

March 1989

MEDICARE

Statutory Modifications Needed for the Peer Review Program Monetary Penalty





Human Resources Division

B-233035

March 30, 1989

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

Medicare seeks to ensure that beneficiaries receive hospital care that is medically necessary and meets professionally accepted standards. To detect any violations of such standards, Medicare contracts with peer review organizations (PROs) to examine beneficiaries' inpatient hospital records. If they identify instances of improper or unnecessary care (that is, instances in which physicians fail to meet their obligations under Medicare law) that are gross and flagrant or of a substantial number,¹ PROs must report them to the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) and provide appropriate recommendations.

Although in the most serious cases Medicare can exclude the provider² from the program, if exclusion is not warranted it can impose monetary penalties instead. The dollar penalty, however, is based on the cost to Medicare of the improper or unnecessary care. In the case of poor-quality care, there may be little or no identifiable cost. This limitation can result in penalties that are only nominal.

During a survey of the PRO program, we noted a change in the OIG's practice concerning monetary penalties for improper or unnecessary care. Because these penalties can be an important sanction against those who provide such care, we examined the reasons for the OIG's change and the actions taken by the OIG on monetary penalties recommended by PROs.

¹Regulations define (1) a gross and flagrant violation as one involving imminent danger or high risk to a beneficiary and (2) a substantial number of cases as a pattern of violations.

²In this report, we use the term "provider" to refer to both physicians and institutional providers, such as hospitals.

Background

Medicare is a federally funded health insurance program covering almost all persons 65 years and older and some disabled persons under 65. In fiscal year 1987, Medicare paid out \$76.7 billion for health services and had about 32 million beneficiaries enrolled. It is administered by the Health Care Financing Administration (HCFA) in HHS.

In an effort to curb rising hospital costs while ensuring that Medicare beneficiaries receive high-quality medical care, the Congress established the PRO program through the Tax Equity and Fiscal Responsibility Act of 1982. PROs, which began operating in 1984, review hospital records for about one-fourth of all Medicare patient admissions.³ Medically trained personnel, usually registered nurses or accredited medical records technicians, screen cases for instances of unnecessary or poor-quality care. These personnel refer potential problems to physician-reviewers, who may also refer them to specialists.

Each case the PRO selects is reviewed for both unnecessary and poor-quality care. If a PRO's physician advisers determine that a beneficiary has been unnecessarily admitted to a hospital, the PRO is required to deny payment to the hospital after providing an opportunity for discussion with the physician responsible for the beneficiary's care.⁴ If the unnecessary admission seems to be part of a pattern of unnecessary care, there is a pattern of poor-quality care, or there are one or two instances of poor-quality care that place a beneficiary's health, safety, or well-being in imminent danger, the PRO must attempt to discuss the case with the physician or hospital responsible. If after this discussion, the PRO determines that a quality-of-care problem exists and the provider has thus violated its obligations under the Medicare law, the PRO sends the provider a written notice that it may be subject to a possible sanction. This notice gives the provider a period of time, depending on the nature of the violation, to request a meeting or submit additional material.

If, as a result of this process, a PRO determines that a physician or hospital has exhibited a pattern of furnishing unnecessary or poor-quality care to Medicare beneficiaries, the PRO must take steps to prevent repetition of the problem. These steps may include placing the provider under

³PROs select cases to review from a random sample of all inpatient hospital cases, and also for selected diagnoses or indicators of potential utilization or quality problems, such as patient transfers to another hospital or hospital readmissions within 31 days of discharge.

⁴Section 9403a of the Consolidated Omnibus Budget Reconciliation Act of 1985 gave the PROs the authority to deny hospital payments for poor-quality care. However, as of February 1989, HHS had not published regulations in final form, so the provision has not been implemented.

the sanctioned party. Furthermore, a monetary penalty constitutes documentation of unacceptable practice and could provide a basis for exclusion from the Medicare program should the problems persist.

Objective, Scope, and Methodology

Our objective was to evaluate the OIG's policy for acting on PRO recommendations for monetary penalties against hospitals and physicians. To accomplish this, we reviewed the OIG's actions on monetary penalties recommended by PROs between October 1984 and February 1988. We discussed with OIG officials their reasons for accepting or rejecting these recommendations, their past and present policies on monetary penalties, and their reasons for changing policies. In addition, we discussed OIG policy changes with PRO officials in four states—Arizona, California, North Carolina, and Virginia.

