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RELEASED

HUMAN RESOURCES
DIVISION

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The Honorable David Durenberger
Chairman, Subcommittee on Health
Committee on Finance
United States Senate

The Honorable Max Baucus
Ranking Minority Member
Subcommittee on Health
Committee on Finance
United States Senate



Subject: Responses to Questions About Performance Evaluation
Criteria for Professional Standards Review
Organizations (GAO/HRD-82-124)

This report is in response to your June 10, 1982, request that we review the criteria and methodology the Health Care Financing Administration (HCFA) used in its 1981 and 1982 evaluation of Professional Standards Review Organizations (PSROs). PSROs are the organizations primarily responsible for assuring that inpatient hospital services, and in some cases other services provided to Medicare 1/ patients, are medically necessary, appropriate, and of acceptable quality. You asked:

- What is the basis for differences between the 1981 and 1982 evaluation criteria and methodology?
- Why were there dramatic changes in the relative rankings of several PSROs from 1981 to 1982?
- Does a quarterly assessment 2/ adversely influence HCFA's capability to measure the relative performance of PSROs?
- Do HCFA's assessments provide a sound basis for terminating PSROs' funding for ineffectiveness?

1/The 1972 law also included the Medicaid and Maternal and Child Health programs. However, mandatory use of PSROs was removed for these programs by the Omnibus Budget Reconciliation Act of 1981 (Pub. L. No. 97-35).

2/This refers to evaluations of individual PSROs at the end of the quarter in which their grant periods terminate.

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Briefly, our responses to the four questions are as follows:

- HCFA officials told us that differences between the 1981 and 1982 evaluation criteria and methodology represent HCFA's effort to better differentiate PSROs' performance by using more objective criteria and placing greater emphasis on their impact toward reducing Medicare hospital days of care and improving quality of care. However, other evidence indicates that the 1982 evaluation criteria and scoring levels were revised with the objective of terminating a specific number of PSROs during fiscal year 1982 to conform to proposed fiscal year 1983 budget limitations.
- Total scores of the four PSRO evaluations we reviewed changed dramatically from 1981 to 1982 generally because of increased emphasis on PSRO impact. In particular, HCFA's 1982 criteria for assessing PSRO impact on improving quality of care are more definitive, objective, and difficult to meet than the 1981 criteria.
- In 1981 HCFA evaluated all PSROs simultaneously, whereas in 1982 HCFA is evaluating PSROs based on the quarter in which their annual grant periods end. We believe that PSROs included in the first quarter evaluations for fiscal year 1982 may have been at a relative disadvantage in the evaluation process since they had less time than their peers to adjust their programs or meet the requirements of new evaluation criteria.
- Because (1) there is evidence that the 1982 evaluation passing score was set with the objective of terminating a specific number of PSROs to meet proposed fiscal year 1983 budgetary constraints rather than to identify ineffective PSROs and (2) errors have been found in the scores of several PSROs which have significantly changed initially reported evaluation results, we have reservations as to whether HCFA's 1982 assessments provide a sound basis for terminating PSROs for ineffectiveness.

BASIS FOR DIFFERENCES IN EVALUATION
CRITERIA BETWEEN 1981 AND 1982

HCFA officials told us that changes in evaluation criteria and methodology from 1981 to 1982 were motivated by the need to better differentiate among PSROs' effectiveness because some of the 1981 criteria were not adequate to show differences in PSRO performance levels. For 1982 evaluations, according to HCFA officials, HCFA increased the difficulty of achieving a passing

score by (1) eliminating certain 1981 criteria on which virtually all PSROs had scored well, (2) strengthening the quality impact criterion by making it more objective and quantifiable, and (3) expanding documentation requirements to support PSRO-reported achievements. Additionally, the weighted importance of the impact section of the evaluation criteria (which addressed days of care saved and improvements in quality of care) was increased from 50 percent of the total score in 1981 to 68 percent in 1982. Enclosures I and II provide more detailed information on differences between the 1981 and 1982 evaluation criteria.

