United States General Accounting Office 131017

GAO

Report to the Administrator, Health Care Financing Administration

September 1986

MEDICARE

Reviews of Quality of Care at Participating Hospitals

131017

036706

GAO/HRD-86-139

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division
B-206588

September 15, 1986

William Roper, M.D.
Administrator, Health Care Financing
Administration
Department of Health and Human Services

Dear Dr. Roper:

As its primary means of monitoring the medical necessity and quality of in-hospital care provided to Medicare beneficiaries, the Health Care Financing Administration (HCFA) contracts with Utilization and Quality Control Peer Review Organizations (PROs). During the first 2 years of the PRO program (1984-86), HCFA contracts emphasized monitoring the medical necessity of admissions. This was partly HCFA's response to the expectation that Medicare's Prospective Payment System (PPS), which became effective October 1983, would encourage hospitals to increase admissions in order to increase revenue. Since then, the quality of medical care provided to in-hospital Medicare beneficiaries has become an issue of increasing concern.

HCFA's scope of work for the second contract period (1986-88) expands requirements for PROs to monitor the quality of care provided. But, based on our survey of the California, Florida, and Georgia PROs, we have identified two areas related to quality issues in which HCFA should make PRO responsibilities more explicit:

1. Profiling data on hospital and physician quality-of-care problems. Although PROs were required to accumulate data on substandard care provided to beneficiaries during the first contract period (1984-86), the three PROs we surveyed did not profile the data—that is, compile and analyze them to identify providers with recurring quality problems that may warrant further review. Although profiling is required for data collected under the new contracts, the PROs we visited did not believe that the new contract provisions called for profiling 1984-86 data. We believe HCFA should require PROs to profile the earlier data because our analysis of data at two PROs—Florida and Georgia— identified a number of providers that the PROs found to have recurring cases with quality problems.[1] Furthermore, profiling the earlier data would enable PROs to use

[1]In the context of PRO work, a quality problem case is any hospitalization for which a PRO's physician determines that some aspect of the medical care provided was substandard This can involve matters ranging from poor documentation of treatment to physician practices that cause injury HCFA has left to the PROs the decision about how many and what kind of quality problems constitute a pattern of poor care requiring corrective action

this quality monitoring technique sooner than if they used only data under the new contracts.

2. Monitoring inappropriate discharges of beneficiaries needing skilled nursing care. Medicare requires hospitals to allow beneficiaries who no longer need acute care but do need skilled nursing facility care to remain in the hospital while awaiting placement in a nursing home. Hospital payment rates include an allowance for the costs hospitals incur in providing this care. PROs, however, review discharges only to determine that inpatient hospital care was no longer necessary. Thus, if a hospital discharges a patient to an inappropriate destination (e.g., home instead of a skilled nursing facility), this would not be identified. Because PPS creates incentives for hospitals to discharge patients as quickly as possible, we believe HCFA should require PROs to monitor hospitals to assure that Medicare patients are allowed to remain in the hospital when their conditions warrant placement in a skilled nursing facility but no bed is available.

Background

Over the past several years, Medicare's program for paying hospital care, monitoring provider activities, and assessing the quality of services has changed substantially. Before October 1983, Medicare generally reimbursed hospitals retrospectively for medical services provided to program beneficiaries based on the reasonable costs of such services. In October 1983, HCFA began implementing changes enacted by the Social Security Amendments of 1983 (Public Law 98-21, Apr. 20, 1983), which required that Medicare pay hospitals a predetermined amount based on diagnosis related groups (DRGs) for each Medicare discharge irrespective of the costs for individual patients.

Not directly related to this payment system change, but occurring at about the same time, was the passage of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248), which created PROs to serve as the primary organizations for monitoring Medicare hospital utilization and quality of care.

Potential increases in hospitalizations and reductions in the quality of care became principal concerns when PPS was implemented because of the incentives it created. Compared with the former cost reimbursement system, PPS gave hospitals much stronger incentives to increase Medicare payments by increasing their number of admissions and to reduce

costs by limiting services or discharging patients earlier. Unless monitored, these incentives could lead to such abusive hospital practices as unnecessary admissions or substandard care.

PROs are charged by HCFA with monitoring hospital performance and, if it is inappropriate, initiating corrective action. Usually private organizations composed of physicians, PROs have 2-year contracts with HCFA to monitor hospital performance in statewide areas The first contracts became effective over a 5-month period from July to November 1984.

To participate in Medicare, hospitals must agree to allow the state's PRO to conduct utilization and quality-of-care reviews. PROs use two primary tools to correct hospital and physician abuse of Medicare services or provision of substandard care identified through these reviews.

