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PSRO: A Status Report on Medical Peer Review Under the 1972 Social Security Act Amendments

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PSRO: A Status Report on Medical Peer Review Under the 1972 Social Security Act Amendments

The elaborately camouflaged effect of this Law is to give final control over medical decisions to the Secretary of HEW who, of necessity, is a politician. Political control means political medicine. Political medicine is *bad* medicine.¹

The Federal Government has no desire or authority to perform review of medical care. HEW agrees with physicians that local practitioners are those best qualified to review care provided by their peers.²

Controversy in the legal and medical professions surrounds the interpretation and implementation of certain of the 1972 Social Security Act Amendments.³ Of particular concern are 42 U.S.C. sections 1320c to 1320c-19. These sections add to Title XI of the Social Security Act a requirement that the United States Department of Health, Education and Welfare (HEW) establish a nationwide system of Professional Standards Review Organizations (PSRO's).

Under the PSRO law, those who provide health care for institutionalized patients under certain federally funded medical programs can be reimbursed only when their services or items have been certified by a local PSRO to be medically necessary, of professionally recognized quality, and incapable of being provided more economically through use of other sites and modes of treatment.⁴ The programs with which the PSRO sections interface are Maternal and Child Health Care (Title

1. ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, PHYSICIANS SHOULD ROLL OVER . . . FOR POLITICIANS? STANDARDIZATION OF MEDICINE: THE REAL ANSWERS ABOUT PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (1973) [hereinafter cited as STANDARDIZATION OF MEDICINE].

2. UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, OPSR MEMO 3 (No. 4, 1974).

3. Act of Oct. 30, 1972, Pub. L. No. 92-603, 86 Stat. 1329, *amending* 42 U.S.C. § 301 *et seq.* (1970). *See particularly* §§ 207(a), 213(a), 229(c), 237(a)(1) and 249F(b) of Pub. L. No. 92-603, codified as 42 U.S.C. §§ 1320c to 1320c-19, 1395pp, and 1396b (Supp. II 1972).

4. Social Security Amendments of 1972, § 249F(b), 42 U.S.C. § 1320c-4 (Supp. II 1972).

V),⁵ Medicare (Title XVIII),⁶ and Medicaid (Title XIX).⁷ Health care facilities and practitioners who accept patients qualifying for aid under these programs are obligated under section 1320c-9 to help achieve the statute's objectives and maintain records that will facilitate PSRO review of their treatment.

This article will discuss ongoing attempts by HEW to enforce the PSRO law, and current efforts to reshape the law by court action, legislative proposals, and alternative review systems.

BACKGROUND OF MEDICAL PEER REVIEW

Peer review is not a new concept in the medical profession.⁸ A wide variety of voluntary and involuntary systems in the past have performed one or more of the PSRO-type functions of peer review of the quality of health care, utilization review of the efficient use of facilities, and medical audit of the necessity for treatment and appropriateness of patterns of care. Self-policing mechanisms developed to achieve these aims include hospital tissue committees, "health facilities planning groups"⁹ and "certificate of need" legislation¹⁰ in many states, and the county-based California medical foundations which served as models for PSRO legislation.¹¹

The federal government has also required medical review. Medicare used hospital committees and insurance carriers contracting with HEW to review utilization of facilities for efficiency and effectiveness.¹² Similarly, states receiving federal funds under Medicaid were required to effect utilization review through either an already established Medicare hospital committee or their own health agencies.¹³

Medicare and Medicaid were especially influential in spawning peer review by physicians' groups.¹⁴ A close look at one such organization

5. 42 U.S.C. §§ 644 *et seq.* (Supp. II 1972).

6. 42 U.S.C. §§ 1395 *et seq.* (Supp. II 1972).

7. 42 U.S.C. §§ 1396 *et seq.* (Supp. II 1972).

8. Roth, Hunter, and Beddingfield, Statement of the American Medical Association Re: Professional Standards Review Organization Before the Subcommittee On Health, Committee on Finance, United States Senate 2 (May 8, 1974) [hereinafter cited as AMA Statement] (available from the American Medical Association, 535 North Dearborn, Chicago, Illinois, 60611).

9. See generally, Palmiere, *Lessons Learned from the Experience of Health Facilities Planning Councils*, 62 AM. J. PUB. HEALTH 1235 (1972).

10. See generally, Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need,"* 59 VA. L. REV. 1143 (1973).

11. The work of one such group is detailed in MEDICAL CARE FOUNDATION OF THE SACRAMENTO COUNTY MEDICAL SOCIETY, CERTIFIED HOSPITAL ADMISSION PROGRAM (CHAP): WORK IN PROGRESS (1971).

12. 42 U.S.C. §§ 1395u(a)(2)(B) (1970), 1395x(k) (Supp. II 1972); 20 C.F.R. § 405.678 (1974).

13. 42 U.S.C. § 1396a(a) (30) (Supp. II 1972); 45 C.F.R. § 250.20 (1973).

14. An extensive bibliography on peer review which emphasizes this development

will illustrate current review mechanisms and allow comparison with the emerging PSRO system.

THE HASP EXAMPLE

The Hospital Admission Surveillance Program (HASP) was organized in early 1972 by the Illinois State Medical Society (ISMS) and the Departments of Public Aid and Public Health¹⁵ of the State of Illinois. It performs utilization review and admission certification functions¹⁶ for Medicaid and Cook County (Chicago) general assistance programs.¹⁷ HASP is managed by the statewide Illinois Foundation for Medical Care, created in 1971 as an arm of ISMS, through regional offices and local foundations which are affiliates of the Foundation.¹⁸

HASP's emphasis is on reducing the length of stay and number of hospital admissions proportionately among eligible state aid beneficiaries,¹⁹ though it also determines the medical necessity of such hospital admissions. Coordinators, specially trained nurses or former military corpsmen,²⁰ are stationed in hospitals and supervised by physician advisors. The coordinators certify elective admissions and indicate permissible length of stay according to predetermined physician-set norms for 177 operative situations and 183 diagnostic groups, which are further subdivided by age.²¹ Some unusual situations require individualized review and certification by the physician advisors.²² For instance, practitioners with a history of non-compliance with HASP standards are placed on a "prior approval list" for pre-admission certification by a physician advisor. Their identities are available to a few key personnel but not to the State of Illinois.²³

phase can be found in an HEW-commissioned study, P. DECKER and D. BONNER, PSRO: ORGANIZATIONS FOR REGIONAL PEER REVIEW (1973).