In contrast to the above stated basis for modifying the evaluation criteria, however, a February 1982 memorandum, addressed to the record and signed by three HCFA officials, states that the 1981 evaluation criteria and scoring methodology were revised in order to terminate up to 85 PSROs during fiscal year 1982.

The February 16, 1982, memorandum states:

"The program funding level for FY 1983 contemplates Federal support for a total of 62 PSROs. There are currently 151 active PSROs, four of which have indicated voluntary terminations by March of 1982. Counting the voluntary terminations, a total of 147 PSROs will have to be reduced by 85 during FY 1982 in order to meet the program's funding level for FY 1983.

"The PSRO Performance Evaluation criteria and instructions were revised with the objective of terminating 85 PSROs during FY 1982. Sections I and II which focus on process and compliance, respectively received 8 and 24 percent of the point values. Section III, which focuses on PSRO impact and is the most difficult section, received 68 percent of the total point values. Documentation is required for the verification of all positive evaluation responses. In addition to these revisions, a minimum acceptable level of performance, identified by a minimum point level, was increased from last year's anticipated 20 percent PSRO reduction level to an anticipated 50 percent reduction level. The resulting minimum point levels were 75 of 135 points for Section I, 285 of 435 points for Section II, and 505 of 1200 points for Section III. A PSRO must score at least

865 of a total 1700 points [1/] and must exceed minimum point levels in two of the three sections to demonstrate achievement of an acceptable level of performance."

This objective of terminating 85 PSROs in order to fund only 62 appears to conflict with section 2112(a)(1) of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. No. 97-35), which requires HCFA to fund at least 131 PSROs during fiscal year 1982, permitting a reduction of only 20 from the 151 existing on February 16, 1982, the date of the memorandum cited above. When we asked about this discrepancy, the deputy director of HCFA's Health Standards Quality Bureau pointed out that only 16 PSROs had failed the first quarter 1982 evaluation and, of those, only 8 had been proposed for termination. The rest were classed as "marginal failures" and were funded for another year if they accepted special conditions on their grants. He stated that in any case no more than the number of PSROs allowed by law would be terminated by September 30, 1982. 2/

REASONS FOR CHANGES IN RELATIVE RANKINGS
OF PSROS BETWEEN 1981 AND 1982

We selected for review the evaluations of four PSROs that had dramatic changes between their 1981 and 1982 rankings. The Montana Foundation for Medical Care, the Iowa Foundation for Medical Care, and the California PSRO Area 23 all ranked in the

1/The correct maximum possible total score for the 1982 evaluation is 1,770 points.

2/Section 150 of the Tax and Fiscal Responsibility Act of 1982 (H.R. 4951) which passed the Congress on August 19, 1982, provides that the Secretary of Health and Human Services shall not terminate or fail to renew any agreement with a PSRO existing on the earlier of the date of enactment or September 30, 1982, until such time as he enters into a contract with the utilization and quality control peer review organization authorized by the new 1982 act to cover the geographical area served by the PSRO. According to an August 23, 1982, internal HCFA memorandum, the President was expected to sign this bill into law, and consequently PSROs scheduled for termination as a result of the 1982 evaluation would be continued.

top one-third in the 1981 evaluation 1/ but failed marginally 2/ in the 1982 evaluation. The Louisiana Medical Standards Foundation passed in 1981 but dramatically improved its score in 1982. The following table shows 1981 and 1982 percentage scores by total and section of the evaluation criteria for the four PSROs we selected.

	PSRO (note a)							
	Montana Foundation for Medical Care		Iowa Foundation for Medical Care		California PSRO Area 23		Louisiana Medical Standards Foundation	
	1981 (note b)	1982	1981 (note b)	1982	1981 (note b)	1982	1981 (notes b,c)	1982
Needed to pass	47	49	47	49	47	49	47	49
Total score earned	84	47	67	47	68	45	52	64
Sections (note d):								
I. Organization and Program Management	76	56	86	80	82	67	86	78
II. Performance of Review- Operations Compliance and Process	88	82	91	84	87	76	88	93
III. Performance of Review- Impact/ Potential Impact	84	34	45	30	51	31	18	51

a/Percent of maximum points rounded to the nearest percent.

b/1981 percentages based on PSRO base score, without bonus points.

c/Scores after appeal.

d/For 1981 and 1982, of the total score, Section I provided 13 and 8 percent, Section II provided 37 and 24 percent, and Section III provided 50 and 68 percent, respectively.

