Policing Cost Containment: The Medicare Peer Review Organization Program

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I. INTRODUCTION

It is commonly believed that the United States Government is spending too much on health care and must constrain many of its expenditures. To accomplish this, the largest federal health care program, Medicare, has relied primarily on restructuring the ways in which it pays for medical services. Specifically, it has adopted payment strategies, such as diagnosis-related group prospective payment for hospitals (DRG-PPS), resource-based relative value schedule payment for physicians (RB-RVS), and capitation.¹ These payment strategies attempt both to pay for health care services on a per-unit basis (such as per-hospital admission) and to hold down per-unit costs. Most of these strategies also define broadly the units of care paid for (hospital admissions for DRG-PPS, patients for capitation)—a way of minimizing opportunities for providers to compensate for reduced prices by increasing volume.

While some of these strategies achieve considerable success in holding down costs, they are not without risks. In particular they increase, on one hand, the potential problem of professionals and institutions providing more and more units of services to increase their income, or, on the other, use fewer resources for each unit of services to reduce their costs. For example, institutions could react to per-admission payment by increasing the number of patients they admit and by decreasing the services they provide for each admission. Some of these responses could result in increased costs. They could

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¹ Under a capitation payment system, the HMO is paid a flat rate per patient per period of time, and must then provide all of the patient's care (or a specified type of care) for that period of time without additional charge.
also contribute to patient harm if patients are provided too few or too many services or services of inadequate quality.

The federal government has in turn established regulatory programs that rely on payment denial and civil sanctions to address these pernicious responses to its payment strategies. The Medicare Utilization and Quality Peer Review Organization (PRO) program is the most important of these programs.

This Article will first examine the problem of health care cost inflation and the payment strategies the Medicare program has adopted to address that problem. It will then discuss the perverse incentives that these payment strategies create, and the role of the PRO program in addressing harmful provider behavior encouraged by those perverse incentives. The Article examines evidence on whether the PRO program is succeeding or failing in this mission, and suggests possible means of improving the effectiveness of the PRO program in policing cost containment. Specifically, it recommends clarifying and strengthening the deterrent role of the PROs, crafting PRO procedures to maximize PRO effectiveness, and networking between PROs and other regulatory entities to enhance PRO effectiveness.

II. HEALTH CARE COSTS

The United States spends a great deal on medical care. In 1990 we spent an estimated $647 billion on health care—$2,511 per person.2 There is, of course, no "right" amount for a society to spend on health care, but there are clear signs that Americans are spending too much. We are certainly spending more than we have ever spent before. Between 1967 and 1990 the proportion of our gross national product spent on health care grew from 6.3 percent to 12 percent.3 We are also spending more than other nations. In 1987, for example, we spent 11.2 percent of our GNP on health care, contrasted with Canada, which spent 8.6 percent, Germany, which spent 8.2 percent, Japan, which spent 6.8 percent, and the United Kingdom, which spent 6.1 percent.4 As an example, we spend more on health care than we do on groceries, owner-occupied housing,
Government spending, the focus of this Essay, is of particular concern. The Health Care Financing Administration (HCFA) estimates that public expenditures on health care reached $269 billion in 1990, and federal health expenditures reached $196 billion. Yet even this level of expenditures falls far short of the level necessary to meet the health care needs of all Americans: At least 31.5 million Americans are at any one time without private or public health insurance. These persons receive far less medical care than the insured population. If the medical needs of the uninsured are to be met, additional resources—certainly including additional public funds—should be made available. Unless we are to dramatically increase total health care expenditures, therefore, the cost of existing health care must be controlled before medical care can be made more widely available.

Well-publicized constraints on public spending, including public resistance to increased taxes and competing priorities for available funds, however, necessitate tight control over gov-

5. STATISTICAL ABSTRACT OF THE UNITED STATES 426 (1990). The fact that we are spending a lot on health care, of course, does not mean that we should spend less. Americans also, no doubt, spend a greater proportion of their wealth on recreation or on luxury items than do the citizens of many other nations and yet, do not fret about spending "too much" on these things. Rather, we trust people to purchase no more than they want of these items, given all of their other needs and desires. The markets for most goods and services operate to ensure that resources are allocated optimally. Few economists, however, trust the market for health care to operate that way. Too many factors distort both the demand and supply for health care to have any confidence that market forces can tell us how much to spend on it. See B. FURROW, S. JOHNSON, T. JOST, & R. SCHWARTZ, HEALTH LAW: CASES, MATERIALS AND PROBLEMS 396-401 (1987).

6. HHS, HCFA, supra note 2, at 1.


9. The medical needs of Americans are being met to some extent within current expenditure levels through direct payment by patients, a complex assortment of public programs and mandates, and widespread cost-shifting by health care institutions and professionals. But despite these expenditures, many of the medical needs of the population go unmet. See, e.g., Braveman, Oliva, Miller, Reiker, & Egerter Adverse Outcomes and Lack of Health Insurance Among Newborns in an Eight-County Area of California, 1982-1986, 321 NEW ENG. J. MED. 508 (1989); Newacheck, Access to Ambulatory Care for Poor Persons, 23 HEALTH SERVICES RESEARCH 401 (1988). Further, any comprehensive solution to the problem of providing health care to the uninsured would almost certainly require increased government expenditure, even if such increases might result in diminished private expenditure.
government health care expenditures. Thus, strategies to control federal expenditures on health care have played a prominent role in recent annual federal budget debates.10 The Medicare program, which at $96 billion is the largest and most costly federal health care program,11 has been a particular focus of attempts to control health care expenditures.

III. MEDICARE COST CONTROL STRATEGIES

Much of the growth in the cost of the Medicare program during the 1960s and 1970s has been attributed to the use by Medicare of cost- and charge-based reimbursement. Under these methods, Medicare reimbursed hospitals for their reasonable reported costs, and doctors for their actual or customary charges up to prevailing community levels.12

Cost- and charge-based reimbursement methods proved spectacularly inflationary. Between 1967 and 1982, payments for hospital care grew more than elevenfold from $2.8 billion to $30.9 billion, while payments for physician care and related services multiplied more than 28 times, from $.43 billion to $12 billion.13


11. HHS, HCFA, supra note 2, at 1.

12. See Iglehart, Medicare begins Prospective Payment of Hospitals, 308 NEW ENG. J. MED. 1428 (1983); Lave, The Impact of the Medicare Prospective Payment System and Recommendations for Change, 7 YALE J. REG. 499, 500-505 (1990); Levy, Borowitz, Jencks, Kay & Williams Impact of the Medicare Fee Schedule on Payments to Physicians, 264 J. A.M.A. 717, 717 (1990). At the outset, the Medicare program adopted these reimbursement approaches from Blue Cross and Blue Shield programs, partly because alternatives were not readily available, and partly because adopting these familiar and relatively generous approaches seemed necessary to ensure that providers would accept Medicare patients. T. MARMOR, THE POLITICS OF MEDICARE 83-90 (1973).

13. HEALTH CARE FINANCING ADMINISTRATION, MEDICARE AND MEDICAID DATA BOOK, Tables 2.10, 2.11 (1988). The growth in the cost of the Medicare program during this time was attributable to a variety of factors: aging of the population, expansion of eligibility, increased usage, etc. Available data, however, point to the key role of reimbursement in encouraging inflation. Between 1967 and 1978, for example, 17 percent of the increase in Medicare hospital expenditures was attributable to an increase in the number of beneficiaries and 2 percent to increased days of care; about 81.5 percent was due to increases in reimbursement per day. See HEALTH CARE FINANCIAL ADMIN., MEDICARE: USE OF SHORT-STAY HOSPITALS BY AGED AND DISABLED INPATIENTS 2 (1983) (prepared by M. Ruther). See generally sources cited
Congress responded to hospital cost inflation by implementing, in 1984, a Diagnosis-Related-Group Prospective Payment System (DRG-PPS).\(^{14}\) Under DRG-PPS, Medicare purchases from a hospital a "product," i.e. the diagnosis and treatment of a specific condition, such as a heart attack or ulcer. For this product, DRG-PPS pays a hospital a uniform, prospectively determined amount on a per-admission basis. Medicare admissions are first classified considering the admitting diagnosis of the patient and, where relevant, such factors as secondary diagnoses, the age and sex of the patient, and whether a surgical procedure was performed. From this classification comes a DRG weight, which is then multiplied by a standardized amount to determine the reimbursement for a particular admission. The standardized amount varies with the hospital's location: large urban, small urban, or rural. Payments for a particular hospital are also adjusted to reflect the labor costs in the hospital's local area, the capital costs of the hospital,\(^{15}\) the costs of professional educational programs within the hospital, and special costs of particular categories of hospitals.\(^{16}\) Finally, some allowance is made for the costs of particularly expensive ("outlier") cases.

Congress has moved more slowly to get control over physician expenditures. Through the Deficit Reduction Act of 1984 and the Omnibus Budget Reconciliation Act of 1986 (OBRA), Congress attempted first to freeze and then to limit the growth of physician reimbursement, and to curtail the extent to which physicians could charge Medicare beneficiaries more than the Medicare rate for a service.\(^{17}\) Nevertheless, expenditures of Part B of the Medicare program (which pays predominantly for physician services) grew at a rate three times that of Part A (which pays for institutional care) between 1985 and 1989.


\(^{15}\) It is the intention of Congress, though, that, in addition, capital costs will be paid on a uniform prospectively paid basis by the end of 1991. 42 U.S.C. § 1395ww(g).

\(^{16}\) Examples of such special categories are hospitals that treat a disproportionate number of disadvantaged patients or that serve as referral centers in rural areas.

almost doubling between 1983 and 1988. Much of this growth was due to an increase in the volume and intensity of physician services provided to Medicare beneficiaries. Even when Congress froze per-service rates, total costs continued to increase dramatically because beneficiaries were given more services by physicians.

In 1989 Congress moved to control physician expenditures through the institution of a resource-based relative value physician fee schedule. When this fee schedule is fully implemented in 1996, Medicare will pay doctors on a predetermined, per-service basis considering the resources required to produce each type of service. The factors considered in establishing the fee schedule will include the time and intensity of physician labor involved, practice expenses, and malpractice premiums. Geographic variations in practice expenses will be reflected in the relative value schedules, but geographic variations in cost-of-living will be taken into account only partially in determining the cost of physician labor. The 1989 legislation also strictly limits physicians' ability to charge Medicare beneficiaries more than Medicare payment rates.

