DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: National Capital Medical Foundation, Inc. DATE: December 18, 1981
Docket No. 81-104
Decision No. 240

DECISION

Introduction

The National Capital Medical Foundation, Inc. (NCMF) appealed the Health Care Financing Administration's (Agency) decision to permit its grant, No. 97-P-99593, to expire after an extension of the grant to November 30, 1981. The decision provided that the grant would be further extended, if necessary, to permit this Board to make a final decision. The Agency based its decision on the number of points NCMF was awarded on various criteria in an evaluation of NCMF's performance conducted by the Agency. NCMF's score of 1083 on that evaluation was 22 points short of the 1105 which the Agency required.

In its appeal letter, dated July 17, 1981, NCMF requested a hearing pursuant to §1152(d)(2) of the Social Security Act (Act). A hearing before the Presiding Board Member was held on September 23, 24 and 25, 1981. 1/ This decision is based on the Record in this case, which includes the written submissions of the parties and the evidence presented at the hearing (as recorded in the transcript of the hearing). 2/ Based on the analysis below, we conclude that the Agency's decision should be reversed.

This decision is divided into two sections. The first provides general background information on the Professional Standards Review Organization (PSRO) program and the nationwide evaluation of PSROs which led to this dispute. The second section sets out the positions of the parties regarding

1/ The Greater Southeast Community Hospital petitioned the Board to participate in this appeal as a party, or in the alternative, as an amicus. The Board Chair ruled that the Hospital could participate as an amicus, but by letter dated September 18, 1981, the Hospital wrote that it had "decided not to submit a statement as amicus curiae."

2/ Below we refer to NCMF's submission of July 17, 1981 as Appeal Letter NCMF's brief dated August 25, 1981 as Appeal Brief; NCMF's brief dated September 15, 1981 as Reply Brief; and the brief dated October 28, 1981 as NCMF Post-hearing Brief. We refer to the Agency's submission of August 25, 1981 as Agency Response and the brief dated October 30, 1981 as Agency Post-hearing Brief. We refer to the transcript for September 23 as Tr. I.; September 24 as Tr. II.; and September 25 as Tr. III.

criterion II.B.2(c) and a discussion of the Board's determination that NCMF should receive the 60 points available for that criterion. 3/

Having determined that NCMF should have passed the evaluation based on that criterion, the Board will not issue any findings on whether NCMF should receive additional points for the other contested criteria. And, although NCMF raised several substantive and procedural legal issues in its appeal, NCMF said that it did not wish to pursue those issues if its grant were reinstated based on a recalculation of its evaluation score. (See Appeal Brief, p. 2.) Therefore, this decision will not address any of those matters.

I. General Background

A. Information on the PSRO Program

The 1972 Amendments to the Social Security Act created the PSRO program in order to involve local practicing physicians in the review and evaluation of health care services covered under Medicare, Medicaid, and the Maternal and Child Health programs. (Title XI, Part B, of the Act.) The PSROs are physician-controlled organizations responsible in specifically designated geographic areas for assuring that the health care paid for under these programs is medically necessary and consistent with professionally recognized standards of care. The PSROs also review whether the health services are provided at the level of care which is most economical, consistent with the patient's medical care needs. The major focus of the PSRO program has been on review of inpatient hospital services. While PSROs are also charged with review responsibilities in other health care settings, budget restrictions have limited the PSROs' ability to review outside the hospital setting.

PSROs are responsible for developing and operating a quality assurance system based on peer review of the quality and efficiency of services and continuing education. In hospitals, the peer review system must include: concurrent review, which is review focusing on the necessity

3/ Because NCMF's evaluation score was only 22 points short of the 1105 required to pass, NCMF raised the issue of whether the Board would make determinations regarding all the evaluation criteria which NCMF claims were incorrectly scored. (Tr. I, pp. 16-24.) At the hearing, NCMF made and then withdrew a request that the Board issue a decision on each criterion in dispute. (Tr. I, p. 16, Tr. III, pp. 61-63.) The presiding Board member said, at that time, that since the function of the Board in this appeal is to determine whether to uphold or reverse the Agency's decision to permit NCMF's grant to expire, if in examining the criteria the Board found that its evaluation on any criterion would give NCMF sufficient points to pass, the Board's decision could be limited to that finding. (Tr. III, p. 62.) The parties did not object to this approach.

and appropriateness of inpatient hospital services performed while the patient is in the hospital; medical care evaluation studies, which are assessments, performed retrospectively, of the quality or nature of the utilization of health care services and assessments of the PSROs' impact where corrective action is taken; and profile analysis, which is the analysis of patient care data to identify and consider patterns of health care services. (See, e.g., PSRO Program Manual, Chapter VII, p. 1, March 15, 1974.)