1/In the 1981 evaluation, bonus points were added in ranking PSROs nationally.

2/HCFA's marginal failure category is explained on page 11.

As the percentage of points achieved in the three sections indicates, dramatic changes in the total scores occurred primarily because of a significant decline in Section III--Performance of Review-Impact/Potential Impact--scores for the Montana, Iowa, and California Area 23 PSROs and a significant increase in the Section III score for the Louisiana PSRO.

The following table shows the three parts of Section III and the percentage of total points achieved for each.

Section III	PSRO (note a)							
	Montana Foundation for Medical Care		Iowa Foundation for Medical Care		California PSRO Area 23		Louisiana Medical Standards Foundation	
	1981	1982	1981	1982	1981	1982	1981	1982
Needed to pass	43	42	43	42	43	42	43	42
Total score earned	84	34	45	30	51	31	18	51
Subsections:								
A. Management of Objectives	65	77	23	64	65	37	50	94
B. Utilization Impact	81	22	22	18	20	25	10	73
C. Quality Impact	100	38	100	38	100	38	14	0

a/Percent of maximum points rounded to the nearest percent.

Overall, the most dramatic changes occurred in the quality impact scores--Subsection C. While all four scores decreased, decreases in three of the four scores occurred because quality criteria were made more definitive and required that impact be better documented. The quality impact score for the fourth, Iowa PSRO, decreased because statistics from three of its six quality studies were not available while another study did not appropriately address quality.

Montana's score on the quality impact section declined between 1981 and 1982 because, of 21 quality studies submitted in 1982, HCFA disregarded 17 because of various deficiencies (see p. 10 for a discussion of some of these studies). California PSRO Area 23 declined in the quality impact section between 1981 and 1982 because, of 35 quality studies submitted in 1982, HCFA disregarded 28 (see p. 10).

Under the utilization impact part, Subsection B, PSROs are required to set objectives which define a problem, describe a planned intervention, and predict results and document achievements. As the utilization impact scores for 1982 indicate, three of the four did poorly in this area. The fourth, the Louisiana PSRO, increased its score substantially. Both the Louisiana executive director and the HCFA regional project officer agreed that the PSRO had improved between 1981 and 1982 for the following reasons. It had begun review only in February 1979, and because of budget constraints had been able to conduct reviews in only about half of its hospitals during its 1980 grant year, the year reviewed in the 1981 evaluation. For the 1982 evaluation, the PSRO had another year's experience with review, had begun review in all the hospitals in its area, and had developed a sufficiently large data base to permit it to identify problems.

According to a Montana PSRO official, its score on the utilization impact section declined significantly between 1981 and 1982 because, of several utilization objectives approved by its project officer, only one demonstrated impact. Consequently, it could receive credit for only this objective on the utilization impact section of the evaluation. A Montana PSRO official told us that the PSRO had not submitted other objectives for approval because of staff shortages.

Subsection A is primarily intended as a predictor of PSRO future impact rather than a measure of past performance. Scores for three PSROs increased in this area while one decreased.

QUARTERLY ASSESSMENTS
MAY HAVE DISADVANTAGED
THE FIRST PSROS EVALUATED

The Omnibus Budget Reconciliation Act of 1981 required that HCFA determine the relative performance of all PSROs as of September 30, 1981. HCFA's evaluation criteria provided a simultaneous review covering either the PSRO's most recently completed grant period or calendar year 1980. Data from 1979 could also be submitted in some cases for some parts of the evaluation.

HCFA modified the 1981 evaluation process to provide that 1982 evaluations be performed on a quarterly basis to cover each PSRO's most recent grant period. The number of PSROs whose grant periods closed at the end of each quarter of fiscal year 1982 is as follows:

<u>Fiscal year 1982 quarter and grant ending date</u>		<u>Number of PSROs to be evaluated</u>
1	12/31/81	<u>a/52</u>
2	03/31/82	<u>a/41</u>
3	06/30/82	38
4	09/30/82	<u>16</u>
Total		<u>147</u>

a/One first quarter and two second quarter PSROs withdrew voluntarily from the program before the completion of the evaluation process, leaving 51 and 39 PSROs actually evaluated for the first and second quarters, respectively.

