a time when PSROs are assuming increased responsibilities as a result of maintaining their present review activities for hospitals under cost-based Medicare payment and beginning

new activities for hospitals entering PPS, the level of financial support has been sharply reduced. AMPRA has heard from many of its PSRO members that the review demanded under PPS cannot be supported by present funding levels. A PSRO from your own state of Minnesota, Senator Durenberger, is a case in point:

> The reivew organization will review about 30% of all Medicare discharges annually. For the interim period, January through June 1984, 19,234 staff hours are required to accomplish PPS activities. The review organization has a total of 7,359 staff hours available during this period of time, leaving it approximately 11,870 hours short of need resources. These figures do not include any move to 100% review where denials exceed the 2.5 ratio set by DHHS, the review of DRG category 468 which is currently being contemplated, nor the costs of appeals which might occur as a result of review activities. These are considerable omissions and thus the estimates of needed staff hours are conservative.

We cannot help but record our disappointment in the Administration for compromising a smooth transition period by seeking termination of PSROs in Fiscal Year 1984. This absence of Administration leadership caused confusion on the Hill and precipitated a divisive struggle between House and Senate for interim PSRO funding. AMPRA wishes to publicly thank Senate Finance members for supporting interim funding so that not all continuity in the peer review process would be lost at a critical juncture in Medicare's evolution. While AMPRA and its PSRO membership swallowed a bitter pill with the 27 1/2 percent cut in our Part I Administrative budgets that resulted from this appropriation's struggle, we continue to hope and believe that, with the implementation of the PRO program, broad based support for physician peer review will be evidenced and its

importance fully recognized. Presently, however, AMPRA can only express its grave concern and question the misplaced priorities of a Medicare budget that in FY 1984 will reimburse hospitals to the tune of 50 billion dollars while spending only 50 million dollars on PSRO medical review activities. This represents one tenth of one percent of total hospital reimbursement dollars spent on assuring quality care and maintaining appropriate utilization of medical services. What other industry would spend such a small percentage of total costs on a quality control program?

Compounding this present financial situation is the uncertainty and ambiguity surrounding the policies and instructions for review under prospective payment. For example, the most recent PPS regulations included an unexpected and unbudgeted function which must be carried out by PSROs engaged in PPS review. The new PPS regulations allow provider institutions to bill individual patients when a hospital's utilization review committee, with concurrence of the attending physician, determines that a patient's stay in a hospital is no longer medically necessary. PSROs will now be required to verify the medical necessity determination of the hospital in each patient billing case. We raise this example not to protest the need for such a critical review function but to highlight how at a time when financial support for medical review should be increasing, the opposite is true. Since January 3, when the regulations were issued, PSROs have been given no instructions as to how the government wants this new function performed nor any evidence that additional monies will be forthcoming to defray the costs of the review now demanded.

Finally, if the schedule for PRO operations is not met, then the funding for existing PSRO's will be exhausted prior to the establishment of PRO contracts in many areas. PSROs were allocated monies in FY 1984 based on the original implementation timetable (one group of PROs coming on line in June of this year and the remainder in September), that is now two full months behind schedule. The consequence is that some PSRO's may be unable to operate until the date for their transition into the PRO system. Indeed, the goal of having all PROs operational by October 1, 1984 is in serious jeopardy given the delays to date and questions concerning the ability of the Federal contracting office to negotiate complex fixed price contracts with PROs at present staffing levels. Not only will a delay between termination of a PSRO and initiation of a PRO be distruptive for the Medicare program, but it will also leave gaps in the hospital review activity under PPS that pose significant risks of adverse results to patients and the Hospital Trust Fund.

For this reason, AMPRA must recommend to the Senate Finance Committee at this time that serious consideration be given to amending the Social Security Amendments of 1983 to assure that, in the event that PROs are not implemented by the close of Fiscal Year 1984, existing PSROs be supported by the Hospital Trust Fund as envisioned by the PRO funding formula that this Committee helped construct. Such an amendment would assure an orderly transition period and preclude another divisive battle for funding through the appropriations process; a process which the Administration has not and will not support. AMPRA would welcome the opportunity to work on this important legislative amendment with Senate Finance Committee members and staff.

For these reasons and others it is imperative that the PRO program get underway on time. Uncertainty about the future of the program is most destructive of the morale of the many committed individuals who are the strength of the PSRO program. We know that you envisioned an orderly transition under which the expertise and resources developed by the PSRO program could be applied to a new generation of review organizations. We are concerned that these resources and expertise may be lost unless we move promptly on PRO implementation.

The consequences of delay and declining funding levels include not only the potential compromise of the PPS, but also the quality of the care provided to Medicare beneficiaries. The functions which PROs are to perform under PPS -- review of admissions and admission pattern monitoring, outlier review, readmission and transfer review, and validation of DRG coding -- are important to the success of PPS and can contribute to reductions in Medicare payments while protecting quality of care. However, PROs must also be prepared to detect and act on situations where needed care is withheld in response to the new financial incentives of PPS.

While we believe that the vast majority of physicians and hospitals will continue to carry out their responsibilities in the best interests of their patients, there is a need to provide assurance that there be no exceptions to this general rule. The law and we believe the intent of Congress specifically directs the PRO program to provide a risk management program aimed at assuring the maintenance of the quality of care for

Medicare patients. It is the expertise embodied in physician-based peer review which can furnish the educated, professional oversight to make medical judgements necessary to assess the quality of care. It is this educated, professional oversight covering the whole range of medical specialities, performed by practicing physicians in the community which distinguishes true peer review from that which organizations, like fiscal intermediaries, are able to provide. This distinction was highlighted recently when the Administration developed contingency plans for fiscal intermediary review in the event that PSROs were defunded in FY 1984. FIs were informed that they would have no quality of care review functions to perform under prospective payment.

While it is too early to have available national data on patterns of hospitalization and other provider behavior under PPS, we would like to share with you several incidents which have already occurred and which may be indicative of emerging problems with which PRO's must deal. A sampling of the incidences which PSROs have identified and acted on under PPS include:

- Notes have been made on medical records by physicians stating that the patients must leave the acute care facility since the DRG reimbursement had run out. In one instance, the patient was discharged to a nursing home, readmitted to the hospital with serious medical problems and died soon after.

- Prior to PPS, bilateral procedures (ie. right and left hip replacements) were done in one hospitalization, thus concentrating

and limiting body trauma to a single treatment episode. Under PPS, however, there are reimbursement incentives to having procedures done in more than one hospitalization. Grave compromises in quality due to multiple hospital stays and surgical procedures have been identified by PSROs.

- There are quality concerns that physicians are not administering the most appropriate care at the onset of treatment given the economic incentives under PPS. Temporary surgical procedures (Ex.: temporary pacemaker insertion case where physician noted on the chart that the patient would have to be readmitted for a permanent implant) that assure multiple admissions are being identified by PSROs.

- One PSRO reviewed 44 charts for peer review of DRG coding...Payment on 35 of the 44 charts reviewed denied because of inaccurate coding.

- Sequencing and coding manipulation examples were identified and corrected by one PSRO resulting in a net savings of over five thousand dollars:

1.	Hosptial listed DRG as	64;	Reimbursement - $2703.
	PSRO corrected DRG to	410;	Reimbursement - $1308.
2.	Hospital listed DRG as	121;	Reimbursement - $6918.
	PSRO corrected DRG to	127;	Reimbursement - $3861.
3.	Hospital listed DRG as	64;	Reimbursement - $2002.
	PSRO corrected DRG to	142;	Reimbursement - $1136.
	Hospital charging	$11,623.	
	PSRO corrected to	$ 6,305.	
	Net savings	$5,318.	

- One hospital was coding chemotheraphy on the claim as if the procedure was a total body perfusion rather than the correct procedure of infusion. Total body perfusion would have moved the claim to a reimbursement rate higher than the rate for infusion.

- A patient was admitted on December 12, 1983 with malnutrition requiring nasogastric tube feedings. During hospitalization, the patient developed osteomyelitis requiring I.V. antibiotics. On December 22, 1983, the patient was discharged to a nursing home and upon arriving at the nursing home, she was refused admission. One half hour later, the patient was returned to the hospital and readmitted with osteomyelitis of the toes and pseudomonas infection. The nursing home was unable to care for the patient due to the need for daily physician observation and the provision of I.V. antibiotics. This patient was subsequently discharged on December 28, 1983. Since both hospital admissions were medically necessary, the hospital potentially can be reimbursed for two hospitalizations under two different DRGs.

- Multiple transfers with an exempt rehabilitation unit is a problem identified by review organizations. Initial review at one hospital identified several cases involving multiple transfer from the medical/surgical floor to the rehabilitation floor and back again to the medical/surgical floor. One case involved four transfers with length of stay on some of the units spanning as little as one day. The hospital justifies transfers by claiming that the rehabilitation unit cannot provide medical/surgical treatment. For example, in a case where a CVA patient develops

deep vein thrombophlebitis. Each time a patient is shifted from one unit to the other the PPS provides a new opportunity for reimbursement (per diem on the rehabilitation unit and a new DRG on the medical/surgical unit).

- Readmissions and transfers are examples of further gaming of the system. In one case, a patient with a heart problem was admitted to a hospital for depression. The attending psychiatrist recommended electro-shock treatment and the internist agreed as long as the patient would be monitored for 24 hours after each electro-shock treatment. The monitoring request required transfer out of the psychiatric unit and the shock treatment required transfer back in. This case clearly identifies the hospital's ability to "ping-pong" a patient back and forth to increase reimbursement.

- One hospital has a notice posted to physicians stating that if a patient requires transfer from the acute care facility to the psychiatic unit, the physician must discharge the patient and then readmit him. In doing this, the hospital many receive multiple payments for a single patient case.

- One hospital accepted a transfer from another hospital into their distinct part alcohol treatment unit; after a few days they transferred the patient to a medical floor. However, in both locations the patient was just a social disposition problem and did not meet medical criteria for admission. If this had not been caught the hospital would have been reimbursed for two admissions.

- Increased admissions have been identified by PSROs conducting PPS review. In one hospital, 30% of the admissions are multiple admissions. Discharging patients to nursing homes and readmitting them within 72 hours for repeat workups are additional incidences identified by PSROs.

These examples illustrate both the importance of maintaining the current PSRO structure as the most orderly transition step to an effective PRO system and the need for review performed by physician peers rather than complete reliance on computers and lay personnel. While I do not wish to imply that effective medical review need not employ the services of computers to profile utilization experience nor non-physician employees to perform initial screening and review of patient cases, I do believe, however, that effective review must go beyond these stages and develop the capability to communicate directly with providers and intervene when problems are identified. Most importantly, effective review programs must have access to the patient's medical record and must have the professional capability for the evaluation of patient care as documented in the medical record. It is AMPRA's strong belief that a professional and financially disinterested entity be given the authority to make judgements respecting these issues. In some cases these judgements will result in saving Medicare dollars; in other cases maintaining standards of quality of care may not permit the saving of program dollars.

We would be remiss not to mention as part of our public testimony the importance of PRO implementation to the private sector. As SubCommittee members I am sure recall, the PRO law was developed in partnership and with the active support of important private sector groups

including, the Washington Business Group on Health, the Midwest Business Group on Health, and Health Insurance Association of America. The critical need for medical review in both the public and private sectors was recognized and important provisions were added to the PRO law to facilitate private review activities. More than ever, private review is critical to assure quality of care, maintaining appropriate utilization levels and identifying the shifting of costs on the private sector. We anticipate that this cost shift problem will be aggravated with the advent of Medicare prospective payment as recent data from an AMPRA member demonstrates:

HOSPTIAL X

DRG	Medicare Cost to Hospital	Medicare Payment to Hospital	Private Charges
127 (Heart Failure & Shock)	$3,799.	$2,300.	$5,277.
88 (Chronic Obstruction Pulmonary disease)	$3,298.	$2,301.	$4,580.
138 (Cardiac Arrhythmia)	$3,144.	$2,055.	$4,367.
82 (Respiratory Neoplasm)	$4,060.	$2,519.	$5,639.

HOSPITAL Y

DRG	Medicare Cost to Hospital	Medicare Payment to Hospital	Private Charges
127	$4,398.	$2,981.	$6,109.
88	$4,757.	$2,982.	$6,607.
138	$3,055.	$2,663.	$4,243.
82	$6,368.	$3,265.	$8,845.

This striking data highlights the potential for even greater cost shifting to the private sector as hospitals seek avenues to minimize the reimbursement gulfs between Medicare cost and Medicare payments. With further delays in PRO implementation, private purchasers will be deprived of an important management tool and greater uncertainty about medical review will be evidenced.

There is one final area related to the implementation of the PRO program which AMPRA wishes to call to your attention. When the Finance Committee developed the original PRO legislation in 1982 to revise the PSRO program, we know that committee members envisioned a competitive bidding process in which physician-based review organizations and the Medicare program would negotiate performance-based contracts. To the extent possible these contracts were to be individually negotiated and as free from prescriptive regulation as the statute would allow. Unfortunately, we believe there has been a migration in the direction of a very detailed set of implementing regulations and instructions which will severely circumscribe the contracting process and stifle innovative review models. We are also concerned that PROs will be burdened with an excessive degree of oversight through frequent and costly demands for review data and program impact. We are not opposed to being held accountable for review conducted, nor the need for an appropriate level of government oversight. We simply object to and must question the cost effectiveness of what we perceive to be unnecessarily zealous oversight activities. Part of AMPRA's enthusiasm for the PRO approach was our hope that we would move towards greater flexibility and freedom in the review process. Just as in other areas

this Administration has sought to bring the decision-making process closer to the community level, we believe it should be consistent with the policy for this program by recognizing the variations from community to community that characterize our health care delivery system. AMPRA wishes to insert for the record the report of the Private Sector Task Force on PRO Implementation that outlines many of our concerns about the draft PRO Scope of Work with Task Force recommendations for alternative approaches.

Mr. Chairman, we very much appreciate this opportunity to furnish information and our views on these important subjects. The critical need for medical review has never been more evident as the health care system finds itself in the throes of great changes. We are anxious to work with you, DHHS, the private sector and other interested parties to move the PRO program forward in a timely manner. We want also to express our thanks to you for your commitment to physician-based peer review. If you or any other members of the Subcommittee have any questions, I will be pleased to respond.

Senator DURENBERGER. Our next witness will be Dr. Alan Nelson, a member of the board of trustees of the American Medical Association, Salt Lake City, Utah.

We welcome you, Dr. Nelson, and assure you that your full statement will be made part of the record of this hearing. You may take whatever time is necessary to summarize that statement and/or comment on any other testimony that has been given here this morning. Thank you for being here.

STATEMENT OF ALAN NELSON, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, SALT LAKE CITY, UTAH

Dr. NELSON. Thank you very much, Mr. Chairman.

My name is Alan R. Nelson, M.D., and I am a physician in the practice of internal medicine in Salt Lake City. I am a member of the board of trustees of the American Medical Association. With me is Ross Rubin, who is director of the AMA Department of Federal Legislation.

We are pleased to have this opportunity to testify before this committee concerning the current status of the implementation of the peer review organization program and the need for corrective action. The comments that I have prepared consist of just summary sentences, although, as you have indicated, we have our full prepared testimony that has been submitted.

The summary sentences are as follows:

(a) The American Medical Association strongly supports medical peer review that focuses on quality assurance and the appropriate utilization of medical services.

(b) The AMA is actively assisting State medical societies in their efforts to become peer review organizations.

(c) Unreasonable delays have occurred in the implementation of the PRO program. These delays could seriously harm medicare beneficiaries. Hospitals may be forced out of the medicare program and review would be conducted by nonphysical organizations.

(d) In order to insure that organizations of physicians and organizations that have access to physicians receive the preferential treatment that Congress intended, Congress must act to extend the time during which payor organizations are prohibited from becoming PRO's. Sixty days is not long enough to prepare a proposal for a PRO in an area without an existing mature review organization.

(e) In order to avoid major disruptions in care to medicare beneficiaries, Congress must extend the deadline by which hospitals must contract with a PRO beyond October 1, 1984.

(f) Congress should encourage the administration to expeditiously implement the PRO law and should continue to closely oversee the administration's action or lack thereof in this area.

(g) State governments should be prohibited from becoming a PRO.

(h) Congress should adopt the AMA amendments to the PRO law in order to help insure physician support for the program.

Mr. Chairman, a record of the administration's delays in implementing the PRO program calls for prompt and effective congres-

sional intervention and direction, as outlined above. We commend you for conducting these hearings toward this end.

I will be pleased to answer any questions that you may have, Mr. Chairman.

[Dr. Nelson's prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Finance
United States Senate

Presented by

Alan R. Nelson, M.D.

RE: Implementation of the Peer Review Organization Program

February 1, 1984

Mr. Chairman and Members of the Committee:

My name is Alan R. Nelson, M.D. and I am a physician in the practice of internal medicine in Salt Lake City, Utah. I am a member of the Board of Trustees of the American Medical Association. Accompanying me is Ross Rubin, Director of the AMA's Department of Federal Legislation. The AMA is pleased to have this opportunity to testify before this Committee concerning the current status of the implementation of the Peer Review Organization (PRO) program and the need for corrective action by Congress.

The AMA strongly supports medical peer review that emphasizes quality assurance. The focus of our testimony is on our strong concern that the significant delays which have occurred in the implementation of the PRO program could result -- contrary to the intent of the Congress -- in review being performed by non-physicians and also result in hospitals losing their Medicare reimbursement. Our testimony will also detail the

efforts the AMA has undertaken and plans to undertake to assist medical societies in their efforts to seek designation as a PRO. In our view changes are needed in the PRO law to help ensure that the primary goal of the Medicare program is quality health care and that the PRO program secures the support and confidence of physicians.

Delays in the Implementation of the PRO Program Are Nullifying Congressional Intent

The Department of Health and Human Services (HHS) and the Office of Management and Budget have not acted promptly in implementing the PRO program. After enactment of the Peer Review Improvement Act (PL 97-248) in September 1982, no rules were proposed to implement the program for almost a full year, until August 15, 1983, when a proposed rule dealing with the issues of PRO area designation and definition of eligible organizations was published in the Federal Register. Later in August, HHS made available for comment a draft PRO Scope of Work and Technical Proposal Instructions. HHS still must publish final regulations concerning area designation and definition of eligible organizations and a final Scope of Work document. In addition, HHS must publish both proposed and final rules in areas such as those concerning the issues of confidentiality, sanctions, conduct of review, and appeals. Most importantly, HHS has yet even to issue requests for proposals for PRO contracts. Following this there must be adequate time provided to interested parties to respond, time to evaluate the responses, and time to negotiate PRO contracts.

Statutory deadlines, with their serious and inescapable consequences, are rapidly approaching. The implementation delays have not been satisfactorily planned by the Administration. We do not know whether

the delays are the result of reported opposition by segments of the Administration opposed to medical peer review, or are merely the result of the normal bureaucratic process. However, regardless of the reason for the delays, we are greatly concerned that they will seriously harm Medicare beneficiaries. The inordinate extent of the delays could also irreparably prejudice worthy PRO applicants and could cause hospitals to lose their status as a participating hospital in the Medicare program.

Failure to implement the program in an orderly and timely fashion seriously undermines not only the intent of Congress as indicated above, but also its objectives in creating the PRO program for medical peer review by those best able to conduct such review - physician organizations. The delays effectively wipe out the period of time specifically reserved by Congress for organizations composed of physicians (physician-sponsored organizations) and organizations that have available to them the services of physicians to perform review (physician-access organizations) to apply and qualify for PRO designation. In light of the Administration's stated preference to have review performed by payor organizations, carriers, and intermediaries, however, the 16-month delay without a single final regulation takes on special significance. The delay must be counteracted if Congressional intent is to be carried out. Mr. Chairman, Congressional intent must prevail regardless of the cause of the delay by the Administration.