- Denying Medicare payment to hospitals for medically unnecessary admissions or substandard care.
- Recommending suspension, removal, or monetary penalties against hospitals and physicians participating in Medicare who are repeatedly associated with cases found to have quality-of-care problems.

Existing Quality-of-Care Data Should Be Used to Profile Providers

Quality-of-care profiling involves analyzing the results of PROs' medical reviews to identify hospitals and physicians that may be providing substandard care to their Medicare patients. Profiling can be as simple as arraying the number of quality problem cases by physician, hospital, or DRG so as to identify patterns of questionable care, focus investigations, and implement corrective action.

During the first contract period, PROs were required to review the medical services given beneficiaries to identify cases of substandard care. At the three PROs we reviewed, data on these cases were available in either manual records or computer-based files. Depending on the PRO, such data are obtainable with varying degrees of difficulty for use in profiling hospitals and physicians. However, PROs were not required to profile the information collected during the first contract period, and the PROs we reviewed had not done so as of July 1986

Profiling of 1984-86 Quality-of-Care Data Not Required

HCFA did not require PROs to profile the results of their quality-of-care reviews performed under the scope of work for their 1984-86 contracts; in fact, HCFA originally did not require quality-of-care reviews on all cases selected for review. In September 1985, however, HCFA acted to

strengthen quality-of-care monitoring during the 1984-86 contract period. It issued a memorandum requiring that every case a PRO reviewed for medical necessity, DRG validation, or any other reason be evaluated for the quality of care provided as well. In October 1985, HCFA also issued a new sanction procedure informing PROs that they should investigate the quality of care provided by hospitals and physicians as a basis for possible sanction activity (e.g., suspension or removal from the Medicare program).

The contracts for 1986-88 also require that a PRO review for quality every case it selects for review and develop physician and hospital quality-of-care profiles as a means of identifying potentially poor performers. The scope of work incorporated by HCFA into PRO contracts states, in part, that:

"Analysis of all data received and/or developed by the PRO, including profiling, is to be performed on at least a quarterly basis to identify aberrant providers, practitioners, DRGs, etc. The purpose of this profiling activity is to identify areas for focused review and/or other corrective action."

The scope-of-work statement does not, however, specifically require that PROs include in their profiles the results of quality-of-care reviews from the 1984-86 contract period.

Profiling results from the new 1986-88 contract requirements cannot be expected from some PROs before February or March 1987. Moreover, if only the review data from the new contract period are analyzed, the data base for profiling initially will be more limited than necessary. Effective dates for second period PRO contracts are planned to range from July to November 1986, depending on the PROs' contract renewal cycles. Once the contract is in effect, another 3 to 4 months will pass before data for the first quarter are available.

Existing Data Show Potential Quality Problems Needing PRO Attention

We profiled data on quality problems identified by the Georgia and Florida PROs during the first contract period to identify patterns of substandard care for certain hospitals and physicians (similar data for the California PRO were not computerized at the time of our visit). The results showed that the PROs identified providers with a relatively high number of cases involving substandard care. But, because the PROs had not profiled the data, they would not necessarily be aware of these providers' records of performance.

At the Georgia PRO, we obtained the results of hospital and physician quality-of-care reviews for cases admitted during the 16-month period from August 1984 to November 1985, the most recent data available when we visited this PRO in March 1986 (see table 1 for a summary of our profiling results). During that period, the PRO identified 7 hospitals that provided substandard treatment for 30 or more Medicare beneficiaries and 44 physicians who provided substandard treatment to 5 or more beneficiaries.

Table 1: Results of Profiling Physician and Hospital Quality Problems Identified by the Georgia PRO

Hospitals		Physicians	
Number of problems	**Number in category**	**Number of problems**	**Number in category**
Over 39	4	Over 20	2
30 - 39	3	15 - 19	2
20 - 29	7	10 - 14	12
10 - 19	27	05 - 09	28
05 - 09	34	02 - 04	161
01 - 04	73	1	417
0	48	0	8,810
Total	**196**	**Total**	**9,432**

A more detailed analysis of the seven hospitals with the most problems is shown in table 2. Of the 44 physicians identified in table 1 as having five or more quality problems, 18 practiced at six of the seven hospitals, as table 2 indicates.