Officials of several PSROs and the American Association of PSROs told us that because 1982 evaluation criteria were made available too late in their grant year, PSROs included in the first quarter evaluation had little or no opportunity to adjust their programs and activities to meet the requirements. They pointed out that PSROs evaluated in later quarters would have more time to make changes if they so desired.

To measure PSRO impact on reducing costs or improving quality of care, HCFA requires PSROs to establish objectives, predict the results of their interventions, and document achievements. According to a HCFA official, to get credit on the evaluation, a PSRO must have such objectives approved by its project officer by the end of the third quarter of its grant period. Thus, utilization and quality objectives for PSROs whose grant periods ended December 31, 1981, had to be approved by September 30, 1981, if they were to be counted for the 1982 evaluation.

The HCFA criteria against which performance was to be evaluated in 1982 were first sent to the PSROs on November 16, 1981. This submission consisted of the draft 1982 performance evaluation criteria and, according to a HCFA official, was the first time PSROs were made aware of HCFA's revisions to the 1981 criteria. A HCFA official agreed that as a result, PSROs included in the first quarter 1982 evaluation were unable to make any changes in objectives after receiving the draft criteria.

A HCFA official advised us that the final 1982 evaluation criteria were issued February 16, 1982, 1/ well after objectives for first quarter PSROs had to be approved and about 6 weeks after objectives for second quarter PSROs had to be approved. On the other hand, officials of PSROs included in the third and fourth quarter evaluations had until March 31 and June 30, 1982, respectively, to change their objectives.

HCFA officials told us that they believe that PSROs included in the first quarter evaluations were not at a disadvantage compared with PSROs evaluated later. They stated that for several years the agency has been emphasizing the importance of the objective setting process as a tool in measuring impact and PSRO officials should not have been surprised by this aspect of the 1982 criteria.

The evaluation's quality impact criteria changed significantly from 1981 to 1982 to make them more objective and quantifiable. In 1981, the criteria required the evaluating official to make a subjective judgment regarding three possible levels of PSRO quality impact. In the 1982 evaluation, to receive credit for improvements in quality of care, PSROs had to submit either approved quality objectives, medical care evaluation studies, or quality review studies. These studies are problem-oriented assessments of health care quality issues. A PSRO's study can receive credit if it adequately identifies a patient care problem, defines the PSRO's intervention, and documents the results achieved.

The evaluation criteria which established this requirement was not provided to PSROs until November 1981, near the end of the grant year for first quarter PSROs when most studies would have been completed.

The 1982 criteria, unlike the 1981 criteria, required specific minimum time frames for a study's baseline and impact periods. A study's baseline period is the period during which a hospital's records are reviewed to determine the extent of a problem and to provide a basis for measuring achievement from PSRO interventions. Records from a later period (impact period) are compared with the baseline data to document PSRO impact. The 1982 criteria included requirements that the baseline and impact periods be at least 3 months in length and that the baseline period occur in 1979 or 1980.

1/These criteria were further revised in April 1982. However, changes were generally not substantive.

Three of the four PSROs we reviewed lost credit for some of their studies because of their failure to meet the new evaluation criteria. The following table summarizes the number of studies that were submitted but received no credit because they did not meet the 1982 study requirements.

<u>1982 time frame criteria</u>	<u>Montana Foundation for Medical Care</u>	<u>California PSRO Area 23</u>	<u>Louisiana Medical Standards Foundation</u>
Baseline period was not in 1979 or 1980	3	6	-
Baseline period was not at least 3 months	-	6	1
Impact period was not at least 3 months	3	1	-
Impact and baseline periods were not at least 3 months	<u>3</u>	<u>-</u>	<u>-</u>
Total	<u>9</u>	<u>13</u>	<u>1</u>

In addition, the 1982 quality criteria required that studies be submitted in terms of the severity of the problem, the degree to which it was solved, and the number of patients affected. We were advised by a HCFA official that, because the 1981 criteria did not require study submissions in this format, PSROs generally had submitted study results in terms of quality of care deficiencies instead of patient cases.