Our work was conducted between December 1987 and September 1988 in accordance with generally accepted government auditing standards.

Dollar Limits Hinder Use of Monetary Penalties

Section 1156 of the Social Security Act limits a monetary penalty to "an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided." When poor-quality care is provided during a hospital stay, there may be no significant costs to Medicare directly relating to the care because costs for the admission are fixed under PPS.⁵ The only clearly identifiable cost to Medicare resulting from the incident of poor-quality care may be the physician's bill for such care. Thus, the penalty may be limited to this amount.⁶

Between October 1984 and September 1988, the OIG acted on 51 monetary penalty recommendations received from PROs. Of these, the OIG accepted 25 and rejected 26. The penalties imposed ranged from \$65 (the amount of Medicare's payment to the physician) for negligence contributing to a patient's death to \$17,512 for substandard care that endangered four patients. The median was \$3,647.

⁵Exceptions occur when a patient's hospitalization exceeds either cost or length-of-stay norms. In such "outlier" cases, hospitals receive additional reimbursement under PPS. If a case becomes an outlier because of inadequate care or if Medicare incurs costs due to such occurrences as a hospital readmission, the additional costs could be added to the monetary penalty.

⁶In some of the earlier monetary penalties, the OIG used a less restrictive interpretation of the law and imposed penalties that included Medicare hospital payments. However, in a 1986 advisory memorandum, an OIG attorney advised that the penalty could include only those costs to Medicare directly attributable to the unnecessary or poor-quality care.

proposed that it be given discretion to impose a penalty of up to \$10,000 for each instance in which medically unnecessary or poor-quality health services were provided. In October 1988, an HHS official told us that the Department was considering the OIG recommendation.

OIG Policy Restricted Use of Monetary Penalties

In part because of problems resulting from the cost-based method of determining monetary penalties, the OIG changed its monetary penalty practice in May 1987, when it began to reject most monetary penalty recommendations. In July 1987, the OIG informed the PROS of its new policy through an information memorandum that advised them not to make monetary penalty recommendations unless such a penalty would be cost-effective. Specifically, the memorandum indicated that PROS should not recommend such penalties unless, among other things

- the provider displayed a pattern, rather than one or two instances, of unnecessary or poor-quality care and
- the Medicare program improperly reimbursed the provider a significant amount of money.

The first criterion—requiring a pattern of poor-quality care—is more stringent than the requirements of the Social Security Act, which specifically allow sanctions for a single gross and flagrant violation. The act clearly states that when a PRO determines that a provider has violated his or her obligations under the act in a manner that puts a beneficiary at risk of death or serious injury in one or more instances, “such organization shall submit a report and recommendations to the Secretary . . .” (emphasis added). The act empowers the Secretary to impose sanctions on providers in such cases. The OIG, under its delegated authority, must consider these cases and decide whether to impose sanctions.

The pattern criterion also arose in part from the belief that providers who had violated Medicare standards on only one or two occasions, but were deemed unlikely to repeat the violations, should not be subject to sanctions, OIG officials said. The OIG has the authority to make this judgment. However, the statute requires PROS to report all instances where providers failed to meet their obligations to the OIG for review.

The second criterion—requiring PROS to submit monetary penalty cases only when there is a substantial reimbursement that could serve as the basis for a monetary penalty—is not a consideration in the law. The OIG established this criterion to discourage cases that would result in trivial penalties while requiring substantial resources to process, according to

violated its obligations under the Medicare program and placed a beneficiary at substantial risk of death or serious injury. But the OIG rejected the recommended monetary penalties because it had found such penalties generally not to be cost-effective and because the particular physician or hospital had not displayed a pattern of offenses. The three cases for which the OIG accepted recommendations for monetary penalties each involved multiple violations and a substantial penalty.

Partially in response to the new policies, PROs have curtailed recommendations for monetary penalties. For example, according to officials at PROs we visited:

- One PRO stopped submitting recommendations for monetary penalties as a result of the OIG's instructions. It did so even though it had identified incidents that would have warranted sanctions under the OIG's previous policy. In the past, this PRO had submitted 12 recommendations for monetary penalties.
- Another PRO halted action on some monetary penalty cases until HCFA could clarify what constituted a "pattern" of violations.
- A third PRO's operations generally were unaffected by the OIG's change, a PRO official told us, but it would take longer to develop a case. This was because the PRO would have to review more cases to develop a pattern. However, in the past this PRO had recommended only one monetary penalty.