Loss of Medicare Eligibility by Hospitals

Under the Social Security Amendments of 1983 (PL98-21), a hospital will not be eligible for Medicare reimbursement if it has not entered into a contract with a PRO by October 1, 1984. This provision applies

even if there is no PRO in the area with which the hospital can contract. Denying Medicare reimbursement to hospitals could have a disastrous effect on the access to and availability of health care for our nation's senior citizens and on our health care system. Hospitals would be faced with the choice of treating only those elderly persons who could demonstrate an ability to pay or shifting the costs of treating those who are unable to pay to private pay patients.

The unreasonable delays in implementing the PRO law have seriously undermined the ability of hospitals to contract with a PRO by October 1, 1984. The AMA believes that the health care needs of America's elderly should not be jeopardized by these delays. Thus it is incumbent that Congress extend the deadline by which hospitals must contract with a PRO. Such an extension is necessary to assure that medical peer review is provided and that physician organizations have an adequate opportunity to bid for and negotiate contracts with HHS and then establish contractual relationships with hospitals to begin review.

Loss of Medical Peer Review by Physician Organizations

Another serious problem could result from the delays in implementing the PRO law. Physician-sponsored organizations and physician-access organizations are losing the preferential treatment they were granted and intended to receive under the Peer Review Improvement Act. The law as originally enacted prohibited organizations which make payments for health care services (payor organizations) from being a PRO for one year after the first PRO contract is awarded. During such period only physician-sponsored and physician-access organizations would be eligible to become PROs. In considering the Social Security Amendments of 1983,

the Congress modified this section of the law to provide that the one-year waiting period for payor organizations would commence when the first PRO contract is awarded or October 1, 1983, whichever is earlier. Since no PRO contracts have been awarded, the waiting period for payor organizations will end September 30, 1984 unless Congress acts to extend it. It is obvious Congress expected that contracts would be awarded prior to October 1, 1983, but included a deadline as well. The continuing Administration action effectively blocking the ability to enter into contracts was not contemplated.

Allowing payor organizations to be awarded PRO contracts would have a strong negative effect on the PRO program. The ultimate success of the PRO program will depend to a considerable extent on the expertise of the reviewing body and the support and cooperation of local physicians. Peer review historically and logically is performed by physicians. Only medical peer review is capable of engendering the support and confidence of local physicians because it is performed by their peers. Review performed by payor organizations has been uniformly unacceptable chiefly because of its failure to provide proper physician review of medical care furnished.

The AMA is also concerned that if payor organizations are permitted to assume review functions, the PRO program will, like the PSRO program, focus primarily on cost containment rather than quality assurance. The AMA supports medical peer review focused on quality of care. We believe that the quality assurance function of PROs is now particularly important because of the financial pressures for under-provision of inpatient services inherent under the new Medicare prospective payment system (PPS)

for hospitals. PROs must ensure that quality medical care is provided to the nation's elderly by supporting decisions to provide medically necessary care. Congress recognized the essential function of PROs as a safeguard of quality care under the new PPS by requiring hospitals to contract with a PRO in order to receive Medicare reimbursement. Thus we urge Congress to extend the priority treatment for physician-sponsored and physician-access organizations for a period of at least one year after the first PRO contract is negotiated.

State Governments as PROs

The preamble to the proposed rule concerning PRO area designation and definition of eligible organizations specified that any state government that operates or is affiliated with a health care facility or association of facilities would be prohibited from becoming a PRO. However, we have heard reports that the Administration may in the final rule allow state governments to become PROs under certain conditions. The AMA strongly opposes permitting state governments to become PROs. Review performed by state governments would not constitute medical peer review. Moreover, we believe the language of the preamble to the proposed rule accurately reflects Congressional intent. Section 1153 (b)(3) of the Social Security Act prohibits "any entity which is or is affiliated with (through management, ownership, or common control), a health care facility, or association of such facilities, within the area served by such entity . . . " from becoming a PRO for that area. Certainly a state that owns or operates a hospital must be considered "affiliated" with that hospital under §1153 (b)(3) and thus should be precluded from becoming the PRO for that area.

AMA Efforts to Assist Medical Societies

Since enactment of the Peer Review Improvement Act in 1982, the AMA has actively assisted state medical societies in their efforts to become PROs. A September 1983 "Conference on Peer Review Organizations and the Prospective Payment System for Hospitals" provided general information on the PRO contracting process and emphasized the importance of setting appropriate objectives in securing a PRO contract. Nearly 400 persons, representing 42 state medical societies, 18 national medical specialty societies, PSROs and various hospitals attended the meeting.

In October 1983 a follow-up AMA seminar was attended by representatives of state medical societies interested in being designated as their area's PRO. The purpose of this meeting was to familiarize the attendees with the provisions of the draft PRO Scope of Work and provide them with some of the technical information their societies will need to submit a responsive PRO contract proposal. Forty-two representatives from 20 state medical societies were in attendance.

The AMA is currently assessing possible additional activities to assist state medical societies interested in becoming a PRO. It is likely that the AMA will sponsor still another seminar for state medical society representatives after the PRO request for proposal is released.

AMA-Proposed Amendments to the PRO Law

Although the AMA is lending support to medical societies in their efforts to become PROs, we believe that amendments to the PRO law are needed to help ensure strong physician support for the program. The AMA has drafted a series of amendments which we believe would improve the current PRO law. A copy of these amendments is attached to our statement.

We also believe Congress should be aware of our serious concerns with the proposed rules on PRO area designation and eligible organizations and the draft Scope of Work. A number of these concerns relate to the undue emphasis on cost containment at the expense of quality assurance. We have also attached a copy of our comments to HHS concerning these matters.

Conclusion

The AMA strongly supports medical peer review focusing on quality assurance and is assisting state medical societies in becoming involved in the PRO program. We are very concerned over the long delays that have occurred in the implementation of the PRO program. We believe Congress must act to extend the time during which fiscal intermediaries are prohibited from qualifying as PROs. It is also imperative that Congress extend the deadline for hospitals to contract with a PRO in order to avoid major disruptions in care to Medicare beneficiaries. Finally, we urge Congress to encourage the Administration to expeditiously implement the PRO program as modified above. To this end, Congress should continue to closely oversee the Administration's action or lack thereof in this area.

Mr. Chairman, the record of the Administration's delays in implementing the PRO program calls for prompt and effective Congressional intervention and direction as outlined above. We commend you for conducting these hearings toward this end.

1277p

SPECIFICATIONS IN DRAFTING AMENDMENTS TO THE PEER REVIEW ORGANIZATION LAW

The following specifications have been developed for drafting amendments to the Peer Review Organization (PRO) law.

(1) Section 1152(1)(A)* does not define the words "substantial" and "representative" for determining whether an entity is a physician organization for purposes of priority treatment. The amendment would define "substantial" to mean at least 25% of the physicians engaged in the practice of medicine or surgery in the PRO area. The amendment would define "representative" to mean geographically representative.

(2) Section 1152(1)(B) which establishes criteria for non-physician PROs would be amended to require that the licensed doctors of medicine or osteopathy who perform review for the entity be directly engaged in patient care.

(3) Section 1153(b)(1) does not state criteria for the Secretary in choosing between two competing physician organizations. The amendment would state that if more than one qualified physician organization desires to contract, priority must be given to the organization that has the greatest percentage of area physicians and is most geographically representative of physicians in the area.

(4) Section 1153(b)(2)(A) provides that the Secretary cannot contract with an entity that makes payments to health care practitioners or providers for at least twelve months after the Secretary begins to enter into contracts. The amendment would extend the time during which the Secretary could contract only with a physician organization from twelve to thirty-six months.

(5) Section 1153(c) fails to reinstate the priority for physician organizations as the area PRO after the termination of a PRO contract. The amendment would require the Secretary to give contracting priority to a physician organization for the first twelve months after a contract between the Secretary and a PRO is terminated for any reason.

(6) Section 1153(c)(7) and 1154(a)(6) refer to national and regional norms of practice for a PRO to use in evaluating services. These sections would be amended to specifically provide that PROs are to ascertain and develop appropriate guidelines as opposed to norms. In drawing up the guidelines, the PROs should utilize the expertise of national, state and county medical associations and specialty societies but should also reflect local practice patterns. The law would also state that the guidelines are to serve as guides only and should not be substituted for the judgment of individual physicians.

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*All Section references are to the Social Security Act.

(7) Section 1153(d)(2) allows the Secretary absolute discretion to accept or reject the findings of panels appointed to review the performance of a PRO before a PRO can be terminated. The amendment would require the Secretary to accept the panel's findings unless the Secretary shows good cause for not doing so and issues a written opinion detailing his reasons.

(8) Section 1153(d)(3) provides that the panel reviewing a PRO's performance must consist of not more than five people each of whom is a member of a PRO. The amendment would require that at least two of the five members of the panel must be directly engaged in patient care.

(9) Section 1153(f) prohibits judicial review of a determination by the Secretary to terminate a PRO contract. The amendment would provide for judicial review in the event that the Secretary terminates a PRO contract to ensure that adequate grounds for termination exist.

(10) Section 1154 gives a PRO the authority to conduct pre-admission review. The amendment would deny PROs blanket authority to perform such review, but would allow physician-composed PROs to conduct focused pre-admission review.

(11) Section 1154(a)(7)(C) allows PROs to examine the pertinent records of any practitioner or provider of health care services who provides services for which the PRO has review responsibility. The amendment would deny PROs such authority because it could easily be abused and is redundant.

(12) Section 1154(a)(7)(D) authorizes PROs to inspect a physician's office if care is rendered to Medicare patients there. The amendment would prohibit PROs from inspecting a physician's office and would also deny PSROs the authority to review services provided there.

(13) Section 1155 provides that a beneficiary who receives an adverse determination by a PRO is entitled to a hearing by the Secretary if the amount in controversy is $200 or more and to judicial review of an adverse decision by the Secretary if the amount in controversy is $2,000 or more. The amendment would provide that practitioners and providers would also be entitled to a hearing and judicial review if the threshold amounts are reached.

(14) Section 1156(b)(1) states that if the Secretary fails to act upon the recommendations submitted by a PRO for sanctions against practitioners within 120 days after receiving them, the practitioner shall be excluded from eligibility to provide services to Medicare beneficiaries on a reimbursable basis until the Secretary determines otherwise. The amendment would provide that all sanctions recommended by a PRO must be accepted or rejected by the Secretary within 120 days.

(15) Under Section 1156(b)(2) the Secretary could provide notice to the public that sanctions have been imposed on a practitioner before the practitioner has exhausted his right to appeal. The amendment would provide that the Secretary shall not provide notice to the public that sanctions have been imposed against a practitioner until the practitioner has exhausted his opportunity for judicial review of the Secretary's decision.

(16) Section 1157(c) provides that physicians will not be held civilly liable if they exercise due care and act in compliance with professionally developed norms of care and treatment applied by a PRO. This provision would be repealed because it would probably have the effect of pressuring practitioners to adhere to the norms.

(17) The PRO law provides only for review of services for which payment may be made under Medicare or Medicaid. The amendment would provide for review of care delivered through federal medical programs under the Veterans Administration.

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JAMES H. SAMMONS, M.D.
Executive Vice President
(751-6309)

September 12, 1983

Philip Nathanson
Director
Health Standards and Quality Bureau
Health Care Financing Administration
Department of Health & Human Services
Attention HSQ-107-P
P.O. Box 26676
Baltimore, Maryland 21207

Re: "Medicare Program; Utilization and Quality Control Peer Review Organization (PRO) Area Designations and Definitions of Eligible Organizations," August 15, 1983 Federal Register (48FR36970)

Dear Mr. Nathanson:

The American Medical Association submits its comments concerning the proposed rule in the Federal Register of August 15, 1983, establishing Peer Review Organization (PRO) area designations and defining organizations eligible to be PROs.

Sincerely,

James H. Sammons, M.D.

James H. Sammons, M.D.

JHS/dap
1084p

COMMENTS

of the

AMERICAN MEDICAL ASSOCIATION

to the

Health Care Financing Administration

RE: "Medicare Program; Utilization and Quality Control Peer Review Organization (PRO) Area Designations and Definitions of Eligibile Organizations," August 15, 1983 Federal Register (48FR36970)

September 12, 1983

The American Medical Association takes this opportunity to comment on the proposed rule in the Federal Register of August 15, 1983, implementing those parts of the Peer Review Improvement Act of 1982 (PL 97-248) that provide for Peer Review Organization (PRO) area designations and define organizations eligible to become PROs.

The American Medical Association supports medical peer review focused on quality of care and has encouraged medical societies to become involved in the PRO program. The AMA has a number of concerns with the proposed rule. The key provisions of the proposal and our comments concerning each are outlined below.

Comments

Eligibility of Physician-Sponsored Organizations

Section 1152(1)(A) of the Peer Review Improvement Act of 1982 states that in order to be eligible for designation as a physician-sponsored PRO an organization must be composed of a substantial number of the licensed practicing physicians (M.D. and D.O.) in the PRO area and be representative of these physicians.

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The proposed rule provides that in order for an organization to be considered composed of a "substantial" number of the area's licensed physicians, a PRO must be composed of at least 5% of the area's licensed practicing physicians. A physician-sponsored PRO would be deemed "representative" if composed of more than 10% of the area's practicing physicians or if it demonstrates in its contract proposal, through letters of support from physicians or physician organizations, or through other means, that it is representative of the area's physicians.

The AMA believes that the proposed rule sets the level for "substantial" and "representative" at unacceptably low levels. We believe that the term "substantial" should be defined, as it was under the PSRO program, to mean at least 25% of an area's practicing physicians.

The ultimate success of the PRO program will depend to a great extent on the cooperation of and participation by local physicians. Establishing the minimum percentage at 25% would ensure that PRO organizations are composed of a significantly large number of physicians to guarantee adequate physician support for the PRO. HCFA's contention that a smaller minimum percentage is appropriate for PROs simply because statewide review areas will be the norm ignores the fact that PSRO review areas, including large states such as Texas, were also statewide. Moreover, the PRO law provides for the establishment of local review areas if the "volume of review activity or other relevant factors" warrant it. In addition, HCFA's concern that a lower minimum percentage is needed to foster competition among physician-sponsored organizations is unfounded since many physicians could be members of more than one physician-sponsored type organization (e.g., state medical society, local

medical society, existing PSRO). Finally we believe that during the contract evaluation process HCFA should give priority to the physician-sponsored organization composed of the greatest percentage of the area's physicians.

The AMA also believes that the proposed definition of the term "representative" fails to accurately reflect Congressional intent. Under the proposal the threshold for qualification is so low that a physician group in one part of a state could create a PRO without any participation from other areas. Similarly a physician group representing only one specialty could be awarded a PRO contract. We believe that the term "representative" should be defined as geographically representative as well as representative of different medical specialties in the PRO area.

Eligibility of Physician-Access Organizations

Section 1152(1)(B) of the Act states that in order to be eligible for designation as a physician-access PRO, an organization must have available to it the services of a sufficient number of licensed practicing physicians in the PRO review area to assure adequate peer review by all medical specialties and subspecialties. The proposed rule would provide that a physician-access organization is deemed to have a "sufficient" number of practicing physicians if it has available the services of at least one physician in every generally recognized specialty.

The AMA believes that requiring only one physician from each specialty is insufficient to assure adequate peer review. Moreover, we believe that reviewing physicians should be required to be directly engaged in patient care. Finally, the definition of "sufficient" should

be amended to require that the PRO have available a geographic balance of reviewing physicians in the PRO area.

PRO Contract Award

The proposed rule states that, if at the end of the 12-month period following the first intended contracting date announced by HCFA in the request for proposal, a non-payor organization submits a minimally acceptable plan, it will be awarded the PRO contract over a "similarly qualified payor organization."

The AMA believes that this provision of the proposed rule should be modified to accurately reflect the statutory language. Section 1153(b)(2)(B) of the Act provides that the Secretary may enter into a contract with a payor entity only "[I]f after the expiration of the twelve month period...there is no other entity available for an area with which the Secretary can enter into a contract...." Thus Congress clearly intended that if a non-payor organization submits an acceptable plan, it should be awarded the PRO contract over a payor organization; it did not specify relative qualifications.

Conflict of Interest

Section 1153(b)(3) of the Act provides that the Secretary of Health and Human Services cannot enter into a contract with an organization "which is, or is affiliated with (through management, ownership, or common control), a health care facility, or association of such facilities, within the area served by such entity...."

The proposed rule would define the word "affiliated" so as to render an organization ineligible for a PRO contract if it has a governing body member, officer, partner, five percent or more owner, or managing

employee who is also a governing body member, officer, partner, five percent or more owner, or managing employee of a health care facility or association of health care facilities in the PRO area.

The AMA is concerned with this provision because many hospitals have practicing physicians on their governing board; some of these physicians may also desire to be on the governing board of a physician-sponsored PRO. We believe the segment of the definition of "affiliated" that would preclude an organization from being a PRO if it has a governing body member who is also a governing body member of a health care facility or association of health care facilities in the PRO area goes well beyond the intent of Congress. House Conference Report No. 97-760 states that by prohibiting contracts with provider or provider-affiliated organizations "[T]he conferees intend that review organizations avoid financial conflicts of interest with providers subject to review." We believe no "financial conflict of interest" would result if a physician were a member of the governing boards of both a hospital and a PRO unless the physician has an ownership interest in the hospital.

The AMA is also concerned that the proposed definition of "affiliated" would make it more difficult for physician-sponsored organizations to be eligible to serve as PROs. The proposal would thus actually serve to deviate from Congressional intent to give priority to physician-sponsored organizations. As a result, we strongly advocate that the proposal be revised to allow physicians to sit simultaneously on the governing boards of both a hospital and a PRO as long as the physicians who are on both boards excuse themselves when the PRO reviews cases involving their hospital.

Ability to Perform Review

Under the proposed rule, HCFA would determine that a physician-sponsored organization or physician-access organization is capable of conducting review if the organization's proposed review system is adequate, its quantifiable objectives acceptable, and it has "available sufficient resources" to implement its system. The AMA is concerned because the proposed rule does not specify the criteria by which HCFA will determine whether an organization's proposed review system is adequate and whether its objectives are acceptable. In addition, the proposal fails to define the terms "resources," "available" and "sufficient." The result is that HCFA would be allowed unlimited discretion in judging whether an organization is capable of performing review.

Conclusion

The American Medical Association supports medical peer review that focuses on quality assurance rather than cost containment, although appropriate quality and site of care will often result in savings. We have encouraged medical societies to become involved in the PRO program and anticipate that many societies will submit PRO contract proposals.

The AMA believes that the support of local physicians is vital to the success of a PRO. Amending the proposed rule to define "substantial" as at least 25% of an area's practicing physicians and to define "representative" to mean geographically representative and representative of the different medical specialties in the PRO area would increase substantially the likelihood of local physician support for a PRO. Similarly, modifying the proposal to require that physician-access organizations have available a geographic balance of area physicians

directly engaged in patient care would greatly increase the chances of local physician acceptance.

Finally, the AMA believes that in order to accurately reflect Congressional intent, the proposal should be amended to provide that a non-payor organization that submits an acceptable plan will be awarded the PRO contract over any available payor organization. We urge the modification of the proposed rule consistent with these comments.