HCFA officials told us that, because of the date on which the 1982 evaluation criteria were available, HCFA allowed many PSROs included in the first quarter evaluations to retabulate within about a week data reported in medical care evaluation studies. However, the officials said that many PSROs were unable to do so.

The result, for California PSRO Area 23, was that 11 studies were disregarded (in addition to the 13 shown above) because results were not reported in the required format. Although a HCFA headquarters official stated that he did not believe it was difficult for PSROs to retabulate quality impact study results in the new format if the study was not too large and data were easily available, a HCFA regional official for California told us that those 11 studies could not be broken down by patient cases.

In justifying the quarterly evaluation process, a HCFA official told us that some PSROs had complained that the 1981 evaluation was not fair to all because PSROs are funded for 12-month periods which terminate at the end of the four quarters of a fiscal year (i.e., the grant periods for some PSROs terminate at the end of each quarter). Thus, some could be evaluated on grant periods which ended several months before the evaluation was conducted or on calendar year 1980, which for many PSROs covered parts of two grant periods. In addition, according to HCFA officials, the number of HCFA headquarters and regional office personnel assigned to the PSRO program was reduced by about 50 percent between July 1981 and July 1982. HCFA officials told us that, as a result, they did not have enough personnel to simultaneously evaluate all PSROs in 1982.

Our review indicates that PSROs included in the 1982 first quarter evaluations may have been at some disadvantage compared with PSROs evaluated later, although we could not determine the extent to which specific scores were affected. This may have occurred because first quarter PSROs had no opportunity to add or change impact objectives after the 1982 criteria were made available and little or no time to adjust study design and study results in terms of the 1982 evaluation criteria for measuring impact on quality of care.

ARE HCFA'S ASSESSMENTS A SOUND BASIS FOR PSRO TERMINATIONS?

We have reservations about the extent to which HCFA's 1982 assessments provide a sound basis for terminating PSROs for ineffectiveness. These reservations center on evidence, discussed on page 3, that the 1982 passing score was set not to identify ineffective PSROs, but to terminate a specific number of PSROs to meet proposed fiscal year 1983 budgetary constraints.

HCFA officials told us that the changes in the 1982 evaluation criteria caused some PSROs with a history of effectiveness to fall short of achieving a passing score in the first quarter evaluation. Apparently as a result, HCFA added a category of "marginal failures" in addition to the pass/fail categories to recognize such past records of achievement and potential for effective performance. According to HCFA officials, they did not create this category until May 1982.

PSROs that failed to achieve the minimum total score by 75 points or less or that satisfied the minimum total score but failed in two of the three performance areas are categorized as marginal failures. Those PSROs (eight in the first quarter

and three in the second quarter evaluations as of August 17, 1982) could appeal their terminations or could negotiate special performance conditions which would address areas in which they were found deficient.

We have reservations also about HCFA's assessments as a sound basis for terminating ineffective PSROs because of errors discovered after HCFA's scoring verification procedures were completed and PSROs were notified of evaluation scoring results.

In one case, we were told that HCFA first orally notified the Iowa Foundation for Medical Care that it had passed the 1982 evaluation but on May 27, 1982, notified it in writing that, because of a 50-point error, its score had been reduced to the marginal failure category. We were told that as a result of this error, the HCFA central office and regional offices again checked all first quarter evaluation scores. HCFA officials said that the same double-check procedure was used to confirm second quarter scores and would be used to review third and fourth quarter results before PSROs were notified of the scores.

Nevertheless, after HCFA's double-check of scores for PSROs reviewed in the second quarter and its issuance of pass/fail notifications, HCFA found errors in the total scores for two other PSROs--Hudson County PSRO, New York, and Riverside County PSRO, California--that had initially been advised in writing on July 29, 1982, that they had failed the second quarter evaluation. In the first case an incorrect adjustment factor was used in the utilization impact section which had given the PSRO credit for 50 fewer points than appropriate. In the second case PSRO-documented utilization impact, initially not submitted under the quality impact subsection per HCFA regional office guidance, was later determined to be eligible for 100 points credit under the quality subsection. In both cases the additional points placed the PSROs in the marginal failure category, which made them eligible for continued funding.