15. The program does not review psychiatric cases. These are handled by Illinois' Department of Mental Health.

16. Flashner, Reed, White and Norris, *The Hospital Admission and Surveillance Program in Illinois*, 221 J.A.M.A. 1153 (1972) [hereinafter cited as Flashner I].

17. Telephone Interview with James Lachabee, Executive Director, Illinois Foundation for Medical Care, Chicago, Illinois, September 27, 1974 [hereinafter cited as Lachabee Interview].

18. Figure I shows the eight areas into which HASP divides Illinois for reviewing purposes. Cf. HEW-designated PSRO areas for Illinois in Figure II. See Appendix *infra*.

19. Interview with Roger White, Executive Administrator, Illinois State Medical Society, Executive Vice President, Illinois Foundation for Medical Care, in Chicago, Illinois, September 27, 1974 [hereinafter cited as White Interview].

20. Flashner, Reed, Coburn and Fine, *Professional Standards Review Organizations: Analysis of Their Development and Implementation Based on a Preliminary Review of the Hospital Admission and Surveillance Program in Illinois*, 223 J.A.M.A. 1473, 1474 (1973) [hereinafter cited as Flashner II].

21. Flashner I, *supra* note 16, at 1155.

22. Flashner II, *supra* note 20, at 1482. These advisors are reimbursed at an hourly rate. *Id.* at 1476.

23. *Id.* at 1481.

Normally, only one pre-operative day is certified, though additional days are allowed if consistent with diagnosis.²⁴ Furthermore, services must be given on an outpatient basis whenever possible.²⁵ Emergency cases are certified automatically for twenty-four hours, after which medical necessity must be demonstrated.²⁶

Once institutionalized, a patient's progress is followed daily by the coordinators, who survey diagnoses for roughly 80 patients.²⁷ They plan with the attending physicians for any extensions of stay, changes to another type of facility, or discharge, and collect data for future evaluation.²⁸ When a revised diagnosis occasions a shorter hospital stay, a patient's admission is recertified to the median length of stay for the new diagnosis. If a longer stay is required, the attending physician makes an extension request. This may be handled by the coordinator alone in cases of obvious medical necessity, such as bleeding or fever. However, consultation with the physician advisor is necessary when the extension is either of doubtful medical necessity, or for a period exceeding the difference between average and median lengths of stay for a particular diagnosis or procedure. Physician advice may also be required if the extension request results from administrative delay, such as lost files or scheduling difficulties.²⁹

Infrequently, the problem of "social" reasons for extending hospitalization must be met. These might include a hospital's failure to transfer a patient to a different facility, or the Department of Public Aid's failure to obtain a prosthetic device, in a timely manner. HASP cooperates with social services in these instances and certifies an extension of stay if it finds that the responsible party is doing its best to alleviate the situation.³⁰

HASP claims that when it "retrospectively" refuses to certify services already rendered, the Department of Public Aid does not deny payment for those services.³¹ However, when HASP "concurrently" refuses to certify services being rendered, bills for those services will never even reach the Department for payment. Since patients in the Medicaid and general assistance programs (like most of those in federally funded programs interfacing PSRO legislation) are indigent, the

24. Lachabee Interview, *supra* note 17.

25. Flashner II, *supra* note 20, at 1480.

26. *Id.*

27. *Id.* at 1482.

28. *Id.* at 1474.

29. *Id.* at 1479.

30. Lachabee Interview, *supra* note 17.

31. *Id.*

particular hospital involved must bear the cost.³² Of course, HASP decisions are not aimed solely at economy. It might refuse to discharge a patient in opposition to the attending physician's wishes, as well as encourage an "early" discharge.³³

Physicians may appeal adverse HASP decisions to local HASP committees, but the number of such appeals has been "inordinately low."³⁴ Such committees all monitor more than one hospital in order to avoid partiality.³⁵ They are part of a tripartite local-regional-statewide HASP structure. The committees on each level consist of physician, consumer and hospital association representatives.³⁶

HASP reported highly successful results in reducing lengths of stay with these procedures after its first 9 months of operation,³⁷ though its statistical methodology was highly criticized.³⁸ Its most recent report³⁹ uses different methods to compare the months of November and December in 1972 with the same months in 1973. In the year that passed between the two periods being compared, the number of those eligible for Medicaid had increased 2.5 per cent, but admissions had decreased from 38,453 to 35,887. Hospital days decreased from 274,053 to 251,467. In 1973, HASP reviewed 282,895 admissions in 235 hospitals, employing 176 physician advisors and 135 coordinators. Though it reports a statewide average length of stay for 1973 of 7.03 days (up from its original report of 6.02), there were 5,291 admission certification denials and 78,756 days for which extension requests were refused. HASP has, therefore, succeeded in reducing hospital stays proportionately among eligible aid beneficiaries.

PSRO PROVISIONS

The statutory plan for establishing PSRO's shares a common purpose with groups like HASP. The statute provides at the outset the reason for conditioning payment with federal funds upon compliance with professional standards: "to promote the effective, efficient, and economical delivery of health care services of proper quality . . ."⁴⁰ HEW

32. *Id.*

33. *Id.*

34. Flashner II, *supra* note 20, at 1478.

35. Lachabee Interview, *supra* note 17.

36. *Id.*

37. Flashner II, *supra* note 20, at 1478-81.

38. See, e.g., Davidson, Wacker and Klein, *Professional Standards Review Organizations: A Critique*, 226 J.A.M.A. 1106 (1973).

39. Illinois State Medical Society, Capsule Comments Regarding HASP (1974) (available from the Society, 360 North Michigan Avenue, Chicago, Illinois 60601).

40. Social Security Amendments of 1972, § 249F(b), 42 U.S.C. § 1320c (Supp. II

is authorized to divide the nation into geographic areas in each of which a single PSRO could effectively operate.⁴¹ The Department then locates organizations which, after initial planning and a period of experimental operation,⁴² can be designated to perform the review functions required by law.⁴³

The PSRO law gives HEW a pattern of preferences to follow in contracting with potential PSRO's.⁴⁴ The type of organization given first preference is a nonprofit professional association which encompasses a substantial proportion of licensed doctors and osteopaths practicing in the particular PSRO area.⁴⁵ Its membership must be voluntary and open to all such practitioners "without requirement of membership in or payment of dues to any organized medical society or association"⁴⁶ Its organizational structure must be conducive to performing all required PSRO functions, without restricting the participation of its members.