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October 13, 1983

Allan Lazar
Director
Office of Professional Standards Review Organizations
Health Standards and Quality Bureau
Health Care Financing Administration
Department of Health and Human Services
1849 Gwynn Oak Avenue
Baltimore, Maryland 21207

Re: Scope of Work and Technical Proposal Instructions and Evaluation Criteria for the Utilization and Quality Control Peer Review Organization Program

Dear Mr. Lazar:

The AMA is pleased to submit its comments concerning the proposed "Scope of Work and Technical Proposal Instructions and Evaluation Criteria for the Utilization and Quality Control Peer Review Organization Program."

Sincerely,

James H. Sammons, M.D.

JHS/hf
1lUJp

COMMENTS

of the

AMERICAN MEDICAL ASSOCIATION

to the

Health Care Financing Administration

RE: Scope of Work and Technical Proposal Instructions and Evaluation Criteria for the Utilization and Quality Control Peer Review Organization Program

October 13, 1983

The American Medical Association takes this opportunity to comment on the proposed Scope of Work and the Technical Proposal Instructions and Evaluation Criteria for the Utilization and Quality Control Peer Review Organization (PRO) program. The AMA has a number of serious concerns with the proposal, many of which relate to the proposal's undue emphasis on cost savings at the expense of quality assurance. The key provisions of the proposal and our comments concerning each are outlined below.

Comments

Quality of Care Objectives

The medical profession has a long history of involvement in quality assurance programs for health care. Many state and county medical societies were active in voluntary peer review before the enactment of the PSRO program. The primary goal of the medical profession in voluntary medical peer review is the improvement of care through the application of appropriate treatment modalities best suited to the individual patient

for his or her illness or injury, and through the creation of programs for the continuing improvement in medical education of physicians. Another important thrust of peer review should be the improvement and advancement of quality assurance programs and the application of the highest degree of technical expertise in the conduct of such review. The overriding objective of all such activities is to improve the quality of patient care.

The American Medical Association, while mindful of the need to constrain health care costs, supports medical peer review focused on quality of care, and to this end, has encouraged medical societies to become involved in the PRO program. Since the proposed Scope of Work emphasizes cost containment, the AMA believes that it should be amended to ensure that quality of care issues play the proper and prominent role in PRO activities. For example, the Scope of Work requires prospective PROs to establish admission control objectives in each of five specified areas for cost containment purposes. By contrast, bidders need include only one "quality objective" from among the following areas:

(1) Reducing unnecessary hospital readmissions resulting from poor care provided during the prior admissions.

(2) Assuring the provision of medical services which, when not performed, have significant potential for causing serious patient complications.

(3) Reducing avoidable deaths.

(4) Reducing unnecessary surgery or other invasive procedures with significant potential for causing serious patient complications.

(5) Reducing avoidable postoperative complications.

The AMA believes that the quality objectives could be strengthened by requiring bidders to establish specific objectives that address each of the five quality of care areas outlined above. Such a requirement would put bidders on notice that quality objectives are indeed as important as cost and admission objectives.

It is particularly important that the quality assurance function of PROs be strengthened and highlighted because of the new financial incentives for providers under the new Medicare prospective payment system (PPS). Under the former retrospective cost-based reimbursement system, there was a financial incentive to provide services and, in some cases, to maximize the length of stay. As a result, one key function of PSROs has been to determine whether the services provided are medically necessary.

Under the PPS, hospitals will generally receive a predetermined amount per admission based on the patient's diagnosis. It is hoped that the PPS will encourage hospitals to provide the least costly treatment consistent with good medical practice. Nonetheless, the strong economic incentive for underprovision of services that is inherent in the PPS could pose a very real danger to patients and to continued high quality care. Hospitals may exert pressure on physicians to discharge patients or to withhold some medically desirable services. An implied threat that staff privileges could be affected could be used to attempt to coerce physician compliance.

In this new environment, PROs must play a vitally important role in ensuring that quality medical care is provided to the nation's elderly by supporting physicians in their decisions to provide medically necessary

care. Congress recognized the essential function of PROs as a safeguard of quality care under the new PPS by requiring hospitals to contract with a PRO in order to receive Medicare reimbursement.

The Scope of Work also provides that quality objectives would be measured in terms of the number of patients affected by the problem and the severity of the problem. Severity would be defined as the adverse effect of the problem on patients as determined by HCFA.

The AMA agrees that quality objectives should be measured in terms of the number of patients affected by the problem and the severity of the problem. However, we believe that HCFA should not have unfettered discretion in determining whether a problem is severe. Instead, contractors should be required to establish their quality goals and document the adverse effect of the problem on patients.

Performance Evaluation

The Scope of Work provides that a PRO's performance will be evaluated in terms of satisfying individual contract objectives and in terms of dollar benefits to the government compared to total contract costs.

The AMA believes contractors should be judged on the extent to which they meet their contract objectives. However, we are concerned that the Scope of Work appears to subordinate quality of care objectives simply because their dollar benefits would be difficult or impossible to calculate. The contract objectives that contractors are required to address are based on the four PRO functions specified in the Social Security Amendments of 1983: to review the validity of diagnostic information provided by hospitals, to review the completeness, adequacy and quality

of care provided, to review the appropriateness of admissions and discharges, and to review the appropriateness of care provided for outlier cases. Since Congress recognized the importance of the quality of care function, we believe that the Scope of Work should be amended to provide specifically that in evaluating a PRO's performance, quality of care objectives will be accorded equal weight with cost and admission review objectives, DRG validation objectives and outlier review objectives.

The AMA vigorously opposes evaluating a PRO based on a cost-benefit ratio. Section 1153(c)(2) of the Social Security Act provides that "the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract." We believe that the functions specified in the PRO contract should be based on the four functions enumerated in the Social Security Amendments of 1983. Since no mention is made in the Social Security Amendments that saving money for the government is a PRO function, it would be improper to judge a PRO based on a cost-benefit ratio.

The Scope of Work also provides that a PRO will be evaluated in part on an "admission factor" based on gross admissions in the PRO area. The admission factor will be calculated by comparing the rate of increase or decrease in the admission rate for the PRO area during the contract period to the increase or decrease in the admission rate before the contract went into effect. If the average admission rate for the PRO area in the four years preceding the contract period is below the national average, the contractor's target rate will be the PRO area

rate. However, for PRO areas in which admission rates have been falling, the contractor's target rate will "be a zero percent change." If the average admission rate for the PRO area in the preceding four years is above the national average, the contractor's target rate will be the rate halfway between the PRO area rate and the national average. Changes in actual admission rates during the contract period will be compared to the contractor's target rate. Changes that are above the target will be calculated as a negative benefit. A rate that is below the target will be credited to the contractor as a positive benefit.

The AMA opposes the use of an admission factor in evaluating a PRO's performance. Not only is there no statutory basis for utilizing an admission factor, but there is no data to show that a "national average" -- a mere mathematical calculation -- represents an appropriate level of admissions. One of the functions of a PRO is to review the appropriateness of admissions and discharges -- not to arrive at a nationally determined quota. Congress did not make PROs responsible for changing the area's overall Medicare admission rates to conform to a national standard. Thus it would be inappropriate to evaluate a PRO based on a function which Congress did not intend it to perform, particularly when the criteria proposed are arbitrary and not based on proper quality considerations. It should be pointed out that national averages do not make allowances for local factors such as variations in population age and catastrophic events.

Evaluation Criteria

The proposal specifies a point system for evaluating the various contract bids. A maximum total of 1000 points is possible (1,100 for physician organizations). The evaluation criteria carrying the most number of points are the quality of the personnel managing the PRO and reviewing care (200 points), admission objectives (185 points), quality objectives (185 points), experience (150 points), and data collection and analysis (100 points).

The AMA has three major concerns with the point system for evaluating PRO bids. One concern is that the point system fails to establish objective standards for HCFA to use in determining how many points a prospective contractor should be awarded for each evaluation criteria. For example, it is not clear whether a bidder who establishes an objective of reducing inappropriate admissions by 20% will receive more points than one who sets an objective of reducing inappropriate admissions by 10%. The result is that HCFA is given excessive authority in awarding points. The AMA believes that objective criteria for awarding points should be clearly specified so that HCFA is not allowed virtually unfettered discretion and bidders are aware of the basis on which they will be evaluated.

Our second concern involves the awarding of 150 points based on an applicant's experience. A maximum of 50 points would be assigned based on the number of years an applicant had been conducting review activities. Another 50 points would be assigned based on whether an applicant had private review or Medicaid review experience. Only 50 of the points relating to experience would be based on the quality of the organization's previous review activities.

In our view, length of review experience and the number of review contracts held by an applicant are irrelevant without taking into account the quality of the applicant's review. For example, an applicant could obtain 50 points for having private review contracts and Medicaid contracts without any measure as to the quality of review activity. The quality of the applicant's review could be minimal or even substandard. However, points would be assigned based solely on the existence of those contracts. Likewise, length of experience fails to recognize that an applicant could have been a minimal performer and had managed to retain review activity for the requisite number of years.

We suggest, instead, that previous experience only be considered in conjunction with the quality of that experience. We also believe that only 100 points should be assigned to this item. An overemphasis on experience could preclude selection of a new organization that, through innovative approaches, could provide greatly enhanced review activities.

Our final concern relates to the awarding of 100 bonus points for physician-sponsored organizations. The AMA believes that the awarding of a mere 100 bonus points (only 10% of the total) for "physician-sponsored organizations" fails to satisfy the statutory mandate that such organizations be accorded "priority" over "physician-access organizations." "Priority" denotes a preference of one party over another in the exercise of rights over the same subject matter. In order to assure that physician-sponsored organizations receive the preferred status that Congress clearly intended, HCFA should establish a different method for evaluating the proposal of a physician-sponsored organization if it is competing

against a physician-access organization. We recommend that HCFA establish a policy whereby a physician-sponsored organization will be awarded the contract over any physician-access organization that submits a bid as long as the physician-sponsored organization receives a specified minimum number of points. The fact that a physician-access organization may accumulate more points would be irrelevant. The number of points that a physician-sponsored organization would need to amass would be the minimum number required to ensure that the organization is qualified to be a PMO.

Admission Objectives

The Scope of Work provides that contractors must develop admission objectives in each of the following five areas:

1) Reducing inappropriate admissions.
2) Reducing the number of admissions for procedures usually performed on an outpatient basis.
3) Reducing the number of admissions for unnecessary invasive procedures.
4) Reducing the number of inappropriate transfers to PPS-exempt psychiatric and rehabilitation hospitals or units, and swing beds.
5) Performing Admission Pattern Monitoring.

Contractors may establish additional admission objectives in the following areas:

1) Reducing overall admissions.
2) Reducing admissions for specific diagnosis related groups (DRGs).
3) Reducing admissions for specific practitioners or providers.

The AMA agrees that contractors should be required to establish admission objectives for the five mandatory areas. Congress specifically stated that one of the functions of a PRO under the PPS is to review "the appropriateness of admissions and discharges." All of the five areas relate directly to the function of reviewing the appropriateness of admissions and discharges.

We are extremely concerned, however, over the sample calculations in Attachment 5 concerning how to compute a contractor's cost-to-benefit ratio because they indicate that PROs will be permitted to establish admission objectives of reducing the total number of admissions in their area for a particular diagnosis. The Scope of Work, for example, suggests that a contractor may establish an admission objective of reducing the number of admissions for pneumonia by 20%. The AMA strenuously opposes the setting of arbitrary standards by which performance is measured. PROs could be encouraged to deny appropriate as well as inappropriate admissions in order to meet their contract objectives. The likely result would be rationing or denial of health care for the nation's elderly.

The AMA also believes that to allow contractors to establish admission objectives of reducing overall admissions, admissions for specific DRGs or for specific practitioners or providers would go well beyond Congressional intent. No language in the statute or the conference report can be found to indicate that Congress viewed PROs as a mechanism for reducing overall admissions for Medicare patients irrespective of the need for the admission. In addition, a PRO could reduce overall admissions, admissions for specific DRGs, and admissions for specific practitioners or providers in its area without successfully performing their

function of preventing inappropriate admissions. The objectives should relate to reducing inappropriate admissions for specific DRGs and inappropriate admissions for specific practitioners or providers.

Peer Review

The Scope of Work states that PRO contractors would be required to utilize physicians to review the care provided by other physicians. The Scope of work also provides that in making reconsideration determinations, a PRO would be required to utilize board certified or board eligible physicians or dentists in the appropriate specialty.

The AMA believes the Scope of Work should be amended to clearly provide that only doctors of medicine and osteopathy are authorized to review the care provided by other such doctors. Dentists should be restricted to reviewing services performed by other dentists. We also believe the Scope of Work should be modified to require that in making reconsideration decisions, PROs must utilize "qualified physicians with appropriate expertise." One of many ways of determining whether a physician is qualified in a specialty is board certification. However, the term "board eligible physician" is no longer generally recognized as denoting that a physician is qualified in a particular specialty.

Time Periods

The Scope of Work provides that within 45 days after the contract is effective, the contractor must submit a brief description of its written criteria for conducting utilization review and quality review. By that time the contractor must also have executed a Memorandum of Understanding (MOU) with each fiscal intermediary (FI) in the area, have commenced

collecting and entering data into the monitoring system and be capable of developing patient profiles, physician profiles, hospital profiles, DRG profiles and diagnosis/procedure profiles.

The AMA believes these time frames may be insufficient for prospective contractors to complete the necessary tasks. As a result, we urge HCFA to lengthen these time periods to 90 days.

Conclusion

The AMA supports medical peer review focused on quality of care. Thus, we want to ensure that the PRO program does not repeat the PSRO program's mistake of becoming devoted primarily to the purpose of restricting health care expenditures. We believe strongly that the Scope of Work and the Technical Proposal Instructions and Evaluation Criteria should be modified as noted above to help ensure that the PRO program emphasizes quality assurance as well as cost containment.

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Senator DURENBERGER. You have heard the testimony by Mr. Scott here earlier and his basic optimism about our being able to move much more quickly. Your written statement and your oral comments don't reflect that same kind of optimism. Can I ask you why?

Dr. NELSON. Well, Mr. Chairman, in an earlier incarnation I established the world's first PSRO and signed a contract for that in 1973 with Senator Bennett and Charley Edwards, and I remember the length of time that that process took. I think that we have a substantial leg up this time around, because we have a bureaucracy that has some experience, and we have peer review organizations that have existing track records. That should help. But we have to also remember that there are substantial numbers of States in which there is not a mature peer review organization or in which the State medical association has taken on the task of establishing the PRO, and that they will require enough lead time to comply effectively even with reasonable scope of work regulations and proposals.

Once we have identified areas and the kind of organizations that are eligible, there is a long time, in my opinion, between identifying an eligible organization and receiving a proposal that complies with a scope of work which is as yet undefined, that is awaiting regulation. We heard today that maybe those regulations will be out when? Late February? No, it is later than that. And after they are out, then an organization who wishes to become a peer review organization will have to go through a process which may involve reaching an agreement with 1,000 hospitals, if it is a large State, to review 25 percent of the outliers, or to validate the diagnoses. The organizations will have to reach agreements, have memorandums of understanding with payors on data acquisition—an incredible lot of difficult work above and beyond assuring and enlisting the physicians support—the training of staff. If I had the task simply of writing a proposal, I would find that a very difficult piece of work, given the scope of work description we have received so far.

Senator DURENBERGER. Let me stop you at that point and ask you to clarify for me your understanding of what happens in what Jim Scott says, after the 60-day period of time once the RFP is out. Implicit in what you said is that a peer review organization that wants to respond to the RFP has to go out and make all these contracts or subcontracts. Is that true, or does it just have to set up a process that can be approved?

Dr. NELSON. No; he has to set up a process. He has to set up a process, but part of that process involves reaching an understanding with the hospital so that a PRO doesn't have to shoot its way in the door. There is a reasonable way to proceed with peer review that involves the support of the community, the hospitals, and all of the other actors, and a wise PRO builds on that kind of understanding. It takes time.

Senator DURENBERGER. In some parts of the country there are wise PRO's that have established those relationships, and I take it they won't have any difficulty.

Dr. NELSON. They will certainly have an easier time.

Senator DURENBERGER. Right. But how much of the country might we be talking about that is going to have some substantial difficulty?

Dr. NELSON. Well, we understand that about 20 State medical associations are actively working toward becoming designated as a peer review organization. None of those medical associations have previous experience directly in that. There are other States where there are multiple existing PSRO's that somehow have to work out a consortium arrangement, either under an umbrella or themselves.

I tend to view the task as a good deal easier, because I come from one State that has had its act together in peer review for a long time. And even under those circumstances I see a big task in the implementation of the program.

Senator DURENBERGER. And one of the problems I have noticed the last couple of months back in Minnesota is that somehow or other I am being blamed for the delay on area designation, because I have got two very active PSRO's and so they are being told the reason nothing is coming out is because of me. But even in that kind of a situation, which you are testifying to it is appropriate to consider what Dr. Dehn said about the prescriptive nature of some of the requirements. Let's say even before you get together or a new association decides it is going to go into business, you ought to know what some of the ground rules are. The one he mentioned specifically is one of those bureaucratic ground rules like "you can't fire your executive director without 6 months' notice," and I don't know what else like that is in there.

But in effect is that what you are saying to us, that before a group of people get together and make a substantial commitment of time and resources and so forth, it is some of those kinds of rules, particularly because they know they are dealing with an agency like HCFA, which is probably better today than it used to be, but it is some of those kinds of rules that become important to an entity before it decides to take on a substantial commitment?

Dr. NELSON. That is exactly correct.

I might parenthetically add that part of the AMA's efforts in this whole area is to provide a college to assist State societies who want to become involved in that, educate them as quickly as we can through a series of workshops and providing technical assistance, both formally and informally, to help them with that, because it is a big task.

Senator DURENBERGER. Are you testifying today on behalf of the AMA, or just as a member?

Dr. NELSON. No, I am testifying on behalf of the AMA.

Senator DURENBERGER. Does the AMA have a current positive position about peer review? They never used to have one, I know.

Dr. NELSON. I just happened to have brought it. [Laughter.]

Senator DURENBERGER. Well, we can make it part of the record, and you can characterize it.

Dr. NELSON. Well, it is three sentences.

Yes, we do. First of all, our commitment to peer review is absolute, and particularly with the future challenges that are coming insofar as cost containment and the need to preserve quality.

Second, without any equivocation, we accept our responsibility to assist the medical organizations who wish to become peer review organizations.

Third, as a national organization we have an absolute commitment to make sure that quality of care continues to be in that equation, that we don't sacrifice quality on the altar of cost containment. We understand that there are savings to be made through effective peer review; that is the reason we are committed to it, but quality considerations have to stay in place.

Senator DURENBERGER. OK. So if I put myself in the position of the consumer, you are telling me that one of the major commitments of the AMA to the peer review process is that, in our effort to contain costs, you are there to protect them on the quality side, or you feel very strongly that there is a contribution that professionals can make that fiscal intermediaries and other kinds of technocrats are not going to make to this process?

Dr. NELSON. I could answer by giving you two very brief examples.

In my hospital now, with DRG's coming online, we have for the first time a hospital formulary being developed. That formulary may be a good thing, or it may be a bad thing, if it begins to restrict my access to needed medications for my patients because they are too expensive. The only way that that kind of thing can be made responsible is if it is managed and directed by physicians. It can be a force for good, or it can be a mechanism to ration care that hurts the patients.

Another example is, many hospitals are now restricting the access to the laboratory in terms of time; that is, you have to have an act of Congress to get certain laboratory studies done in the middle of the night, regardless of how important they are or how critical they are. That is another kind of consideration, direct quality consideration that organized medicine has to be involved in monitoring.