The Act, and regulations governing the program, provide that a PSRO is "conditionally designated" for a period of time, and that there will be an agreement between the Secretary and the PSRO "fully designating" the PSRO after it has satisfactorily performed PSRO functions during its trial period as a conditional PSRO. After a maximum of six years, a conditional PSRO must be fully designated or it can no longer participate in the program. (Section 1154(b) and (c) of the Act.) A fully designated PSRO may be terminated only after an opportunity for a hearing, upon a finding by the Secretary that the PSRO "is not substantially complying with or effectively carrying out the provisions of such agreement." (Section 1152(d) of the Act.) NCMF is a fully designated PSRO.

B. The Nationwide Evaluation of PSROs

The Agency has stated that it implemented a nationwide evaluation of the performance of PSROs in response to proposals by the President, in February and March, 1981, to phase out the PSRO program within three years, and to reduce funding for fiscal year 1981. In June, 1981 Congress approved a rescission of $28,701,000 from the PSRO program. (Pub. L. No. 97-12, Title I, Chapter VIII; 94 Stat. 3166.) The Agency maintained that the legislative history of the rescission bill indicated that the Agency was to accomplish the rescission by terminating ineffective PSROs. (Agency Response, pp. 2-4.)

The Agency stated that, in order to identify ineffective PSROs, it developed evaluation criteria to measure performance. It further asserted:

> [t]he criteria were based on program and priorities in effect at least two years prior to the evaluation, and in particular the criteria used to convert PSROs from conditional to fully designated status, policy issuances, and previous performance assessment protocols. The major difference from the criteria previously used to assess PSROs was the increased emphasis placed on cost effectiveness examined in Section I and the PSRO's impact on the utilization and quality of health care services examined in Section III.

(Agency Response, pp. 4-5.)

The proposed criteria were sent to all PSROs for review and comment on March 20, 1981. After considering and implementing some of the suggestions, the Agency distributed the final version to all PSROs on April 15, 1981. The criteria were not promulgated as a regulation nor published in the Federal Register.

The final version of the criteria was also sent to the Agency's Regional Offices to be completed for each PSRO. The Agency stated that to insure uniformity and objectivity the "Regional Offices were instructed that no consideration was to be given to factors not included in the criteria." (Agency Response, p. 6.)

C. The Format of the Evaluation Criteria and the Scores Needed To Pass

The evaluation was composed of criteria which measured three areas of performance: Part I — organization and program management; Part II — performance of review: compliance and process; and Part III -- performance of review: impact/potential impact. Each criterion was assigned a point value which the Agency awarded to a PSRO if it "met" the criterion or, with some criteria, the points were awarded based on the PSRO's level of performance, as described in the criteria. In order to pass the evaluation, a PSRO needed a total score of 1105 (of the 2350 available points) and passing scores on two of the three parts.

Part I evaluated organization and management by examining the following areas: commitment of the PSRO Board and committees; administration and financial management; cost efficiency and relations with the State. A PSRO needed 190 of the 300 available points to pass this part. Part II examined performance of PSRO review based on compliance with established review processes including the acute care review process, special actions taken to address identified problems such as the modification of a review system and adverse actions, medical care evaluation studies, the adequacy of the PSRO's data system, and the use of profiles. A PSRO needed 400 of the 850 available points to pass this part. Part III evaluated PSROs on the basis of their impact and potential impact on utilization objectives and the quality of health care. A PSRO needed 515 of the 1200 available points to pass this part. (See Agency Response, pp. 6-7.)

II. The Evaluation of NCMF

A. Summary of the Scores Awarded NCMF

The Agency awarded NCMF a base score of 1083 points, 22 short of the 1105 needed to pass the evaluation. NCMF passed Part I with 203 points and Part II with 595 points. NCMF did not pass Part III, as its score of 285 was 230 short of the 515 needed to pass that part.