As RB-RVS payment will continue to reflect actual physician costs, it does not constitute as dramatic a change as DRG-PPS payment did for hospitals. However, Medicare Volume Performance standards, implemented as a part of RB-RVS, may eventually have a dramatic impact on physician payments. On the advice of the Department of Health and Human Services and the Physician Payment Review Commission, Con-

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21. By 1992, physicians who choose to bill Medicare beneficiaries directly rather than to participate in the Medicare assignment program, will only be able to bill 115 percent of 95 percent of the fee schedules, or 109.25 percent of the Medicare rate. See Physician Payment Rev. Comm'n, supra note 18, at 26-27.
22. The Physician Payment Review Commission is a panel of experts established by Congress in 1986 to advise it on reforms in the methods used to pay physicians under the Medicare program.
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Congress will annually set target rates for increases in the volume and intensity of physician services—called volume performance standards.\textsuperscript{23} If the volume of physician services billed to Medicare grows at a rate exceeding these standards, the increase in the standardized amount (by which the relative value schedule is multiplied to yield per-service rates) will be cut proportionately, thus placing a limit on total expenditures. Congress has also mandated stepped-up research to develop practice guidelines in hopes of reaching a consensus as to the appropriate intensity of services for particular conditions, and thus, ultimately, to reduce the volume of service increases.\textsuperscript{24}

As an alternative approach to cost control, Medicare has also encouraged its beneficiaries to enroll in health maintenance organizations (HMOs). The Tax Equity and Fiscal Responsibility Act of 1982 authorized Medicare to enter into risk contracts with HMOs and Competitive Medical Plans (CMPs) under which Medicare pays them 95 percent of the adjusted average per-capita cost paid by Medicare for the care of comparable non-HMO beneficiaries.\textsuperscript{25} If this amount exceeds an HMOs normal adjusted community premium rate, the HMO must return the difference to enrolled beneficiaries through increased services or lower premiums. HMOs may also participate in Medicare on a cost-contract basis. About 1.4 million Medicare beneficiaries currently belong to Medicare-financed HMOs.\textsuperscript{26}

\section*{IV. Incentives Created by Medicare Payment Strategies (Desired and Undesired)}

The payment strategies just described were crafted to encourage institutional and professional behavior that would limit the costs of the Medicare program. But they also can encourage under- or over-provision of services, in turn increasing Medicare program costs and threatening harm to beneficiaries.

Under DRG-PPS, for example, hospitals that can dis-


\textsuperscript{25} 42 U.S.C. 1395mm; see Krasner, \textit{New Directions in Medicare and Medicaid Managed Care}, 2 Med. Staff Couns. 23 (Fall 1988).

\textsuperscript{26} \textit{Prospective Payment Assessment Comm'n, Medicare Prospective Payment and the American Health Care System}, 106 (1990) [hereinafter ProPAC].
charge Medicare patients in fewer days than the average length of stay on which the DRG rate is predicated, or provide fewer or less costly services to hospitalized Medicare beneficiaries, can keep the difference between the DRG payment and their cost. Conversely, hospitals that retain patients for longer than average lengths of stay, or provide more or costlier services to their patients than the norm, will rarely be able to recover their excess costs from Medicare. Thus, efficient and waste-avoiding behavior is encouraged. As compared to cost-based reimbursement, which rewarded the hospital for using more resources, DRG-PPS rewards the hospital for using less.

DRG-PPS appears to have been quite successful as a cost control strategy. The rate of increase in inpatient hospital costs, which stood at 19.8 percent in 1981, fell to a historic low of 3.1 percent in 1987, before climbing again to 7.8 percent in 1989.27 It now appears that actual costs of Medicare Part A for 1990 will be, when totaled, $18 billion less than those the trustees of the Medicare Hospital Insurance Trust Fund predicted for 1990 in the late 1970s and early 1980s before PPS was introduced.28

Nothing in the DRG system itself, however, guarantees that cost cutting by hospitals will stop at the point where the patient is provided the optimal amount of services for economical, yet effective, care. Indeed, absent constraints external to the DRG system, the incentives it creates would drive a hospital to use fewer and fewer resources per-admission to permit a greater and greater profit.29 Thus, possible products of DRG-PPS reimbursement include premature discharges of patients, provision of insufficient medical care to patients while hospitalized, and "dumping" of patients who are likely to require

27. Id., Table 4-7, at 96.


29. The term profit is used here in a generic sense to mean the excess of revenues over costs, because most hospitals are technically non-profit institutions. Even nonprofit hospitals, however, often attempt to maximize their revenues and minimize costs to free up funds for capital investment or to benefit their managerial or medical staff. P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 437-38 (1982); Clark, Does the Nonprofit Form Fit the Hospital Industry?, 93 HARV. L. REV. 1416, 1436-37 (1980); Etzioni & Doty, Profit in Non-Profit Corporations: The Example of Health Care, 91 POL. SCI. Q. 433 (1976).
extraordinary amounts of resources on other hospitals.30

In addition to under-service, DRG-PPS reimbursement creates incentives for perverse behaviors that could likewise increase costs and threaten patients. For example, because hospitals are paid under DRG-PPS on a per-admission basis, they could cause a patient with multiple complaints to undergo multiple admissions. Alternatively, the hospital could create multiple admissions by transferring patients among hospitals or distinct parts of hospitals (to nursing facility or rehabilitation wings, for example). Hospitals might also attempt to "upcode"31 patients to a more lucrative DRG, or to "unbundle"32 charges by, for example, requiring outpatient testing before or after an admission, to increase reimbursement.33

Since RB-RVS physician reimbursement still pays physicians on a per-service basis, the incentives it creates for good and for ill are less dramatic than those of DRG-PPS. The cost-containment opportunities in RB-RVS are found more in the control it gives the Medicare program over increases in the prices it pays than in incentives it creates for individual professionals to render care more cost-effectively. Insofar as the RB-RVS system contemplates increasing payment for cognitive services and decreasing payments for technological services, however, it creates incentives for early, preventive intervention, and decreases the incentives created by charge-based reimbursement for excessive and costly technical interven-


31. Upcoding is identifying a rendered service as a more complex and costly service for billing purposes to increase reimbursement, e.g., billing a simple examination as a comprehensive examination.

32. Unbundling is billing a single service under more than one code as more than one service.

33. See Roe & Gong, supra note 30, at 34-35; Enthoven & Noll, supra note 30, at 107-110; Lave, supra note 30, at 261-262; Lewis, supra note 30, at 642-643. Hospitals may also attempt to engage in "cost-shifting," whereby they bill other payers for the shortfall they experience from Medicare payments. Though this practice may result in higher costs for other payers, and thus increase the cost of health care generally, it does not increase the cost of Medicare generally. In fact, significant cost-shifting does not seem to have occurred under DRG-PPS, as other payers have also limited their payments to hospitals. See Russell, supra note 28, at 77-78.
tions. Moreover, the volume performance monitoring built into the system may provide weak incentives for limiting excessive provision of services.

RB-RVS physician payment may also create perverse incentives, however. It might, for example, motivate upcoding and unbundling as a means of increasing payment per-service or the number of reimbursed services. If implementation of volume performance standards in fact results in reduced per-service payment, individual physicians may face even greater incentives to increase the volume of services they provide to maintain their income. Limitations imposed by OBRA 1989 on the ability of physicians to bill Medicare beneficiaries beyond Medicare payment levels might also encourage physicians to increase the volume of their services.

Capitation payment to HMOs also generates both cost-containment opportunities and potential hazards. Capitation should save money by reducing unnecessary services. It could also, however, result in under-service to HMO enrollees or favoritism in the selection process—attempts to enroll only healthy Medicare beneficiaries who will demand less than average amounts of services.

In sum, the structure of the payment method could stimu-

34. See Furrow, Physician Payment Reform: Plugging the Drain, ST. LOUIS U. L. REV. (1990). The issues of whether, and to what extent, physicians are able to increase the demand for their own services is hotly debated in the economics of health care literature. Compare Feldman & Sloan, Competition Among Physicians Revisited, 13 J. HEALTH POL'Y & L. 239 (1988); Reinhardt, Economists in Health Care: Saviors or Elephants in a Porcelain Shop?, 79 AEA PAPERS & PROCEEDINGS 337 (1989). It is clear, however, that during the Medicare physician fee freeze of the mid-1980s the volume of physician services rose dramatically, driving a steady increase in Medicare expenditures on physician care, and suggesting that physicians are capable of increasing volume of services if necessary to protect their income. See Mitchell, Wedig, & Cromwell, supra note 19. Recent studies demonstrating that physicians who own laboratory or imaging equipment tend to order more tests or images also sustain this hypothesis. See Hillman, et. al., Frequency and Costs of Diagnostic Imaging in Office Practice — A Comparison of Self-Referring and Radiologist-Referring Physicians, 323 NEW ENG. J. MED. 1604; Iglehart, Congress Moves to Regulate Self-Referral and Physician's Ownership of Clinical Laboratories, 322 NEW ENG. J. MED. 1682 (1990) [hereinafter Congress Moves].

35. The method by which risk-based Medicare HMOs are paid, which requires them to pass on profits to beneficiaries, diminishes the strength of incentives to reduce cost, however. In fact, Medicare HMOs do not seem to have saved money. Indeed, Medicare beneficiaries in HMOs cost Medicare more than they would have cost in the fee-for-service sector. Hadley, Evaluation of Medicare Competition Demonstrations, 11 HEALTH CARE FIN. REV. 65, 76 (Winter 1989).

late either under- or over-provision of medical care. DRG-PSS- and capitation-based payment would generally be predicted to encourage under-provision of services rendered any particular patient during any particular hospital admission. DRG-PPS could, however, result in both under- and over-provision of services, thereby encouraging excessive admissions coupled with under-provision of services during any particular admission. RB-RVS (and cost- or charge-based reimbursement, which survives for various other services), on the other hand, should generally encourage over-provision.

Both under- and over-provision of medical services could harm patients. The patient discharged from a hospital prematurely, with, for example, an uncontrolled infection, may suffer further complications or die. The patient denied preventive care may later require acute care. The patient who receives too many services, on the other hand, is at increased risk for iatrogenic injury, which is a possible result from many forms of medical care. Medicare’s payment of more and more services, albeit a reduced per-unit cost, could cause over-provision of services, resulting in increased costs.

V. CONTROLLING THE UNDESIRED EFFECTS OF COST-CONTAINMENT

Altering methods of payment for services to encourage cost-control is likely to create incentives for under- or over-provision of services. Moreover, these incentives are undesirable because they could harm patients and increase costs. Thus, assuming the accuracy of these assertions, what can be done to offset the incentives?