Only the preferred type of association can be awarded HEW contracts before January 1, 1976. Until that date, the PSRO selection process will include a poll of local physicians to test whether the association is representative.⁴⁷ After that date, other organizations can be used when the preferred type is unavailable or unwilling. In those circumstances, nonprofit private or public agencies, and organizations which have "professional competence and [are] otherwise suitable" may be selected.⁴⁸ However, such contracts will not be renewed if a preferred organization becomes available and is willing to be a PSRO.

The mechanisms for judging medical necessity, quality, and economy are: (1) "concurrent" certification⁴⁹ of a patient's admission to an in-

1972). There is little question, however, that the central thrust of the legislation is cost control. See discussion at pp. 102-03 *infra*.

41. Figure II. See Appendix *infra*.

42. Social Security Amendments of 1972, § 249F(b), 42 U.S.C. § 1320c-3 (Supp. II 1972).

43. *Id.*

44. *Id.* § 1320c-1(b), (c).

45. *Id.* § 1320c-1(b)(1)(A).

46. *Id.*

47. *Id.* § 1320c-1(f). Only two such polls have so far necessitated formal votes on a PSRO's viability, and both elections favored the HEW-designated organization. White Interview, *supra* note 19.

48. Social Security Amendments of 1972, § 249F(b), 42 U.S.C. § 1320c-1(b)(1)(B) (Supp. II 1972).

49. "Pre-admission" certification is authorized by 42 U.S.C. § 1320c-4(2), but has proven unrealistic and will not be required by HEW. It may be used at the option of the PSRO. "Concurrent" certification generally means certification within 48 hours of a patient's admission to an institution. Telephone Interview with Pat Schoeni, Information Officer, Office of Professional Standards Review, United States Department of Health, Education and Welfare, Rockville, Maryland, August 30, 1974 [hereinafter cited as Schoeni Interview]. Certification of emergency (as opposed to elective) admissions

stitution, and any extension of his length of stay; (2) medical care evaluation studies; and, (3) analysis of data profiles for patients, hospitals and practitioners.⁵⁰ Each type of review is based on "norms," "criteria," and "standards." These are terms of art indicating, respectively, "statistical measures of usual observed performance," "predetermined elements against which aspects of the quality of a medical service may be compared," and "professionally developed expression of the range of acceptable variation from a norm or criterion."⁵¹ They of course vary with each diagnosis, health problem, or surgical procedure, as well as with a patient's age. The norms, criteria and standards developed for admission certification may indicate to a reviewer, for instance, that admission is always justified for Diagnosis X; that the average length of stay is 6 days; that such stay may be automatically extended 2 days for Complication Y; and that removal to a long-term care facility is appropriate should Situation Z develop.

The specific standards (here used generically) for review are not set out in the legislation, but rather are left for the individual PSRO to develop.⁵² In practice, however, several factors indicate that standardization of review is inevitable, at least regionally, and perhaps nationwide. For instance, a National Professional Standards Review Council⁵³ is established by statute to advise HEW and Congress.⁵⁴ This Council is also authorized to compile and distribute "regional" standards and other data, and it will be able to intervene when local standards substantially deviate from the regional ones.⁵⁵ Further, interim guidelines published by HEW indicate that eventually the Council will issue "sample sets of norms and criteria" to each PSRO,⁵⁶ which must then "adopt or adapt them for their use."⁵⁷ The possibility that

can be performed across the board or on a sample basis. UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, PSRO PROGRAM MANUAL, § 705.15 (March, 1974) [hereinafter cited as PSRO MANUAL].

50. PSRO MANUAL, *supra* note 49, § 701.

51. *Id.* § 707.

52. Social Security Amendments of 1972, § 249F(b), 42 U.S.C. § 1320c-5 (Supp. II 1972).

53. The Council, composed of 11 "physicians of recognized standing and distinction in the appraisal of medical practice," supervises both the local PSRO's and Statewide Professional Standards Review Councils. *Id.* § 1320c-12(a) (Supp. II 1972). The latter are established wherever there are three or more PSRO's in one state. *Id.* § 1320c-11. There are 31 states which are single PSRO areas. PSRO MANUAL, *supra* note 49, § 204.4. Statewide Councils supervise data capabilities for PSRO's, assist HEW to evaluate and replace PSRO's, and report unsatisfactory physician behavior. Social Security Amendments of 1972, § 249F(b), 42 U.S.C. § 1320c-11(c) (Supp. II 1972).

54. Social Security Amendments of 1972, § 249F(b), 42 U.S.C. § 1320c-12 (Supp. II 1972).

55. *Id.* § 1320c-5.

56. PSRO MANUAL, *supra* note 49, § 709.11.

57. *Id.* § 709.12.

a PSRO may develop its own norms, criteria and standards is phrased as merely an alternative.

When a PSRO denies certification, it must give immediate notice to the provider of care and afford an "opportunity for discussion and review."⁵⁸ A patient need not be discharged when the physician's course of treatment is disapproved; however, federal funds will not be applied to any subsequent treatment.⁵⁹ An adverse judgment may be addressed by the patient, institution, or practitioner by asking the PSRO to reconsider its review. Upon reaffirmation in matters involving \$100 or more, review of the PSRO decision is available in the Statewide Council if there is one for the area,⁶⁰ or in an HEW hearing if no Council exists. Although HEW may review all Statewide Council decisions, judicial review of HEW determinations is available only in matters involving \$1,000 or more.⁶¹

PSRO's must report to HEW (through the Statewide Council, if one exists) the failure of providers of care to discharge their statutory obligation to achieve PSRO objectives.⁶² HEW has two alternatives if it determines that the practitioner or facility has failed "in a substantial number of cases, substantially to comply" with, or in one or more cases has "grossly and flagrantly" violated these obligations.⁶³ One is to exclude the violator from participation on a reimbursable basis in federally funded medical programs.⁶⁴ The other is to require the practitioner or facility to pay the actual cost of the services which were judged medically unnecessary, up to \$5,000, as a condition of continued participation.⁶⁵ An HEW hearing and judicial review are available to challenge adverse decisions.⁶⁶

Any information acquired by a PSRO is declared to be confidential by the statute,⁶⁷ which provides criminal penalties for disclosure outside the PSRO framework. Those who provide a PSRO with information that is relevant to review operations, unless it is knowingly false, are exempt from criminal and civil liability.⁶⁸ Similarly exempt are those

58. Social Security Amendments of 1972, § 249F(b), 42 U.S.C. § 1320c-10 (Supp. II 1972).

59. *Id.* § 1320c-7.

60. *Id.* § 1320c-8(a). See discussion of statewide councils at note 53 *supra*.