Senator DURENBERGER. Well, let me put the glove on the other hand. I am not a consumer, I am the payor; I am the person who has to pay so all of these folks can utilize services. And I have begun the process of redesigning the way I pay. And we have generally been calling it "prospective," and eventually it will take other kinds of forms.

Does the AMA currently have a position on prospective reimbursement in general for hospitals or doctors or any other providers?

Dr. NELSON. Well, our position on prospective pricing continues to be that it should have been tested more before it was implemented, that certainly we support that kind of change being tested and further evaluated. Now, since it is law, then our responsibility is to make sure that we monitor it carefully, that we instruct our physicians on the best ways to work within that system for the betterment of the entire system, and yet make sure that when quality deviations are identified, that we know about it and count it and let others know about it. And on a regular basis we are asking our component societies to make available to us instances of deficient care that are resulting from prospective pricing.

Senator DURENBERGER. All right.

Now, you know my problem, or maybe you can presume my problem. We passed this legislation 1 year ago. Everybody knew it was coming. We had pretty well had the hospitals onboard and a lot of other people, but we haven't had the doctors onboard, and we still don't have the doctors onboard. And they are spending millions of dollars in a very good study to eventually, I assume, sort out the role of the physician in this more consumer-choice oriented health care delivery system.

But we have also provided the physicians of America and—and this makes me a little more squeamish—the physician associations of America with an opportunity to interface directly with the genesis of this prospective payment system. And I suppose the AMA or its State organizations converted into peer review organizations could defeat this system. They could use my first half, the consumer, to point out all of the deficiencies in this system—early discharges, the death we just heard about, and so forth—to defeat this system. I worry about that and I want you to tell me that is in no way the objective of the organization nor any of its subsidiary organizations, nor anybody that you know that is engaged as a physician in peer review.

Dr. NELSON. Well, you are asking for me to commit affiliated organizations, and so forth, in a way that I can't in honesty do, because I haven't gone around and asked them all. I can certainly tell you that the American Medical Association does not have as its primary intention provoking or bringing about the failure of prospective pricing. And we don't have in mind collecting data on the deficiencies or difficulties with that as a primary objective. We are going about that because that is our job.

We see ourselves as defenders of the public health and welfare, regardless of what sometimes we may be painted by others. But we take that very seriously.

Senator DURENBERGER. You are going about it because Max Baucus and I said, "You are a key to the success of this program." That is why you are going about it. Yes, individually there are doctors—you are one of them, for 10 or 12 years, something like that, and there are a lot of very good physicians in this country—that preceded our entry into this system. But as of today, the involvement of 20 State medical societies, and so forth, trying to get into peer reviews, and so forth, is because of us.

So we have a lot at stake besides our little reputations and whatnot else. But the whole system has a lot at stake in where the professional associations of physicians are headed in this country with regard to the changes that are taking place in reimbursement.

I would hope that at least, if not an endorsement of prospective pricing, something positive about the entry of physicians into peer review as part of prospective pricing would be an articulated and a committed position of the American Medical Association as we continue this process.

Dr. NELSON. I think it is fair to say that we have articulated such a position, that we recognize the importance of the role of peer review in not only taking advantage of the possible savings that can come about from prospective pricing but also in making sure that the health of the public isn't affected adversely.

Senator DURENBERGER. All right.

Well, I thank you very much for your personal commitment and for your testimony today, and I am sure we will see more of you in the future. Thank you very much.

Dr. NELSON. Thank you, Senator.

Senator DURENBERGER. Our last witness will be Vita Ostrander, president-elect of the American Association of Retired Persons. Vita is here from Atlanta, Ga.

Vita, as I indicated to the other witnesses, we have your full statment, which will be made a part of the record. You may read it or summarize it, as you deem appropriate, and as with the other witnesses, we will not put a timer on you or anything like that, so you can say what you want to say. And if you want to react in any way to any testimony you have heard here this morning or questions that have been asked, you may feel free to do that.

STATEMENT OF VITA OSTRANDER, PRESIDENT-ELECT, AMERICAN ASSOCIATION OF RETIRED PERSONS, ATLANTA, GA.

Ms. OSTRANDER. Thank you.

I have with me Jack Christy from our Federal legislation staff.

I want to thank you for this opportunity to state for the subcommittee the American Association of retired persons' deep concerns about the development of peer review organizations under the DRG prospective pricing system. At this time I will summarize our statement which will be submitted for the record.

AARP's concerns arise from the economic incentives created under the medicare DRG system and the Health Care Financing Administration's apparent disregard for the impact such incentives have on the quality of care provided to medicare patients.

Mr. Chairman, I have already heard cases where too-early discharge is severely straining home health capabilities. I spoke to one State association last week, and I was quietly informed by many of the providers.

The incentives in DRG payment for hospitals that is potentially "manipulate caseloads, over-admit patients, discharge patients too early, and under-provide ancillary services" argue for safeguards in the form of quality and utilization review.

PRO's may be the only mechanism for monitoring and maintaining quality of care under the new DRG system. Yet the PRO program as it is currently being developed by HCFA appears inadequate to assure the maintenance of quality care.

The quality objectives in the proposed scope of work for PRO contracts represents a commitment to quality care that falls far short of the risks created by DRG. We cannot afford to wait until patients have been damaged to be responsive. Responsible peer review must require monitoring mechanisms initiated in those places in the system where there are incentives not to provide adequate, appropriate, or quality services.

Moreover, there should be a strong consumer role built into the system. There should be consumer representation on every PRO board.

Additionally, the scope and quality of PRO data will directly affect the ability of the PRO to contain costs and assure the maintenance of high quality care. PRO's must be encouraged to main-

tain data sources and processing systems that provide the basis for effective peer review. HCFA, PRO's, providers, and consumers must begin to develop guidelines that permit greater dissemination of provider specific information.

In conclusion, the DRG system introduces much needed cost controls in our hospitals, but it also has potential negative implications for quality of care. A strong utilization review mechanism is necessary both to avoid unnecessary and costly increases in admission and readmission and to protect patients from too-early discharge, and the underprovision of services.

A strong PRO program is necessary to insure that the new medicare payment system does not create a system of second-class care for its beneficiaries.

That concludes my summary statement. AARP is gratified by Mr. Scott's statement about beefing up quality of care, but it is meaningless unless quality objectives are matched with a PRO evaluation system that appreciates, awards points, for these objectives. Otherwise, they are meaningless.

We are also impressed with the AMA's commitment to quality of care. But unless data is maintained, we will have no assurance that that quality of care is there.

Senator DURENBERGER. Vita, thank you very much.

[Ms. Ostrander's prepared statement follows:]

Statement of the American Association of Retired Persons on Peer Review Organizations

INTRODUCTION

Thank you Mr. Chairman for this opportunity to state for the Subcommittee the American Association of Retired Persons' deep concerns about the development of Peer Review Organizations under the DRG prospective pricing system. AARP's concerns arise from the economic incentives created under the Medicare DRG system and the Health Care Financing Administration's apparent disregard for the impact such incentives have on the quality of care provided to Medicare patients. AARP believes that the virtual neglect of quality of care issues in HCFA's "Scope of Work" proposals for PRO contracts is harmful not only to Medicare patients, but to the DRG prospective pricing concept. Responsible policy makers cannot neglect new incentives that adversely impact the quality of medical care and expect to maintain public support for the DRG prospective pricing system.

CONTEXT OF THE PROBLEM

The DRG prospective payment system establishes a new set of financial incentives for hospitals that differs from those found under both cost-based reimbursement and other kinds of prospective payment systems for hospitals. Two fundamental incentives are created by the DRG system: to reduce the hospital cost of each inpatient stay; and to increase the number of inpatient admissions.

The incentive to reduce the cost per case is predicated on the belief that hospitals can save money by operating more efficiently and by offering a more cost-effective mix of

services. But this incentive to provide the least costly care to patients by avoiding unnecessary care, carried to the extreme, could result in adverse impacts on quality of care.

Reductions in cost per admission can be achieved, for example, by reducing length-of-stay or reducing the number and mix of services provided during the stay. Reducing the length of stay is not per se violative of standards of quality of care. However, discharging a patient too early could place the patient at risk of inadequate care and threaten recovery. In the same way, a reduction in ancillary services does not necessarily indicate a quality of care problem. But maximizing profit by lessening needed resource consumption or ancillary hospital services such as rehabilitative therapy would adversely impact quality of care.

DRG payment also encourages hospitals to increase admissions and to increase admissions selectively. Whereas cost-based reimbursement gave the hospital an incentive to keep occupancy rates high by increasing either admissions or length-of-stay, only admissions produce or increase revenue under DRG payment. Thus, serving patients in some DRGs will be more profitable than in others, because those DRGs will have higher ratios of price to cost.

As indicated in a study by the Congress, Office of Technology Assessment (OTA), "Diagnosis Related Groups and the Medicare Program: Implications for Medical Technology," July 1983, unique to DRG per case payment is the "revolving door" incentive. In

effect, hospitals eager to increase admissions could hospitalize marginally ill patients and discharge and readmit patients at a later date for deferrable procedures that might otherwise be performed as part of a single stay. Such patient "shuffling" could very well adversely impact on quality of care.

In summary, the incentives in DRG payment for hospitals to potentially manipulate case load, or overadmit patients, discharge patients too early and underprovide ancillary services argue for safeguards in the form of quality and utilization review. As stated by OTA in the report cited above, "It is important that at the Federal level the real need for quality assurance presented by DRG payment be recognized."

PEER REVIEW ORGANIZATIONS

Appreciating the incentives in the DRG payment system, Congress mandated that all hospitals participating in Medicare contract with a PRO by October 1, 1984. This mandate is intended, among other things, to provide a permanent institutional mechanism for maintaining the commitment to high quality care.

In fact, PROs may be the only mechanism for monitoring and maintaining quality of care under the new DRG system. HCFA has given no indication of support for any other mechanisms by which to monitor quality of care. Yet the PRO program as is currently being developed by HCFA appears inadequate to assure the maintenance of quality care. AARP believes that insuring quality medical care must be a primary objective of the PROs.

PROs AND PROPOSED "SCOPE OF WORK"

The proposed "Scope of Work" for PRO contracts represents a commitment to quality care that falls far short of the risks created by the new DRG system. HCFA states that it does not intend to give more weight to cost control than to quality assurance. However, PRO contracts are required to include only one quality of care objective compared with at least five objectives to control admissions.

The admission objectives and admission pattern monitoring are intended to stop hospitals from behaviors that enhance payments under the DRG system: they are essentially cost control devices developed in recognition of the incentives to game the system.

HCFA fails to acknowledge the incentives of the DRG system with respect to quality. HCFA requires only one quality objective "verified" as a "significant problem in medical care". The assessment of the quality objective is a relatively subjective process focusing on how many patients are affected and the "severity of the problem" as determined by HCFA.

In summary, when the objective is cost control rather than

quality, HCFA acknowledges and establishes mechanisms for monitoring every last incentive. The system should work the same way in the area of quality assurance. We cannot afford to wait until patients have been damaged to be responsive. It is too convenient to forego quality assurance because of the relative difficulty of specifying and measuring criteria for quality of care. Responsible peer review under the DRG system must include detailed quality objectives.

AARP RECOMMENDATIONS FOR QUALITY REVIEW

The quality objectives in the "Scope of Work" for PRO contracts must be revised to do more than achieve improvement in at least one of the five stated areas: First, "improvement" is not an acceptable standard. Nowhere is it defined. What happens if there is little or no baseline data by which to measure improvement? Second, all, not merely one, of the outcome-oriented objectives should be achieved. All of these should be minimum quality objectives. Third, the definitions for "significant potential" and "serious patient complications" must be broadened. As the second quality objective now reads, any medical omission short of causing death or near-death, is acceptable. Further, there must be a demonstrated frequency of death or near-death in order to reinstate the medical service that has been declined. This is not acceptable. Fourth, "reducing avoidable deaths" is such a universal quality standard that to allow it to be the one quality objective chosen by a PRO is not an adequate commitment to meaningful quality assurance.

Although the outcome-focused objectives are a necessary component of any quality review, patient-focused objectives must also be developed. Patient focused objectives acknowledge the actual condition of the patient in the context of addressing that patient's health needs and rehabilitative needs to insure maximum physical functioning. The total package of quality assurance must have as its objective a review of the adequacy, appropriateness and quality of all services provided in the facility.

Executing this quality assurance objective requires monitoring mechanisms initiated in those places in the system where there are incentives not to provide adequate, appropriate or quality services. Monitoring is essential to determining whether services have been reduced only to the appropriate minimum. Consequently, mechanisms for monitoring quality should be a large part of the PROs' work, and so should be included in the "Scope of Work."

For example, the PROs could monitor a representative sampling of all Medicare admissions per facility, following the sample through treatment. The data collected would focus on reasons for admission, actual condition of the patient with a determination of functional capacity at the point of admission, actual services provided, and actual condition upon discharge with an evaluation of functional capacity. A second, independent random sampling, could follow beneficiaries from the point of discharge through a predetermined time period. The data collected would focus on

functional capacity upon discharge, discharge destination and whether there was a readmission. The monitoring of these two representative samplings could be achieved through a mechanism akin to the "Inspection of Care" reviews done by state Medicaid agencies in reviewing nursing home care.

Moreover, there should also be a strong consumer role built into the system. The PROs should maintain a consumer initiated complaint file. Additionally, there should be strong consumer representation on every PRO Board.

AARP believes that the issue of quality assurance even goes beyond the scope of the PROs. There are several areas that appear ripe for further study, either through a HCFA grant or contract. One such area is the development of norms of care for geriatric patients. Currently, we have no standards by which to evaluate quality of care for the older patient. Such norms would be invaluable for the PRO's wrestling with quality assurance issues. A second area for study focuses on specific DRGs and rehabilitative services. This study would select a number of DRGs for which rehabilitative services are indicated within days of a surgical procedure to insure functional recovery. A national sampling of these DRGs would determine whether necessary rehabilitative services were being routinely omitted.

AARP and virtually every other group representing Medicare beneficiaries that testified before Congress on HCFA's prospective pricing plan, called for strong quality assurance reviews. HCFA's draft proposals do not meet that expectation.

Consumers, providers and PRO contractors alike must be called upon to assist in the development of the kind of quality assurance mechanisms that will insure quality care while reducing overall increases in cost.

PRO DATA COLLECTION AND DISSEMINATION

Data collection and dissemination are the heart and lungs of PRO existence. The scope and quality of PRO data will directly affect the ability of the PRO to contain costs and assure the maintenance of high quality care. Though the "Scope of Work" proposals include strong incentives for the PRO to rely solely on data supplied by fiscal intermediaries (FI), AARP questions whether FI data is sufficient, at this point, for review purposes. Much must be done to improve the accuracy and adequacy of FI data for review purposes. The changes necessary to make the data reliable will cost money. Hence, the cost of FI data is as much of a concern as is the cost of purchasing non FI data.

AARP supports the development of a uniform collection and processing system that meets the needs of both fiscal intermediaries and PROs. However, until such a system is operational AARP believes PROs must be encouraged (or at least permitted) to maintain data sources and processing systems that provide the basis for effective peer review.

PROs are mandated to be able to develop patient profiles, physician profiles, hospital profiles, DRG profiles and diagnosis/procedure profiles. Health care consumers need this

information to make sound decisions about the care rendered by specific providers. While we recognize there are sensitive aspects to the provider information PROs develop, AARP firmly believes that a great deal more information about specific physicians and hospitals must be available to the public. HCFA, PROs, providers and consumers must begin to develop guidelines which permit greater dissemination of provider specific information. Providers must be accountable for the care they render and PRO data is crucial to that purpose. Effective quality review and consumer choice demand that the vague and questionable claims of provider confidentiality be ~~strictly~~ limited, and that consumers be afforded the information necessary to make vital health care decisions.

CONCLUSION

AARP believes that prospective payment can help stabilize the uncontrolled growth in hospital costs. The DRG system introduces much needed cost controls in hospitals, but it also has potential negative implications for quality of care, access to care, and systemwide costs. A strong utilization review mechanism is necessary both to avoid unnecessary and costly increases in admission and readmission and to protect patients from too early discharge and the underprovision of services. A strong PRO program is necessary to insure that the new Medicare payment system does not create a system of second-class care for its beneficiaries.

Senator DURENBERGER. On the quality point, your written statement has a set of recommendations for quality review, commenting on improvement as an unacceptable standard. Let me ask you the degree to which AARP has already been involved, since August, in the formulation of these objectives. We heard from Mr. Scott that the reason it took so long was that everybody is in the act and trying to be very comprehensive in their review. To what extent have the recommendations that are in this statement already been made?

Ms. OSTRANDER. I will have Jack respond to that, who has been actively involved with it.

Senator DURENBERGER. All right.

Mr. CHRISTY. Aside from the formal comments to the scope of work proposals, we have tried to participate in ongoing discussions with HCFA but have not been allowed to do so. So the only thing they have from us are the formal comments.

Senator DURENBERGER. What have you tried to do besides send written comments?

Mr. CHRISTY. Open informal dialog with the leadership of HCFA regarding a more extensive review of what their quality proposals are going to be and what we think they should be. That door has not been open to us.

Senator DURENBERGER. All right.

Let me ask about the comment in the statement about a consumer member on the pur review board. Now, I take it what is behind that—well, let me ask you what is behind that recommendation, then I will have another question.

Mr. CHRISTY. Well, earlier you characterized this system as a more consumer-oriented system that we are going to, and perhaps it is. If it is, the whole basis for consumers to be able to intelligently select within this system, to give it the competition which I assume is the intent, is to have information. And consumers have been locked out of medical information. There is a cloak of secrecy cast over the whole thing in the name of privacy—privacy, more often to the benefit of the hospitals and the doctors than to the patient. Until that cloak is completely withdrawn, there is going to be no ability for consumers to intelligently force competition. Having consumers on PRO boards is going to add that extra insight, that extra ingredient, to push that system toward disclosing information.

Ms. OSTRANDER. Senator, I have been working with PSRO's in my own State for some time. Six or eight months ago, when there was an effort to build a community-based long-term care system, I discovered that we had 24 doctors and no consumers on the PSRO board. When I began to zero in, I asked "How do you get your consumer input?" That was the big nebulous question that could not be answered. The more I worked in developing these programs and helping the State to begin implementation of a plan, I realized that it was more essential for doctors to have this perspective. While we could not provide highly technical information to those committees, there were certainly a lot of things that we could provide. I am more convinced than ever that there is great value in that consumer representation.

Senator DURENBERGER. My only point on the question is that there are two large ways to look at this and to go about it: One, typical of any professional-based function, whether it is a licensing board for architects, or whatever it is, is that we have gradually, at the State level in particular, moved a consumer or a citizen into some of those processes so that the professional can start to think like a consumer. I mean, we as consumers, make assumptions that they, as professionals, don't; they think like professionals only, and whatever is good for the profession is best.

So I can understand that to a degree that you could look at the peer review process as being designed in some way to protect professionals. But I think the whole emphasis behind peer review, for 10 years really, has been more consumer-oriented than anything else, to try to get that quality and efficiency linkage.

I don't argue against your proposal. I am much more concerned about what you can do to help all of us respond to the question I asked of Mr. Scott about how we can inform everyone who is a consumer about what this whole process is telling us—the peer review process—and particularly now what it is going to be telling us about the implementation of prospective payment systems and about the DRG's, and about the woman who was discharged early near Milwaukee and died. You know, once that story gets all around—your organization is certainly as skilled as anyone in the country to help us deal with that part of the issue. So I am inviting, here, your recommendations about how we can better—not me, sitting here; maybe I have to change a word here or a word there, but how this process might be better designed in order to make sure that that information is accessible to all users of the system.