During the 14 months between the July 1987 information memorandum and September 1988, the PROs submitted only four new monetary penalty recommendations to the OIG. In contrast, the PROs submitted 35 monetary penalty recommendations during the 15-month period May 1986 to July 1987.

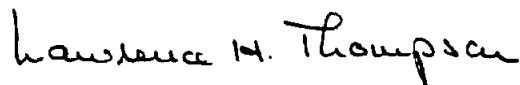
OIG's Planned Actions

In June 1988, we discussed with senior OIG officials the appropriateness of applying the July 1987 criteria to monetary penalties. At that time, they agreed that cost-effectiveness was not an appropriate consideration and said they would modify instructions to the PROs accordingly. The OIG official in charge of PRO sanctions later told us that as a result of that discussion, the Inspector General had decided that the July 1987 criteria would no longer be applied. He said that under the new policy, each case submitted by a PRO was being reviewed based on the criteria in the law. The official told us that this change had been informally communicated to the PROs. However, as of February 1989 the OIG had not

from the program. They said that monetary penalties would be considered only in cases in which providers are willing and able to change their behavior. We concur with this criterion, and we found that the OIG had consistently followed it in accepting monetary penalty cases. Therefore, the only cases considered for monetary penalties are those in which the provider is deemed able and willing to correct the aberrant behavior. Thus, we did not specifically address this criterion in our report.

We are sending copies of this report to the Secretary of HHS; the Director, Office of Management and Budget; and other interested parties, and we will make copies available to others on request.

This report was prepared under the direction of Michael Zimmerman, Director, Medicare and Medicaid Issues. Other major contributors are listed in appendix II.



Lawrence H. Thompson
Assistant Comptroller General

**Appendix I
Comments From the Department of Health
and Human Services**

**COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT,
"MEDICARE: STATUTORY MODIFICATIONS NEEDED FOR THE
PEER REVIEW PROGRAM MONETARY PENALTY"**

GENERAL COMMENTS

We have reviewed the subject General Accounting Office (GAO) draft report and generally agree with its conclusions. However, some areas need clarification before the report is released in final form. There is some misunderstanding about the Office of Inspector General's (OIG) policies concerning the criteria used in processing peer review organization (PRO) monetary penalty cases.

The GAO report discusses two of the criteria which were set forth in an OIG Technical Information Memorandum, dated July 24, 1987. Specifically, GAO references two criteria employed by the OIG for deciding case acceptance. These criteria are: identified pattern of unnecessary and poor quality care; and, significance of the amount of program reimbursement. However the GAO report does not address what the OIG considers to be the criterion of prime importance, the requirement that "the PRO must be satisfied that such an improper pattern of care will not continue to occur". This third criterion which was addressed in the July 24 memorandum is based upon section 1156(b)(1) of the Social Security Act and relates directly to the question of willingness and ability of the provider to render quality care to Medicare patients.

The July 24 release was the result of the OIG's reevaluation of its position on the processing of monetary penalty cases, particularly those containing only one potential violation. The OIG found that the nominal penalties being assessed did not have the appropriate deterrent effect and in fact could leave the wrong message with the medical community that these penalties were trivializing potentially serious situations. Additionally, the OIG found that the levying of monetary penalties was not cost effective in program or administrative costs. Given these considerations, the OIG determined that the criteria for accepting monetary penalty cases would have to be strengthened. In that regard, the July 24 memorandum defined the parameters to be used in selecting future monetary penalty cases and provided guidelines on the types of information to be included in future sanction recommendations to be made to the OIG.

Once the new criteria were in place the OIG found many cases in which it appeared that the violation concerned an isolated incident and there appeared to be no indication that such a violation would recur. In other words, analysis of the file indicated that the provider was both willing and able to take the necessary steps to persuade the PRO and/or the OIG that a similar violation would not occur again. In only one of the cases processed during the early implementation period was the reason

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GAO RECOMMENDATION

The GAO recommends that "the Senate Committee on Finance, and the House Committees on Ways and Means and Energy and Commerce develop legislation amending section 1156 of the Social Security Act to set a fixed upper limit to the size of monetary penalties in lieu of the current cost-based limit".