61. *Id.* § 1320c-8(b).

62. *Id.* § 1320c-6.

63. *Id.* § 1320c-9(b).

64. *Id.* § 1320c-9(b)(1)(B).

65. *Id.* § 1320c-9(b)(3).

66. *Id.* § 1320c-9(b)(4).

67. *Id.* § 1320c-15.

68. *Id.* § 1320c-16(a).

PSRO personnel and advisors who exercise due care in their authorized or required functions.

The PSRO law exempts from civil liability, including malpractice, a practitioner or institution (including any of its trustees, officers and employees) acting in compliance with or reliance upon local PSRO standards.⁶⁹ The exemption applies only to professional conduct or functions in which due care was exercised.

CURRENT STATUS OF PSRO

Until a PSRO is fully operational in a given area, the existing network of groups like HASP and individual hospitals' own "in-house" review systems will continue to operate.⁷⁰ Recent amendments to HEW regulations make existing Medicare and Medicaid review systems more compatible with the PSRO plan.⁷¹ There is even some opportunity for a PSRO to use these existing review mechanisms. HEW may allow planning PSRO's to adopt alternative review procedures that are as effective as those promulgated under the statute.⁷² Further, an operational PSRO may accept the findings of existing groups which are operating effectively.⁷³

Although fiscal problems were the real genesis of PSRO legislation, some of these problems were caused by the ineffectiveness of existing systems. Conflicts of interest interfered with smaller institutions' "in-house" reviews,⁷⁴ and tolerance of sample basis rather than case-by-case review often led to tokenism.⁷⁵ Financially troubled institutions tended to overutilize the current surplus of their medical facilities in order to cut costs.⁷⁶ Furthermore, "peer review" had been largely unacceptable in the medical community because of retrospective denials of payment, and lack of professional participation in developing norms (or even in reviewing, when done by insurance carriers).⁷⁷ In dealing with these problems, Congress not only vastly underestimated the cost of Medicare and Medicaid,⁷⁸ but subsequently faced generally

69. *Id.* § 1320c-16(c).

70. *Id.* §§ 1320c-2, 1320c-3(b), 1320c-4(e); S. REP. NO. 1230, 92d Cong., 2d Sess. 258 (1972) [hereinafter cited as S. REP. NO. 1230].

71. 39 Fed. Reg. 41605, 41610 (1974).

72. PSRO MANUAL, *supra* note 49, § 405.34.

73. Social Security Amendments of 1972, § 249F(b), 42 U.S.C. § 1320c-4(e)(1) (Supp. II 1972); PSRO MANUAL, *supra* note 49, § 702.1.

74. S. REP. NO. 1230, *supra* note 70, at 257; 116 CONG. REC. 32845 (1970).

75. S. REP. NO. 1230, *supra* note 70, at 255-56.

76. Havighurst, *supra* note 10, at 1156-59.

77. S. REP. NO. 1230, *supra* note 70, at 255, 256.

78. *Hearings on Medicare and Medicaid Before the Senate Comm. on Finance*, 91st Cong., 1st Sess., 28-33 (1969).

rising medical prices⁷⁹ and particular instances of abuse in existing programs.⁸⁰

The formation of PSRO's to solve these problems has been slow. Though HEW has designated 203 PSRO areas⁸¹ and received applications for PSRO status from organizations in all but four states,⁸² there will be no fully operational PSRO's until at least late 1975.

There are, however, 11 "conditional" PSRO's.⁸³ Many of these are outgrowths of Experimental Medical Care Review Organizations, HEW-funded prototype operations begun over 3 years ago to test the PSRO concept.⁸⁴ HEW awarded 18-month "conditional" contracts in June, 1974, at a cost of \$13,244,132; at the same time it awarded 6-month "planning" contracts to 91 other organizations at a cost of \$5,520,695.⁸⁵ HEW distinguishes the two types of contracts in the following manner:

The major differences between planning organizations and conditional PSROs are (1) conditional PSROs must, when they apply, have as members of their organization at least 25 percent of the physicians eligible for membership whereas planning organizations, when they apply, must show a potential for obtaining this level of membership and (2) conditional PSROs must, *as part of their application*, submit a plan for the assumption of PSRO health care review responsibilities in their area, whereas planning organizations, must, as part of their application, evidence the support and understanding necessary to develop such a plan during the period of their planning contract. In other words, planning contracts are available to organizations who demonstrate the *potential* to meet the qualifications for conditional designation (See Chapter V) but who require financial assistance to complete the

79. These price rises were often directly attributable to the demand generated by Medicare and Medicaid. Posner, *Regulatory Aspects of National Health Insurance Plans*, 39 U. CHI. L. REV. 1, 2 (1971). This is a continuing problem, since medical costs have increased 50 per cent faster than the economy as a whole since the end of price controls on April 30, 1974. Chicago Sun-Times, Sept. 16, 1974, at 44, col. 1.

80. *Hearings on Medicare and Medicaid Before the Senate Comm. on Finance*, *supra* note 78, at 210-14, 217-21; S. REP. NO. 1230, *supra* note 70, at 254.

81. Figure II. See Appendix *infra*. UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, PSRO PROJECT DIRECTORY, p. vi (1974) [hereinafter cited as PSRO PROJECT DIRECTORY]; PSRO MANUAL, *supra* note 49, § 204.

82. UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, OPSR MEMO (No. 5, 1974).

83. These are in Salt Lake City, Utah; Nashville, Tennessee; Portland, Oregon (Multnomah); Minneapolis, Minnesota; Jackson, Mississippi; Newton Lower Falls, Massachusetts; Boston, Massachusetts; Hyattsville, Maryland; Denver, Colorado; Stockton, California (San Joaquin); and Cheyenne, Wyoming. PSRO PROJECT DIRECTORY, *supra* note 81.

84. The W. R. Kellogg Foundation has commissioned a one million dollar study of six PSRO prototypes. UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, OPSR MEMO (No. 5, 1974).