Ms. OSTRANDER. It is difficult to explain the DRG's and the process involved in implementing them. It is very difficult for many elderly to understand, there is no question about it. But I think that we have to begin to put in place an extensive education program, and that is the responsibility of an organization like ours and should also be the responsibility of many others, and it should be the responsibility of the people who pay the bills to do that. And that comes right back to HCFA.

I have a commitment on this, because I know the value of the PRO in this whole role, that in that education process we do not eliminate educating the elderly as to the role of the PRO; even though they see it as primarily a technical review committee, they must understand what is there as a protection mechanism for them.

So the education process has got to be a broad-based one, but the payors have got to be the initiators to show good faith with those beneficiaries.

Mr. CHRISTY. If I could add to that, having an all-payor system would certainly make the information dissemination a lot easier. It would get a lot of people that are currently not concerned about DRG's, because they are not elderly, into thinking about prospective pricing, whether it is DRG's or something else. But at least it would bring more people onboard a lot quicker when all of their feet are to the fire too.

Senator DURENBERGER. Well, I won't argue with the point you are making about consumer information, but I don't think your

recommendation is healthy for the consumer, and there ought to be better ways to define that linkage.

But the point here, as we have watched the demonstration projects on vouchers, for example, it has been the senior organizations in the States and the communities who really have made those things go, once they caught on to what they were all about, because there are built-in educational functions. So it seems to me there is an important role here for all of us in designing that educational linkup between what is going on now in Washington with the community out there.

Ms. OSTRANDER. I think one of the things that comes through loud and clear is that there is hardly any meeting that I attend with older people that they don't ask very basic questions about the DRG. That is telling me that they desperately need that basic information.

Senator DURENBERGER. Yes.

Ms. OSTRANDER. And I would like to see HCFA initiate a serious educational program on it. I think we can supplement those programs; all of our organizations that deal with the elderly can become involved in that facet. But I don't think that they should be the ones to take the primary responsibility for it.

Senator DURENBERGER. And I think the hospital associations can do a job too. I met with my association yesterday, and that is one of the things we talked about, what their role might be in explaining to patients—like we now have the patients bill of rights, or something like that, that they have to pass out. Well, they ought to start finding some understandable way to say what is going on in that hospital that may not have gone on under medicare in the previous year, and communicate that to people.

Senator Bradley, do you have comments or questions? We are about to wind this up. I appreciate your being here.

Senator BRADLEY. Thank you, Mr. Chairman.

I have just one question for the witnesses, and that is: You have said, in your testimony, that you want to make sure that consumers get the information the PRO's have. Is that correct?

Ms. OSTRANDER. Well, what we are interested in is in working with PRO's as a member of their board, so that there is a give-and-take at that level. We think that is essential.

Senator BRADLEY. How would you think it would be most effective for the information that is developed from PRO's to be made available to the public at large?

Ms. OSTRANDER. Perhaps Mr. Christy would like to respond.

Mr. CHRISTY. It could start with an informational bank that is available to the public, and utilizing organizations like AARP and other major groups that have an interest in getting out this kind of information to their memberships. We would take on the responsibility of making sure our members were informed and people who pick up our publications could have the information too.

Senator BRADLEY. Do you mean in your local chapters?

Mr. CHRISTY. In our local chapters, right. At that level.

Ms. OSTRANDER. They would also cover your national membership, so that there would be a broad coverage.

Mr. CHRISTY. We are doing that sort of thing in terms of the assignment data that HCFA is now making available. We are taking

it from the local social security office and publishing it for our membership in an easy-to-read form.

Senator BRADLEY. Clearly, you can't provide all of the information. What kind of information do you feel would be most helpful to your members?

Mr. CHRISTY. Well, if we are really going down the road of competition, we have got to really start separating out providers and making quality determinations about specific providers. So we are going to start asking some very difficult questions about practice patterns and results. These are all very complicated things and hard to quantify and hard to put down in understandable forms, but we have got to go down that road if competition is where we are going.

Senator BRADLEY. About various hospitals?

Mr. CHRISTY. Hospitals and doctors.

Senator BRADLEY. Doctors, too? In other words, you support providing information on a doctor basis?

Mr. CHRISTY. Doctor specific.

Senator BRADLEY. Thank you.

Senator DURENBERGER. Thank you, Bill, very much. And thank both of you. I thank your association for its contribution to this effort over a long period of time and today, also. Thank you.

[Whereupon, at 11:35 a.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
TO THE SUBCOMMITTEE ON HEALTH
OF THE
SENATE COMMITTEE ON FINANCE
ON
IMPLEMENTATION OF
THE PEER REVIEW ORGANIZATION PROGRAM

February 10, 1984

The American Hospital Association (AHA), which represents approximately 6,300 institutions and more than 35,000 personal members, is deeply concerned about the Department of Health and Human Services' (HHS) implementation of the Peer Review Organization (PRO) program, and is pleased that the Subcommittee on Health, Committee on Finance, is exercising oversight over the Department's directions and delays in putting the program in place. The Association appreciates this opportunity to share its views with the Subcommittee on this vital program.

These views can be summarized, as follows:

- need for statutory revision of the October 1, 1984, deadline for hospitals to have contracts with PROs;

- objection to HHS' establishment of target utilization standards based upon fiscal objectives;
- significance of permitting delegated review;
- necessity for hospital representation on PRO governing boards;
- essentiality of confidentiality of information; and
- importance of provision for payment of hospital compliance costs.

OCTOBER 1, 1984 DEADLINE FOR HOSPITAL/PRO CONTRACTS

A major hospital concern is the October 1, 1984, deadline set nearly a year ago by P.L.98-21, the Social Security Amendments of 1983, for hospitals to have agreements for medical review with PROs or lose their Medicare provider status. With this deadline less than eight months away, HHS has not yet published regulations even to implement PROs. Given the delay, the AHA believes there is not enough time to complete the extensive and time-consuming process of HHS' negotiating contracts with PROs and the subsequent working out of agreements by PROs with hospitals, facility by facility.

Nonetheless, hospitals--and ultimately, Medicare beneficiaries who would be denied access to services--face the penalty of such procrastination, for circumstances totally beyond their control. These circumstances are compounded by confusion, as Professional Standards Review Organizations (PSROs) and fiscal intermediaries, in the absence of PROs, attempt to handle

medical review under Medicare prospective pricing, filling the vacuum of HHS inaction through policy decisions, sometimes conflicting, of their own.

The AHA believes that the Congress should revise the October 1 deadline--if a deadline is needed--to make it effective no sooner than 90 days after a PRO has been awarded a contract for a hospital's area.

TARGET UTILIZATION REDUCTION OBJECTIVES FOR PRO CONTRACTORS

Although revision of the October 1 deadline is crucial, it is not the AHA's primary problem with HHS implementation of the PRO program. The AHA's chief concern, based upon HHS' draft Scope of Work for PROs, released for public comment August 30, 1983, is the Department's intent to require PRO contractors to enforce state-by-state limits on Medicare hospital admissions.

The Peer Review Improvement Act, as created by P.L.97-248 and amended by P.L.98-21, states that the HHS Secretary must "include in the contract negotiated objectives against which the organization's performance will be judged, and negotiated specifications for use of regional norms, or modifications thereof based on national norms, for performance of review functions under the contract ...." In the AHA's view, HHS does not have the capability at this time to establish appropriate utilization objectives, although it may gain that capability--at least in part--through research connected with implementation of Medicare prospective pricing. Taking such

uncertainty into account, the AHA believes that any objectives developed should, in addition to avoiding arbitrary numerical quotas for admissions:

- be developed according to medical criteria;
- be based on identified utilization problems;
- use local data; and
- take into account the many nonhospital factors, such as demographics, that affect utilization patterns.

The draft Scope of Work goes far beyond these reasonable conditions. First, it implies that the setting of objectives will be according to fiscal, rather than medical, criteria. Not only are PRO contractors urged to suggest utilization objectives that "have potential for impacting [sic] Medicare reimbursement under the payment system that applies to the subject providers," but also sample cost benefit calculations are provided as indicators of fiscally motivated utilization targets. In short, the draft Scope of Work proposes that PRO objectives be justified on the basis of PROs' ability to meet dollar targets, rather than on medical needs of beneficiaries. The result can be a rationing of care, in order to meet arbitrary fiscal targets, thereby increasing the probability that medically appropriate care will be denied by the PRO and jeopardizing essential services for Medicare beneficiaries that the PRO program is in part designed to protect.

Second, the draft Scope of Work, while specifying that quality objectives "be in areas determined and verified as significant problems in medical patient

care, not suspected or potential problems," makes no such claim for utilization objectives. Surely the same realistic standard should apply to the problems of utilization.

Third, although the statute favors the use of area rather than national norms, the draft Scope of Work encourages whichever would be most efficacious for meeting the PRO contract objectives. According to the Peer Review Improvement Act:

> The organization shall, consistent with the provisions of its contract under this part, apply professionally developed norms of care, diagnosis, and treatment, based upon typical patterns of practice within the geographical area served by the organization as principal points of evaluation and review, taking into consideration national norms where appropriate ....

According to the draft Scope of Work:

> The contractor shall use explicit written criteria ... applying professionally developed norms of care, diagnosis, and treatment, based upon typical patterns of practice in the geographic area or, when such area norms would not be effective in achieving contract objectives, regional or national norms.

Fourth, the draft Scope of Work implies that hospitals will be held responsible--and PROs accountable--for any changes in utilization. It fails

to recognize epidemiological, demographic, social, and other factors that affect utilization rates. In the AHA's view, PROs should take into account (rather than be accountable for) these factors, particularly in terms of federal attempts to impose national norms and standards. In short, the AHA believes that implementation of the draft Scope of Work would lead to the federal government's denying payment for needed hospital care provided to some Medicare beneficiaries.

DELEGATED REVIEW

Another AHA concern is HHS' opposition, as reflected in its draft Scope of Work for PROs, to hospital performance of certain review functions on a delegated basis from a PRO.

This ban is counter to congressional intent, as expressed in Report No. 97-760 to P.L.97-248, which reads: "The conference agreement does not, however, bar a review organization from delegating the review function to a provider by subcontract, if the organization finds that the provider will effectively and efficiently review itself." In other words, the language makes the matter discretionary for the PRO.

A prohibitic against PRO subcontracting with hospitals is inconsistent with the efficient and effective administration of the PRO program. First, the review system as presently designed is completely compatible with a system of delegated review. Currently, a medical review entity will review a sample of

hospital cases, and perform more focused review if the hospital's denial rate exceeds a certain threshold. Such a threshold also could be used to trigger hospital eligibility for subcontracting to perform delegated review. If a hospital can demonstrate its ability to keep utilization under control, it should be given a chance to do so. Second, a new system building upon hospital utilization review efforts would be more cost effective than one lacking such efforts because it would avoid duplication of them and emphasize external review of truly aberrant providers and practitioners.

HOSPITAL REPRESENTATION ON PRO GOVERNING BOARDS

Yet another AHA concern is HHS' objection to even a minority of hospital representatives on PRO governing boards. The Department's opposition is based on a broad interpretation of "affiliated with" in the Peer Review Improvement Act. In language prohibiting a hospital or hospital-affiliated organization from contracting with HHS to serve as a PRO, it states: "The Secretary shall not enter into a contract ... with any entity which is, or is affiliated with (through management, ownership, or common control), a health care facility, or association of such facilities, within the area served by such entity ...."

In its August 24 proposed rules, HHS interpreted an organization to be "affiliated with" ... "a health care facility, or association of such facilities" ... "if it has a governing body member, officer, partner, 5 percent or more owner, or managing employee" with the same status on a PRO area facility or association.

While the AHA believes that the Congressional intent of the "affiliated with" clause is to prevent conflicts of interest--due to common ownership or control between the PRO and hospitals under review--it is also clear that allowing a hospital representative to sit as one of several members on a PRO governing board would not bias the activities of the PRO. On the contrary, precluding such representation would deny appropriate hospital participation, essential to making the PRO program work. It also would prevent physician and community representatives (such as those from consumer groups, insurers, employers, and unions) who serve on hospital boards from participating on PRO governing boards.

The AHA is pleased that this Subcommittee, as well as its counterpart on the House Committee on Ways and Means, recognized the necessity of hospital representation by adopting a provision--now part of S.2062, the Omnibus Reconciliation Act of 1983, and H.R.4170, the Tax Reform Act of 1983--to permit one hospital representative on a PRO governing board of 15 or fewer members and two representatives on a board of 16 or more.

CONFIDENTIALITY OF INFORMATION

A concern of the AHA since the founding of the PSRO program has been its lack of adequate confidentiality guidelines. This concern applies equally to the PRO program, for which confidentiality regulations have been drafted but not released. In the absence of appropriate implementing regulations, it is difficult to assess the extent to which HHS will meet the statutory

requirement that the Secretary "assure the adequate protection of the rights and interests of patients, health care practitioners, or providers of health care." There are two clear issues: access to information by PSROs/PROs and constraints on disclosure of that information by them.

In terms of access to information, the Peer Review Improvement Act requires a PRO to "collect such information relevant to its functions." The PSRO statute included identical language, made explicit by HHS in an early transmittal to mean that data collected by the PSRO must be necessary for the performance of the organization's functions.

In terms of information disclosure, the PRO statute contains a confidentiality provision that requires that "any data or information acquired by [a PRO] ... in exercise of its duties and functions shall be held in confidence and shall not be disclosed" except as necessary to carry out the purposes of the Act, "in such cases and under such circumstances as the Secretary shall provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care," or as necessary to assist federal and state fraud and abuse agencies, planning agencies, and licensing and certifying agencies in the pursuit of their functions, in accordance "with procedures and safeguards established by the Secretary." Information must therefore be protected except to the extent necessary for PROs and other agencies to pursue their statutory functions, and only under guidelines provided by the Secretary. In line with such protection, the PRO statute specifically excludes PROs from the Freedom of Information Act.

With appropriate confidentiality and disclosure guidelines not yet written, two difficulties have already arisen, which are in fact exacerbations of the absence of guidelines. The first is the potential compromise of patient confidentiality represented by a pending requirement that hospitals send copies of medical records to medical review entities. The second is a recent HHS requirement--opposed by AHA--that PSROs include hospital identifiers on hospital discharge data they release to HHS.

PAYMENT OF HOSPITAL COMPLIANCE COSTS

A final concern of the AHA involves the costs incurred by a hospital in complying with PRO information and other requests. To the extent that PRO requirements to hospitals are the same as those for PSROs, such costs will be covered by Medicare prospective prices. However, there are additional services, such as draft requirements that all hospitals provide space and telephone access to PRO staff when they are in hospitals and that medical records be copied and mailed.

In the AHA's view, these costs should be considered program administration expenditures and be paid to the hospital by the PRO. This recommendation is supported by language in P.L.98-21 that establishes that the costs of performing review be considered allowable costs under Medicare Part A, but paid directly to the PRO by HHS. It does not specify that such costs refer only to those directly incurred by the PRO ("The cost of such agreement should be considered a cost incurred by such hospital in providing inpatient services

under Part A"), so that a hospital's compliance costs could be recovered from the PRO as a function of the hospital's agreement with that organization.

CONCLUSION

The AHA, which has submitted extensive comments to HHS on the proposed area designation and eligible organization regulations and draft Scope of Work, is pleased to have this opportunity to outline its concerns--based upon the legislation governing the program--in a Congressional forum. Such a forum allows not only the delineation but also the clarification of issues and the emphasis they merit: in this case, while the October 1 deadline for hospitals to have contracts with PROs looms large, it is secondary to the need for reasonable utilization objectives, delegated hospital review, fair hospital representation, protective confidentiality guidelines, and adequate administrative payment when the program eventually is in place.

The AHA would like to work with the Subcommittee on these and other goals in order to achieve prompt PRO implementation, so vital to the success of the Medicare prospective pricing system that was established in partnership between the Congress and the hospital field.

TESTIMONY OF

AMERICAN MEDICAL CARE AND REVIEW ASSOCIATION

Mr. Chairman, the American Medical Care and Review Association (AMCRA) (formerly the American Association of Foundations for Medical Care) congratulates you for scheduling this oversight hearing on the implementation of the PRO legislation incorporated in the 1982 TEFRA legislation and as further modified by the prospective payment legislation passed some ten months ago.

Our Association is composed of health care organizations, including Peer Review Organizations. We supported the original PSRO program, and we support with even more enthusiasm the PRO program. It is an investment that will pay high dividends. Currently, our membership includes 140 health organizations representing 34,000 participating physicians.

The failure of the executive branch to implement this legislation in a timely fashion in our judgement risks putting the prospective payment system in serious jeopardy. Several of the members of AMCRA intend to compete for PRO contracts and have geared up to the extent possible before final regulations and scope of work are issued. Some members seem to be losing their initial enthusiasm for this program in light of the action, more a lack of action, on the part of the executive branch.

It may very well be that the delays have already reduced the number of organizations which will compete for the contracts, with the resulting loss of some potentially excellent PROs.

We urge you and the Committee to do what you can to get the executive branch moving. It seems to us to be a matter of will rather than capability on the part of the government to get this program moving.

We appreciate the opportunity to make our views known on this important matter and stand ready in any way we can to further the objectives that we share.

WRITTEN STATEMENT OF

THE AMERICAN MEDICAL RECORD ASSOCIATION
Chicago, Illinois

The following comments are submitted to the Senate Finance Health Subcommittee from the American Medical Record Association. We present these written comments for the subcommittee's consideration during its deliberations on the implementation of the Peer Review Organization (PRO) Program.

The American Medical Record Association is composed of 25,000 medical record administrators, technicians, and others interested in promoting the art and science of health record administration. Since its founding in 1928, AMRA has been committed to complete and accurate health records for the provision of patient care, collection of statistical information for use of the health care delivery system, and protecting the privacy of health information contained in medical records and resulting statistics. The emphasis on fulfilling that commitment is heightened by prospective payment, as our members are responsible for assuring the accuracy and timeliness of clinical data submitted to the fiscal intermediary for DRG calculation and thus hospital payment. We also are responsible for developing and enforcing policies that assure full documentation of reasons for admission and transfers, rationale and response to therapy, and justification for diagnoses and procedures--information necessary for patient care as well as reviewing organizations.

Our concern with the medical record and its data extends to concern with the program authorized by the Federal government to review and judge clinical data. We have several concerns we would like you to consider

as PROs are implemented. We speak to these points based on years of experience with PSROs, and even longer experience dealing with external review agencies.

First, there are no requirements that the staff employed by the medical review entity be skilled in ICD-9-CM coding conventions or Uniform Hospital Discharge Data Set definitions. The PPS regulations require that the medical review entity review, at least every three months, a random sample of discharges to verify that diagnostic and procedural coding is substantiated by the corresponding medical record. If the information is found to be incorrect, the medical review entity is authorized to change the coding used for the Medicare claim. Decisions may be appealed only to the PRO.

We recommend that, at a minimum, PROs be required to employ persons with proven competency in coding conventions and UHDDS definitions. The training of medical record administrators and medical record technicians combined with national certifying exams assure HCFA of one group of competent individuals. Recognizing that others with clinical backgrounds may be trained and become competent in coding and sequencing, we suggest that HCFA work with its sister branch, the National Center for Health Statistics, in developing a testing system to identify those who are qualified to validate clinical data and coding.

Without appropriate expertise on the part of the reviewers, the Federal government cannot be assured of the integrity of data upon which future evaluations of the PPS will undoubtedly be based.

A second concern is an extension of the first. Many individuals, both within and apart from existing medical review entities, are making decisions that affect the quality of this nation's health data. For example, we have had experience with one medical review entity which alters coding in ways incongruous with principles of ICD-9-CM. In other instances, decisions on codes which the authorized grouper will accept or reject interfere with accepted coding practices.