DEPARTMENT RESPONSE

The Department concurs. The OIG has also recommended that section 1156 be amended to set a fixed upper limit to the size of monetary penalties.

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The following are GAO's comments on the Department of Health and Human Services' letter dated February 10, 1989.

GAO Comments

1. HHS states that at no time did the OIG delegate authority to any PRO to do anything other than make recommendations for OIG consideration.

We believe that the OIG did, in effect, delegate a part of its authority to the PROs in its July 1987 technical information memorandum. Section 1156(b)(1) of the Social Security Act states that when a PRO determines that a provider has "grossly and flagrantly violated any such obligation in one or more instances, such organization shall submit a report and recommendations to the Secretary." The law requires HHS to determine what action to take, using criteria including whether the provider is willing and able to reform.

In the memorandum, the OIG instructed the PROs that:

"... monetary penalties should only be recommended in those instances where the PRO has identified a pattern of care, as opposed to one or two instances, by a practitioner or provider where the Medicare program has improperly reimbursed a significant amount of money and the PRO is satisfied that such an improper pattern of care will not continue to occur."

The memorandum thus instructs the PROs, rather than HHS, to make the "willing and able to reform" determination. Furthermore, the memorandum instructs the PROs not to report a single instance of care placing a beneficiary at risk of death or serious injury (gross and flagrant violation) as required by the act. If the OIG does not receive a report from the PRO on a case, it cannot carry out its statutory responsibilities regarding the case.

2. HHS commented that the OIG did not issue another technical information memorandum modifying its instructions to the PROs because the July 1987 memorandum did not contradict HCFA's instructions already in use. OIG officials told us that as a result of our June 1988 meeting with OIG officials, the Inspector General had decided that the criteria in the July 1987 memorandum would no longer be applied, and that each case submitted by a PRO would be reviewed based on criteria found in the law. However, as of February 1989, this policy modification had not been formally communicated to the PROs. Until this is done, PROs may fail to submit reports on sanctionable violations as required by law.

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for closure specified as being strictly cost effective. In every other case closure, the primary reason that the case was rejected was because the provider was deemed to have violated his/her obligation in an isolated instance and was determined to be willing and able to preclude a future violation. The appropriate PRO was then requested to monitor that provider's pattern of practice to insure future compliance. If at that point compliance was not achieved, then the PRO could use the rejection to support a future exclusion recommendation.

We agree that language used in the rejection letters released during the implementation period may have been somewhat misleading. Therefore, the language relating to the cost effective issue was deleted as of October 1987. However, even considering the faulty language in the early letters, the OIG did not violate its statutory or regulatory obligations. At no time was any PRO delegated the authority to do anything other than make recommendations for OIG consideration and in all but one case that was referred, the OIG based its rejections on the willing and able question.

