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Better Controls Needed for Peer Review Organizations' Evaluations

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

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

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

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

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for Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

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

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

Background

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

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

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

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

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

Results in Brief

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

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

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

GAO's Analysis

Inadequate Internal Controls Over Evaluations

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

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

HCFA Monitoring Inadequate

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

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

PRO Program Funded at Legal Minimum

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

Recommendations

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

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

Agency Comments

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

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

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Abbreviations

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

Introduction

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

Medicare and Its Utilization and Quality Review Policies

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

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

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

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

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

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

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

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

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

The PRO Evaluations

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

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

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

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

The Evaluation Process

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

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

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

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

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

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

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

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

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

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

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

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

The Evaluation Scoring System

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

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

Table 1.1: PRO Evaluation Scoring

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

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

Objectives, Scope, and Methodology

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

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

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

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

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

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

- Indiana Peer Review Organization (Indiana).

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

In addition, we analyzed the scoring of 46 evaluations for inconsistencies with the instructions,[1] and observed the contract negotiation between HCFA and the California PRO.

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

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

[1]Detailed scores were unavailable for 4 evaluations.

Insufficient Internal Controls Over the Renewal Evaluation Process

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

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

HCFA Lacks Documented Internal Controls Over the Evaluation Process

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

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

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

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

Inconsistencies in Instructions for Evaluating PRO Performance on Quality Objectives

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

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

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

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

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

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

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

Inconsistency in Instructions on Profiling

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

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

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

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

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

Error in Panel Instructions

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

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

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

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

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

Incorrect Scoring of PROs by Panels

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

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

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