85. Schoeni Interview, *supra* note 49.

development of these qualifications. Organizations which feel that they meet the eligibility requirements for conditional designation specified in Chapter V may apply for such designation *without* first securing a planning contract.⁸⁶

"Planning activity" may still be needed in the initial stages of conditional status.⁸⁷ However, conditional PSRO's essentially will have graduated from liaison work among fiscal agents and physicians to actually developing norms, polling physicians, and ultimately performing medical review.⁸⁸ Conditional PSRO's can press for full operational status as soon as they can fulfill all statutory duties, including review of long-term care facilities.⁸⁹

A third type of contract is available to those organizations which will not themselves seek PSRO status. These statewide "support centers" will be organized to help those groups that seek conditional or planning contracts in at least 5 of the HEW-designated geographic PSRO areas.⁹⁰ Although this type of contract is not specifically authorized by statute, HEW defends it as consistent with the policy provisions⁹¹ directing the Department to give all assistance necessary to potential PSRO's.⁹² Support centers are physician groups with some expertise in both peer review activities and in other areas where they furnish assistance. These fields include: computer data capability; recruitment of specialists to develop norms; advising groups on obtaining the nonprofit corporate status necessary to qualify for a conditional contract; educating area physicians about peer review; and various other functions.⁹³ Thus far HEW has designated 13 such support centers.⁹⁴ Since a PSRO can choose whether or not to use its area support center, this third type of organization may prove to be an interim device that will phase out.⁹⁵

Statistical studies necessary to gauge the impact of conditional PSRO's are still in preparation. However, an examination of those programs longest in existence, first as prototype and now as conditional PSRO's, may illustrate their operation. The Utah Professional Review

86. PSRO MANUAL, *supra* note 49, § 400.

87. *Id.* § 500.

88. Schoeni Interview, *supra* note 49.

89. *Id.*

90. PSRO MANUAL, *supra* note 49, §§ 300-314.

91. Social Security Amendments of 1972, § 249F(b), 42 U.S.C. §§ 1320c-5, 1320c-12, 1320c-18 (Supp. II 1972).

92. PSRO MANUAL, *supra* note 49, § 300.1; OPSR MEMO (No. 1, 1973); OPSR MEMO (No. 3, 1974).

93. PSRO MANUAL, *supra* note 49, §§ 302, 304.

94. PSRO PROJECT DIRECTORY, *supra* note 81.

95. Telephone Interview with E. David Buchanan, Utah Professional Review Organization, Salt Lake City, Utah, August 30, 1974 [hereinafter cited as Buchanan Interview].

Organization (UPRO) is particularly useful in this regard. While some conditional PSRO's are experimentally reviewing in pilot hospitals, UPRO already has instituted extensive review procedures in many hospitals.⁹⁶

UPRO was founded in July 1971 by the Utah State Medical Association. It developed medical norms with 17 physician specialty committees in order to perform On-Site Concurrent Hospital Utilization Review (OSCHUR).⁹⁷ UPRO has evolved from an experimental program as a PSRO prototype in a 30-bed ward of one hospital⁹⁸ into a conditional PSRO with 1 to 3 coordinators in each of 19 institutions.⁹⁹

Volunteer physicians took an estimated 1000 man-hours to draft admissions criteria for 125 diagnoses or procedures, as well as general indicators, such as fever. Like most PSRO's, UPRO has eschewed "preadmission" certification for "concurrent" review, which usually takes place the morning after or within 48 hours of admission.

OSCHUR coordinators are mainly registered nurses. They are employed full-time by UPRO and have no hospital care duties in the institutions where they are stationed. Coordinators initially determine that admission is medically necessary, and project the length of stay, according to the physician-set criteria mentioned above. If there are no criteria applicable to a certain case, a physician will review it after the coordinator gives him information sufficient to make a judgment. The frequency with which a patient's care is subsequently reviewed depends upon his diagnosis, symptoms, and length of stay. Data profiles are kept on every patient and subsequently computerized.¹⁰⁰

Coordinators work closely with attending physicians, making rounds with them whenever possible. They also collect data for review by a physician advisor in unusual circumstances which seem to indicate a need for discussion with the attending physician. The UPRO staff attempts to resolve its disagreement with an attending physician before withdrawing certification, of which it gives advance notice.¹⁰¹ Despite objection by fiscal agents, UPRO recognizes non-medical or "social" reasons for hospitalization, of the sort that cannot effectively be classified among admissions or length of stay criteria. These may require coordinators to serve broader functions.¹⁰²

96. *Id.*

97. Orme and Lindbeck, *Nurse Participation in Medical Peer Review*, 22 *NURSING OUTLOOK* 27 (1974).

98. *Id.*

99. Buchanan Interview, *supra* note 95.

100. Orme and Lindbeck, *supra* note 97, at 28.

101. *Id.* at 29.

102. *Id.*; Buchanan Interview, *supra* note 95.

UPRO in effect has two review processes, since it has hospitals with 200 or more beds as well as hospitals with fewer than 60 beds. In smaller hospitals, "retrospective" review is more likely. Although the possibility of fee disputes keeps alive the potential for retrospective denial of payment, certification withdrawal will not itself cause payment to be denied for services already rendered. These services will be paid for up to the point where certification is denied.¹⁰³

While operating in the private sector as a prototype, UPRO denied admission in 1 of every 900 cases.¹⁰⁴ While reviewing Medicare and Medicaid patients, it has withdrawn 1 in every 400 certifications, with financial ramifications in only 1 case.¹⁰⁵ When treatment continues after certification is withdrawn, the hospital, in Medicaid cases, or the patient, in other types of cases, pays the bill.

UPRO is not anxious to accumulate withdrawals, except insofar as necessary to give its procedures "teeth."¹⁰⁶ It otherwise feels that such withdrawals reflect the failure of reasonable people to agree on a proper course of patient care—the failure, rather than success, of UPRO.¹⁰⁷ The UPRO experience, therefore, has proven the PSRO concept to be much less rigid, or revolutionary, than the legislation and HEW guidelines suggest.

PHYSICIAN DISCONTENT AND RESHAPING ATTEMPTS

Physician feeling against the PSRO law has run high,¹⁰⁸ and much of the discontent echoes physician opposition to Medicare in the 1960's.¹⁰⁹ The above sketch of the statutory provisions may suggest some of the points of controversy raised in the health care and medical-legal fields. They include fear of the nationalization of medicine and the specter of a socialist government controlling physician behavior;¹¹⁰ disruption of the physician-patient relationship; violation of patient rights to privacy and confidentiality; lowering of the quality of health care;¹¹¹ stratification of standards into "cookbook medicine;"¹¹² sub-

103. Schoeni Interview, *supra* note 49.

104. Buchanan Interview, *supra* note 95.

105. *Id.*

106. *Id.*

107. *Id.*

108. Editorial, *I LANCET* 60 (January 12, 1974); Moser, *Adventure at Anaheim*, 227 *J.A.M.A.* 1169, 1170 (March 11, 1974).