Undoubtedly the most important and effective force counterbalancing financial incentives for over- or under-provision of services is the commitment to the well being of patients that characterizes the vast majority of health care professionals and institutions in this country. The notion of allegiance to the patient’s best interests runs deep in the training and culture of physicians and other health care professionals. In all likelihood, it will be adequate in most cases to deter a professional from ordering or providing services that are likely to be harm-

37. INSTITUTE OF MEDICINE, I MEDICARE: A STRATEGY FOR QUALITY ASSURANCE 211-216 (1990) [hereinafter IOM].
ful and unlikely to be efficacious, or from failing to order services that are clearly necessary. This sense of obligation to the patient, and a sense of civic responsibility, should also be sufficient in many cases to sway a doctor from providing unneeded, but probably harmless, services or from withholding services that would probably be beneficial.

An influential trend of quality assurance literature argues for relying primarily on these instincts to ensure the quality of medical care. The "continuous quality improvement school" contends that most providers of health care services will be willing to improve the quality of those services if the environment in which they practice encourages improvement. They argue against strategies of quality assurance that rely primarily on identifying instances of wrongdoing and punishment of "bad apples" as wasting resources and encouraging fear and evasion.

While much can be said generally favoring quality assurance strategies that rely primarily on encouraging and informing professionals, one can still question whether these strategies are, in the final analysis, adequate for policing cost containment. First, there are bad apples who because of ignorance, incompetence, or greed, harm their patients by providing too many or too few services. Second, it is likely that even the best doctors (and even more likely, the vast majority of doctors who are neither the best nor the worst) yield from time to time to the temptation to err on the side of providing too many or too few services when it is in their financial interest to do so and where it is unlikely that the patient will be affirmatively harmed by the decision. The uncertainty that attends much medical decision-making offers ample opportunity for such decisions.

If we cannot rely exclusively on the good will and professionalism of health care providers to protect against over- or under-provision of services, where can we turn for help? First,

39. IOM, supra note 37, at 58-61; Berwick, Continuous Improvement as an Ideal in Health Care, 320 NEW ENG. J. MED. 53 (1989).
40. Berwick, supra note 39, at 53-54.
41. See IOM, supra note 37, at 211-216.
42. See Hillman, supra note 34; Congress Moves, supra note 34, demonstrating the tendency of physicians to order more services where they are directly benefited by the orders.
43. See discussion of medical uncertainty in the text accompanying notes 98-103, infra.
the threat of medical malpractice litigation undoubtedly serves as a deterrent to under-provision of care. Arguments that the potential of malpractice liability results in "defensive" medicine—i.e., over-provision of unnecessary care—are quite common. In fact, defensive medicine may well be encouraged less by the threat of medical malpractice than by the reward of cost- and charge-based reimbursement. Under-provision of medical care can result in malpractice liability only if it can be characterized as "negligent," i.e., sub-minimal, and if it results in dramatic, measurable damages to the patient.

The vast majority of victims of medical negligence never recover damages. Moreover, the elderly, who receive most Medicare-financed care, are far less likely to sue for medical malpractice than the general population. Thus, under-payment systems that reward under-provision of care, practitioners and institutions may well opt for the direct financial benefit of under-provision and discount the uncertain and distant threat of medical malpractice liability.

Administrative responses may also be possible as a means of protecting against over- and under-provision of services. To some extent payment systems can be structured to create counter-balancing incentives—for example, to control the volume of, as well as the payment level for, services. The German health insurance system places overall expenditure caps on physician services so that increased volume results in decreased per-service payments. The RB-RVS system will do the same thing through the volume performance standards; but because imposition of these standards is ultimately discretionary with Congress, they may be less effective. However, such overall limits have little impact on the individual service provider, who still faces incentives to expand volume to increase payment.

Another alternative is policing cost containment: to adopt regulatory programs that attempt to detect and penalize over-

44. See, e.g., 1 American Med. Ass'n, Professional Liability in the '80s 16 (1984).
or under-provision of care, or in other words, to adopt an overall strategy of driving the herd of institutions and professionals in the direction of cost containment through incentive programs and then picking off through regulation the strays who go too far or too fast.

To police Medicare cost containment, Congress has created several regulatory programs. First are the Medicare and Medicaid Fraud and Abuse laws. Enforced by the HHS Office of Inspector General (OIG), the Department of Justice, and state Medicaid fraud and abuse units, these laws punish a wide variety of perverse provider responses to payment systems—such as payment dumping or hospital financial incentives to encourage under-provision of care—through criminal and civil penalties or exclusion from the Medicare program. Second, the insurance companies that administer the Medicare program (denominated “intermediaries” for Part A and “carriers” for Part B), may refuse payment for services that are not reasonable and necessary. The third regulatory program, the Medicare Utilization and Quality Peer Review Organization (PRO) program, is the focus of this essay.

48. Though Medicare fraud and abuse is criminal conduct, 42 U.S.C. § 1320a-7b, the fraud and abuse enforcement efforts of Health of Human Services also resemble a regulatory program. Because a substantial proportion of fraud and abuse enforcement is carried out through civil sanctions and program exclusions administered by the Office of Inspector General (OIG) of HHS, 42 U.S.C. § 1320a-7 -7(a), subject to administrative and judicial review and because the OIG has power to bind the enforcement of the criminal fraud and abuse laws through the promulgation of “safe harbor” regulations, 42 U.S.C. § 1320a-7b(b)((3)(D), the fraud and abuse enforcement efforts of HHS bear many of the characteristics of a regulatory program.


49. 42 U.S.C. § 1395y(a)(1); 42 C.F.R. § 405.310(k). Intermediary review focuses on non-covered experimental care and on appropriate use of non-hospital institutional settings, such as nursing homes and hospices. Carrier utilization review focuses on specific service likely to be used unnecessarily. For descriptions of carrier and intermediary utilization and quality review efforts, see GENERAL ACCOUNTING OFFICE, MEDICARE: IMPROVING QUALITY OF CARE ASSESSMENT AND ASSURANCE, (1988) 25-41; Nyman, Feldman, Shapiro, Grogan & Link, Changing Physician Behavior: Does Medical Review on Part B Medicare Claims Make a Difference?, 27 INQUIRY 127 (1990).
While the Fraud and Abuse program primarily oversees the financial and business practices of providers, and the Medicare insurers police overutilization of particular procedures or by particular providers, the PRO program is the primary medical watchdog of the Medicare program. It specifically examines medical care provided by institutions and professionals to determine whether the care was necessary, appropriate, and provided in accordance with professional quality standards. Thus, the Fraud and Abuse program is Medicare's front-line defense against over- or under-provision of medical care.

PROs are statewide, non-governmental, medical peer-review organizations, usually but not necessarily physician-sponsored. They contract with HHS to review the records of Medicare cases, chosen both at random and by focused selection criteria, to identify utilization and quality problems.

The PRO program was instituted in 1982 as a successor to the Professional Standards Review Organization (PSRO) program that had existed for the preceding decade. At its inception, the PRO program, like the PSRO program, was concerned primarily with excessive utilization of medical care, and utilization review continues to be an important mission of the PROs. However, the PSRO program, which monitored cost-based hospital reimbursement, focused on hospital admissions and length of stay. With the arrival of DRG-PPS reimbursement, excessive length of stay ceased to be a problem.

The PROs, therefore, refocused their utilization review efforts to determining whether admissions were necessary, policing readmissions and transfers, and reviewing the necessity and appropriateness of specific procedures in particular settings (e.g., should cataract surgery be done on an outpatient or inpatient basis?).

The primary utilization review instrument of the PROs is retrospective review of patient records, first by a non-physician reviewer, then, if problems are identified, by a physician. If inappropriate or unnecessary services are identified, the PRO can instruct the intermediary to deny payment. The PROs also review and can deny prospectively requests for performance of certain procedures.\(^55\)

In the late 1980s and into the 1990s, the PROs, while continuing their utilization review efforts, have become more concerned with deficiencies in the quality of medical care, in particular with problems that stem from under service. Indeed, the PROs now view quality control as their primary mission.\(^56\) The PROs identify potential problems with the quality of medical care through a variety of approaches, including the application of generic quality-screens and premature-discharge criteria to the medical records of selected cases.\(^57\) Most of the cases are selected from hospitals, although PROs also review skilled nursing, home health, outpatient, HMO, and, on a limited basis, ambulatory care.\(^58\)

Once non-physician reviewers identify potential quality infractions in medical records, these problems are further reviewed by physician reviewers.\(^59\) If the physician reviewer (and perhaps further specialist reviewers), after contact with the physician whose care is questioned, agrees that the care was substandard, the case enters the PRO's quality assurance process.\(^60\) PROs are also responsible for reviewing beneficiary complaints about quality of care or beneficiary appeals when providers deny further Medicare-covered care.\(^61\) Finally, PROs continually assemble profile data on patients, physicians,

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55. PRO Third Scope of Work, §§ VI, X. at 16-22, 26-27 [hereinafter Third Scope]. (The PRO Scope of Work sets the terms for the contract between the PROs and DHHS. The Third Scope of Work covers the contracts currently in effect from 1988 through 1990).


57. Id. at 6-7; Third Scope, supra note 55, § V(B), at 6-7. Such screens and criteria, for example, flag cases involving patients discharged with abnormal vital signs or who contracted an infection, suffered a trauma, or unexpectedly returned to surgery while in the hospital.

58. See IOM, supra note 37, at 178, 195-99.

59. Third Scope, supra note 55, § V(B), at 6-7; Jost, supra note 51, at 34-35.

60. Third Scope, supra note 55, § § V(D)-(G), at 7-15; Jost, supra note 51, at 36.

DRGs, hospitals, diagnoses and procedures to identify quality aberrations.

When quality problems are identified, the deficient physician or institution is usually placed under a corrective action plan. This may involve continuing education, intensified monitoring, involvement of hospital committees, or other appropriate interventions to improve quality.62 PROs undertook 11,786 quality interventions between the term of the implementation of the contract under which the PROs are currently operating (the Third Scope of Work)63 and June 30, 1990.64 If the corrective action plan is unsuccessful, or if the physician or institution otherwise demonstrates an inability or unwillingness to resolve quality deficiencies, the PRO can refer the physician or institution to the HHS Office of Inspector General (OIG) for sanctions.65 The OIG can either impose a civil fine or exclude the physician or provider from the Medicare program.66

The PRO must also report the noncompliant physician to the state licensing board at the time it notifies the OIG (if it has not already done so),67 and the OIG must publish notice of sanctions in local newspapers.68 HHS also has statutory authority to simply refuse to pay for care that the PROs find to be of substandard quality.69 This provision has not yet been implemented.

