UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 9:30 a.m.
Monday, March 23, 1981


STATEMENT OF

GREGORY J. AHART, DIRECTOR

HUMAN RESOURCES DIVISION

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

U.S. SENATE

ON

PROPOSAL TO PHASE OUT THE

PROFESSIONAL STANDARDS REVIEW PROGRAM

Mr. Chairman and Members of the Subcommittee we are pleased to be here today to discuss the Administration's proposal to phase out the Professional Standards Review Organization (PSRO) program and repeal the requirement for institutional utilization review committees for providers not covered by PSRO review. PSROs were established under the Social Security Act in 1972 to ensure that services paid for under the Medicare, Medicaid, and Maternal and Child Health programs were necessary and appropriate. Your request for our testimony asked us to discuss five areas:

--The history of the utilization review requirements under the Medicare and Medicaid programs including how the PSRO program came into being.

--Our views on the meaning of the various studies to measure the cost effectiveness of PSROs particularly those conducted by the Department of Health and Human Services (HHS) and the Congressional Budget Office (CBO).

--How extensively PSROs are being used by the private sector to review care paid for under non-government health insurance programs.

--Our views on the Administration's proposal to repeal the institutional utilization review requirements.

--Our suggestions as to alternatives, including possible improvements in the effectiveness of PSROs.

We will discuss each of these areas in turn.

In summary, however, we believe that, at the time the PSRO legislation was developed and enacted, the Congress had a valid basis for its (1) concern for the marked increase in institutional utilization particularly under Medicare and (2) dissatisfaction with the existing utilization review requirements. In view of the uncertainty as to the cost effects of repealing the program, and the time, energy and money already invested to bring the program to where it is, we are unable to support the administration's proposal until some alternative is postulated which would clearly be more effective.

## HISTORY OF MEDICARE AND MEDICAID UTILIZATION REVIEW REQUIREMENTS

The Medicare and Medicaid programs were added to the Social Security Act as titles XVIII and XIX, respectively, by the Social Security Amendments of 1965 (P.L. 89-97). The legislative history of the enabling Medicare legislation shows that the Congress was concerned that the program be carried out in a manner which would provide necessary hospital care to beneficairies, but at the same time that beneficiaries would stay in the hospital only as long as necessary. To control the extent and cost of care provided to beneficiaries in hospitals and extended care facilities--now called skilled nursing facilities (SNF)--the original Medicare law required such facilities to establish in-house utilization review committees consisting of at least two physicians to review the medical necessity of admissions, duration of stay, and professional services rendered. Apparently, based on similar concerns,

the Medicaid law was amended in 1967 to require utilization review procedures in that program.

As experience grew with the performance of the Medicare and Medicaid utilization control programs, dissatisfaction with their performance also grew. In response to this dissatisfaction the Senate Finance Committee developed legislation establishing the PSRO program. The Senate initially approved the PSRO program in December 1970, as an amendment to H.R. 17550, a broad omnibus bill amending various provisions of the Social Security Act including Medicare and Medicaid. The 91st Congress adjourned before H.R. 17550 could be enacted, but the PSRO amendment was again approved in the 92nd Congress in the Senate version of H.R.1 and was enacted in October 1972 as the Social Security Amendments of 1972 (P.L. 92-603).

Before PSROs, the utilization control mechanism consisted of (1) review of medical necessity by the facilities' title XVIII utilization review committees, (2) review of claims by Medicare intermediaries and carriers or by Medicaid State agencies, and (3) certification and recertification by the patient's physician that the care provided in institutions was medically necessary. There was congressional dissatisfaction with essentially four aspects of this mechanism.

First, it was perceived that the title XVIII utilization review committees focused on form rather than substance.

Compliance with the utilization review requirements was determined by whether the committees were appropriately constituted, met when required, and reviewed the appropriate number of long-stay (extended duration) cases. The nominal effectiveness of the program appeared to be directly related to facility occupancy rates--that is, where hospital beds were in short supply, peer pressure for effective utilization of these beds could be intense, but, when occupancy rates were low, utilization review was essentially a token process.