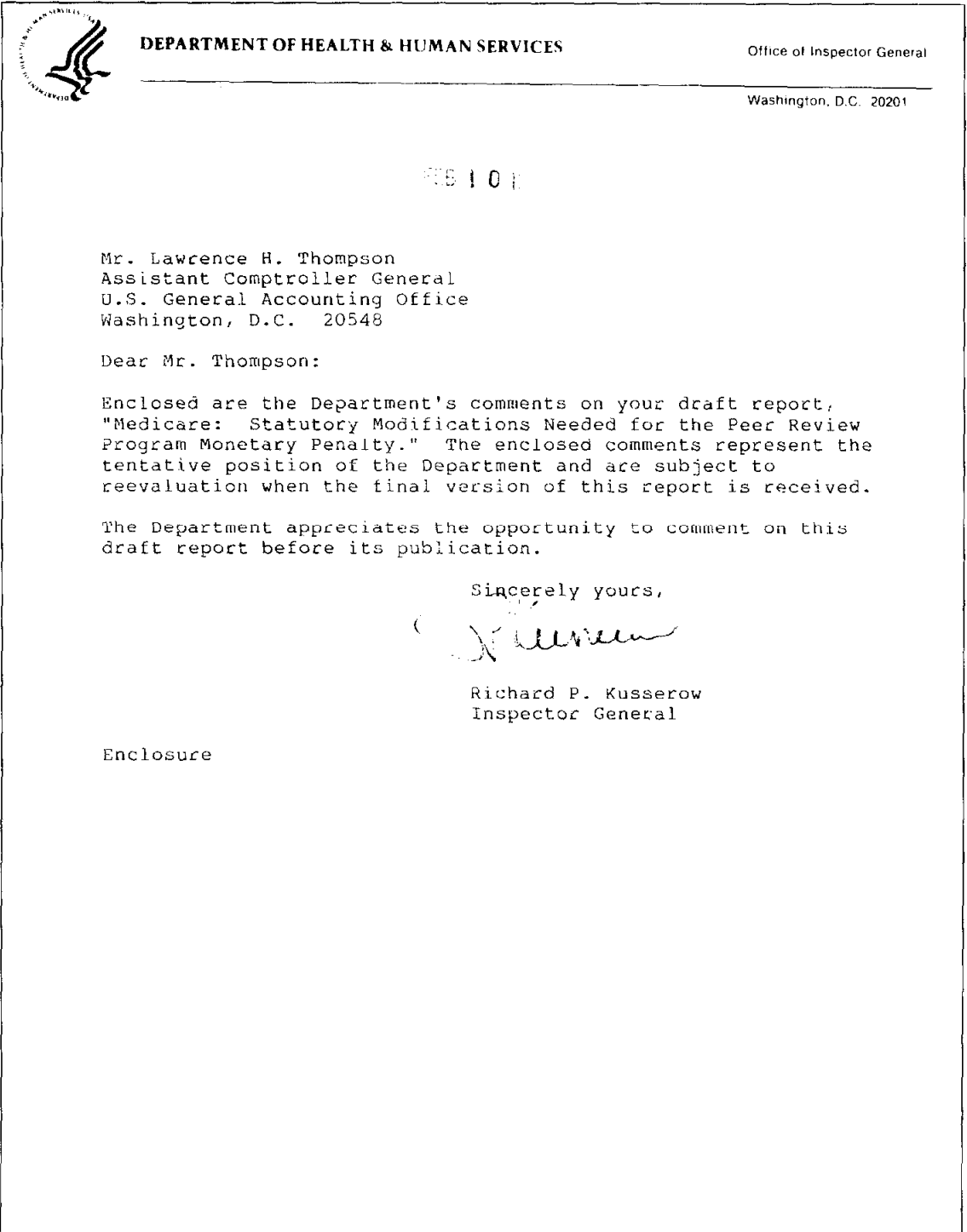
The OIG's actions did not contradict the Health Care Financing Administration's (HCFA) instructions already in use by the PROs. Section 6020.A of the PRO manual, dated October 1, 1985, clearly states that when a PRO identifies a potential gross and flagrant violation, they should send an initial sanction notice and meet with the provider to determine if he/she is willing and able to change his/her pattern of practice. The requirement that a provider be contacted in each and every case has never been relaxed. It has been OIG policy not to interfere with how each PRO develops a sanction case prior to referral to the OIG for fear that undue pressure would inhibit the free flow of medical dialogue between the PRO and the provider when initially discussing the medical issues involved in an initial case review and when initially making their determination on a provider's willingness or ability to change. Therefore, because the OIG's actions did not contradict the HCFA instruction already in use by the PROs, there was no reason to release another technical information memorandum or field instruction to the PROs on how to handle monetary penalty recommendations. We will, however, issue an instruction to the PROs reminding them of their responsibilities and detailing the OIG policy on monetary penalties.

See comment 1.

See comment 2.

Comments From the Department of Health and Human Services

Note: GAO comments supplementing those in the report text appear at the end of this appendix.



issued new written instructions formally superseding the July 1987 information memorandum.

Conclusions

In part, the OIG's policy revisions were prompted by the statutory limit on penalty size, which sometimes resulted in penalties disproportionate to the nature of the offense. According to OIG officials, the monetary penalty will not be effective until the statute is changed to permit monetary penalties of sufficient size to constitute a credible deterrent. To make the PRO monetary penalty a useful alternative when exclusion is not appropriate, the Congress should consider amending the Social Security Act by substituting a fixed dollar limit on monetary penalties for the current cost-based limit. Such an amendment would provide for monetary penalty amounts to be determined in the same manner as other provisions administered by the OIG.

The Social Security Act requires that PROs submit a report with recommendations regarding a sanction to the OIG in all cases in which they find deficiencies that are sanctionable under the statute. The OIG is responsible for deciding whether to impose a sanction. In instructing the PROs to submit only cases that met its criteria, the OIG partially delegated that authority to the PROs. The OIG's policy changes, when effectively communicated to the PROs, should correct this problem.