OBJECTIVES, SCOPE, AND METHODOLOGY

We discussed your questions with HCFA headquarters officials, reviewed legislation that established the PSRO program and required evaluations of PSRO performance, compared HCFA's 1981 and 1982 PSRO evaluation criteria and methodology, and analyzed the final results of the 1981 and 1982 (first and second) quarter evaluations.

We selected evaluations for five PSROs included in the 1982 first quarter evaluation to more closely analyze the reasons for major changes in evaluation results between the 2 years. Four of the five--Iowa Foundation for Medical Care, Montana Foundation for Medical Care, California PSRO Area 23, and Louisiana Medical Standards Foundation--were selected because their evaluation results changed dramatically from 1981 to 1982. We selected the fifth evaluation--for Richmond County PSRO of New York--because that PSRO failed the 1982 evaluation by not passing two of the three sections evaluated even though it received more than the minimum total points needed to pass. Because of time constraints and questions raised by the HCFA regional office regarding the validity of the 1982 evaluation quality impact data submitted by the Richmond County PSRO for the 1982 evaluation, we later dropped that PSRO from our review.

We selected PSROs evaluated in the first quarter of 1982 because the results of the second quarter evaluations were not available when we selected our sample. We discussed the 1981 and 1982 results for those five with PSRO and HCFA headquarters and regional office officials, reviewed documents relevant to those PSROs, and analyzed the evaluation results to determine why the changes occurred. We also talked with and reviewed documents submitted by the executive director of the American Association of Professional Standards Review Organizations.

Several PSROs we contacted stated that the 1982 evaluation did not consider any cost savings impacts except for reductions in Medicare hospital days. 1/ These PSROs indicated that they had saved considerable amounts, for which they received no credit, through such means as reviewing hospital ancillary services and long-term care in nursing homes. However, the PSROs did not provide us with sufficient information to determine the validity or magnitude of any such savings. Therefore, we did not include this issue in this report.

Our review was conducted in accordance with the Comptroller General's current "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions."

1/In addition, HCFA officials advised us that PSROs funded for Medicaid review during the 1981 grant period could also receive 1982 utilization impact credit for their approved Medicaid objectives.

As requested by the Subcommittee office, we did not obtain agency comments from the Department of Health and Human Services on this report. As agreed, we are sending copies of this report to Representative George M. O'Brien and the Secretary of Health and Human Services. Unless you publicly announce the report's contents earlier, no further distribution will be made until 10 days from its issue date. At that time, we will send copies to interested parties and make copies available to others upon request.



Gregory J. Alart
Director

Enclosures - 2

BACKGROUND ON THE PSROEVALUATION CRITERIA AND PROCESSES

In 1972, the Congress authorized the establishment of medical review organizations called Professional Standards Review Organizations (PSROs). 1/ PSROs are voluntary local organizations, made up of local practicing physicians, which receive grants or contracts from the Department of Health and Human Services to review health care services furnished to Medicare beneficiaries to determine whether they are (1) medically necessary, (2) of good quality, and (3) provided in the most appropriate setting. The PSRO program is administered by the Department's Health Care Financing Administration (HCFA).

Congressional Budget Office studies have indicated that the PSRO program costs more to administer than the savings it achieves. To encourage competitive market forces to control health care costs, the administration has proposed phasing out the PSRO program. The administration's proposed budget for fiscal year 1983 plans to terminate all Federal funding for PSRO activities by the end of fiscal year 1983.

To prevent too many PSROs from being terminated, the Congress enacted section 2112(a)(1) of the Omnibus Budget Reconciliation Act of 1981, which specified that not more than 30 percent of those in existence on May 1, 1981, could be terminated during fiscal year 1982. This legislation ensured that at least 131 of the 187 PSROs in existence at that time would continue to receive Federal funding in fiscal year 1982.