In addition, NCMF received 175 bonus points for performing "Additional Review Activities" and documenting significant impact in those activities; and it received the maximum 100 bonus points available for "Special Contributions for the Art of PSRO Review." The additional review activities included long term care review, review of physician services, review of ancillary services, and review of home health agency services. The special contributions were in the form of "special studies or review activities which resulted in advances in the state of art of quality assurance," specifically, for being "a leader in the ambulatory surgery area." (Evaluation Criteria, p. 42.) The bonus points were not included in the PSRO's base score of 1083 for the purpose of determining whether it passed the evaluation; they were (to be) used only for the purpose of ranking PSROs nationwide.

B. Discussion of Criterion II.B.2(c)

Criterion II.B.2(c) was worth 60 points, and read as follows: 4/

> PSRO has documentation of resolution of problem(s). Worked with institution(s) and/or practitioner(s) thereby eliminating the need to proceed with sanction recommendation.

NCMF's Position

NCMF submitted three examples in support of its claim that NCMF resolved problems and worked with institutions and practitioners, thereby eliminating the need to proceed with sanction recommendations.

The first involved activities relating to doctors who admitted patients into hospitals to perform surgery that should have been done on an out-patient basis. NCMF said that the medical community generally agreed that there were "51 surgical procedures which should be done on an ambulatory basis unless specific reasons for hospital admissions are documented." (Appeal Brief, Appendix 13.) NCMF adopted a position statement on ambulatory surgery and notified physicians practicing in the District of Columbia of this policy. NCMF then monitored admissions for these surgical procedures and sent letters to physicians who did not conform to the policy. The letters informed the physicians that

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4/ This criterion was part of a criteria section on "Special Actions to Address Identified Problems — Adverse Actions," which included the following other sanction-related criteria for which NCMF did not receive points:

> Criterion II.B.2(b) Warning letter(s) to institution(s) and/or practitioner(s) issued on actions which could lead to sanction recommendations.
> Criterion II.B.2(d) PSRO prepared recommendation(s) on sanction to Secretary and forwarded to appropriate party.

"continued inappropriate admissions will raise the need for pre-admission certification of these procedures." (Id.) NCMF said of its activities:

> 52 letters were sent to physicians concerning inpatient surgery which should have been provided in an ambulatory setting rather than an inpatient setting. Twenty six physicians received one warning letter, covering a total of 36 procedures, 7 physicians received two warning letters covering a total of 17 procedures and four physicians received three warning letters covering a total of 28 procedures. As a result of these letters, the physicians involved changed from use of inpatient to ambulatory facilities.

(Appeal Brief, p. 18.)

The second example involved developing a Memorandum of Understanding with Greater Southeast Community Hospital. NCMF explained that it negotiated with the Hospital; that the discussions culminated in a telegram notifying the Hospital that its authority to conduct review activities on behalf of NCMF would be withdrawn unless the agreement was signed; and that the agreement was signed the next day. (Appeal Brief, pp. 16, 19.)

The third example involved a physician who admitted patients into the hospital for taste and smell dysfunction tests. NCMF maintained that, after NCMF action, the hospital involved retroactively denied some of the physician's admissions and established guidelines for pre-admission certification. (Appeal Brief, pp. 16-17, 19, and Appendix 15.)

The Agency's Position

The Agency did not dispute that NCMF performed these activities (Tr. I, p. 75), but maintained that "a PSRO cannot meet the standards of criterion II.B.2(c) unless it has first issued a 'sanction recommendation.'" 5/

5/ The Act provides that if, after giving reasonable notice and opportunity for discussion, a PSRO finds that practitioners and providers of health care are violating their obligations as defined under §1160(a), the PSRO may recommend sanctions to the Secretary of HHS. (Section 1160(a) requires practitioners and providers to ensure that services to beneficiaries under the Act are provided only when and to the extent medically necessary, and that the services are of a quality which meets professionally recognized standards.) The Secretary then decides whether to impose sanctions. The sanctions which the Secretary may impose are to exclude the practitioner from eligibility to be reimbursed for services provided under the Act, either permanently or for a shorter period of time, or to require the practitioner to pay a monetary penalty. (See §§1157 and 1160 of the Act.)

(Post-hearing Brief, p. 10.) The Agency stated that to meet this criterion the PSRO had to have sent a "warning letter" which included a reference to possible fines or exclusion from the program. The Agency said that this PSRO had "not issued any warning letters to hospitals that could be classified as 'sanction recommendations' within the meaning of the Act, regulations, PSRO manual, and case law." (Id.)