The regulatory strategy that the PROs implement—review of individual patient records and profiling of physicians and institutions to police utilization and quality—is a logical approach to policing the potential problems of Medicare payment incentive systems. It resembles the review systems used in central European nations that rely on social insurance for financing health care. In Germany, for example, physicians are paid on a fee-for-service basis out of a fixed negotiated

62. Third Scope, supra note 55, § V(G), at 10-13; Jost, supra note 51, at 36.
63. For most of the PROs, the Third Scope of Work was implemented on April 1, 1989. For 13 of the PROs, however, it was implemented on October 1, 1988, and for one, in December, 1989.
64. HHS, RESULTS OF PEER REVIEW ORG. REVIEW FOR THE THIRD SCOPE OF WORK, 12 (1990) [hereinafter RESULTS].
68. 42 C.F.R. 1004.100(d).
overall budget. The Kassenärztlichen Vereinignungen, or organization of insurance doctors, then relies on utilization profiling and sanctions to control doctors who abuse the system.70 But do the benefits of this form of regulation outweigh its costs?

VI. THE COSTS AND BENEFITS OF POLICING COST CONTAINMENT: A CRITICAL ASSESSMENT OF THE PRO PROGRAM

The PRO program currently costs about $300 million a year.71 While this represents less than a third of a percent of the Medicare budget, it is nonetheless a great deal of money. Moreover, the time that institutions and professionals spend in responding to PRO information demands for corrective action is also costly.72 It is, therefore, appropriate to ask if the program is worth its cost.

One indicator of PRO performance might be volume of activity. From the implementation of the Third Scope of Work through June 30, 1990 PROs retrospectively reviewed 2,489,633 hospital cases.73 They denied payment on only 47,708 (1.92 percent) of these.74 During the same period, PROs reviewed 176,364 ambulatory surgery cases, denying payment on 1,034 (0.59 percent) of them; and reviewed prospectively 2,995,573 proposed procedures, denying payment on only 4,531 (0.15 percent) of them.75 Ten PROs denied fewer than 10 cases on preprocedure review during that time period, 16 PROs denied 0.5 percent or fewer of the preprocedure cases reviewed.76 Of course, because the PROs review only about one quarter of all


73. Results, supra note 64, at 4.

74. Id.

75. Id. at 2, 6.

76. Id. at 1-2.
Medicare hospital admissions,77 and a much smaller percentage of Medicare-financed care in other venues, the percentage of total Medicare cases for which payment was denied by PROs is even smaller than these numbers indicate.78

When the volume of PRO quality intervention is considered, PRO achievements are equally meager. From the 2,489,633 quality reviews completed during the Third Scope of Work through June 30, 1990, PROs identified 31,008 minor quality problems, 12,671 more serious problems, and 1,879 very serious quality problems.79 Thus, PROs identified quality problems in 1.83 percent of the cases then reviewed, serious quality problems in only 0.08 percent of the cases.80 Eleven thousand seven hundred and eighty-six confirmed problems resulted in quality interventions involving 2,782 physicians and 725 hospitals.81 During fiscal year 1990, the PROs recommended 29 sanctions to the OIG, resulting in 13 exclusions from the Medicare program.82

While on its face this work product seems insignificant, it is, of course, impossible to determine PRO effectiveness from these data unless the extent of inappropriate, unnecessary, and substandard care is known. Unfortunately, the full extent of questionable medical care is not known. Indeed, given the complexity of the issues involved, accurate data may never become available. Such data as exist, however, indicate that PROs fall far short of identifying all instances of over service


78. HHS itself is reportedly considering whether the PRO program has proved cost-effective. HHS has announced that it is considering eliminating preprocedure review and review of readmissions, and cutting PRO budgets by 10-25 percent for the Fourth Scope of Work, beginning later in 1991. HHS's proposed decision is based largely on the disappointing statistical performance of the PROs. HCFA Wants to Kill Preprocedure Review, Cut PRO Budgets 10-25 Percent, 18 Med. Utilization Rev. 1-2 1990.

79. Results, supra note 64, at 8. Under the Third Scope of Work, the PROs are to assign one of three severity levels to identified quality problems. Level III problems involve medical mismanagement with significant adverse effects on the patient, level II problems involve medical mismanagement with potential for adverse effects, and level I problems involve medical mismanagement without potential for significant adverse effects on the patient; Third Scope, supra note 55, § V(D), at 7.

80. Results, supra note 64, at 8.

81. Id. at 12.

or poor quality.83

A Rand corporation study involving expert panel review of 5,000 hospital patient records determined that 17 percent of upper-gastrointestinal endoscopies were inappropriate and 11 percent not clearly appropriate; 17 percent of coronary angiographies inappropriate and 9 percent not clearly appropriate.84 A subsequent GAO study found 20 percent of coronary angiographies inappropriate and 10 percent not clearly appropriate.85 A study of carotid endarterectomies indicated that 32 percent were inappropriate and 32 percent not clearly appropriate.86 Other studies estimate that 14 percent of coronary artery bypass surgeries and 20 percent of cardiac pacemaker implantation are inappropriate.87 Overuse of more common diagnostic and x-ray procedures is also suspected, as evidenced by significantly greater use of radiography by physicians who own their own x-ray equipment when compared to those who must refer patients out for x-rays.88

Evidence also exists of excessive hospitalization of the elderly. A study conducted by the HHS OIG of 7,050 Medicare patients in 1984 and 1985 concluded that 10.5 percent of hospital admissions were unnecessary.89 The recent Rand Corporation PPS quality study concluded that 23 percent of the 1,168 patients with five diseases whom it reviewed had too long a hospital stay.90 Last year's Institute of Medicine study of the quality of Medicare-financed care interviewed physicians in focus groups. They estimated that 10 to 30 percent of services provided by the health care system were unnecessary.91

83. On evidence of overuse, see generally IOM, supra note 37, at 221-223.
88. Hillman, supra note 34.
89. HHS OFFICE OF INSPECTOR GENERAL, NATIONAL DRG VALIDATION STUDY: UNNECESSARY ADMISSIONS TO HOSPITALS, 4 (1988).
91. IOM, supra note 37, at 224.
haps most damning are the findings of Systemetrics, Inc., the so-called SuperPRO, which contracts with HHS to review PRO performance. Replicating PRO retrospective admission review in 53,942 cases, the SuperPRO denied 12.1 percent of the admissions, over 4.6 times the rate of PRO denials for the same cases.92

With respect to quality of care, the recent Harvard Medical Practice study, which reviewed 30,121 medical records from hospitalizations in New York in 1984, found adverse events in 3.7 percent of the cases, of which 27.6 percent, or 1 percent of the total, were attributable to negligence.93 The Rand Corporation study of quality of care under PPS concluded that 12 percent of the 1,366 patients it studied from 1985-1986 received poor or very poor care.94 A study published in 1988 concluded that 14 percent of 182 deaths reviewed were preventable.95 An OIG study of 7,050 Medicare patient records found that 6.6 percent of the patients received poor quality care.96 Physician-owned liability companies terminated .66 percent of their insured physicians in 1985 because of "negligence-prone behavior" and limited the scope of covered practice or otherwise sanctioned another 2.5 percent.97

This evidence suggests that PROs fail to capture the vast majority of instances of unnecessary care, and probably miss a significant, if less substantial, number of quality deficiencies. Does that mean that the PRO program is not worth its cost? This is an inappropriate conclusion, however, until the apparently meager volume of PRO activity addressing utilization and quality problems is explained.

VII. BARRIERS TO PRO ACTIVITY

A. Lack of Professional Consensus

One reason for the low volume of PRO review of utiliza-

92. GAO, INAPPROPRIATE, supra note 85, at 46.
94. Rubenstein, supra note 90, at 1978.
96. OIG, NATIONAL DRG VALIDATION STUDY, QUALITY OF PATIENT CARE IN HOSPITALS 4 (1989).
tion and quality problems is the absence of a professional consensus on what is "appropriate" medical care for many conditions. This lack of consensus is amply illustrated by literature showing that the use of certain medical procedures varies dramatically even within small geographic areas. Thus, the well-known research of Professor John Wennberg has found that in a single state (Maine) the likelihood that a woman 70 years old would have had a hysterectomy varies from 20 percent to 70 percent among different hospital markets, and the probability that a man aged 85 would have undergone a prostatectomy varies from 15 to 60 percent.98 Another study of Medicare beneficiaries found that the number of total knee-replacement surgeries ranged from 3 to 20 per-10,000 beneficiaries, and the number of hip arthroplasties (not total hip) ranged from 2 to 18 per-10,000.99 While there is substantially greater consensus as to the appropriate treatment for other conditions, the overall level of uncertainty as to appropriate diagnosis and treatment of many medical conditions is much higher than is commonly appreciated.100

The PROs themselves further evidence the lack of professional consensus on appropriate utilization of medical care. PROs vary dramatically among themselves with respect to the number of cases that they determine to fail identical quality screens and the percentage of screen failures that are eventually confirmed as representing quality problems.101 Out of 4053 cases evaluated by both PRO and SuperPRO physicians for appropriateness, the physicians of the two entities agreed only 56.9 percent of the time.102 During the most recent reporting period, 42.95 percent of PRO payment denials for which reconsiderations were requested were reversed or modified on reconsideration.103

Given this lack of consensus, it is understandable that PROs err on the side of finding that care is necessary, appropriate, and of acceptable quality by generating low numbers of

101. OIG, supra note 56, at 14.
102. GAO, INAPPROPRIATE, supra note 85, at 48.
103. RESULTS, supra note 64, at 10.
payment denials and quality reviews. Several other factors support this tendency.

B. PROs as Self-Regulating

First, PROs embody professional self-regulation, at least to some degree. The PRO statute gives preference for obtaining PRO contracts to “physician-sponsored organizations,” i.e., entities that are composed of a substantial number of licensed physicians in the area served by the PRO and that are representative of practicing physicians in the area. The Health Care Financing Administration defines a physician-sponsored organization as one composed of 20 percent of the physicians in the area or, if composed of between 10 percent and 20 percent of the physicians, possessing letters of physician and physician organizations demonstrating that it is representative of area physicians. As of 1986, 44 of the 54 PROs were physician-sponsored organizations.

One would expect physician-sponsored PROs to be unlikely to engage in robust review that might offend their constituents. Professionals engaging in self-regulation always face the temptation to be too understanding, to be more sympathetic to a specific colleague who has committed an understandable, though perhaps serious, error, than to the faceless public who may be harmed by that error.