The International Classification of Diseases was developed by the World Health Organization to classify medical information for statistical purposes of a variety of international users. The ICD-9-CM is a more detailed clinical modification of the World Health Organization's ICD-9. Use of the UHDDS, which dictates definitions of clinical data and sequencing, is and has been HCFA policy for a number of years. Together, the ICD-9-CM and the UHDDS form the basis for aggregation of hospital statistics nationwide. To arbitrarily or thoughtlessly allow variation from those prinicples will erode the quality of data used in DRG determination; further, the quality of data used in evaluating and improving PPS, data used for hospital planning, and data used to assess this nation's morbidity and mortality may be inconsistent across PRO areas.

We urge your attention to the latitude given the PRO Program in changing codes, with the hospital able to appeal only to the decision-maker - the PRO. Controls in the PRO Program should clearly state that ICD-9-CM coding

principles are to be followed and UHDDS definitions adhered to, and that hospitals may appeal inappropriate decisions to a higher level than the PRO making the decision.

Our concern for protecting the individual patient's right to privacy is the basis for our final comment. DRG validation requires a review of medical records and, at HCFA's discretion, this may take place either at or away from the hospital. We have also learned of HCFA deliberations that would encourage certain smaller hospitals to submit records to the PRO to avoid the travel involved in on-site visits. DRG validation should be always performed on-site in order to protect the privacy of the patients whose records are being reviewed. It is the hospital's ethical responsibility to the public to assure release only to those properly authorized. Confidentiality is the hospital's legal responsibility under the Conditions of Participation, the standards of the Joint Commission on Accreditation of Hospitals, and many state laws. The physical act of sending copies of the record to the medical reviewer endangers the record's confidentiality and security. Further, allowing the PRO to maintain that copy also erodes the hospital/patient privacy relationship as the current PSRO program has never had final HCFA guidelines on confidentiality, release, security, or destruction of the information it keeps.

We ask your consideration of this important confidentiality and efficiency issue as PRO policies and guidelines are implemented.

Finally, we would like to offer the assistance of the American Medical Record Association in the implementation and evaluation of PROs and decisions regarding their scope of responsibility. Thank you for this opportunity to submit our comments.

AMERICAN OSTEOPATHIC
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February 7, 1984

Senator David Durenberger
Chairman, Subcommittee on Health
Committee on Finance
United States Senate
SD-219
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Durenberger:

The American Osteopathic Hospital Association (AOHA), the national association representing the 200 osteopathic hospitals nationwide, commends the Senate Finance Committee's subcommittee on Health for its interest in expediting the Peer Review Organization (PRO) regulations. Since osteopathic hospital participation in Medicare will eventually be contingent on contracts with PROs, we are very concerned about the delay in the promulgation of these regulations.

PROs are given a wide ranging role under Medicare prospective payment. They will be responsible for reviewing such occurances as transfers, readmissions, "day" and "cost" outliers, changes in level of care, reviewing a sample of admissions, and other activities. Since their functions are integrally linked to prospective payment, AOHA urges that some assurances be given to the osteopathic profession that osteopathic physicians will not be "locked-out" of PROs. As a minority profession, we are concerned about the composition of PROs and urge fair osteopathic representation nationwide.

AOHA feels that since osteopathic physicians are most familiar with osteopathic hospitals and the services provided, they would also bring a sensitivity to the review process. The Health Care Financing Administration (HCFA) would be remiss in not offering such an assurance to the osteopathic profession and we hope the Committee will be supportive of this recommendation.

AOHA also supports the pending amendment requiring hospital representation on PRO boards. The precedent for the appropriateness of hospital administration representation on such boards was set under the Professional Standards Review Organization (PSRO) program. There has been common practice to have osteopathic hospital chief executive officers sit on PSRO boards. Such representation added to the knowledge base and productivity of many PSROs. We urge your support of this legislative amendment.

Thank you for your consideration of these issues.

Sincerely,

Martin A. Wall

Martin A. Wall
Director, Government Relations

American
Psychiatric
Association

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Telephone: (202) 682-6000

January 9, 1984

The Honorable Robert Dole
Chairman
Senate Committee on Finance
Room SD-221
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

The American Psychiatric Association, a medical specialty society representing over 28,000 psychiatrists nationwide, is pleased to provide our comments on the implementation of the Peer Review Organization (PRO) program. We request that these comments -- and the attached APA comments on the Scope of Work and Technical Proposal Instruction -- be made part of the Subcommittee on Health's hearing record on this most important subject.

As the APA has testified before the Congress, the APA strongly supports -- and indeed conducts -- medical peer review programs which emphasize quality assurance through a system of professional evaluation by peers. We were gratified by the Committee's decision in crafting this legislation, now public law, to ensure that physician organizations such as the APA and AMA and physician-access organizations receive first consideration as designated PROs before contracts can be let to third-party payors or other non-physician organizations to provide such services. We believed that Congressional intent was to permit medical specialty organizations such as the APA to seek PRO designation, or at the very least, to become subcontractors in our specialty to a statewide PRO. HCFA's activities -- or lack of them in some cases -- may well serve to deny organizations such as the APA either opportunity.

Physician Organizations as PROs Endangered by Delay

That Congressional commitment is being frustrated by the Administration, evidenced by both the long delay in the publication of final PRO regulations and the RFP for PRO designation as well as the very nature of the Scope of Work for PRO proposal published in August.

After enactment of the Peer Review Improvement Act in September, 1982, almost a full year passed before proposed, not final, regulations dealing with PRO area designation and definitions of eligible organizations were published. Final regulations are "imminent" according to the Administration, but not yet forthcoming. In August, 1983, DHHS made available for comment a draft Scope of Work and Technical Proposal Instruction upon which we and other concerned

medical organizations commented at length. (A copy of the APA's comments are enclosed.) The final Scope of Work document -- the draft of which we have had serious reservations -- remains to be published.

Most critical, the aforementioned problems have caused unconscionable delay in the period during which physician and physician-access organizations may seek to become PRO contractors, before third-party payors or other non-physician organizations may be considered. By statute, that one-year waiting period will end September 30, 1984, just six months from now. We are concerned that the Administration's failure to promulgate regulations may serve to effectively block the ability of physician organizations to enter into contracts within that time frame.

Cost Versus Appropriateness of Care

Our concern in this regard relates directly to the differing views of PRO activities held by physician organizations and payor organizations. That difference is highlighted by the contrasting phrases "quality assurance" and "cost containment" as the focus of the PRO program. To date, DHHS activities seem to favor the latter, evidenced by the delays in promulgation of regulations as well as what we believe to be an improper emphasis on cost of care in the Scope of Work for PROs document.

The APA -- as indicated by the enclosed -- commented strongly upon that document to HCFA. We argued that the Scope of Work differs from both statute and Congressional intent by emphasizing dollars over appropriateness and quality of care. We are extremely concerned that HCFA is structuring PROs as extensions of the Prospective Payment/DRG system rather than as a balance to that system. The PPS provides hospitals with incentives to save money -- which may be at the expense of quality patient care and underutilization of services. This is effectively an untried reumbursement system, and thus it is more important than ever for peer review to assure that appropriate levels of care are being provided. As drafted, the PRO Scope of Work falls far short of this assurance.

The proposal listed four PRO functions with which we do not disagree, for they are based in statute which states that any peer review organization should determine whether services provided are reasonable and medically necessary, the quality meets professionally recognized standards, and the appropriateness of inpatient versus outpatient delivery of services. However, the Scope of Work document itself departs from both the governing legislation and the four goals stated on the Scope's opening page.

According to the proposal, contractors must achieve "admission objectives" in each of five areas, all related to cost containment. In stark contrast, the contractor is expected to achieve only one of five quality objectives. Among those objectives is to "reduce unavoidable deaths," not an area which is prone to regulation or achievement by a PRO. The required cost benefit analysis, too, stresses money over quality of care, stating "PRO evaluation shall be based on contractors' success in meeting these specific objectives where actual dollar benefits accrue and can be calculated." (emphasis

supplied). We do not believe that this was Congressional intent. Indeed, to the contrary, we believe Congressional intent was to establish PROs as a check against the emphasis on dollar savings in the Prospective Payment System.

Subcontracting

The Peer Review Improvement Act of 1982 gives PROs the option of subcontracting in a given area, either based on specific expertise or for total review. The Scope of Work, however, strongly implies, contrary to Congressional intent, that subcontracting would be based on geographic breakdowns for total review, rather than specialty breakdown for local or statewide review.

The American Psychiatric Association peer review program has been active since 1976 and has demonstrated effectively its ability to evaluate the medical necessity and appropriateness of psychiatric treatment. The APA program is nationwide in scope and centrally administered. Currently, more than 450 psychiatrists representing all subspecialties of the profession are providing peer review services. The peer review contract now extends to more than twenty private insurers (including three Blue Cross/Blue Shield plans) as well as to the Department of Defense's CHAMPUS program. The program includes utilization review, quality review and continuing education of psychiatrists as well as consultation with intermediaries to improve both availability of appropriate services and cost management.

The reported cost savings resulting from use of the APA peer review program are impressive. The Aetna Life and Casualty's peer review costs in 1981 were $20,000 and its estimated savings were $2.4 million. The Mutual of Omaha Insurance Company has estimated a savings of between $250,000 and $300,000 in its first year of participation. According to Dr. Alex Rodriguez, Medical Director of CHAMPUS, the peer review services have led to "outright savings" of between $4 and $5 million per year since participation began. These are additional savings above the annual cost of the program to CHAMPUS.

The Health Insurance Association of America in 1979 recommended the APA peer review as a model to other medical societies. The Vice President and Medical Director of the Prudential Insurance Company stated that "psychiatric peer review is a model program and the best one of its kind I've seen in over 30 years with the insurance industry....It has proven a worthwhile endeavor.

With this proven track record, this type of program is ideally suited to subcontract with the new PROs. Indeed, as the contractor is required to "use board certified or board eligible physicians or dentists in the appropriate specialty," in its review and reconsideration, an in-place, nationally recognized program such as APA's would be an easily integrated one.

We urge the Committee to ensure Congressional mandate is carried out with respect to the contracting process, the balance it has struck between quality assurance and cost containment, and the use of specialty breakdown for local or statewide subcontracting by PROs. The savings by-product envisioned by HCFA will evolve naturally, but must not be the primary mission of a national Medicare peer review program. If the Committee permits HCFA to succeed in making cost the sole mission of the PRO program, then Medicare beneficiaries -- our patients -- will have no one to protect their care and treatment.

Sincerely,

Melvin Sabshin, M.D.
Medical Director

MS/tf
enclosure

THE SENATE FINANCE SUBCOMMITTEE ON HEALTH HEARING ON
IMPLEMENTATION OF PEER REVIEW ORGANIZATIONS FOR MEDICARE
February 1, 1984

STATEMENT SUBMITTED BY
THE CHICAGO FOUNDATION FOR MEDICAL CARE

Effects of Delay in Implementation of Peer Review Organizations (PROs)

By statute Professional Standards Review Organizations (PSROs) are required to continue to perform review mandated by the Social Security Amendments of 1972 until such time as the Secretary enters into a contract with a PRO for the area. By Federal Regulations published September 1, 1983, PSROs are required to perform the complex review duties under the Prospective Payment System (PPS) in lieu of a PRO until a PRO contract is awarded in the area.

At the time of passage of the Social Security Amendments of 1983 last April it was evident that Congress assumed the Secretary would commence contracting with PROs well before October 1, 1983. On the basis of this assumption, the interim additional review responsibilities of PSROs would have been easily manageable under existing grants, with existing staffs and resources.

CHICAGO FOUNDATION FOR MEDICAL CARE

Continuing congressional optimism respecting the time-frame for implementation of PRO contracts is reflected in the September, 1983 Report of the Senate Committee on Appropriations which states: "The Committee allowance will permit PSROs to continue to conduct hospital utilization review activities until the new Professional Review Organizations (PROs) take over the job possibly by the Spring of 1984."

The time-frames for PRO implementation announced by the Health Care Financing Administration (HCFA) last fall are now eighty days behind schedule. The goal of the Senate Appropriations Committee to "enable PSROs to continue as efficient and effective organizations including...maintenance of adequate staff" is becoming increasingly more difficult to realize.

The remaining PSROs, which have weathered many storms, have survived on faith in the promises of Congress that the concept of physician peer review has not been abandoned. That concept, written into bills and reports, and enacted into laws signed by the President, has not had universal support within the present Administration. If the bridges built between government and the private sector of health care over the past decade are to endure, there must be prompt action on the part of the Administration to carry out the clear intent of Congress expressed in the Social Security Amendments of

1982 and 1983. Further delay can only compound the difficulties ahead for all involved in the restoration of a viable Medicare program. The burden of continued uncertainty and frustration is gravely weakening the foundation on which the future professional review program was built.

This PSRO's experience in implementation of the PPS to date in forty-five of the eighty-one hospitals under review in this area provides convincing evidence that hospitals sincerely wish to cooperate with the PSRO review under PPS. Among the hospital medical staffs there is increasing realization that true physician peer review offers the best prospect for a viable transition into the Medicare prospective payment system despite its constraints.

These promising beginnings cannot be sustained unless the basic concept of physician peer review has the active support of the government as well as the health care community.

CHICAGO FOUNDATION FOR MEDICAL CARE

Federation of American Hospitals
Michael D. Bromberg, Esquire, Executive Director

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Statement of the

Federation of American Hospitals

on the
Implementation of the Peer Review Organization (PRO) Program

Subcommittee on Health
Committee on Finance
United States Senate

February 1, 1984

The Federation of American Hospitals is the national association of investor-owned hospitals representing over 1,000 hospitals with over 120,000 beds. Our member hospital management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

We appreciate this opportunity to present our views on the subject of the implementation of the Peer Review Organization (PRO) program. The Federation has always been an advocate of medical peer review at the hospital level to assure not only the quality of patient care but also to eliminate and/or minimize admissions that are medically unnecessary; lengths of stay that are medically unjustifiable; and modes of treatment or performance of procedures that do not contribute to the well-being of the patient.

The Federation believes that the PRO program as developed by Senator Durenberger and ultimately enacted into law is a vast improvement over the Professional Standards Review Organization (PSRO) program that was created by the Medicare Amendments of 1972. The PSRO program as implemented by the regulatory process became an onerous, inflexible and complex system of Federal standards, criteria and norms that proved to be so expensive, unworkable, and uncontrollable that both the Executive Department and the Congress were willing to let it expire. The PRO program appears, however, at least in the legislative language and Congressional intent, to improve the medical review process by allowing greater flexibility at the local level and less rigidity at the Federal echelons. The Federation's prime concern is that in the process of implementing the program through rule making at the Departmental level (Health and Human Services), those who have been involved with the program for over a decade do not again twist the program into a rigid and unworkable system.

Another concern is that associated with the delay by the Department in publishing the final regulation on area designations and eligible organizations because the Department will not publish its Request For Proposal (RFP) for potential PRO contractors until the final regulation is published. The Department has testified before your Subcommittee (on February 1, 1984) that they are revising the RFPs Scope of Work provisions in accordance with comments received by them. However, until the Federation has reviewed the final RFP, we will be unable to evaluate the degree to which the PRO program adheres to the law and Congressional intent.

Another concern of ours relates to program monitoring and evaluation by the Department, particularly the aspect which would identify dollar savings achieved by the PRO to meet or exceed target rates established by the Department for each contractor to meet predetermined objectives in admission review, outlier review, and DRG validation. This smacks of a quota system established by a state highway patrol division or a metropolitan police department to issue so many speeding or parking tickets a day or a month. Other performance criteria can and should be used than a quota system, to make certain that denials are not issued for appropriate care. The program should be concerned about the quality of care, not costs alone.

Finally, the Federation is concerned about the October 1, 1984 deadline when hospitals must be subject to PRO review or lose Medicare payments. The alternative of having fiscal intermediaries authorized to perform this function because either "physician-sponsored" or "physician access" organizations have not been selected because of the delay in the final regulation and RFP is unacceptable. Fiscal intermediaries are not qualified to perform the PRO functions unless they themselves subcontract medical personnel to do the work. The Federation recommends an extension of the October 1, 1984 deadline for at least six months.

# # # #

AFFILIATED WITH THE AMERICAN HOSPITAL ASSOCIATION
MEMBER OF SOUTHEASTERN HOSPITAL CONFERENCE

LOUISIANA HOSPITAL ASSOCIATION

ROBERT D. MERKEL
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JANUARY 30, 1984
STATEMENT OF THE LOUISIANA HOSPITAL ASSOCIATION
TO THE SENATE FINANCE SUBCOMMITTEE ON HEALTH
ON
IMPLEMENTATION OF PEER REVIEW ORGANIZATIONS FOR MEDICARE

I am John Jurovich, III, and I represent the Louisiana Hospital Association. I want to thank you on behalf of the Association for granting this opportunity to express the Association's views on the implementation of Peer Review Organizations (PRO) for Medicare. This issue is one of great concern and interest to health care providers, as well as many others in the private and public sectors who have faced the questions of assuring continuity in the delivery of quality health care.

The Problem:

The current problem facing both the members of this committee and hospital providers of health care is the October 1984 deadline for implementing peer review. To date the Health Care Financing Administration (HCFA) has issued only one proposed rule regarding area designations and definitions of eligible organizations and a draft proposal regarding the scope of work of PROs. It therefore appears that other critical regulations cannot be promulgated within legislative time frames.

Solutions:

There are several solutions to this problem. One of which is to direct compliance with the legislative deadline. While this might be the simplest solution, it could result in very

serious repercussions. If HCFA rushes into compliance and promulgates hastily construed rules and requests for bids, numerous legal and operating problems will invariably result.

As an example, the LHA has enclosed for the committee's review our comments to the HCFA proposed rule entitled "Utilization and Quality Control Peer Review Organizations, (PRO) Area Designations and Definitions of Eligible Organizations", published in the August 15, 1983, Federal Register, (see attachment A), and those on the HCFA draft release entitled "Parts I & II, Scope of Work for PRO Contract", (see attachment B). While these HCFA documents were not hastily created, the seriousness of their effect on health care providers and Medicare beneficiaries in their original format cannot be overlooked. Ample time MUST be allowed for the institutional and private sectors to digest the content of these regulations and offer informed comments. HCFA officials should be congratulated for their desire to implement well thought-out rules with an allowance for comment and consideration from the industry it regulates.

The establishment of peer review is a very difficult task involving not only personal issues but what could be construed as a national dictate for socialized medicine -- for he who controls payment and the quality standards will control the practice. Due to this control, whether it be through HCFA or the Office of Management and Budget (OMB), this Association is adamantly opposed to nationally dictated controls. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), calls for the establishment of peer review, but does not address the imposition of national or mandatory standards that have and will be addressed by the bureaucracy in the promulgation of rules and other implementing documents.

These issues will be addressed in any rule making process, and they must be carefully reviewed by all parties concerned to insure that a national dictated practice of medicine does not become a reality. It is our opinion that such peer review is more detrimental to the provision of quality health care than the reduction of Medicare expenditures.