Table 2: Results of Profiling Quality Problems Identified by the Georgia PRO

Hospital			Physician		
Provider	Bed size	Quality problems[a]	Provider[b]	Quality problems[a]	Number of months[c]
A	123	82	A1	43	15
			A2	15	10
			A3	7	11
B	73	50	B1	25	9
			B2	13	10
			B3	6	10
			B4	5	8
C	257	47	C1	17	13
			C2	9	12
D	517	45	0	0	0
E	87	39	E1	11	8
			E2	10	12
			E3	7	12
			E4	5	12
F	40	34	F1	13	12
			F2	7	11
G	75	34	G1	12	14
			G2	7	5
			G3	6	12

[a]These PRO findings represent patients admitted during the 16-month period from August 1984 to November 1985

[b]Only physicians with five or more identified quality problem cases are listed The A, B, C, etc , designators for the providers are ours

[c]Number of months between the admissions for the first and last quality problems identified

Table 2 shows that profiling can identify hospitals and physicians with the most Medicare cases identified by the PRO as receiving substandard care. For example, the table shows that in one 123-bed hospital (provider A), the PRO identified 82 cases with quality problems that occurred within the 16-month period reviewed and that one physician was responsible for more than half of these cases.

Since the scope of our survey did not include collecting data on the nature of the deficiencies reported, the seriousness of the quality problems in table 2 cannot be determined. However, we believe our profiling of existing data shows the value of using such data to identify potential problem providers who should receive more detailed PRO review. As of June 3, 1986, when we presented our findings to HCFA regional and Georgia PRO officials, the PRO had neither profiled these data nor targeted any of the 7 hospitals or 44 physicians for more detailed review. Also, there were no plans to profile these data, we were told, because profiling was not required and priority was given to meeting contract requirements.

We also profiled quality-of-care review data for Florida hospitals for an 18-month period from July 1984 to December 1985. Only hospitals' data were analyzed because physicians' data were not readily available. We identified 8 hospitals for which the PRO had identified 10 or more quality problems and another 17 with 5 to 9 problems. The PRO had investigated only one of these hospitals, although in four others it was investigating a physician on each hospital's staff. Had it profiled these data, the PRO would have identified numerous cases in these four hospitals that it had previously found to involve substandard care in addition to those associated with the physicians under investigation. For example, in one hospital the PRO had identified 13 quality problems occurring over a 2-month period not associated with the physician under investigation.

PROs Should Assess the Appropriateness of Discharge Destinations

Medicare patients who no longer need acute hospital care but do need skilled nursing facility care can be appropriately discharged to a nursing home when a bed is available. The computation of Medicare's PPS rates included an allowance for costs incurred in continuing to provide care to beneficiaries who are awaiting placement in a skilled nursing home bed; thus, the rates provide an allowance for hospitals to continue such care. While this care should be provided until a nursing home bed is available, HCFA does not require PROs to assess whether hospitals provide it.

Since the implementation of PPS, hospitals have had a financial incentive to discharge patients as soon as their need for acute care ends. However, no data exist to assess whether hospitals are providing skilled nursing facility care for patients awaiting a bed in such a facility or discharging patients to inappropriate settings.

Changed Incentives Raise Concerns

Before PPS, Medicare generally paid hospitals for providing skilled nursing level days of care at the same rate they were paid for providing acute care days. Hospitals, therefore, had financial incentives to keep patients needing skilled nursing facility care because they required less resources than patients who needed acute care and were less costly to the hospital.

In the Omnibus Reconciliation Act of 1980 (Public Law 96-499, Dec. 5, 1980), the Congress required HCFA to pay hospitals for care of patients awaiting nursing home placement at the lower skilled nursing facility per diem rate; however, HCFA did not implement this provision. The historical costs on which PPS rates are based, therefore, include days

awaiting placement that were paid as acute care days. Each PPS rate includes, to some extent, a payment for these days whether or not the hospital incurs the cost. Hospitals are therefore expected to provide these days when appropriate.

Hospitals no longer have financial incentives to keep patients hospitalized when acute care is not needed because, under PPS's fixed payments, additional days generally result in added costs for which hospitals receive no additional payment. Faced with this, hospitals have an incentive to discharge patients as quickly as possible and to eliminate nonacute days of care that a patient may need while awaiting placement in a nursing home.

Hospitals are generally discharging Medicare patients earlier in their recovery period than before PPS. From fiscal year 1983, the last year before PPS, through April 1986, the average length of stay in all short-stay hospitals decreased 19 percent (from 10.0 to 8.1 days).

In a June 1986 report,[2] we noted that under PPS some patients will probably have a greater need for posthospital care than they would have had in the pre-PPS environment. Thus, patients who might not have needed skilled nursing facility care in the past may need it now during their recovery from acute illness.

PROs Do Not Assess Appropriateness of Discharge Destination

Neither HCFA's 1984-86 PRO contracts nor its 1986-88 proposed contracts require PROs to assess the appropriateness of the destination to which a hospital discharges a Medicare beneficiary. There are two related review activities that HCFA requires PROs to undertake in the 1986-88 contract period, but neither activity requires such an assessment.