The Agency's project officer testified at the hearing that he marked the criterion "not met" because:

> [i]t was the HCFA position that in order to be credited with a met on that item [II.B.2(c)], there must have been an adequate warning letter containing the language . . . as described in the prior criteria. So in order to meet that [II.B.2(c)], you would have had to have a met on the prior item [II.B.2(b)].

(Tr. II, p. 65.)

The Chief of the Operations Planning and Policy Branch of the Agency's PSRO program also testified regarding the criterion. He said the reason for including sanction-related criteria in the evaluation was:

> the view of HCFA that PSROs which had actually warned a provider or practitioner that the sanction of exclusion or fine would occur were a high priority for continuation . . . .

(Tr. II, p. 72.) He explained further:

> [t]he test here is the willingness of the PSRO to use all of the authorities at its disposal. The view of HCFA is that some PSROs are not willing to use all available means to accomplish the goals of the program, and, therefore are ineffective or less likely to be effective.

(Tr. II, p. 73.)

Discussion of Whether NCMF Met Criterion II.B.2(c)

The Board is not persuaded that a criterion which required the PSRO to "[work] with institution(s) and/or practioner(s) thereby eliminating the need to proceed with sanction recommendations," can reasonably be interpreted to require that the PSRO actually have issued a statutory sanction recommendation.

The Act and the Program Manual state that the PSRO should attempt to resolve problems in a voluntary manner before recommending sanctions.

The Program Manual also states that:

> [t]he legislative history of §1160 indicates that the PSRO in its operation is expected to use voluntary, educational methods, and/or denial of payment as the initial and primary methods for correction of behavior which is inconsistent with the obligations of persons under this Title.

(Chapter XX, §2005.2, p. 5, October 21, 1977.)

In addition, the Chief of Program Operations Planning and Policy for the Agency's PSRO program admitted that sanction is "neither the common nor preferred method" of dealing with problems, and agreed that sanction was a "method of last resort." (Tr. II, p. 73.)

The Board is also not persuaded that in order to receive points for this criterion the PSRO had to issue a letter warning of the potential sanctions available to the Secretary under the Act. Although the regulations and Program Manual outline a procedure for dealing with potential sanctions which include the use of a warning letter, criterion II.B.2(c) did not say that such a process must be used to satisfy the criterion. This criterion on its face makes no mention of that requirement, and in addition, a different criterion — II.B.2(b) — deals specifically with whether a PSRO has issued warning letters.

The Agency argued essentially that this criterion means more than it says. But the criterion simply does not say the substantial things the Agency would add to it by interpretation. The criterion does not specify the methods that a PSRO must have used to resolve problems. It would require an attenuated and unreasonable interpretation to say that one must infer from the term "worked with" in the criterion that NCMF could only receive points if it had issued written threats of statutory sanctions before it "worked with" an institution or practitioner. Since the criterion is unambiguous on its face, we do not need to test it with alternative interpretations.

The Act provides that sanctions can be taken against a practioner if the practitioner violates his obligations under §1160 of the Act. Section 1160(a)(2) specifically directs that practitioners not authorize a patient to be admitted as an inpatient unless it is necessary for the proper care of the patient. Two of the examples NCMF submitted fit into that category. NCMF could have recommended sanctions against the doctors who unnecessarily admitted patients for surgery or taste and smell dysfunction tests, if they had continued that practice. The Agency did not contest NCMF's claim that the surgical procedures or tests at issue were inappropriate for inpatient care, or that NCMF satisfactorily resolved the problems. (See e.g., Tr. 1, p. 75.)

The Board therefore concludes that NCMF is entitled to points under criterion II.B.2(c) because it showed that it worked with institutions and practitioners and resolved problems which, if not resolved, could have led to sanctions under the Act.

Conclusion

The Board concludes that NCMF should receive 60 additional points on its evaluation for criterion II.B.2(c). This would raise NCMF's total score to at least 1143 points, which is more than the 1105 points needed to pass. It was not disputed that NCMF met the other requirement of the evaluation, which was to receive passing scores on two of the three parts. Based on the foregoing analysis, the Board concludes that the decision permitting NCMF's grant to expire should be reversed.

/s/ Cecilia Sparks Ford

/s/ Norval D. (John) Settle

/s/ Alexander G. Teitz
Presiding Board Member