Statement of the Louisiana Hospital Association
To the Senate Finance Subcommittee on Health on
Implementation of Peer Review Organizations for Medicare
January 30, 1984

Recommendation:

It is the recommendation of the Louisiana Hospital Association that the legislative deadline for mandatory peer review stand. However, an allowance should be made for a grace period of ninety (90) days. During the grace period, hospital providers would be able to negotiate with existing Professional Standards Review Organizations (PSRO) or their Federal Medicare Intermediary for utilization review. Where there are no PSROs, a hospital could be allowed to negotiate with their state medical society should they not desire to do so with the local intermediary. Secondly, HCFA should be directed to promulgate appropriate regulations with sufficient comment periods (60 days) as feasible. In the meantime, current review instructions already in the field should be followed. Thirdly, should this recommendation be approved, that the organization within each state region that has contracted with a simple majority of that state's hospital providers be given top priority as that region's PRO when final regulations are issued and contracts awarded by the Secretary of HCFA.

It is also recommended, that any rules, regulations, or implementing documents utilize only locally established criteria and measurement standards. It is especially important that incentives to review organizations are not skewed one way or the other. They must be impartial and cannot have their efficiency ratings or contract award based upon Medicare dollar savings.

Summary:

This Association is seriously concerned over utilization review and the possibilities of misuse such review presents. The LHA is especially concerned that due to legislative deadlines and OMB involvement, ill conceived arbitrary and capricious regulations governing utilization review will be forthcoming. The problems encountered with the effectiveness and acceptance of prior utilization review programs enacted will be many times compounded

Statement of the Louisiana Hospital Association
To the Senate Finance Subcommittee on Health on
Implementation of Peer Review Organizations for Medicare
January 30, 1984

by that imposed in TEFRA; unless, all involved parties have an equal chance to communicate and have serious consideration given to their concerns. It should be remembered that the ultimate party that will be most effected is the Medicare beneficiary.

It is the recommendation of the LHA, that the regulations be postponed until such time that HCFA can grant reasonable comment periods and give consideration to those comments prior to implementation. In the meantime, current review protocol can be utilized. Secondly, that a ninety (90) day grace period be granted from the October 1984 deadline for hospital providers in which they will be able to negotiate utilization review activities with existing agencies or medical societies. Thirdly, that once a simple majority of providers within a state have contracted with a review organization, that organization be given top priority as that area's PRO by HCFA.

The Louisiana Hospital Association would like to express our appreciation to this subcommittee for allowing this comment opportunity. Should you have any questions or need additional information, please feel free to contact us.

STATEMENT OF THE LOUISIANA HOSPITAL ASSOCIATION
TO THE SENATE FINANCE SUBCOMMITTEE ON HEALTH
ON
IMPLEMENTATION OF PEER REVIEW ORGANIZATIONS FOR MEDICARE

ATTACHMENT A

AFFILIATED WITH THE AMERICAN HOSPITAL ASSOCIATION
MEMBER OF SOUTHEASTERN HOSPITAL CONFERENCE

LOUISIANA HOSPITAL ASSOCIATION

ROBERT D. MERKEL
PRESIDENT

9521 BROOKLINE AVENUE
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BATON ROUGE, LOUISIANA 70898-0720

September 1, 1983

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration
United States Department of Health and
Human Services
Post Office Box 26676
Baltimore, Maryland 21207

ATTENTION: HSQ-107-P

Dear Dr. Davis:

The Louisiana Hospital Association (LHA) and its 150 member institutions appreciates this opportunity to present our comments and recommendations regarding the proposed rule; **Utilization and Quality Control Peer Review Organizations, (PRO) Area Designations and Definitions of Eligible Organizations,** 42 CFR Parts 460 and 462, HSQ-107-P. While this proposed rule generally follows the law, there are areas reflecting administrative interpretations that in our opinion need to be reassessed by the Health Care Financing Administration (HCFA).

This association is especially concerned with Section II, B, 4 which states in part "...This proposed rule provides that the "substantial number" test would be met if an organization is composed of at least 5 percent of the licensed physicians practicing in the PRO review area..." This section goes on to state that under the PSRO program a 25 percent minimum is no longer applicable due to the generally larger or more populous review area being recommended for PROs.

The LHA seriously disagrees with HCFAs reasoning that a smaller percentage can constitute a significant number in a larger, more populous area. HCFAs reasoning appears to be just the opposite of the findings of the Senate Finance Committee and General Accounting Office. One of the major shortcomings disclosed was insufficient physician participation in final review decisions. How HCFA can justify reducing the minimum 25 percent to 5 percent just to increase the number of eligible organizations is highly questionable and runs counter to the congressional intent of increasing physician participation. Changing reviewing areas from several regionalized PSROs to one statewide PRO does NOT in any manner change the total workload requirements for proper review nor does it encourage additional physician participation. On the contrary, it could very easily discourage physician participation by amplifying existing localized politics into statewide issues of dispute.

The HCFA position that 5 percent of a total population is the same as or equal to 25 percent of that same total population be it sub-categorized or not is ludicrous. Changing from a quartered pie to a whole pie does not change the total volume of that pie. The only change in the total population will be the number of recognized eligible groups of which ONLY ONE will receive authorization to perform reviewing activities. The LHA recognizes that the authorized contracted PRO could subcontract with those other "losing" eligible groups; however, HCFAs assumption that this would be the case is NOT necessarily valid. It is our opinion that just the opposite is true.

HCFA should consider the local politics, rivalries, medical practice, and geographical differences between these eligible groups. Consideration should be given for rural versus urban; especially in cases where only one or two regions within a State consider themselves to be the major supplier of advanced medical services yet do not qualify for separate reviewing status. What would happen should the PRO be contracted from one of these centers and not subcontract with the other, or a rural group obtain the contract and not subcontract with either group?

It is strongly recommended by the LHA that HCFA must stand by its current minimum standard defining the "substantial number" test to be met at the 25 percent level. The total population workload is no different under the PRO concept than under PSRO; only the number of reviewing agencies. It is also the opinion of the LHA that HCFAs assumption that non-contracting eligible groups will be sub-contracted or want to be sub-contracted by the PRO is subject to serious question.

Under both Section II, B, 4 and 5 the requirements that the organization would submit documentation such as "a statement of support" or "number of practicing physicians represented by the organization" is meaningless. There are two types of support -- passive and active. The LHA believes that something as important as the determination of a State's medical practice should not be left up to just a few; especially when left to a group who only has to say that it supports a particular organization. It is bad enough when only 5 percent of a total population actively supports reviewing activities, but when those 5 percent passively support such review, it borders on the obscene. Lists can be furnished from any group indicating massive support and membership, but the number of ACTIVE participants represents only a very small fraction of the total. Physicians listed by number or available "through arrangement or otherwise" is an entirely too loose construction easily manipulated to reflect greater support and participation than in actuality. HCFA must re-evaluate its position to force documentation of an organization's ACTIVE roster of participating physicians and require, at least biennially, documentary proof of participation. Should it be shown that less than the minimum "substantial number" of physicians actively participate; then, termination of the contract is warranted unless that organization reaches minimum standards within 30 days. This would not significantly increase or add to the costs of administering utilization review activities and would defer the increase in para-medical personnel determining medical practice.

Section II, B, 5 in which HCFA proposes a "straight-forward and simple interpretation" in which no formal contractual relationships would be required but rather a demonstration

that a relationship exists is also questionable. Without a contract there would be no binding obligation for the physician to conduct medical review. The LHA recommends that this section be clarified such that some form of contractual relationship is called for. This simplistic solution could be acceptable provided license had not been granted regarding participation by listing alone.

Requiring that "there be available at least one physician in every generally recognized specialty" by a letter of support from a physician organization or physician is meaningless unless that support was of a proven active nature. With rapidly changing techniques and technology in the medical professions, requiring only one specialty in a generally recognized field is insufficient to meet the demands. This need is readily apparent in our major diagnostic and treatment facilities. The LHA recommends that the minimum of one specialist per specialty be broadened and increased by specific specialty based on the total number of specialists practicing within each PRO region. Furthermore, specialist should be defined such that the qualifications mandate that the physician be board certified by that specialty's respective board. The currently proposed qualification that a specialty be represented by a licensed practicing physician is insufficient. Just because a physician claims to be a practicing specialist is not necessarily indicative of his qualifications to perform in that specialty. Whereas if he were board certified in that specialty; then, his credentials and abilities are more acceptable to the physician community. It is extremely important that a QUALIFIED specialist determine the utilization review plans and procedures of the PRO.

Section II, B, 7 which sets forth the Prohibitions and Restrictions should be clarified. According to HCFAs proposal, a managing employee who is also a governing body member could be construed to eliminate a PRO from utilizing a physician who is a director of a hospital department even though that physician has no direct control on the total operations of the institution. Also, many physicians serve as a member of a facility's Board of Trustees and have little or no influence on the day-to-day operations of that facility. It is

recommended that the managing employer prohibition be redefined to allow physicians who are directors of departments or board members of health care facilities to be eligible for participation. If HCFA does not desire to make this recommended change; then, it is recommended that where the physician does NOT receive compensation by the health care facility, but directs a department or sits on the board be eligible to participate in a PRO.

In summary, the LHA strongly disagrees with HCFAs proposed "substantial number" test being met by only 5 percent of the licensed physicians practicing in the PRO review area as the workload will not decrease nor the total population substantially change. Solving the problems of obtaining active physician participation in reviewing activities is not being met by decreasing the number of physicians required to substantially reflect a community's needs. HCFA must encourage increased physician participation by including them with hospital providers of care, sharing the same risks of non-payment before they will actively support utilization review. Until HCFA can impose penalities upon the physician practitioners for their treatment methodologies, or offer other rewards and incentives, physicians will not take a more active roll in medical review. Lessening the required percentage of physician involvement, will not encourage eligible organizations from offering the needed compensation to bring those physicians into active participation.

Broad, simple approaches to medical reviewing activities are not the answer for quality of care demands. Simple listings of supporters are of little or no use when active participation by the physician community does not occur. This results in para-medical personnel dictating medical practice and a decreasing quality of care for all consumers. The LHA seriously objects to the listing requirements proposed in this rule. While we do not object to informal relationships between physicians and PRO organization, we must strongly question the means by which HCFA will monitor and ensure that at least the minimum substantial number of physicians actively participate in the reviewing organization. The LHA recommends that rules be promulgated to force active participation by physicians in

setting review plans and utilization review itself by the contracted PRO organization. Failure to provide adequate substantial review would subject the PRO to cancellation of its contract.

Lastly, the LHA recommends that the prohibitions and restrictions be clarified to allow physicians in charge of departments or uncompensated board members to be held eligible to perform utilization review activities.

Sincerely,

John Jurovich

John Jurovich
Director of Finance

cc: Lawrence Goldberg
James T. Marrinan
American Hospital Association

ssc

STATEMENT OF THE LOUISIANA HOSPITAL ASSOCIATION
TO THE SENATE FINANCE SUBCOMMITTEE ON HEALTH
ON
IMPLEMENTATION OF PEER REVIEW ORGANIZATIONS FOR MEDICARE

ATTACHMENT B

AFFILIATED WITH THE AMERICAN HOSPITAL ASSOCIATION
MEMBER OF SOUTHEASTERN HOSPITAL CONFERENCE

LOUISIANA HOSPITAL ASSOCIATION

ROBERT D. MERKEL
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October 11, 1983

Mr. Allen Lazar
Health Standards Quality Bureau
Health Care Financing Administration
1849 Gwynn Oak Avenue
Baltimore, Maryland 21207

RE: Parts I & II, Scope of Work for PRO Contract

Dear Mr. Lazar:

The Louisiana Hospital Association (LHA) on behalf of its 150 institutional members appreciates this opportunity to comment on the Health Care Financing Administration's (HCFA) draft document entitled, "Part I, Scope of Work for PRO Contract Part II Technical Proposal Instructions and Evaluation Criteria Scope of Work PRO Contract," (SOW).

Under Section 1554 (a) (1) of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Public Law 97-248, it is stated "(1) The organization shall review some or all of the professional activities in the area, subject to the terms of the contract, of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items....." However, the only entities listed under the SOW's specific objectives and selected for review are acute hospital care, including care in swing beds, providers of Medicare services.

The LHA questions such selectivity by HCFA; especially when the Medicare Part B budgeted expenditures are such a prominent portion of Medicare health dollars. It is the

SOW

recommendation of this Association that individual physicians and health care practitioners be subject to peer review as permitted under TEFRA; that the SOW be expanded for their inclusion; and, that physicians and other practitioners be subject to the same penalties as hospitals.

HCFA's presumption that acute hospital care and swing bed facilities are the only entities guilty of providing inefficient medical management is objectionable. The inclusion of physicians and individual practitioners would act as a control on admission and quality objectives and provide a strong incentive for their active participation in peer review organizations.

Section 1154 (a) (3) states in part, "Whenever the organization makes a determination that any health care services or items furnished..... are disapproved, the organization shall promptly notify such practitioner or provider..." However, HCFA states in its SOW (C) (2) (a) (1) (b) that "denial determinations should generally be made within one year of the date of the claim containing the services in question." Based on this criteria it would be possible for a facility to undergo review just once or twice a year. Consideration must be given to the hospital's need for timely review. Denials should be made within sixty to ninety days of claim submission not three hundred sixty days. This criteria is bordering on historical review and not timely retrospective review.

While Section 1154 outlines the functions of peer review organizations within the "contract limits", it appears that HCFA has used great license in its interpretation of those functions. The admission objectives (C (1) (a)) listed in the SOW are designed to encourage the reduction of health services available to Medicare beneficiaries. When every objective except item 5 begins "To reduce" is coupled with PRO evaluation criteria D (2) (b) and ATTACHMENT 5, "SAMPLE CALCULATION OF COST-TO-BENEFIT RATIO," all incentives

SOW

within the SOW are for PROs to perform NOT according to established norms of care based upon the organizations determination within its geographical area but rather dictated levels of care tied solely to the dollar savings to the Medicare Program.

This in effect will act similar to a nut-and-bolt. The reimbursement levels established under the Prospective Payment System (PPS) being the cap of the bolt and the PRO's acting as the nut. Should HCFA have problems maintaining budget neutrality, all they would have to do is tighten-up on their admissions objectives to reduce the Medicare payments. Under present SOW guidelines, this has nothing to do with maintaining quality care. It is just another means of curtailing Medicare expenditures and the governments inability to admit that it cannot afford the price of quality care for its beneficiaries.

Item C (1) (a) (3) is an example whereby all Class One cases, as identified by Uniform Hospital Discharge Data Set, could be deemed inappropriate and denied by a PRO in order to meet their evaluation requirements. This entire objective field is designed to specifically change the current medical delivery system such that access to quality care is limited and controlled by HCFA guidelines. These goals, as presently written, have only one specific objective "potential for impacting Medicare reimbursement." The TEFRA Section 1154 does not grant HCFA this much authority. Nowhere does Section 1154 state that the organization's functions are "to reduce" or to be evaluated based on dollar savings. /

The LHA seriously objects to the evaluation criteria for the effectiveness of PROs being based upon their impact on Medicare reimbursement. The incentives "to reduce" must be modified such that reductions or increases of admissions are performed on an "exception" basis. Under the Admission Pattern Monitoring (APM), as currently utilized by the fiscal intermediary (FI), only those facilities exceeding the average overall admission rate in the prior (4) years established for that facility would come under review. Admission review for

SOW

all facilities within a PRO area is a duplicative and costly process. By using FI generated admissions data which is hospital specific local region admission trends are taken into consideration. Should national trim points be utilized as indicated in the SOW, PRO evaluation criteria could be erroneously calculated due to regional fluctuations.

The SOW's quality objectives need clarification. In the opening paragraph it is stated, "The quality objective shall be in the areas determined and verified as significant problems in medical patient care, not suspected or potential problems."

The LHA agrees with HCFA that an alternative definition for "significant potential" and "serious patient complications" is warranted. It is suggested that the five quality objectives be further defined; thereby, eliminating many extraneous statistical data. For example, under goal (1) "The Reduction of Unnecessary Readmissions," should HCFA change the requirement of 100% review of admissions within 7 days of discharge to 100% review of readmissions within 3 or 4 days of discharge many legitimate readmissions could be removed from mandatory review. This could be done with little or no loss of effective readmission monitoring.Three or four days should be used instead of the current seven day limit for the following reasons:

(1) The probability of a complication arising from a premature discharge is more likely to occur within 72 hours. If the complication has not manifested itself within this time frame (i.e. infection, drug regulation, thrombophlebitis, hemorrhage, and other post-op complications) the likelihood of it being related to the original cause of admission is remote; and,

(2) There are a number of diagnoses or treatments that by virtue of their condition require acceptable treatment plans that would require readmission within 7 days (i.e. cancer; D&C; dialysis)

SOW

Once legitimate causes are removed from the statistical base, APM flagging could be used to identify any abuse in unnecessary readmissions.

Goal (2), To Assure The Provision Of Medical Services, can be determined to be significant by the other goals listed under quality review. Trend reports that indicate one facility is above its regional peers in a majority of the remaining three goals (3, 4, & 5) could be used to determine "significant potential."

Also HCFA must clarify and define "verified." In its present structure, PROs could use this as a means to perform review for problems which may not exist or may occur so infrequently as to be insignificant. This ability to "verify" could pose a very serious threat to the internal practice of medicine. With "quality" such a subjective determination and the professional qualifications of the on-site reviewer subject to serious question; this could allow for minority medical opinions to determine medical practice. It could also provide for harassing tactics on the part of a PRO. A PRO in order to "verify" is given unlimited rights of access to any and all information. This would include access to in-house utilization review committee reports, minutes, etc. All in the name of "verification." Verification must be limited to trend analysis based upon the quality goals and limited to medical records examinations only, otherwise PRO's will engage in harassing fishing expeditions.

The LHA seriously objects to HCFA's interpretation of TEFRA that prevents subcontracting for retrospective utilization review with an organization which is a facility or which is affiliated with a facility or with an association of such facilities in its area. TEFRA only states that a facility cannot become a PRO, it does not preclude a facility from subcontracting. Once again, we reiterate, that the FI's monitoring of admissions, DRGs etc. that has been performed or which will be performed can flag abusing facilities for stricter PRO review. Precluding hospitals and related organizations from subcontracting, based upon an unwarranted presumption of guilt, is erroneous, inefficient, and costly.

SOW

Under Special Requirements for Contractors (2) (d) DRG Validation, HCFA has set a 2.5 percent reject level. This level is entirely too small when the subjectivity of ICD-9-CM coding and DRG assignment is taken into consideration. It has been estimated that as much as 40 percent of the ICD-9-CM coding steps are subjective. If even one tenth of this projected subjectiveness holds true; then, a minimum error will occur 4% of the time. Other agencies evaluating the appropriateness of DRG validation use at a minimum a reject level of 5%. It is the recommendation of the LHA that HCFA seriously consider upgrading their proposed reject level to a minimum 5%. If this is not done, PROs will find themselves forced to perform 100% review of the entire universe for all providers.

In (2) (e) Outlier Review (1) (b) (1) it states "If the hospital has the capability of determining length of stay by DRG, it will notify the contractor within the five working days prior to a particular beneficiary entering the day outlier category." It is the LHA's recommendation that "capability" be defined. In the vast majority of cases, a hospital does not have the capability of determining the appropriate DRG classification even 30 - 60 days after discharge, let alone determining the appropriate ICD-9-CM codes prior to discharge. The appropriate ICD-9-CM codes cannot be assigned until "after study of the entire medical record," to determine the principal diagnosis. It is further recommended that HCFA define "capability" such that once a hospital has determined that a particular beneficiary is a day outlier, it will notify the contractor within five working days.

Under (2) (e) (2) (b) Cost Outliers will be reviewed, using medical records, to determine whether the admission and all subsequent days of care and services rendered were medically necessary and appropriate. Up to this point the LHA has no objections; however, this Association seriously objects to a contractor performing financial review. It is the opinion of the LHA that HCFA has over stepped its authority in granting financial review, even on such a limited basis, to the PROs. This same section continues, "If all costs are necessary and appropriate, the contractor shall certify the claim and return it to the FI for payment."