The act also required that "the Secretary shall assess and determine the relative performance of each of such Organizations * * * as of September 30, 1981." The Secretary of Health and Human Services was also required to report to the Congress by September 30, 1982, on his assessment of PSROs' performance and on his subsequent decisions not to renew agreements with PSROs that failed to meet the minimum performance levels established.

HCFA terminated 37 PSROs (includes some voluntary terminations) between May 1981 and the end of February 1982, and 3 PSROs voluntarily withdrew from the program during preliminary budget negotiations for fiscal year 1982. This reduced the number of PSROs by about 21 percent.

During the 1982 first quarter evaluations, HCFA reviewed 51 PSROs, and according to a HCFA official, 1 withdrew voluntarily from the program. Of the 51 evaluated, 16 (or 31.4 percent) failed to attain a passing score. According to HCFA officials,

1/Public Law 92-603.

they classified 8 of these 16 as marginal failures because they failed by 75 points or less. Marginally failing PSROs were, HCFA officials advised us, refunded for another year if they agreed to accept special conditions to their grants that would address areas in which they were found deficient. All but one agreed to do so. A HCFA official said this PSRO, and the eight that failed by more than 75 points, have appealed for a reconsideration of evaluation results. 1/

During the second quarter of 1982, HCFA evaluated 39 PSROs. HCFA officials advised us that one additional PSRO voluntarily withdrew from the program and another was terminated before its evaluation was completed. Of the 39 evaluated, 7 (or about 18 percent) failed to attain a passing score, 3 of which failed marginally.

DIFFERENCES BETWEEN THE 1981 AND 1982 EVALUATION CRITERIA AND METHODOLOGY

HCFA's 1981 PSRO evaluation criteria were designed to measure individual PSRO performance characteristics in three major program areas. Section I, "Organization and Program Management," was designed to evaluate the effectiveness of a PSRO's board of directors and executive committee, management of administrative and financial matters, operational cost efficiency, and working relationships with the States. Section II, "Performance of Review Operations - Compliance and Process," was designed to evaluate actions taken as a result of a PSRO's acute care reviews, special actions such as issuance of warning letters or recommended sanctions against a physician or hospital that has violated Federal requirements, studies on quality of medical care, the PSRO's data system, and profiles used to identify potential misutilization by institutions and practitioners.

Section III, "Performance of Review - Impact/Potential Impact," the most heavily weighted of the three sections, addressed a PSRO's objective setting process and its impact on utilization and quality of care based on objectives set by the PSRO and approved by HCFA. For example, the Louisiana Medical Standards Foundation established and received credit for a utilization objective directed at reducing the average length of stay for its area hospitals whose individual average initially exceeded the area's average by 20 percent.

1/As of August 25, 1982, two of these nine PSROs had won their appeals, one had been offered refunding if it would accept special conditions on its grant, and six had lost their appeals and are slated for termination. However, a HCFA official told us that because of the passage and anticipated presidential approval of the Tax and Fiscal Responsibility Act of 1982, none would actually be terminated. (See footnote 2 on p. 4 of this letter.)

The Iowa Foundation for Medical Care received credit for a quality objective directed at reducing the use of a specific antibiotic in 16 hospitals.

The 1982 evaluation criteria were similar to those used in 1981 in that they focused on the same three program areas. However, HCFA changed percentage weights among sections, deleted parts, and added new requirements. One major change in 1982 was HCFA's increased emphasis on PSRO impact in Section III. The relative weight of importance given to this section increased from 50 percent of the total points available in 1981 to 68 percent in 1982. This in turn reduced the relative importance of the first two sections.

HCFA eliminated two of the four parts of Section I evaluated in 1981 from the 1982 evaluation because, according to HCFA officials, most PSROs had received full credit for them and they did not differentiate PSRO performance.