Recommendation to the Legislative Committees

We recommend that the Senate Committee on Finance, the House Committee on Energy and Commerce, and the House Committee on Ways and Means develop legislation amending section 1156 of the Social Security Act to set a fixed upper limit to the size of monetary penalties in lieu of the current cost-based limit.

Agency Comments

HHS generally agreed with our conclusions and our recommendation. HHS stated that the OIG has also recommended that section 1156 be amended to set a fixed upper limit to the size of monetary penalties.

HHS commented that we did not address the criterion for accepting monetary penalty cases that the OIG considers of prime importance: the requirement that the provider must be willing and able to reform his or her unacceptable behavior. OIG officials said that where providers are unwilling or unable to change their behavior, they should be excluded

OIG officials. Although relatively nominal penalties may weaken the sanction's deterrent effect, the amount of the penalty is not its sole deterrent. Deterrence can also be expected because when it applies a monetary penalty, the OIG informs the public, other providers, and state licensing boards. Unless some penalty is imposed, no public notice is possible, even though the OIG may have confirmed that a violation occurred.

Furthermore, the statutory provision requiring PROs to forward reports on all providers who violate their Medicare obligations provides a mechanism for the OIG to assure consistent sanction determinations. However, the OIG's instruction to the PROs not to forward cases that do not meet these criteria limits its ability to assure consistent application of sanction criteria.

The OIG's policy is stated in many of its letters to PROs informing them of why their recommendations for monetary penalties were being rejected. For example, its letter to one PRO stated:

"We have found the levying of a monetary penalty is not the most cost effective utilization of the PRO's resources. A recent study indicated that the average monetary penalty is approximately \$5,200 per case and the average cost to a PRO processing a case is over \$11,000. In addition to the PRO's cost, the cost to the Federal government through the use of OIG staff as well as the cost of an administrative hearing, since most cases are appealed, must be considered. Therefore, since the levying of a monetary penalty is not cost effective, we are closing this case."

One of the four PROs we visited interpreted the OIG's guidance to mean that a monetary penalty must exceed the costs of developing and processing the cases. This PRO had been the most active among all PROs nationwide in recommending monetary penalties. The requirement that monetary penalties be cost-effective was one reason this PRO stopped recommending such penalties.

Monetary Penalties Now Seldom Used

Since the May 1987 policy went into effect, the OIG has seldom imposed a monetary penalty against a provider, and PROs have made significantly fewer recommendations. The OIG has approved just 3 of 24 recommendations for monetary penalties since the effective date,⁷ compared with 22 of 27 between October 1984 and May 1987. In 15 of the cases rejected since mid-May 1987, the OIG agreed that the hospital or physician had

⁷All but two of these were cases recommended before the July 1987 memorandum informing the PROs of the OIG's monetary penalty policy change.

The requirement that penalty assessments be based on costs sometimes has resulted in penalties that were nominal in comparison to the severity of the violation. For example:

- One PRO found that a physician who admitted a patient to a hospital for gastrointestinal bleeding neglected to monitor and aggressively treat him even after being notified of his rapidly deteriorating condition, possibly contributing to the patient's death. The PRO recommended a monetary penalty to the OIG. But because the patient's hospitalization was medically necessary, there was no additional hospital charge associated with the substandard care. Thus, the monetary penalty was limited to Medicare's payment to the physician—\$65.44.
- A physician mismanaged administration of a toxic drug, possibly contributing to the patient's death. Because the patient's condition required hospitalization, the hospital costs were considered necessary. The OIG penalized the physician Medicare's cost for his professional services—\$292.
- A physician endangered a cardiac patient by discharging her from the hospital despite symptoms of a second heart attack. The hospital did not bill Medicare for a second admission, and the physician did not bill Medicare for his services. Consequently, there was no additional cost to the program stemming from the negligence, and the OIG could not impose a penalty.

Since 1984, in five instances, because of the statutory restriction, the OIG imposed penalties of less than \$1,000 on physicians for medical care not meeting quality standards. In four of these instances, the poor-quality care may have contributed to a beneficiary's death. OIG officials believe such small monetary penalties for serious violations of medical standards trivialize Medicare's monetary penalty sanction.