Having acknowledged the self-regulatory nature of PROs,

105. 42 C.F.R. 462.102.
108. A recent GAO study of Medicare utilization review noted that PRO physicians tended to have a “non-confrontational, collegial style” in approaching their colleagues. “They often have extensive interactions with the attending physicians to discuss particular cases and to discover if there is any additional information that might justify the admission in question.” The GAO study it noted further that PRO reviewers “are themselves part of [the] professional community and must maintain their standing within it.” Interaction with attending physicians whose services are questioned, therefore, might “facilitate the creation of a rationale for not denying payment even though the admission remains truly questionable.” GAO, INAPPROPRIATE, supra note 85, at 33, 52.
it is important not to make too much of it. Ten of the PROs are not physician-sponsored organizations, but rather "physician-access" organizations,\textsuperscript{109} insurance companies or utilization review firms that hire physicians to conduct reviews. Moreover, physician-sponsored organizations always face the possibility of being replaced by physician-access organizations during the next three-year contract cycle if they do not fulfill their contract obligations. The American health care industry is sufficiently complex and diverse that subcultures of professionals can, and have, developed more beholden to the public than to organized medicine. The all-out wars that have developed between some of the PROs and their corresponding state medical societies argue against a simplistic view of the PROs as mere self-regulation.\textsuperscript{110}

\textbf{C. PROs' Corrective Emphasis}

The PROs' apparent lack of aggressiveness in pursuing regulatory interventions may also reflect the corrective purpose of the PRO program. Generally, regulatory intervention is directed toward one or more of several goals: (1) education and redirection of one who has made a mistake to achieve correction, (2) punishment of a wrongdoer, (3) deterrence of future errors on the part of the sanctioned party or of others who may be tempted to error, or (4) incapacitation of a potential source of harm. To illustrate, the goals of sanctions initiated under the Medicare fraud and abuse laws are deterrence and punishment. Thus the OIG can sanction a physician whose billing clerk files false claims—even though the physician claims absolute ignorance of the problem—thereby encouraging physicians to keep close watch over their billing clerks.

By contrast, the primary purpose of the PRO quality assurance program, and its ancillary sanctions, is correction: A physician may be sanctioned only if the PRO can demonstrate

\textsuperscript{109} See 42 C.F.R. § 462.103.

\textsuperscript{110} See, e.g., Schorr, Peer Review: Still Tilting at Windmills, 27 Physician's MGMT. 124 (October 1987); PROs Draw Fire from AMA House, Medical World News, Jan. 12, 1987, at 24. The OIG, which ultimately imposes sanctions recommended by the PROs, is even more independent than the PROs from professional self-regulation. The office employs far more lawyers than doctors, and under the leadership of Richard Kusserow has developed a sharply confrontational relationship with the AMA. See AMA Again Flays HHS IG Kusserow, 18 Med. Utilization Rev. 1 (Dec. 6, 1990).

that the physician lacks ability or willingness to comply with professional standards of care. Incapacitation and deterrence are secondary goals; punishment is of little importance.

Because the goal of the PRO quality assurance program is correction, sanctions can be brought only after all efforts at correction have failed. Only after a physician or institution has clearly demonstrated that it lacks the capacity or will to reform itself—usually after a lengthy attempt at correction—can the PRO impose sanctions. Thus sanctions are the rare exception rather than the rule. PROs do not sanction the vast majority of poor quality care. Moreover, to the extent that the PROs respond to identified quality problems by corrective action, information concerning the action is usually by law held strictly confidential.

Similarly, utilization review efforts are aimed primarily at correction and incapacitation. Only payment for particular services is denied. Thus the physician who has rendered an unnecessary service is not deterred from billing for it. The bill may be paid; at worst payment will be denied; no other consequences will follow.

Two consequences flow from the PROs’ heavy emphasis on correction. First, the public and the industry may perceive the PROs as far less active than they actually are. Corrective action plans and utilization review denials go forward quietly, usually shrouded by absolute confidentiality. They have, presumably, little effect beyond those directly involved in them. Second, correction-based regulatory systems such as the PROs are exceedingly resource-intensive, particularly in comparison to a deterrence-oriented system. One major Medicare fraud case resulting in criminal or high-dollar civil penalties will widely publicize the fact that certain conduct is very risky (especially when aided by the explosion of continuing education programs and newsletters disseminating information about the Medicare and Medicaid fraud laws). PROs, on the other hand, have to proceed physician by physician and institution by institution when addressing problems of excessive utilization or poor quality.

112. 42 U.S.C. 1320c-5(a); see Jost, supra note 51, at 43-44.
113. 42 U.S.C. § 1320c-9; see Jost, supra note 51, at 69-70 (discussing restrictions on sharing information regarding physician correction plans with hospitals).
114. Incapacitation here means denying the institution or the professional the ability to receive funding from Medicare for a particular service.
Perhaps the most significant limitation on PRO activism in utilization and quality regulation is “procedural inertia.” A regulatory agency such as the PRO may not simply refuse payment for a medically unnecessary or inappropriate service, or terminate the participation of a professional or institution that provides poor quality care by peremptory edict. Various procedures are available for challenging PRO payment denials and participation terminations. Under procedural protections established by the PRO statute and regulations, a physician or hospital denied payment for a service by a PRO may request reconsideration by the PRO.\textsuperscript{115} If the denied payment is sufficiently large, the beneficiary who received the care may appeal to an Administrative Law Judge, and may seek judicial review once administrative remedies are exhausted.\textsuperscript{116} A physician sanctioned for providing substandard care by the OIG on the recommendation of a PRO has the right to review by an administrative law judge, the HHS appeals council, and, ultimately, the courts.\textsuperscript{117} Rural physicians who are sanctioned may additionally have the right to pre-sanction review.\textsuperscript{118}

The aggregate effect of these procedural requirements is to create considerable inertia, by limiting a PRO’s ability to impose swift and effective utilization denials or quality sanctions. A PRO that denies payment for a service, asserting the service to be unnecessary or inappropriate, must be confident that its decision is sufficiently supported by the consensus of opinion in the medical community and that the decision either will be accepted without appeal or will be upheld on appeal. The PRO must be capable of marshalling evidence sufficient to sustain the decision should it be reviewed. The decision must be defensible. Given the variance in medical opinion as to the appropriateness of many diagnoses and the necessity of many procedures, however, defensible certainty in utilization review

\textsuperscript{115} 42 U.S.C. 1320c-4; 42 C.F.R. 473.15, 16.20; For descriptions of the utilization review appeal process, see Gosfield, supra note 51, at 379-80; Jost, supra note 51, at 64-68; Manning & Miller, Strategies for Appeals of PRO Payment Denials, 4 MED. STAFF COUNSELOR 21 (Fall, 1990).

\textsuperscript{116} 42 U.S.C. § 1320c-4, 42 C.F.R. 473.40 and .46. The amount in controversy must be $200 for an appeal and $2,000 for judicial review.


\textsuperscript{118} 42 U.S.C. § 1320c-5(b)(5). Pre-sanction review for rural physicians is available only if the judge does not determine that the provider or practitioner will pose a serious risk to Medicare beneficiaries.
is hard to come by, and thus the program tends to err on the side of too little, rather than too much, intervention.

With respect to quality issues, defensible certainty of PRO decisions is even more important. The doctor facing Medicare exclusion has a career on the line, and, if well advised, will seek the best legal advocacy affordable. The PRO must first convince the OIG (which has rejected 20 of the 45 PRO referrals it has received in the last two years)\textsuperscript{119} that sanction is appropriate. Based on the material provided by the PRO, the OIG must then defend a normally spirited challenge to the sanction recommendation brought by the physician’s lawyer at multiple levels of administrative and judicial review.\textsuperscript{120} Sanction cases consume considerable resources, for which the PRO is not wholly compensated. A sanction recommendation that is not ultimately upheld can also cost the PRO dearly in terms of its credibility and support in the physician community. Absent conviction that a sanction is absolutely necessary, the PRO is unlikely to take on this expenditure of resources.

Procedural due process is, of course, important. The existence of procedures to review governmental actions serves important values: avoiding error, protecting the innocent, and preserving accountability and respect of the governed for the institutions of government. But the existence of procedural due process is also the source of great inertia; it erects barriers to action that are often difficult for the PROs to surmount.\textsuperscript{121}

\textbf{VIII. PRO Effectiveness Revisited}

Do the accomplishments of the PRO program justify its cost? Here we encounter a paradox. Despite the fact that the output of the PRO program, as described above, seems almost trivial, the goals of the PRO program are apparently being accomplished.

For example, it was feared that with the introduction of DRG PPS reimbursement, which paid hospitals on a per-admission basis, hospitals would increase admissions in order to increase their revenue.\textsuperscript{122} A primary goal of the PRO pro-

\textsuperscript{119} OIG REPORT, supra note 82.

\textsuperscript{120} For an account of a case in which the sanctioned doctor alleged, successfully, that his defense was not sufficiently spirited, see \textit{Jury Awards Medicare-Sanctioned Doctor $6.4 Million in Legal Malpractice Case}, 18 MED. UTILIZATION REV. 1 (1990).


\textsuperscript{122} RUSSELL, supra note 28, at 25; and Lave, supra note 12, at 513. Of course,
gram in the early years of PPS, therefore, was to monitor and disallow inappropriate hospital admissions.\textsuperscript{123} In fact, hospital admissions, which had been increasing steadily in the years preceding the introduction of PPS, declined annually from 1983 to 1987, only then beginning to rise slowly.\textsuperscript{124} Much of the decline was attributable to the movement of patient care from inpatient to outpatient settings, the primary goal of much of PRO "appropriateness" review.