109. See T. MARMOR, *THE POLITICS OF MEDICARE* 49 (Amer. ed. 1973).

110. See, e.g., *STANDARDIZATION OF MEDICINE*, *supra* note 1, at 17, 20; Jenkins, *Professional Standards Review Organizations (P.S.R.O.)*, 13 *J. MISS. ST. MED. ASS'N* 358 (August, 1972) (The law's "main purpose is to continually monitor every doctor's practice."); Etzioni, *PSRO: A Poor Mechanism and A Possible Alternative*, 64 *AMER. J. PUB. HEALTH* 415 (May, 1974) (PSRO is a "tool of societal management.").

111. See, e.g., Editorial, 108 *ARCHIVES OF SURGERY* 397 (April, 1974) ("There is

poena or discovery of PSRO records; abuse of HEW's power to examine records and inspect facilities; loss of income to providers of care; and lack of due process in statutory purposes and procedures. There is also some confusion about interrelating PSRO sections with other apparently overlapping sections of the 1972 Social Security Act Amendments.¹¹³

Lack of physician acceptance is undoubtedly a factor in the slow implementation of the law. But this may have less meaning after January 1, 1976, when HEW can contract with organizations other than physician groups to be PSRO's, including insurance carriers as a last resort.¹¹⁴ Physician attempts to forestall implementation of the PSRO law have taken several forms. Many bills of repeal have been introduced in Congress, though none raises hope for consideration since the law has barely been tested.¹¹⁵ An American Medical Association (AMA)-sponsored bill¹¹⁶ proposes 19 amendments. No congressional hearings have been scheduled to study the proposed amendments,¹¹⁷ if they are not passed, the AMA will press for repeal of the PSRO law.¹¹⁸

The AMA bill postpones until July 1, 1978, HEW's authority¹¹⁹ to contract with organizations other than physician groups, with a view toward possible elimination of that authority after further study.¹²⁰ A new subsection is added to section 1320c-1(a) directing HEW to amend its geographical PSRO areas, and, in doing so, to consider the wishes of local doctors and medical associations.¹²¹ Challenge by civil suit is allowed against final HEW decisions in this matter.¹²² The amendment also allows a statewide PSRO area to be designated irrespective of its number of doctors, a concession to state medical societies.¹²³

Several of the AMA bill's provisions address the prospect of PSRO standards becoming "rigid federal minimum requirements."¹²⁴ The

no clear connection between this frantic political activity and the quality of clinical care."); STANDARDIZATION OF MEDICINE, *supra* note 1, at 16.

112. AMA Statement, *supra* note 8, at 7.

113. See Social Security Amendments of 1972, § 249F(b), 42 U.S.C. §§ 1395pp, 1396b (Supp. II 1972).

114. S. REP. NO. 1230, *supra* note 70, at 259-60.

115. See 1974 CONG. Q. 1230 (May 11, 1974).

116. H.R. 15090, 93d Cong., 2d Sess. (1974).

117. Schoeni Interview, *supra* note 49.

118. 1974 CONG. Q. 1230 (May 11, 1974).

119. Social Security Amendments of 1972, § 249F(b), 42 U.S.C. § 1320c-1(c)(1) (Supp. II 1972).

120. AMA Statement, *supra* note 8, at 9.

121. *Id.*, app. B at 2.

122. *Id.* at 3.

123. See discussion at pp. 104-05 *infra*.

124. AMA Statement, *supra* note 8, at 7.

bill deletes the word "norms" throughout the Act¹²⁵ and substitutes "guides" that may not replace a physician's judgment. Concomitantly, the proposed bill requires that the local PSRO's rather than the National Council develop standards of care. The Council would provide only such technical assistance as the local PSRO might request.¹²⁶ The bill guards against these standards being used "in any civil litigation . . . as evidence of the standard of proper medical care . . . in the absence of competent medical testimony."¹²⁷

More flexibility in both physician sanctions and reporting of unfavorable physician behavior is written into the AMA bill, tailoring the former to the gravity of the violation and confining the latter to repeated or gross abuse.¹²⁸ Provision is made for outright repeal of both monetary penalties¹²⁹ and the civil liability exemption which affects practitioners and facilities.¹³⁰

Repeal of other apparently overlapping peer review sections in the 1972 Social Security Act Amendments is provided for in the AMA proposal.¹³¹ The bill also focuses on issues of patient privacy and confidentiality and the "clear potential for mischief in the very existence of such exhaustive computerized records."¹³² It provides discretionary authority to store information,¹³³ but does not require "universal patient profiles"¹³⁴ as does the existing law.¹³⁵ The AMA bill also seeks to protect PSRO personnel, medical records and review deliberations from subpoena and civil discovery.¹³⁶

Attempts to address these and other issues have also taken the form of two federal suits by physician groups against HEW. In *Association of American Physicians and Surgeons, et al. v. Weinberger*,¹³⁷ the plaintiffs assert several grounds for declaring the statute unconstitutional. Among these are alleged violations of the physician-patient right to privacy,¹³⁸ and violations of the physicians' fifth amendment

125. *Id.*, app. B at 9-10.

126. *Id.*

127. *Id.* at 10.

128. *Id.* at 12.

129. *Id.* at 10-11.

130. *Id.* at 12.

131. *Id.* at 12-13; see 42 U.S.C. §§ 1395pp, 1396b (Supp. II 1972).

132. AMA Statement, *supra* note 8, at 8.

133. *Id.*, app. B at 5-6.

134. AMA Statement, *supra* note 8, at 8.

135. Social Security Amendments of 1972, § 249F(b), 42 U.S.C. § 1320c-4(a)(4) (Supp. II 1972).

136. AMA Statement, *supra* note 8, app. B at 15.

137. No. 73 C 1653 (N.D. Ill., filed June 26, 1973). A decision is pending on defendant's motion for summary judgment, argued before a three-judge panel on October 17, 1974.