This perception was reinforced by data which showed that hospital utilization--as well as costs--was increasing at a higher than anticipated rate. As a matter of fact, from 1967--the first full year of Medicare--to 1969 hospital utilization expressed as inpatient days per 1,000 enrollees had increased by an alarming 9 percent before it began to fall off in 1970 and 1971. The chart we have brought provides some historical perspective on the unanticipated increase in hospital utilization that the Congress was attempting to deal with in the early years of Medicare.

Our work also tended to support these perceptions. In July 1971 we reported 1/ that although review committees helped to some extent to reduce unnecessary costs, a review of medical records by our consultant physicians of a random sample of 1969 extended duration Medicare cases suggested that

---

1/"Improved Controls Needed Over the Extent of Care Provided by Hospitals and Other Facilities to Medicare Patients," B-164031(4), July 30, 1971.

--of 732 hospital cases only SNF care was necessary for about 3,000 days of hospital care provided to 98 patients;

--of 1,003 SNF cases, the SNF level of care was not necessary for about 26,000 days of care provided to 354 patients; and

--of the 1,735 hospital and SNF cases, care could have been provided on an outpatient basis in lieu of about 1,000 inpatient care days for 13 patients.

We reported also that, consistent with the existing law and regulations, utilization review committees tended to focus on "extended duration" cases but that for hospitals the length of stay criteria for determining when the committees reviewed such cases ranged from 7 to 90 days. The most frequently used criteria were 21 days or the period within which 85 percent of Medicare patients were discharged. Thus, many beneficiaries who remained in hospitals for relatively long times did not have their cases reviewed. Furthermore, we reported that institutions were not complying with the legislative requirements regarding (1) the frequency of the committee reviews of extended duration cases, (2) sample reviews of admissions by the committees, and (3) certification by physician that the institutional care provided to Medicare patients was necessary.

Second, dissatisfaction was generated by a general lack of acceptance of the review activities of the Medicare and Medicaid

paying agents. Doctors, in particular, expressed strong resentment that their medical judgments were being challenged by insurance company "clerks." Also, the after-the-fact review conducted by Medicare intermediaries resulted in retroactive denials of payment after services had been rendered (that is, after the costs were incurred and the patients discharged). This was considered onerous and manifestly unfair by the medical profession as well as the institutional providers most directly affected.

Third, aside from the economic impact of the perceived over-utilization, the Senate Finance Committee was also concerned about the effect on the health of the aged and poor. Simply stated, unnecessary hospitalization and unnecessary surgery are not consistent with proper health care.

And fourth, dissatisfaction arose from the lack of professionally developed and accepted norms and criteria for carrying out the then existing utilization review requirement. This resulted in a series of subjective, case by case determinations of medical necessity.

In light of these shortcomings of the existing utilization review system, the Congress concluded that a new approach was needed and enacted the PSRO program, embodying, the concept that, in general, only doctors are qualified to judge whether services ordered by other doctors are necessary and appropriate.

Progress in implementing the PSRO legislation was slow. 1/ The act required HEW (now HHS) to designate PSRO service areas throughout the United States by January 1, 1974. In March 1974, the Department designated 203 PSRO areas, 28 of which were state-wide areas.

PSROs in the designated areas were developed in three stages--planning, conditional, and fully designated. In the planning stage, PSROs were expected to establish an acceptable organization structure and recruit physician members. In the conditional stage, PSROs were to actually implement or delegate to hospitals their concurrent review activities. 2/ The fully designated stage was to be reached when HHS considered that a conditional PSRO was capable of fulfilling its responsibilities, including long-term care review.

In June 1974, the Department awarded 102 contracts--91 planning and 11 conditional. By June 1977, 170 PSROs were in place but 62 were still in the plannning stage. A year later, the number has increased to 190--37 planning and 153 conditional--

---

1/"HEW Progress and Problems in Establishing Professional Standards Review Organizations", HRD-78-92, September 12, 1978.