It was also feared that per-admission DRG payment would cause hospitals to discharge patients "quicker and sicker," increasing post-discharge complications and mortality.\textsuperscript{125} The recently-released Rand study of the effects of PPS on the quality of medical care found some increase in the proportion of patients discharged from hospitals in an unstable condition (from 15 percent prior to PPS to 18 percent afterwards for five diseases studied).\textsuperscript{126} Nevertheless, the study also established that 30-day mortality (adjusted for sickness at admission) has actually dropped since the introduction of PPS, while 180 day mortality has remained essentially unchanged.\textsuperscript{127} In-hospital mortality has also declined.\textsuperscript{128} The Rand study also discovered that the quality of care in hospitals, measured by process criteria, has improved significantly since the introduction of PPS, despite concern that resource constraints brought on by PPS

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\textsuperscript{123} K. LOHR, supra note 54, at 16-17, 22-29 (1985).
\textsuperscript{124} ProPAC, supra note 26, at 65-66.
\textsuperscript{125} RUSSELL, supra note 28, at 47.
\textsuperscript{127} Kahn, Keeler, Sherwood, Rogers, Draper, Bentow, Reinisch, Rubenstein, Kosecoff & Brook, Comparing Outcomes of Care Before and After Implementation of the DRG-Based Prospective Payment System, 264 J. A.M.A. 1984, 1985 (1990). Multitudinous contemporaneous developments, such as technological advances, make it difficult to assess independently the ultimate impact of DRG-PPS on the quality of care. Nevertheless, it is clear from the Rand study that quality has not seriously deteriorated since that introduction of DRG-PPS. It should be noted, though, that the Rand data came from the early years of DRG-PPS, when hospital reimbursement was quite generous. Further belt-tightening in the very recent past may have a greater negative impact on quality. See Lave, supra note 12, at 521-24; Oday & Dobson, Paying Hospitals Under Medicare's Prospective Payment System: Another Perspective, 7 YALE J. REG. 529 (1990).
\textsuperscript{128} Kahn, Comparing Outcomes, supra note 127, at 1985.
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would reduce the quality of patient care.\textsuperscript{129}

Many factors no doubt contribute to these developments. The role of the PROs should not, however, be discounted. Although PRO denials of payment for unnecessary or inappropriate care and quality sanctions are relatively rare, the possibility of such disallowances and sanctions may have a substantial sentinel effect.

Paradoxically, this effect may be magnified by the procedures that govern review of PRO utilization determinations. The inertia that results from the procedural requirements with which the PROs must comply before taking action has already been noted as a possible explanation for apparent inaction of the PROs. Procedural barriers that institutions and professionals face in responding to PRO actions may, on the other hand, significantly enhance the effect of actions PROs do take.

To understand this paradox, consider again the procedures attending PRO utilization review denials, discussed earlier. A provider denied payment may ask the PRO to reconsider its decision. If the PRO affirms its decision, however, the provider has no further recourse. No direct appeal is permitted to providers;\textsuperscript{130} but the provider may seek payment through "waiver of liability" proceedings. In such proceedings, the provider or beneficiary claims that even though the service provided was unnecessary or inappropriate, Medicare should nonetheless pay, because the provider did not know, and could

\textsuperscript{129} See Kahn, Measuring Quality of Care with Explicit Process Criteria Before and After Implementation of the DRG-Based Prospective Payment System, 264 J. A.M.A. 1969 (1990); Rubenstein, supra note 90. Most other studies have also found that the quality of health care for Medicare beneficiaries has not deteriorated under DRG-PPS, see Russell, supra note 28, at 47-60; Lave, supra note 12, at 519 (1990). But see Fitzgerald, Moore & Dittus, The Care of Elderly Patients with Hip Fractures, 219 New Eng. J. Med. 1392 (1988) (suggesting that hip fracture patients were being discharged earlier under DRG-PPS, with deleterious effects). Also, as PPS continues to pay hospitals less and less relative to their costs, adverse quality effects that were not apparent during the early, relatively generous, years of PPS, may begin to appear. See Lave, supra note 12, at 521-24.

\textsuperscript{130} 42 U.S.C. § 1320c-4, 42 C.F.R. 473.40, 46. If the amount in controversy exceeds $200, the beneficiary for whom the service was denied may appeal the adverse decision to an administrative law judge. If more than $2,000 is involved, the beneficiary may seek judicial review. Though providers and practitioners can represent beneficiaries in other Medicare appeals (if they do so without charge and having waived rights to payment from the beneficiary), and thus effectively have the right to appeal, this right is not available for PRO appeals. See 42 U.S.C. § 1395ff(b)(1)(D), Jost, supra note 51, at 66-67. Thus the fact that beneficiaries do have appeal rights does not by any means guaranty a provider denied payment a route for directly appealing the denial.
not reasonably have known, that Medicare would not pay.131 For example, Medicare may refuse to pay for a particular therapeutic modality ordered to treat a beneficiary's chronic condition, determining it to not be medically necessary, but may waive liability, and therefore reimburse treatments received before a necessity determination was made if it concludes that the beneficiary and provider both reasonably believed that the treatment was necessary. Providers may appeal and obtain judicial review of adverse "waiver of liability" determinations.132 A beneficiary making a waiver of liability claim will usually prevail. A provider, however, will have a more difficult time establishing its ignorance of Medicare standards of appropriateness or necessity because of its much greater experience with Medicare reimbursement. A provider who fails to win a reconsideration of an adverse PRO decision on the merits or to establish the right to waiver of liability is thus unable to collect either from Medicare or from the patient, and must itself absorb the cost of the unnecessary care.133

PRO and Medicare procedures create obvious incentives for providers to ration care directly. Patient demand may play some role in how often forms of treatment as to which there is considerable variation in use among physicians are ordered. Hip replacements or cataract surgery, for example, may be procedures often requested by patients. Providers, however, aware of the difficulties they may face in getting paid for particular procedures, may attempt to manipulate demand. First, where a procedure is not requested, they may simply omit mentioning it as a possibility.134 Second, if the patient requests the procedure or admission, the provider may inform the patient that Medicare will not pay for it. A study of the PRO preadmission review process conducted by Project Hope in 1987 found that 31 of the 34 hospitals surveyed had established

132. If the amount in controversy exceeds $100 for Part A and $500 for Part B determinations the provider may appeal an adverse decision. Judicial review is available for adverse decisions involving more than $1,000. 42 U.S.C. 1395pp(d), incorporating 42 U.S.C.ff(b)(2).
133. See 42 C.F.R. § 411.402 permitting Medicare to indemnify a beneficiary who unwittingly received and paid for unnecessary care, and then to collect the amount as an overpayment from the provider, who knew or should have known the care to be unnecessary.
their own preadmission review processes. These hospital preadmission review procedures resulted either in a formal notice to the patient that the admission would probably not be covered by Medicare, and thus was the patient’s responsibility under waiver of liability, or in informal attempts to discourage the admission. The primary reason given by the hospitals for instituting their own preadmission review process was to avoid retrospective PRO denials.

The Supreme Court in Blum v. Yaretsky denied the right to due process review to patients denied care under utilization review decisions of institutions, even though the decisions may have ramifications for the payment of public benefits. Thus the patient may have no means of reviewing this provider decision. Though the PRO program provides review under some circumstances for provider decisions that care is no longer necessary, this review is focused primarily on hospital discharge decisions. Indeed, to the extent that providers simply omit mention of possible services that they do not believe the PROs will approve, patients will be denied the possibility of review of providers’ decisions. Patients denied care through provider rationing will, in most instances, therefore, have no recourse.

Where prospective PRO approval must be sought for an admission or procedure, moreover, providers may fail to seek approval of even procedures that are likely to be approved to avoid the inevitable hassle that utilization review entails. The much-publicized case of Wickline v. California illustrates this phenomenon. In that case Mrs. Wickline was hospitalized for vascular problems. The California Medicaid program, which financed her care, required length of stay utilization review. When her condition had not stabilized by her initially

136. Id. at 4-35.
138. 42 U.S.C. 1320c-3(e); Third Scope, § 32-33.
139. But see the settlement in Sarrasat v. Sullivan, No. C 88-20161 (N.D. Cal.) (May 17, 1989), Medicare & Medicaid Guide (CCH), ¶ 38,504 (requiring the Health Care Financing Administration to compel nursing homes that determine beneficiaries to be ineligible for Medicare-financed care to notify the beneficiary of this determination, and, if the beneficiary requests, to file a claim with Medicare, which would result in an appealable denial).
scheduled discharge date, her physicians requested approval of an additional eight days of hospitalization. The Medi-Cal utilization program approved only four days. At the end of the four-day period Mrs. Wickline was discharged. No additional extension was sought. Her treating physician, Dr. Polansky, testified:

... that at the time in issue he felt that Medi-Cal Consultants had the State's interest more in mind than the patient's welfare and that that belief influenced his decision not to request a second extension of Wickline's hospital stay. In addition, he felt that Medi-Cal had the power to tell him, as a treating doctor, when a patient must be discharged from the hospital. Therefore, while still of the subjective, non-communicated, opinion that Wickline was seriously ill and that the danger to her was not over Dr. Polansky discharged her ...[at the end of the four day extension period.]

Mrs. Wickline's condition deteriorated after her discharge, necessitating a readmission and eventual amputation of her right leg. When she sued Medi-Cal however, the court refused to find the program liable, faulting her treating physicians for not more aggressively pursuing a further extension of her hospitalization if they felt it was necessary. While the court acknowledged that Dr. Polansky was "intimidated by the Medi-Cal program," it also noted that he was not "paralyzed" by Medi-Cal's response or "rendered powerless to act appropriately if other action was required under the circumstances."

While the court is, of course, right in the abstract, one can understand the reluctance of the Dr. Polanskys of the world to engage in the tedious (and often unremunerated) task of filling out paperwork for approval of utilization requests and to face the annoyance and humiliation that denial of the request may entail when the proposed procedure or admission is a close call. One cannot but wonder what would happen on our highways if we had no speed limits, but every time one wanted to exceed 55 miles per-hour one had to submit a lengthy form in triplicate and await a response. It is reasonable to suspect

141. Id. at 1640, 228 Cal. Rptr. at 667.
142. Id. at 1645, 228 Cal. Rptr. at 671.
143. Id.
144. See GAO, INAPPROPRIATE, supra note 85, at 57 (noting the deterrent effect of preprocedure certification requirements in private utilization review programs).
that the number of cases in which PROs deny payment for care on a preadmission or preprocedure basis does not begin to represent the number of cases where the existence of the PRO preprocedure or preadmission review processes discourages practitioners from providing services.

Indeed, the simple existence of focused PRO reviews may of itself articulate standards that substantially affect utilization of medical services. Perhaps the most remarkable change in Medicare-financed medical care over the last decade has been the shifting of cataract surgery from inpatient to outpatient settings.145 One study found that this change alone accounted for 54 percent of the decline in admissions in 646 hospitals studied in 1984 and 1985,146 and thus a substantial share of the savings Medicare has experienced in payments for inpatient hospital care since the adoption of DRG PPS. During the First Scope of Work (1984-1986) many PROs focused their preprocedure and preadmission reviews heavily on lens procedures.147 Providers got the message, and rapidly accommodated the new standard by shifting cataract surgery to the outpatient venue. Though relatively few procedures were in fact denied, practice changed dramatically.148

The PROs’ quality review program may also have an impact greatly disproportionate to that revealed by their minimal sanctioning activity. Though PRO corrective action plans are carried out in secrecy and thus little noticed, PRO quality sanctions have received notoriety in the medical press greatly disproportionate to their volume.149 In California and Texas particularly, the highly-publicized adversarial stance of organ-


146. RUSSELL, supra note 28, at 28, citing DesHarnais, Chesney & Fleming, The Impact of the Prospective Payment System on Hospital Utilization and the Quality of Care: Trends and Regional Variations in the First Two Years (1987) (unpublished manuscript).