First, PROs are required to assess the hospital's discharge planning activities as a part of their quality screens applied to each case they review. This activity is directed at establishing whether the hospital engaged in discharge planning and developed a plan for follow-up care, but not specifically in determining the appropriateness of the discharge destination. Nor is the PRO required to ensure that patients who need skilled nursing facility care are either discharged to a nursing home or kept in the hospital until an appropriate nursing home bed is available.

[2]Post-Hospital Care—Efforts to Evaluate Medicare Prospective Payment Effects Are Insufficient (GAO/PEMD-86-10)

Second, the 1986-88 scope of work requires PROs to assess each case they review to determine if the patient was discharged prematurely. The scope of work defines premature discharges as

> ". . . discharges (other than those where the patient left against medical advice) where, in the opinion of the PRO reviewing physician, the patient was not medically stable or where discharge was not consistent with the patient's need for continued acute inpatient hospital care." (Underlining added)

Under this definition, the appropriateness of the discharge destination need not be a factor in determining the appropriateness of a patient's discharge. Thus, PROs are not required to, and therefore might not, review the appropriateness of the discharge location (i.e., to a skilled nursing facility bed, if necessary) when determining whether the discharge was premature.

Data Not Available on Patient Days Awaiting Nursing Home Placement

No data exist on the extent to which hospitals either before or after PPS's inception have kept patients who needed skilled nursing facility care when no nursing home bed was available. In June 1983, before PPS, we reported that reliable data on this issue were not available.[3]

Under PPS, data still are not available because hospitals generally are not required to report information on these days to fiscal intermediaries. The only reporting requirement applies when a hospital requests an additional payment for cases with extremely long stays that include these days.

Conclusions

During the 1984-86 contract period, the three PROs we surveyed had accumulated quality-of-care review data but were not profiling such data. HCFA's contract provisions for 1986-88 do not require PROs to include 1984-86 data in their profiles. In the absence of any specific HCFA direction, it is unlikely that the PROs we visited will use the data collected from the 1984-86 contract period for identifying problem providers. Because these data are available and can be used for such purposes, we believe HCFA should direct PROs to profile the data to identify providers with potential quality problems. Furthermore, because delaying such profiling may allow additional Medicare beneficiaries to be unnecessarily exposed to substandard care, we believe that HCFA's directive regarding this profiling should be issued as soon as possible.

[3] Federal Funding of Long-Term Care for the Elderly (GAO/HRD-83-60, June 15, 1983)

PPS gives hospitals an incentive to limit days of care at the nonacute skilled nursing facility level, and PROs do not monitor whether hospitals are providing them or discharging patients to inappropriate settings. HCFA should require PROs to assess the appropriateness of discharge destinations and assure that hospitals provide the skilled nursing facility level of care when appropriate and a bed is not available in such a facility.

Recommendations

We recommend that you require PROs

- to include quality-of-care review data available from the 1984-86 contract period in their profiling of hospitals and physicians and
- as part of their discharge reviews, to include an assessment of the appropriateness of discharge destinations to better assure that patients needing skilled nursing care are allowed to remain in the hospital while awaiting placement in a nursing home.

Objective, Scope, and Methodology

We undertook a survey of PROs because of their key role in monitoring the quality of medical care under PPS. Our objective was to evaluate the PROs' reviews of the quality of care provided hospitalized Medicare beneficiaries under PPS.

We examined (1) HCFA's PRO monitoring processes and its internal control of those processes at the Atlanta and San Francisco regional offices and at HCFA's headquarters in Baltimore; (2) HCFA's scope of work for the 1984-86 and 1986-88 PRO contract periods, and (3) processes used by the PROs for California, Florida, and Georgia to implement the initial scope-of-work requirements.

The three PROs we visited were selected because of the significant percentage of Medicare beneficiaries they cover. At each, we examined the results of their quality-of-care reviews. We also performed computer analyses of Florida's and Georgia's review results. Specifically, in Georgia we arrayed the physicians and hospitals by the number of associated quality problems the PRO had identified. We then compared the results to PRO-developed information to test the extent to which the PROs were identifying poorly performing hospitals and physicians and taking corrective actions. In Florida, we profiled only hospital data because physician data were not readily available. We did not profile data from the California PRO because it had not computerized its data base at the

time of our visit. The scope of our survey did not include collecting data on the specific nature of the PRO-reported deficiencies.

Our work was conducted from November 1985 through July 1986 in accordance with generally accepted government auditing standards.

We would appreciate hearing from you within 30 days on whatever action you take or plan regarding the recommendations in this report.

Sincerely yours,

Michael Zimmerman
Senior Associate Director

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