138. Complaint at 11-12.

right to practice their profession and use their best professional judgment.¹³⁹ The Complaint raises due process questions concerning vague and uncertain obligations imposed by section 1320c-9 upon practitioners and facilities under threat of penalty. Also at issue is the lack of adequate notice and hearing in the penalty procedures.¹⁴⁰ Furthermore, the suit questions the authority of Congress to exempt practitioners from common law tort liability,¹⁴¹ or alternatively to violate the fifth and seventh amendment rights of federal health care beneficiaries by such a provision.¹⁴²

Nearly parallel constitutional issues are raised by the case of *Texas Medical Association v. Weinberger*.¹⁴³ Additionally, that suit challenges the HEW division of Texas into 9 PSRO areas as "arbitrarily, capriciously, and unreasonably adopted."¹⁴⁴ The Texas Medical Association had in mid-1973 incorporated the nonprofit Texas Institute for Medical Assessment (TIMA) in the hope of qualifying as the PSRO for a single statewide area.¹⁴⁵ HEW rejected this plan, and suit was filed to declare the law unconstitutional, or alternatively to declare invalid the regulations under which HEW determines geographical PSRO areas. Should the Association be granted the latter relief, it further seeks to compel "the HEW Secretary, on a trial basis, to designate the State of Texas as a single PSRO area and to enter into an appropriate agreement with TIMA as a single statewide PSRO for Texas."¹⁴⁶

Another attempt to reshape the PSRO concept in the face of adverse physician reaction is the October, 1973 incorporation of Illinois Professional Standards Review Organization (IPSRO) by the Illinois Foundation for Medical Care.¹⁴⁷ The Foundation, operating as an arm of ISMS, is modifying its existing statewide review system (HASP)¹⁴⁸ so

139. *Id.* at 11.

140. *Id.* at 9-10, 13.

141. *Id.* at 13.

142. *Id.* at 14.

143. No. A-74-CA-102 (W.D. Tex., filed May 8, 1974).

144. Complaint at 19.

145. *Id.* at 12-13.

146. *Id.* at 20. A similar challenge to HEW's PSRO area designation process had been filed but later dismissed without prejudice in *Florida Medical Association, Inc. v. Weinberger*, No. 74-280-Civ.-J-S (M.D. Fla., filed April 26, 1974). HEW has promulgated guidelines under § 1320c-1 which list the criteria for drawing geographical PSRO area lines. PSRO MANUAL, *supra* note 49, § 202; Figure II. See Appendix *infra*. They are: no crossing of state lines or dividing of counties except where necessary because of large populations; consideration of the boundaries of existing review groups; coincidence with natural geographic and medical service areas; broad representation of medical specialties; physician population generally ranging from 300 to 2500; and coordination with Medicare and Medicaid fiscal agents.

147. Lachabee Interview, *supra* note 17.

148. See discussion at pp. 92-94 *supra*.

as to be able to perform PSRO functions.¹⁴⁹ HASP divides Illinois for reviewing purposes into eight areas which parallel HEW designations with only slight variation.¹⁵⁰

Although it never formally applied for a PSRO contract, ISMS lobbied for a single statewide PSRO area in Illinois.¹⁵¹ The Foundation and ISMS had planned to retain the statewide committee structure of HASP and achieve local review by subcontracting with its local foundation affiliates, as well as with new reviewing groups, in its eight areas.¹⁵² HEW rejected the idea as not consonant with its guidelines or its desire to emphasize local control in small groups of 300 to 2,500 physicians.¹⁵³ However, the only two Illinois groups to which HEW subsequently awarded planning contracts were local HASP foundations. One of these covers Cook County (Chicago) and involves 72 per cent of HASP operations and 9,600 doctors.¹⁵⁴

The fate of IPSRO now depends on the attitudes of local physicians and the State of Illinois. Should the PSRO concept succeed completely, IPSRO plans will dissolve. Local foundation affiliates can, at their option, contract with HEW, and the Foundation will act unofficially in a role similar to that of a "statewide support center."¹⁵⁵ However, the ISMS membership have voted their basic opposition to the PSRO law.¹⁵⁶ If PSRO does not succeed, ISMS and the Foundation hope to build IPSRO into a "voluntary" review system superior to the PSRO model. Under the ISMS interpretation of section 1396b, HEW would then have to allow IPSRO to function.¹⁵⁷ Liaison work with long-term care facilities, state government, hospital associations, and insurance carriers has already been completed toward this goal.¹⁵⁸

CONCLUSION

In light of the above, the status of the PSRO concept is uncertain. The statute's implementation has certainly been slowed by adverse physician

149. White Interview, *supra* note 19.

150. Compare Figures I and II. See Appendix *infra*.

151. White Interview, *supra* note 19.

152. *Id.*

153. Schoeni Interview, *supra* note 49.

154. Interview with William D. Gannon, Operations Officer, Chicago Foundation for Medical Care, Chicago, Illinois, September 13, 1974.

155. Interview with Roger White, Executive Administrator, Illinois State Medical Society, Executive Vice President, Illinois Foundation for Medical Care, Chicago, Illinois, November 18, 1974.