2/PSROs perform principally three types of review activity (a) concurrent review which involves looking at the medical necessity of hospital admissions and extensions of patients' stays, (b) medical care evaluations which are designed to identify poor quality of care in institutions, and (c) profile analysis which involves the identification of inappropriate utilization patterns or practices through the statistical analysis of large amounts of data.

still leaving 13 areas of the country not covered. By October 1979, however, the number of PSRO areas had been adjusted to 195 with 186 conditional PSROs, 3 planning PSROs and 6 areas not covered. According to PSRO officials, between July 1980 and January 1981, 47 conditional PSROs became fully designated.

Briefly stated, the impediments to implementation over the first 5 years of the program involved (1) fragmented authority and program responsibility within the Department involving the health financing agencies and the public health service, (2) less than anticipated financing because of Office of Management and Budget and Congressional funding restrictions, (3) delays in issuing regulations and program guidance, (4) lack of agressive administration of contracts with PSROs, and (5) perhaps most important, lack of physician support for the program in many areas of the country.

In summary, the establishment and development of the PSRO program can be viewed as an attempt by the Congress to build a better "mouse trap" in response to evidence of significant increases in Medicare hospital utilization and dissatisfaction with the utilization control mechanism that existed. Despite the problems in implementing the program, by 1979, of the 195 PSRO areas, there were 186 conditional PSROs with about half the eligible physicians participating which indicates that some of the early problems had been overcome.

## STUDIES TO MEASURE THE COST EFFECTIVENESS OF PSROs

Before discussing the various studies aimed at assessing the cost effectiveess of PSROs, it is important to understand that most studies were dealing with relatively small changes to relatively large numbers. From 1974 to 1978 the total days of covered care for the aged and disabled beneficiaries in short-stay hospitals under Medicare increased from about 87.9 million to 98.1 million. In terms of the common denominator principally used in the evaluations (total days per 1,000 aged beneficiaries in short-stay hospitals), however, the changes from 1 year to the next became relatively small, with total swings of less than 3 percent and a net difference of less than 1 percent over the same period of time. 1/

---

1/This is illustrated by the following table which also shows the changes in the average amount of Medicare reimbursement per day of care in short-stay hospitals during the same period.

| Year | Total Medicare inpatient hospital days per 1,000 aged enrollees (a) | Percent change (b) | Average Medicare reimbursement per hospital day (c) | Percent change |
|---|---|---|---|---|
| 1974 | 3,641 | -- | $ 90 | |
| 1975 | 3,604 | -1.0 | 109 | +21.1 |
| 1976 | 3,698 | +2.6 | 127 | +16.5 |
| 1977 | 3,647 | -1.4 | 144 | +13.4 |
| 1978 | 3,667 | + .5 | 162 | +12.5 |
| Net Increase 1974 - 1978 | + .7 | | | +80.0 |

Note a: Source - Page 23, Professional Standards Review Organization 1979 Program Evaluation, HCFA.
Note b: On a regional basis, the changes are much more significant.
Note c: Source - Page 96, Health Care Financing Review, Spring 1980; HCFA Office of Research Demonstrations and Statistics; excludes deductivel and coinsurance amounts which are the responsibility of the beneficiaries.

Thus, relatively insignificant errors in the data or faults in the methodology used in any study can have an important impact on the findings.

The question of the cost effectiveness of PSROs has been the subject of three comprehensive studies by HHS and numerous estimates of cost savings computed by individual PSROs. Both we and CBO have reviewed the HHS studies, and we have also looked at some of the estimates prepared by individual PSROs. These reviews disclosed certain problems that exist with respect to the accuracy of the data used and with the methodologies employed to compute savings.

OPEL Study of 1974-1976 Data

The first comprehensive study was prepared during fiscal year 1977 and finalized in February 1978 by HHS's Office of Planning, Evaluation and Legislation (OPEL) of the Health Services Administration. This study focused on changes in Medicare hospital utilization rates from 1974 to 1976 for 18 areas where PSROs were making concurrent reviews of hospital utilization. The utilization rates for these areas were compared to 26 areas where PSRO concurrent reviews were not being performed in order to determine the effect of PSRO review. 1/ The study concluded that in the aggregate, PSRO review had no significant effect on the days of Medicare hospital utilization. The study also concluded that seven of the

---

1/In the non-PSRO areas, utilization review committees were operative.