The major criteria change was in the quality impact part of Section III. Criteria used for measuring quality impact in 1981 appeared to be general and subjective. In comparison, the 1982 evaluation criteria are more definitive, objective, and quantifiable. For example, the 1982 instructions specified that points could be obtained only for resolving problems identified by a PSRO in an impact objective or an acceptable medical care evaluation study. The points awarded depended on the number of cases affected and the magnitude of the adverse effect on a patient's well-being; that is, whether the situation was life threatening, caused a major loss of function, or prevented complications or unnecessary patient discomfort.

Another change that may have significantly affected scores in the 1982 evaluation was a new requirement that all evaluations submitted to the HCFA central office must be accompanied by adequate documentation to support the ratings assigned by the HCFA project officer for each category. For the 1981 evaluation, HCFA instructions directed regional offices not to submit documentation to the HCFA central office, but to maintain it on file.

SCORING PROCESS

After the performance evaluation criteria were established, point values and minimum acceptable levels were assigned to each section by the HCFA central office. Of the 2,350 maximum points available on the 1981 evaluation (1,770 points in 1982), a PSRO was required to score at least 1,105 total points (865 in 1982) and obtain the minimum point levels in at least two of the three sections evaluated in order to demonstrate acceptable performance. Receiving unsatisfactory scores in two sections was regarded as unsatisfactory overall performance even if the total score was equal to or greater than 1,105 in 1981 or 865 in 1982.

Although PSROs need to earn only about half of the total available points to pass the 1982 evaluation--about the same as in 1981--it is more difficult to obtain the necessary points in 1982 because of changes in the evaluation criteria and the weighting factors, heavier emphasis on the evaluation section designed to measure impact, and the new 1982 requirement that all evaluations sent to the HCFA central office must be accompanied by adequate documentation to support the scores awarded.

Although 2,350 points were the maximum available during the 1981 evaluation, a PSRO was permitted to increase its Section III impact score up to the total points (1,200) available for that section through the addition of bonus points. The bonus criteria measured achievement in areas outside the scope of minimum PSRO responsibility, but were not considered in determining whether a PSRO met minimum performance requirements; that is, whether it passed or failed.

Bonus points were included in the total score only for purposes of determining a PSRO's fiscal year 1981 national ranking among all PSROs. According to a HCFA official, this national ranking gave HCFA a method, if needed, for selecting PSROs to be terminated in addition to those which failed to achieve minimum passing scores. However, HCFA did not use the 1981 ranking to terminate PSROs.

Besides reducing the number of points available between the 1981 and 1982 evaluations, HCFA changed the rating periods to permit a PSRO's impact to be evaluated against objectives established for its individual grant period. The 1981 evaluation was based on PSRO performance during calendar year 1980 or the most recent grant period and was based on 12 months of performance data. The 1982 evaluations, however, are based on the most recent grant period completed, and PSROs are being evaluated in the quarter after their grant periods expire. Thus, PSROs whose grant periods ended on December 31, 1981, were designated as the PSROs to be included in 1982 first quarter evaluations.

COMPARISON OF SECTIONS AND POINTS AVAILABLE ON THE
1981 AND 1982 PSRO PERFORMANCE EVALUATIONS

<u>Program areas</u>	<u>1981 Evaluation</u>			<u>1982 Evaluation</u>		
	<u>Maximum points</u>	<u>Percent of total maximum points</u>	<u>Minimum acceptable passing level (note a)</u>	<u>Maximum points</u>	<u>Percent of total maximum points</u>	<u>Minimum acceptable passing level (note a)</u>
Section I-- Organization and Program Management	300	13	190	135	8	75
Section II-- Performance of Review Operations-- Compliance and Process	850	37	400	435	24	285
Section III-- Performance of Review--Impact/ Potential Impact	<u>b/1,200</u>	<u>50</u>	<u>515</u>	<u>1,200</u>	<u>68</u>	<u>505</u>
Total points	<u>2,350</u>	<u>100</u>	<u>1,105</u>	<u>1,770</u>	<u>100</u>	<u>865</u>
Percentage of total points needed to pass			47			49

a/PSROs must obtain the total minimum passing score and pass two of the three sections.

b/For purposes of ranking the PSROs in 1981, bonus points were permitted to increase the section III impact score up to the total points (1,200) available for that section. Bonus points were not considered in determining whether a PSRO passed or failed.