Under other monetary penalty authorities in the Social Security Act, the OIG may impose a penalty up to a specified maximum dollar amount. For example, the OIG may penalize hospitals up to \$50,000 for refusing to treat uninsured patients in emergency situations. The OIG also may penalize health maintenance organizations up to \$25,000 for failing to provide necessary care to a Medicare beneficiary and that failure adversely affects the beneficiary. Finally, providers that fraudulently bill Medicare may be penalized up to \$2,000 per instance.

The OIG recognizes the problems with the current cost-based monetary penalty provision and in June 1988 recommended to HHS that it submit to the Congress a proposal to amend the provision. Specifically, the OIG

(1) intensified review (that is, reviewing all or a sample of the provider's cases for a specified period) or (2) a corrective action plan. If problems continue or have placed a beneficiary at risk of death or serious injury, the PRO must submit a report to the OIG with recommendations on imposition of a sanction against the provider.

Sanctions involve either a monetary penalty on the provider or exclusion of the provider from the Medicare program. The statute permits exclusion only when it can be established that the provider is either unwilling or unable to meet his or her obligations to provide only necessary and appropriate care to Medicare beneficiaries. The OIG has interpreted the law to mean that a monetary penalty may be imposed for violations not meeting this criterion.

Monetary penalties for providing poor-quality care are limited by law to the amount that care cost the Medicare program. Such costs may be low because under Medicare's prospective payment system (PPS) for inpatient care, hospitals are paid a fixed, predetermined amount based on a patient's diagnosis. Therefore, instances of poor-quality care may not result in extra hospital costs to Medicare. In this case, the penalty is limited to the amount of the physician's bills, and penalties can be nominal compared to the risk of harm the patient has been exposed to.

The Secretary of HHS has delegated to the OIG the responsibility for deciding whether to impose a provider sanction. After reviewing the evidence and determining that the PRO has complied with regulatory and legal requirements in preparing the case, the OIG may accept, reject, or revise the PRO's sanction recommendation. Providers dissatisfied with sanction decisions may request a hearing by HHS and appeal the decision to an administrative law judge. If still dissatisfied, the provider may appeal to the federal courts. If a sanction is imposed, HHS regulations require the OIG to notify the public, local hospitals, state licensing boards, and other appropriate entities.

Representing a lesser level of sanction, monetary penalties are an alternative to excluding a provider from participation in the Medicare program when the latter is not appropriate. The monetary penalty was intended to serve as a deterrent against providers' violating their obligations under the program. As in the case of exclusion, public notice of the sanction may add to the deterrent effect and alert beneficiaries, state licensing boards, and other providers of the problems encountered with

Results in Brief

Prompted in part by the statutory limit on penalty size, the OIG advised PROS in 1987 not to submit cases with recommendations for monetary penalties unless the penalty would be cost-effective. To this end, it advised PROS that the cases should meet two criteria:

- The physician or hospital must display a pattern, rather than one or two instances, of unnecessary or poor-quality care.
- The Medicare program must have improperly reimbursed the provider a significant amount of money.

The OIG's instruction imposed on PROS criteria for sanctions that are more stringent than Medicare law. Medicare law makes no reference to the costs of the poor-quality or unnecessary care to Medicare as a consideration for determining whether to impose sanctions on a provider. Instead it stipulates that PROS must make recommendations to the OIG when one or more instances of poor-quality care occur that place beneficiaries' health, safety, or well-being in imminent danger.

As a result of this policy change, the OIG ceased to impose monetary penalties except under very limited circumstances. The PROS reacted by making fewer recommendations for monetary penalties.

In part, the OIG's policy revisions were prompted by the statutory limit on penalty size, which restricts the penalty to the cost of the unnecessary or poor-quality care to the Medicare program. As a result, monetary penalties have sometimes been disproportionately low compared with the nature of the offense. The OIG recognizes the problems with the current cost-based monetary penalty and has recommended to HHS that it submit to the Congress a proposal to amend the provision.

To make the PRO monetary penalty more meaningful in circumstances where exclusion of providers from the Medicare program is not appropriate, the Congress should consider amending Medicare law to permit the OIG to impose a penalty up to a specified maximum dollar amount, without reference to the cost of the unnecessary or poor-quality care.

The OIG official in charge of PRO sanctions told us that as a result of our concerns, the Inspector General had decided that the 1987 criteria would no longer be a consideration for monetary penalties. However, as of February 1989 this policy change had not been formally communicated to the PROS.