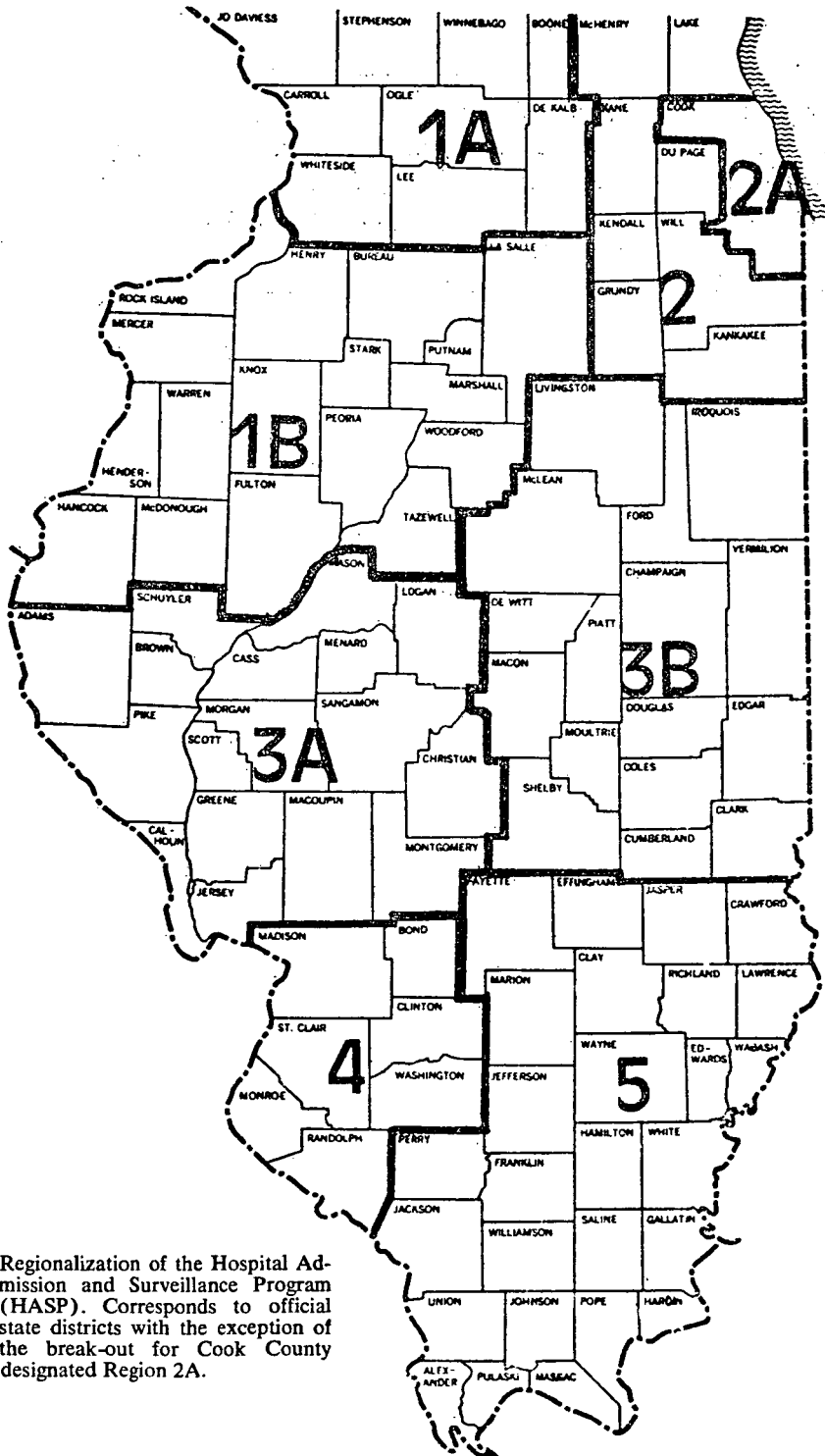
156. *Id.*

157. White Interview, *supra* note 19. This is disputed by HEW, which considers the language in § 1320c *et seq.* to be mandatory and that in § 1396b precatory. Schoeni Interview, *supra* note 49.

158. Lachabee Interview, *supra* note 17.

reaction. However, physician challenges to the law have themselves proved time-consuming. Congressional inaction on suggested amendments, the posture of court suits, and the financial and legal risks involved in building alternative review systems are sources of possibly fatal delay. The effect of physician opposition will certainly be tempered if it must be carried beyond the January 1976 statutory deadline for awarding PSRO contracts exclusively to physician groups.

MARILYN KUHR



Regionalization of the Hospital Admission and Surveillance Program (HASP). Corresponds to official state districts with the exception of the break-out for Cook County designated Region 2A.

FIGURE I

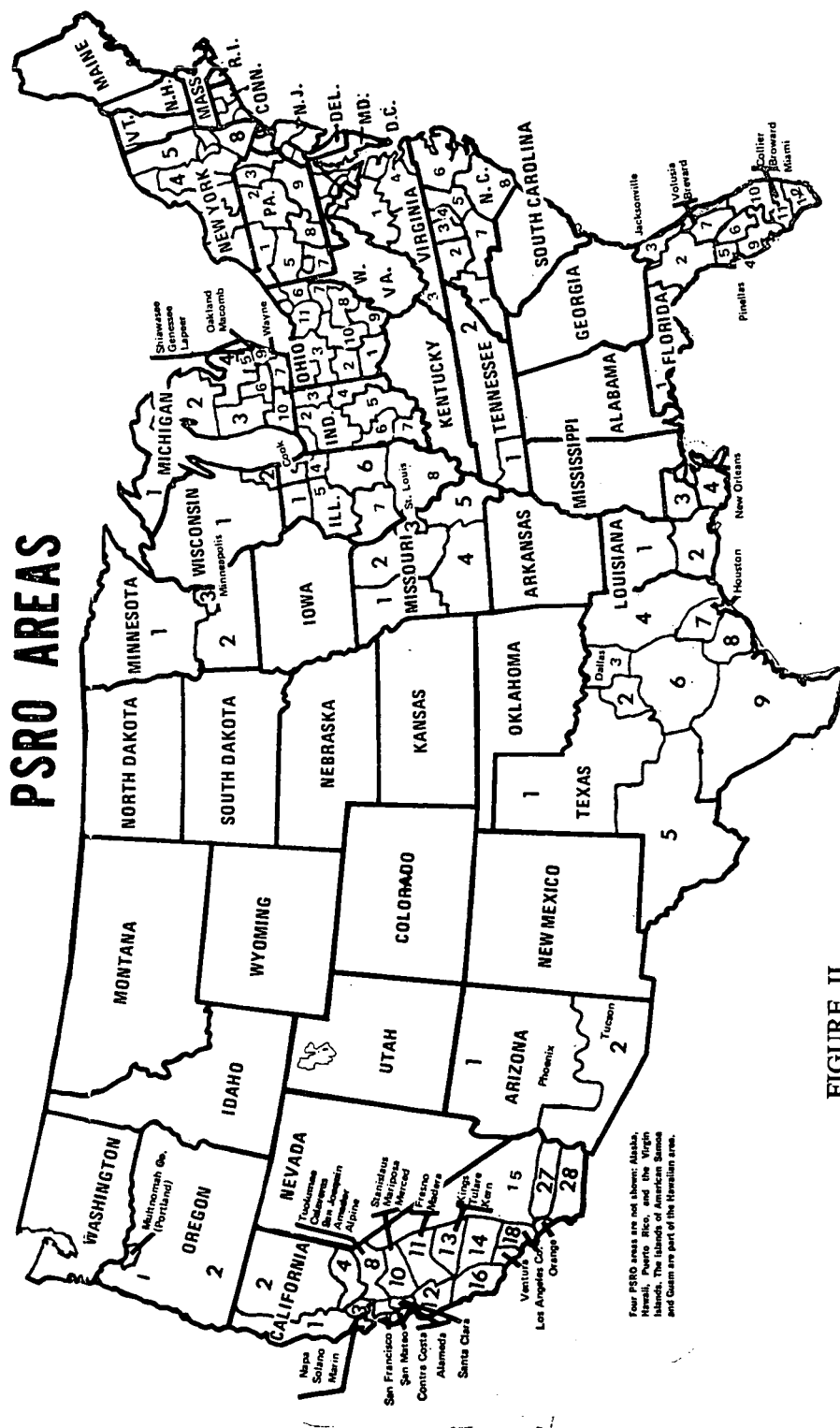


FIGURE II