147. RUSSELL, supra note 28, at 27; LOHR, supra note 54, at 25, 27.

148. The dramatic decline in inpatient cataract surgery was accompanied by an even more dramatic increase in outpatient cataract surgery. See Leader & Moon, Medicare Trends in Ambulatory Surgery, 8 HEALTH AFFAIRS 158 (1989). Though the PRO program was effective in accomplishing its goal, its goal may have been too narrowly drawn. The overall effect did not achieve cost savings for the Medicare program as a whole.

149. See e.g. sources cited supra note 110; Schorr, Peer Review Battle Heats Up, 27 PHYSICIAN’S MGMT. 145 (1987); AMA Tries to Nip Regulation, HOSPITALS, Jan. 20, 1987, at 94.
ized medicine toward the PRO no doubt raised doctors' consciousness of the threat of PRO sanctions.

Moreover, PROs may sanction hospitals for substandard care, and have in fact done so. Though only one hospital has so far been excluded from Medicare under a PRO sanction, PROs have brought 725 quality interventions against hospitals during the third PRO contract period.\textsuperscript{150} As Medicare finances 28 percent of hospital care, exclusion of a hospital from Medicare is a disaster of the greatest magnitude. The threat of potential PRO sanctions, as impressed upon a hospital through a PRO quality intervention, has no doubt caused more than one hospital to take strong corrective action against the physician or physicians responsible for the problem. Thus hospital response may act as a lens, magnifying the force of PRO quality initiatives.

In sum, the PROs' full impact on the utilization and quality of medical care is probably not reflected in the small number of instances in which PROs deny payment for services or sanction physicians or hospitals. Research that would fully describe the effects of PROs on the utilization and quality of medical care would be very useful but extraordinarily difficult to conduct, given all of the other factors impacting on the health care industry contemporaneously with the implementation of the PRO program.\textsuperscript{151} Nonetheless, assuming that the PRO program is more effective than it appears at first glance, what can be done to make it even more productive?

IX. AN AGENDA FOR IMPROVING PERFORMANCE OF THE COST CONTROL POLICE

A number of considerations are essential for establishing an agenda for improving cost control regulation. First, the development of practice guidelines or similar articulations of optimal processes for medical care is essential.\textsuperscript{152} Such articu-

\textsuperscript{150} Results, supra note 64, at 12; OIG Report, supra note 82.

\textsuperscript{151} The GAO attempted such a study, but abandoned it in consideration of the methodological difficulties involved. Interview with George Silberman. (October 19, 1990).

\textsuperscript{152} GAO, Inappropriate, supra note 85, at 22; Physician Payment Rev. Comm'n, 1989 Annual Report to Congress (1989); Brook, Practice Guidelines and Practicing Medicine: Are They Compatible?, 262 J. A.M.A: 3027 (1989); Chassim, Standards of Care in Medicine, 25 Inquiry 437 (1988); Furrow, supra note 34; Mehlman, Assuring the Quality of Medical Care: The Impact of Outcome Measurement and Practice Standards (unpublished manuscript) [hereinafter Mehlman]. The Omnibus Budget Reconciliation Act of 1989 officially endorsed the
ations would assist the task of utilization and quality review in several respects. Guidelines or protocols could in many instances eliminate the need for regulatory intervention. As the shift of cataract surgery from the inpatient to outpatient venue illustrates, articulation of standards may in itself be sufficient to change practice. Articulation of standards may largely eliminate the need for extensive case-by-case PRO determinations of necessity, appropriateness, or standard of care. The vast majority of cases could, given viable guidelines, simply be disposed of with minimal review by reference to the standards, with individual consideration focused on marginal cases. Where appeals are brought for denials of non-standard care, evidentiary issues would be greatly simplified. Presumptions could be used and expert testimony disposed of. The recent commitment of federal resources to the creation of practice guidelines is thus a very positive development to improve utilization and quality review. Another step in this direction is the imminent implementation of the Uniform Clinical Data Set, which will permit the PROs to screen cases applying a uniform set of computerized decision rules to a more complete clinical data set, enabling more objective and systematic quality decisions.\textsuperscript{153}

Second, the recent emphasis on networking among review entities could be quite helpful and should be encouraged as a means of magnifying the effect of PRO interventions. The 1990 OBRA further encourages PROs to communicate with state licensure agencies, a trend begun by OBRA in 1986.\textsuperscript{154} PROs and Part B carriers need to strengthen their communications to ensure that PRO-initiated Part A hospital payment denials result also in Part B physician payment denials.\textsuperscript{155} The substandard care payment denial program, once implemented, may result in PRO quality determinations triggering medical negligence litigation by Medicare beneficiaries who are informed that they have been the victims of substandard care. Thus, the PRO quality review program is connected to another


\textsuperscript{154} Pub. L. 101-508 § 4205(d) (to be codified at 42 U.S.C. §§ 1320c-3(a)(9), (9)(b)(1)); Jost, supra note 51, at 69.

\textsuperscript{155} See Jost, supra note 51, at 68.
potent quality assurance mechanism: medical negligence litigation.

Networking among quality assurance programs can have several beneficial effects. It improves the quality and quantity of information available to each regulator. A licensing agency that learns of a potential quality problem with a doctor from a report of a judgment in a malpractice case or a patient complaint can proceed more confidently with disciplinary action if it learns that the PRO has independently taken action against the doctor. It can also reduce repetition of action. Once the OIG sanctions a physician for PRO identified quality problems, the licensure board may be able to take disciplinary action based strictly on the PRO action, without having to prove the underlying case all over again.156 Networking can enhance the consequences—and thus the deterrent and incapacitation effect—of the actions taken. There is fear that denial of payment for substandard care by PROs may provoke the filing of malpractice actions. Substandard care denials, therefore, have much greater force than they would have as simple payment denials.157

In particular, it is important that PROs work together with hospitals, which are best positioned to oversee the practice of physicians on a day-to-day basis. PROs should notify hospital medical staffs when they identify problem physicians, and work together with the hospital in formulating correction plans. All of these networking opportunities should magnify the effect of PRO regulatory interventions.

Third, and perhaps most important for our purposes, greater awareness of the impact of procedure—insofar as it both limits and enhances program effectiveness—is necessary in program design. We have already noted that procedural protections currently available to providers under the PRO statute and regulations constrain the aggressiveness of the PROs and thus limit the volume of PRO interventions. At the same time, however, we have also noted that the existence of other procedural impediments may force providers to limit utilization of medical care, consistent with PRO objectives. Further discussion is, therefore, appropriate as to what proce-

156. See, e.g., OHIO REV. STAT. § 4731.22(B)(25).
157. See Hospitals Anxious Over Payment Denials for Quality, 61 HOSPITALS 48 June 20, 1987 (expressing this concern).
dural protections providers are entitled to and what procedural burdens they may be subjected to in dealing with the PROs.

Any obligation of the PROs to provide procedural due process is ultimately grounded in the fifth amendment of the United States Constitution. The fifth amendment, however, provides due process protection only against deprivations of "life, liberty and property." The Supreme Court in Board of Regents v. Roth\(^{158}\) concluded that property interests for purposes of invoking these protections are not created by the Constitution, nor do they exist wherever there is a unilateral expectation of a benefit from government.\(^{159}\) Rather, property interests are created by laws, rules, and mutual understandings created by state and federal law.\(^{160}\)

Courts have differed as to whether a provider of medical care has a property interest under federal or state law to sell its services to the beneficiaries of public health care programs such as Medicare and Medicaid. The issue has arisen most commonly in situations where a provider or professional has been suspended or excluded from the Medicare or Medicaid programs.\(^{161}\) In this context, a few federal courts have explicitly found that property interests exist.\(^{162}\) More have assumed that such rights exist as a predicate to finding that adequate procedural due process was in fact provided in the particular case.\(^{163}\)

Others have, however, explicitly found that providers are

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160. Roth, 408 U.S. at 577.
161. Though this article is concerned with the Medicare program rather than the Medicaid program, the application of constitutional requirements of procedural due process apply similarly to both programs, so Medicaid as well as Medicare precedents are cited and discussed here.
not the intended beneficiaries of Medicare or Medicaid and do not have a legitimate expectation of continued participation in these programs.\textsuperscript{164} To quote one recent case involving a clinical laboratory suspended from the Medicaid program for improper billing: "We recognize that plaintiff may encounter considerable economic hardship in serving out this suspension. That hardship, although unfortunate, is not of constitutional significance under a \textit{Roth} analysis since the provider is an incidental beneficiary under the Medicaid program . . . ."\textsuperscript{165} Notably, the Second Circuit, which had provided leading precedents for the position that Medicaid providers have a property interest in continued participation in the Medicaid program,\textsuperscript{166} has recently cast serious doubt on this position in cases where the governing statutes permitted termination of a provider without cause.\textsuperscript{167}

Several courts have either explicitly recognized or conditionally assumed that terminating a provider for incompetency or fraud affects the provider's personal and professional reputation sufficiently to implicate a liberty interest.\textsuperscript{168} The ironic implication of this position is that a provider terminated for good cause, such as incompetence or fraud, may be entitled to due process, whereas one terminated without cause may not be, since its reputation is not put in jeopardy.\textsuperscript{169} Other courts have refused to find a liberty interest in these cases, especially where there are no allegations of moral turpitude affecting

\textsuperscript{164} See Koerpel v. Heckler, 797 F.2d 858, 863 (10th Cir. 1986) (no property interest in physician providing services to Medicare patients); Geriatrics, Inc. v. Harris, 640 F.2d 262, 264 (10th Cir.), \textit{cert. denied}, 454 U.S. 832 (1981) (no property interest in nursing home participating in Medicaid); Cervoni v. Secretary of HEW, 581 F.2d 1010, 1018 (1st Cir. 1978) (no property interest in physician in reimbursement under Medicare Part B); H.E.A. of Massachusetts, Inc. v. Bowen, 685 F.Supp. 13, 15 (D.Mass 1987) (no property right in nursing home in providing services to Medicare or Medicaid).


\textsuperscript{166} Case v. Weinberger, 523 F.2d 602, 606 (2d Cir. 1975); Patchogue Nursing Center v. Brown, 797 F.2d 1137, 1145 (2nd Cir. 1986).

\textsuperscript{167} Plaza Health Laboratories, Inc. v. Perales, 878 F.2d 577 (2d Cir. 1989).