SOW

The contractor has been established by TEFRA solely to perform medical review. The FI established to perform financial review. It is our contention that current FI auditing procedure are more than adequate to ascertain the appropriateness and correctness of all costs billed to the medicare program. It is the responsibility of the contractor to ascertain that the admission, subsequent days of care, and services rendered were medically necessary ONLY. Not only is the appropriateness and correctness of a beneficiary's bill more involved than reflected in the medical record, but the financial accounting system utilized by hospitals is completely separated from the medical abstracting system. One-on-one correlations between the beneficiary's bill and the medical record cannot be made without a thorough knowledge of the accounting system and an examination of all supporting documents besides the medical record.

It is the recommendation of the LHA that HCFA place the roles of medical versus financial review into proper perspective and remove the words "if all costs are necessary and appropriate." It is recommended that "if the admission, days of care, and services rendered were medically necessary and appropriate," be inserted in lieu thereof.

Under (2) (g) Criteria there is no reference stating that "the organization shall consult with nurses and other professional health care practitioners... and with representatives of institutional and noninstitutional providers of health care services..." as indicated under Section 1154 (5). The SOW should reflect the need for provider inputs in determining the reviewing criteria and state that the organization must refer to those inputs.

In conclusion, the LHA takes exception to HCFA's interpretation of the functions of a Utilization and Quality Control Peer Review Organization (PRO) as defined in TEFRA. It is obvious from studying this Scope of Work draft that HCFA has taken an arbitrary and capricious position designed specifically to reduce Medicare reimbursement. Every element

SOW

within this proposal is structured to create incentives for the PRO to change the practice of medicine and the availability of health care services to Medicare beneficiaries. However, it is aimed at the inappropriate group. Medical practice can only be effectively influenced by changing the physician's attitudes and methodologies. Hospitals do not practice medicine, they assist and provide a site for the performance of medical care at the direction of the physician.

The key to the provision of less expensive quality health care rests solely in the hands of the physician; yet this is the one area ignored by the Scope of Work. HCFA must include the physicians and other health care practitioners within the reim of peer review. Not until the physician is faced with direct review of his practice methods and the penalties for inappropriate or unnecessary care, will he endeavor to change. HCFA is attacking the site of the infection not the cause with this liberal interpretation of TEFRA.

As HCFA is unwilling to direct their reviewing activities to the source of the problem, the LHA would suggest that the SOW be modified to reduce the costs and adverse incentives built into this proposal as follows:

* The design and reviewing methodologies are set in such limiting confines as to insure 100% review of all providers. It is recommended that HCFA "manage by exception." The FI already has the necessary admissions, DRG, and financial trends available to flag abuse. It is recommended that the FI's data be used to delineate those facilities to be reviewed by the PRO rather than having the PRO review all universes all the time.

* The use of delegated review should be greatly expanded from its current strict limitation. When used in conjunction with FI data, the PROs could spend valuable resources only on those facilities indicated as needing intense review.

SOW

* The review of cost outliers should be for both medical necessity and costs; however, the PRO is not the proper authority for cost review. The FI is the recognized financial auditing authority and routinely audits hospital providers to insure the accuracy of billed charges and cost reports. The audit of the accuracy of cost in such outlier classifications must be remanded to the FI. Considering that only .9 percent of all cases will qualify as high cost outliers, the impact of possible billing errors will be very limited. As financial auditing by untrained personnel is a very costly and tedious process, it is highly recommended that the FI perform this function and the PRO be limited to the medical necessity function. Errors and/or exceptions on costs could easily be settled using current FI methods.

* Managing by exception has proven itself in industry as a viable alternative to detailed examination. Abuses in all systems are readily apparent and less resource consuming under this method. The LHA highly recommends that HCFA modify its SOW to conform to management by exception using the recommendations discussed above.

Should you have any comments or questions, please feel free to contact me at your convenience.

Sincerely,

John Jurovich

John Jurovich
Director of Finance

cc: Louisiana Congressional Delegation
Margaret Heckler, Secretary Health and Human Services
Carolyn Davis, Administrator, HCFA
Jim Scott, HCFA
Larry Oday, HCFA
James Marrinan, AHA

Statement of David Axelrod, M.D.
Commissioner of Health
State of New York

Testimony Presented to the
Committee on Finance
United States Senate

On the Implementation of Peer Review
Organizations for Medicare

February 1, 1984

I am grateful for the opportunity to present the position of New York State on the implementation of Peer Review Organizations (PROs) for Medicare.

We believe that New York State's comprehensive approach to controlling health care costs can provide valuable information for the implementation of P-R-O monitoring of Medicare. The system that we have designed and which has proven to be successful is based on three principles:

1. effective prospective rate setting;
2. effective health planning; and,
3. effective utilization review.

In all three of these efforts we have followed the critical guiding principles of uniformity and consistency, regardless of payment source.

New York State's prospective reimbursement methodology has played an important role in controlling unnecessary hospital utilization. The methodology, first implemented in 1970, includes a length of stay standard. The standard is hospital specific and recognizes each hospital's case mix. The rates of payments to New York's hospitals explicitly exclude the cost of excessive lengths of stay.

On January 1, 1983, New York achieved the long-standing goal of extending its system to all payors with the approval of a federal waiver for Medicare. The major features of the New York prospective hospital reimbursement methodology (NYPHRM) are:

1. Uniformity, it covers all payors including Medicare;
2. A three year revenue cap;
3. Allowances of bad debt and charity care, discretionary purposes, and financially distressed hospitals;
4. Peer group efficiency standard including a length of stay standard; and,
5. A volume adjustment which provides hospitals a financial incentive for decreasing utilization and a financial disincentive for increasing utilization.

Our experience in New York State led us to conclude that an effective cost containment program requires that all payors participate. Otherwise, the primary effect is simply cost shifting among third party payors. That is, the focus is on reallocating the same costs rather than on more effective and efficient management of hospital resources. Ironically, some concern has been expressed that we now have the authority to cause major cost shifting to the Medicare cost structure. In fact, since we are interested in demonstrating that NYPHRM is an effective cost controlling reimbursement methodology for all payors, we would view a rise in Medicare expenditures to be counterproductive.

Our success in containing costs was noted in the Department of Health and Human Services' December 1982 Report to Congress on Hospital Prospective Payment for Medicare which reported that we had the best record of any state in the Nation in restraining hospital costs. Between 1975 and 1979, total hospital costs in this country increased by 64.5 percent while New York's hospital costs increased at less than half that rate, 31 percent. From 1977 to 1981, the national annual percent increases in cost per adjusted admissions averaged 13 percent. During that same period, costs in New York increased by only 9.78 percent.

In conjunction with New York's prospective all payor hospital reimbursement methodology, we strongly support a rational and aggressive health planning system at the local and state level.

In 1965, New York began the nation's first certificate of need program. Our health planning program has become an effective complement to our reimbursement programs. Since 1975 and through these programs, we have removed over 12,000 excess beds from our hospital system, increased the efficient use of our remaining beds, and encouraged the development of alternative modes of care. However, we continue to face a more recent problem which has the potential of restarting the cycle of escalating costs. In 1983 we were faced with capital construction projects totalling nearly $3 billion and that figure will exceed $5 billion during 1984. This figure is well in excess of anything which we consider reasonable or acceptable in an era of limited and contracting resources.

By some estimates, the total capital costs including interest costs could be $10 to $15 billion. The cost to the federal Medicare program could be $6 billion.

New York is currently considering major changes in its certificate of need program to deal with this problem by adding the concept of relative need and affordability. Governor Cuomo has proposed a new capital budgeting process for hospitals and other health care facilities that will add discipline to this process. As in the case of prospective reimbursement, we believe that a strong role for state government is critical to the success of health planning efforts.

A strong utilization review program, which I will describe later in my testimony, is the third component in our comprehensive cost containment strategy.

We believe that this comprehensive approach is crucial to successfully containing system costs. The current P-R-O regulations, which preclude states from becoming the designated P-R-O is a step in the opposite direction -- one that will fragment the system. This approach is contradictory to the comprehensive approach to cost containment that has been incorporated into both the reimbursement system and the health planning system in New York State. Utilization review should also incorporate a comprehensive approach, stressing uniformity and consistency regardless of payment source. While I realize your main concern today is with the Medicare program, it is important not to lose sight of the benefits of a uniform utilization review program among all payors and the disadvantages of disparate programs. These effects will be felt not only by health care payors in terms of administrative costs, but also by the hospital industry which may have to deal with different review agents, different review criteria, and different administrative protocols depending upon the patient's source of payment. In addition, a uniform system assures equal and fair treatment for all patients regardless of their economic status. Therefore, I would ask that in your deliberations on P-R-O implementation, this matter not be viewed in the context of Medicare only, but rather the acute care industry.

In fact, we believe that an effective utilization review program is critical to the success of the unique reimbursement methodology we are now implementing in New York. Without an independent monitoring and control of health care services utilization, health costs can spiral and undermine the entire premise upon which the reimbursement methodology is based.

State's that have a record of both strong cost containment and strong quality assurance programs should not be precluded from that role. New York State's extensive experience with utilization review has prepared us to capably assume the duties of the P-R-O. We have, as you may know, conveyed our strong objections to the exclusion of State's being eligible to be designated as the P-R-O. We do not believe that Congress intended to prohibit state governments from the assumption of P-R-O duties and feel strongly that if a state is otherwise qualified to serve as the P-R-O, it should be eligible to assume the duties.

Following is a brief discussion of why we believe it is unnecessary to preclude states in general from assuming these duties, and then a description, in some detail, of New York State's successful utilization review experience.

The rationale presented for prohibiting P-R-O contracts with providers or provider-affiliated organizations was to avoid conflicts of interest or even the appearance of a conflict of interest. We do not believe, however, that there is a rationale for extending this prohibition to state governments. In many other instances, the federal government has authorized state governments to regulate state operated facilities on its behalf. This regulatory authority includes establishing Medicaid rates of payment, surveying for Medicare and Medicaid certification and granting certificate of

need. The federal government has also permitted New York and other states to establish Medicare rates of payment for acute care facilities, including state-owned facilities. Without exception, state governments have used the same rules and guidelines for regulating state operated facilities as they do for other facilities. In these instances, the question of a conflict of interest has become moot.

The New York State Department of Health regulates several state operated facilities. The State University of New York (SUNY) at Stony Brook Medical Center, the SUNY Upstate Medical Center and the SUNY Downstate Medical Center are operated by the State Education Department. The State's current surveillance track record of these facilities indicates no conflict of interest in regulating them.

Our experience in operating and regulating these facilities and others clearly supports the State's capability to capably perform both duties without any conflict of interest related problems.

We are well acquainted with the operation of all hospitals in the State and have the regulatory mechanisms in place to assure an effective monitoring program. We in New York have demonstrated our long standing commitment to and capability of assuring quality health care and containing hospital costs. At a time when the Congress, business and taxpayers are demanding strong utilization review, we believe it would be a serious mistake to exclude for consideration states with a record of achievement in this area.

More importantly, New York State has had successful experience with utilization review, beginning with the onsite program, established in 1976. Nurses and physicians were hired to perform Medicaid reviews in 60 of the State's largest hospitals. During the program's operation, which lasted until the beginning of 1979, savings achieved equaled an estimated $41 million. The program ended when the federal government mandated agreements with PSROs to conduct Medicaid utilization reivew. Given this mandate, we were successful in developing effective relationships with the physician peer review groups. In fact, when TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) gave the states the right to terminate these contracts for Medicaid review, we chose to continue and strengthen our relationship with the most effective physician peer review organizations. This relationship continues today and we believe we are the only State which forged such a successful partnership between state authority and the existing independent physician peer review network.

The State monitoring program of PSRO performance clearly exhibited our active interest in and involvement with utilization review. Our experience with this program has shown that State involvement has increased the cost effectiveness of the PSROs.

GAO studies have shown that the PSROs are only slightly cost effective for Medicare review. For every $1 spent, $1.05 is saved. New York State's experience with the Medicaid review by PSROs and our PSRO monitoring program indicated that for every $1 spent, $4 were saved.

It should also be noted that the State was the first in the nation to include performance standards within Medicaid utilization review contracts with PSROs. These standards served, to a great extent, as a model for the P-R-O regulations.

The State's current plan for Medicaid utilization review will now be described. We are implementing different utilization review systems across the State. This is consistent with our overall objective of experimenting with various utilization review approaches in order to identify those review activities that are most effective in controlling Medicaid utilization and state expenditures.

The different programs are as follows:

1. In the first type of utilization review program the State is continuing to conduct concurrent onsite review in five large Buffalo area hospitals. In those hospitals in the Erie Region not designated as onsite hospitals, hospital utilization review committee decisions will be relied upon subject to retrospective monitoring by State review staff.

2. In the second type of utilization review program we will continue contracts with four PSROs -- two in New York City, two in the Upstate area. The PSROs will administer utilization review systems for Medicaid patients which assure that inpatient services provided to Medicaid clients are medically necessary and appropriate, of a quality which meets professionally recognized standards of care, and provides the most economical level of care. The Department of Health will continue to monitor PSRO performance and based on the findings, PSRO performance standards will be modified as appropriate.

3. In the third type of utilization review program, the Department of Health has entered into an arrangement with a consortium of employers and third-party payors in the Albany region of the State for the review of inpatient services. The overriding purpose of the consortium is to develop and maintain an effective system of quality control and cost management for the Medicaid recipients and Blue Cross clients of Northeastern New York. This program will cover 900,000 Blue Cross subscribers and 120,000 Medicaid recipients in the region. Nearly 5,000 employer groups purchase health insurance coverage from Blue Cross of Northeastern New York. These employers, along with Blue Cross and the State, have formed the Northeastern Health Care Consortium for the purpose of conducting this review.

4. In the fourth model, the Department of Health issued three separate Requests For Proposals -- two for separate areas of the State and one for hospitals operated by the New York City Health and Hospitals Corporation -- to existing or potential health care organizations for the review of inpatient Medicaid services. We requested proposals to implement utilization review programs which encompass the goals of quality of care and cost containment. The Department of Health's objective through this approach is to draw on the experience and expertise of diversified health care organizations in the development and implementation of new approaches to inpatient utilization review.

Among the criteria for evaluating proposals were the following:

1. A demonstration of a scope of knowledge and ability to translate the given review goals and requirements into an effective and efficient hospital review program;

2. Plans to coordinate and develop linkages with the physician and hospital communities; and,

3. Consistency with all relevant federal and state laws and regulations.

Specific attention was given to cost effectiveness, particularly with regard to the control of administrative costs, innovative utilization review approaches, and plans in dealing with quality of care issues.

Because we are conducting a number of different utilization review systems, we recognized the need for a coordinating body between the Department of Health and the various review organizations. The role of this body is to (1) act as liaison between the Department and the review organization; (2) assure the equitable treatment of Medicaid patients on a statewide basis in terms of scope of service provided; (3) act as an oversight agency, assisting the Department in its continued monitoring activities to assure contract compliance; and, (4) handle appeals resulting from adverse utilization review determinations.

The New York Statewide Professional Standards Review Council, Inc. serves as the coordinating body. The Council has coordinated the entire utilization review framework since the beginning of the State's Medicaid relationship with PSROs. We believe the Council could assist us in coordinating our Medicaid utilization review program with the federal Medicare utilization review program.

Finally, the Department of Health has issued a Request for Proposal soliciting proposals for the evaluation of these various utilization review programs. The evaluator will be called upon to assess the impact of the various utilization review systems on cost, utilization, and quality of care. The administrative costs of the various systems will also be analyzed. We expect the evaluation process to begin in March of this year and expect a report by early fall of this year.

Part of the objective of developing and implementing these various utilization review projects for Medicaid purposes is to evaluate a number of different utilization review models which could be used if the State were to receive federal P-R-O designation.

To reiterate our position:

-- A comprehensive all payor cost containment approach, encompassing reimbursement, health planning, and utilization review is necessary;

-- A state government should not be precluded from receiving the P-R-O designation merely because it is a state government; and,

-- We believe that New York State's experience and commitment to a strong cost containment program and a strong utilization review program qualifies us for P-R-O designation. In addition, the State offers the ability to make this program uniform and consistent for all payors, providers of services, and patients.

We have learned a great deal and will continue to learn even more about the most successful methods for utilization review. We think that the Medicare P-R-O program can benefit a great deal from our experience.

Statement of the National Association of Private Psychiatric Hospitals to the Senate Finance Committee on the Implementation of the Peer Review Organization Program

The National Association of Private Psychiatric Hospitals (NAPPH) would like to take this opportunity to express its concern to the Subcommittee on Health of the Senate Finance Committee about implementation of the Peer Review Organization program by the Health Care Financing Administration. NAPPH represents the nation's freestanding, nongovernmental psychiatric hospitals comprising approximately 24,000 beds, providing for the care and treatment of persons suffering from mental illness. NAPPH commends the Subcommittee on Health for its oversight activities with respect to the implementation of the PRO program and welcomes this opportunity to share our views.

The position of psychiatric hospitals differs somewhat from that of the medical community with respect to the larger question of program implementation. Our hospitals are thus far exempt from the prospective payment system. Although it is not clear what the effect of implementation of the program will be on psychiatric hospitals, we do have several concerns about the program.

Our first concern is shared by everyone: The October 1, 1984, deadline for hospitals to have contracts with PROs. In view of the time constraints involved in a contracting process, this deadline must be lifted. It is an understatement to say that

this target date will place a severe burden on both potential contractors and hospitals. The result could very well be denial of access to Medicare beneficiaries of needed services. We therefore urge that this target date be changed or abandoned altogether.

Our second concern deals with the approach taken by HCFA with respect to the focus of the PRO program. The draft scope of work for PROs indicates that the program objectives are fiscal concerns rather than the assurance of the quality of care provided to beneficiaries. A fiscal priority is unconscionable as the focus of peer review has always been, and should continue to be, quality of care rendered rather than cost savings to the Medicare program. Cost considerations are obviously of concern to everyone in these cost conscious times; however, a dual level of care with Medicare beneficiaries receiving secondary quality must not be allowed to happen.

Another matter of great concern is the confidentiality issue. This is especially important because of the stigma that continues to be attached to mental illness. The PSRO program has not dealt successfully with this issue in the past and there is no indication that the PRO program will fare any better. The rights of patients and of providers must be protected and access to confidential information and its disclosure carefully safeguarded. Pending PRO requirements that hospitals send copies of medical records to reviewers and that PSROs include hospital identifiers on hospital discharge data released to HHS will endanger the confidentiality of all concerned.

Finally, we have great reservations on what the situation will be with respect to transfer of patients from hospitals covered by the prospective payment system to exempt hospitals or units.

HCFA has cited in its draft scope of work that an admission objective for PROs should be "to reduce the number of inappropriate transfers to PPS-exempt psychiatric and rehabilitation hospitals or units, and swing beds." However, review of pychiatric services has not even been addressed by HCFA in the draft scope of work. And, there is no target date for when psychiatric hospitals will have to contract with PROs, if at all. Obviously, if transfer patients have to be reviewed, there must be provisions made for such a review. To leave it in the hands of the fiscal intermediaries which are not capable of conducting medical peer review would be to place the system in jeopardy. And yet this is an option being considered by HCFA. We must stress that any review must be conducted by those medical professionals who render care to patients, not by those whose main objective is saving money.

In summary, we have concerns over the implementation of this important program and trust that the Subcommittee on Health will continue to monitor the situation closely. And, if we can be of service, we feel that it is important that all segments of the industry and population contribute to the process.

Thank you.

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