\textsuperscript{169} Kelly Kare v. O'Rourke, 751 F. Supp. 1154, 1157 (S.D.N.Y. 1990).
personal reputation. 170

Where the issue does not concern participation in a health care benefit program, but rather payment at a particular level or for particular kinds of services, it is even more difficult to find that a provider has a property or liberty interest. The case of Friedrich v. Secretary of Health and Human Services 171 involved a challenge to the refusal of the Medicare program to pay for chelation therapy, a controversial treatment for atherosclerosis. As a precedent to examining the plaintiff’s due process challenge, the court considered whether the plaintiff beneficiary had a property right in payment for chelation therapy. The court stated:

The Supreme Court has defined those property interests entitled to constitutional protection as “more than a unilateral expectation;” instead, a claimant must have “a legitimate claim of entitlement to property” [citing Roth]... The only legitimate claim of entitlement under Medicare is to those services that are reasonable and necessary (citations omitted). There is no legitimate claim of entitlement to a given medical procedure just because a doctor prescribes it or a patient requests it. 172

The court then noted that HHS had consistently and clearly rejected chelation therapy as a “reasonable and necessary” service over a period of time, and thus there was no basis for the plaintiff to claim an entitlement protected by due process. 173

Even where courts have assumed or found a property or liberty interest, they have generally afforded agencies administering health benefits programs considerable procedural flexibility. Applying criteria articulated in Mathews v. Eldridge 174 the courts consider (1) the private interest at stake, (2) the risk of erroneous deprivation of the protected interest through the procedure employed and the benefits of additional procedural

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170. Id. See also Roller v. United States Department of Health and Human Services, Civ. No. 8-86-338 (D. Nev. 1986).
171. 894 F.2d 829 (6th Cir. 1990), cert. denied, 111 S.Ct. 59 (1990).
172. Id. at 838.
173. Id. See also New York State Ophthalmological Soc'y. v. Bowen, 854 F.2d 1379, 1391 (D.C. Cir. 1988), cert. denied, 490 U.S. 1098 (1989) (no constitutional right in Medicare beneficiaries to choose the number of surgeons participating in cataract surgery absent definite showing of medical necessity); American Medical Association v. Bowen, 659 F.Supp. 1143, 1150 (N.D. Texas 1987) (physicians do not have a property interest in Medicare payment rates set at a particular level.)
 protections and (3) the government's interest, including the additional burden to the government of additional procedures. Though the risk of erroneous deprivation and the benefit of additional procedures vary from case to case, the courts tend to weigh heavily the government's primary responsibilities for guarding beneficiaries from incompetent care and protecting health care programs from unnecessary costs, and put little weight on the interest of providers in continued ability to provide services financed by the programs.  

Even assuming, therefore, that a professional or provider has either a property or a liberty interest in Medicare program participation as such, and thus cannot be terminated without due process, entitlement to payment for any particular service should depend on the provider's or professional's ability to establish that the service was rendered in accordance with program requirements of necessity, appropriateness and quality.  

To the extent that the Constitution requires due process before disallowing payment for a service or excluding a provider or professional from Medicare, the Mathews v. Eldridge calculus permits agencies considerable latitude in crafting appropriate procedures, given the importance of the government interests involved.

The procedural flexibility available to the PROs is also not limited significantly by the liability threats that increasingly daunt private utilization review efforts. In several recent cases private utilization reviewers have been threatened with tort liability when they have denied payment for care subsequently found to have been necessary. Potential tort liability does not, however, create a significant barrier to aggressive action on the part of the PROs. PROs are shielded by statute from liability for decisions made with due care. Some courts have

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176. In the vast majority of cases, of course, it will be unnecessary for the provider to prove that the care was rendered in accordance with program requirements. Where the care is challenged, however, the provider, not the program, should bear the burden of establishing compliance.


gone even further, finding absolute immunity.\textsuperscript{179} This is not to say that PROs should be careless or cavalier in their utilization review decisions. They should always be cautious to avoid decisions that might result in harm. Liability concerns, however, need not cause them to engage in “defensive” utilization review.

PRO regulatory procedures should be designed to take full advantage of the flexibility PROs enjoy under the Constitution and under tort immunity provisions alternatively to overcome procedural inertia or to enhance their own effectiveness. For utilization review, this could mean, on the one hand, minimizing procedural barriers to payment for procedures provided in compliance with necessity and appropriateness requirements. On the other hand, procedural barriers to payment could be increased for procedures identified as likely to be abused or falling outside of practice guidelines, or for physicians or providers identified by profiling as overutilizers.\textsuperscript{180} The Uniform Clinical Data Set might be a useful tool for identifying such procedures or professionals.\textsuperscript{181} The PROs could require, for example, additional documentation, perhaps second opinions,\textsuperscript{182} for questionable procedures. The burden of convincing the PRO that payment is appropriate should be borne by the professional or institution in these cases.

When review is focused on under-service or other quality problems, the PROs have less scope for manipulation of procedures. The consequences of a PRO’s finding a quality deficiency are much more significant than are those of a utilization-based payment denial, particularly if the PRO sanctions the provider or notifies a state licensing agency of the problem. A quality-based sanction or even denial of payment (as distinguished from a utilization review intervention) could


\textsuperscript{180} See Mehlman, \textit{supra} note 150 (advocating a similar procedural structure for outcome-based quality review).

\textsuperscript{181} See Lohr & Walker, \textit{supra} note 37, at 200-201.

\textsuperscript{182} COBRA 1985 required second opinions for ten procedures, Pub. L. 99-272, § 9401, 100 Stat. 82, 196. This provision has not yet been implemented.
have a profound effect on a physician's reputation if it becomes known. Because a PRO quality intervention is based on the judgment of a professional's peers, it should have greater impact on the physician's reputation than the judgment of a lay jury in a malpractice case.\textsuperscript{183} It may result in hospital or licensing disciplinary action that can destroy a physician's practice. Quality-based actions that later prove unfounded can be the source of much resentment and ill-feeling.

Even here, however, if the program is to be effective, procedural barriers to enforcement should not become insurmountable. It is appropriate that in the first instance the PRO or OIG bear the burden of proving that a physician is not rendering care of acceptable quality. It might also be appropriate, however—once it is established that the physicians performance has fallen substantially below standards in several instances—for the burden then to shift to the physician to establish his or her competence generally. This is similar to the approach taken by some state licensing boards that require a physician to establish competency by passing the SPEX exam (perhaps after some retraining), once it is established that the physician has performed below standard in one or more instances.\textsuperscript{184} Correction plans currently serve this purpose to some extent. Perhaps, however, the physician should bear the burden of showing compliance with a corrective action plan once the PRO has established the initial necessity for quality intervention.

Finally, consideration should be given to greater reliance on deterrence in the PRO program. Though the difficulty that attends many judgments of necessity, appropriateness and quality of medical care justify the dominant corrective, rather than deterrent or punitive, approach of the program, there are undoubtedly some circumstances where standards are so clearly breached that public condemnation is appropriate. In OBRA 1990 Congress amended the PRO statute to specify that PROs had to establish the inability or unwillingness of an institution or professional to comply with a correction plan as a

\textsuperscript{183} For example, as the supervisory member of the Ohio Medical Licensing Board, the author takes more seriously reports of PRO quality interventions than malpractice reports in determining the appropriateness of initiating disciplinary action.

\textsuperscript{184} The State Medical Board of Ohio, of which the author is a member, has required a passing grade on the SPEX as a condition of readmission to practice in a number of cases where the physician's license has been suspended on the basis of competency.
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condition of sanctioning the provider only "where appropriate."185 Under this amendment, the PROs can, therefore, sanction providers for some quality deficiencies without affording an opportunity for correction. Where clear breaches of standards are evident, sanctions without opportunity for correction are appropriate, and, if publicized, might have deterrent effect. HHS should promulgate regulations specifying when sanctions without opportunity for correction might be appropriate.

Similarly, where institutions or professionals bill Medicare for services that are clearly unnecessary or inappropriate (as judged, for example, by their deviation from practice guidelines) it may be fitting not only to refuse to pay for the service, but also to impose a civil fine, measured by some multiple of the improper bill. This parallels what is done with false claims under Medicare fraud and abuse,186 and would magnify the effect of PRO utilization review denials.

X. Conclusion

Public cost-containment in the United States has relied on payment methods that attempt to limit increases in the price or intensity of medical services. These payment methods, however, can have undesired side-effects, encouraging the over- or under-provision of medical care. The federal government has responded to this problem with several regulatory programs, one of which, the PRO program, was explored here. Though the interventions of the PRO program directed toward stemming over- or under-provision of services seem unimpressive, the indirect effect of the program may be much more significant. Paradoxically, while procedural requirements may explain the paucity of PRO activity, procedural barriers may also be the lens through which the effects of the relatively insignificant level of PRO activities have been magnified. Fuller understanding of the positive and negative effects of procedural requirements; better direction of procedural inertia through the development of practice guidelines; and enhancement of the effectiveness of PRO actions through networking and more conscious attempts at deterrence of undesired behaviors, might assist in improving the PROs' policing of cost containment.

AFTERWORD

As this essay goes into print in the Spring of 1991, The Health Care Financing Administration, preparing for the Fourth Scope of Work, is seriously challenging the effectiveness of PRO preadmission review. HCFA argues that preadmission review has resulted in minuscule rates of denials and has not impeded continued growth in the number of procedures performed per month at a rate far in excess of the rate of beneficiary growth. HCFA suggests that the requirement for preadmission review by the PROs be eliminated while the rate of random sample retrospective review be increased.

The procedural inertia model developed in this essay would predict the phenomena HCFA observes in its position paper. Under preadmission review, a PRO denial usually means that the beneficiary will be denied the reviewed service. (This is in contrast to retrospective review, where denial usually means that the provider will not get paid, but the service has already been delivered). Preadmission denials, therefore, maximize the likelihood of beneficiary requests for reconsideration and appeals. Moreover, if a service is denied, and the beneficiary subsequently suffers from lack of the service, the PRO may receive adverse publicity, or at least a Congressional constituent inquiry. Thus the PRO faces great incentives to approve preadmission review requests.

The provider, on the other hand, has little reason not to request a service on a preadmission review basis. If the service is denied, the provider loses nothing other than the time it took to make the request. If is approved, and the procedure is rendered, the provider is wealthier, and the beneficiary, it is hoped, healthier. Thus preadmission review discourages PRO denials, but does little to discourage provider requests, and, accordingly, growth in the rate of service use. Thus this paper would support HCFA in its proposal to decrease preadmission review and increase random retrospective review.

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