PSROs had favorable benefit-to-cost ratios. Whereas, the other 11 cost more to operate than they saved.

At the same time that the OPEL study was being conducted, and its findings debated, many other studies and estimates were being made of cost savings resulting from the activities of individual PSROs. Most of these were done by the PSROs themselves and showed significant cost savings which tended to conflict with the OPEL study findings. To help sort out this conflict, in December 1977, the Chairman, Subcommittee on Oversight, Committee on Ways and Means requested that we review certain aspects of the OPEL study and evaluate on a sample basis the validity of estimates of cost savings made by individual PSROs.

In this effort we selected nine estimates of cost savings for individual PSROs. These totaled $21.4 million plus 67,049 patient days of care. We adjusted the data used in the estimates in order to make it as current, complete, and accurate as possible. Using this adjusted data and applying the same methods as used in the original estimates, we recomputed the estimated savings to be only $4.7 million plus 23,126 patient days of care. The most significant problem we noted was the use of incomplete hospital utilization data. This problem existed in eight of the nine estimates we reveiwed.

Also, because of deficiencies in the methods used by the PSROs to compute the savings, we believe even that the savings remaining after adjusting the data were highly questionable.

For example, seven of the estimates did not consider the fact that most hospital costs are fixed and in the short term are not dependent on the number of patients.

With respect to the OPEL study, we learned that the data used were incorrect. We made site visits to five of the areas where the PSRO review was being performed and to six of the comparison areas. For these 11 areas OPEL included statistics for 225 hospitals. However, we found that 20 of the hospitals should not have been included in the study and 3 hospitals were inappropriately excluded. These incorrect data significantly changed the results with respect to one of the five PSROs.

HCFA 1978 Evaluation of 1977 Data

The 1978 HCFA evaluation concluded that in areas where PSRO concurrent review was being performed, Medicare hospital utilization was reduced by 1.5 percent as a result of the PSRO's review, and that for every dollar spent by the program during calendar year 1977 for Medicare concurrent review, there was a savings of $1.10 in Medicare reimbursements. However, we learned that in this study the problem of inappropriate inclusion and exclusion of hospitals which we identified in the prior OPEL study, had not been resolved. Further, after reviewing the HHS evaluation, CBO concluded in June 1979 that, based on what it considered more appropriate methodologies, the savings were only $.70 for every dollar spent.

In addition to discussing the overall effect of PSRO concurrent review, the HCFA 1978 evaluation also ranked the 96 PSROs studied according to how effective they were in reducing Medicare days of care. The ranking showed that the most effective PSRO reduced utilization by 8.75 percent and that 12 PSROs reduced utilization by 5 percent or more. The evaluation also showed that 23 PSROs were associated with an increase in utilization or a reduction of 0.1 percent or less. The cause or causes for these variations were not explained. CBO concluded that such estimates of the effectiveness of individual PSROs were highly unreliable.

HCFA 1979 Evaluation of 1978 Data

The most recent HHS evaluation of the PSRO program (1979 program evaluation) concluded that PSRO review reduces the average days of hospital care by 1.7 percent and that for every dollar spent by the program during 1978 for Medicare concurrent review there was a savings of $1.27. However, in a January 1981 report CBO concludes that the reduction in hospital days was 1.5 percent and that the savings were only $.40 for every dollar spent. These differences are again the result of differences in methodologies applied. These differences are in the areas of what constitutes savings, how utilization rates are measured, and how monetary values are assigned to the days of care saved.

The HCFA cost-benefit analysis measured savings resulting from PSRO review as the amount by which Medicare expenditures for

hospital services were reduced. CBO measured savings as the amount by which total expenditures (governmental and private) for hospital services were reduced. There is a significant difference between measuring savings in those two ways because Medicare's cost allocation procedures result in a lowering of the percentage of fixed costs borne by the program when its share of total hospital utilization decreases. However, because fixed costs are not lowered in the shortrun by decreased utilization, non-Medicare patients will be allocated more cost per day of care to cover fixed costs.

The HCFA method looks at PSROs as a Government program and measures the savings to the Federal Government. CBO's method looks at PSROs as a national program and measures the savings to all hospital payors. This difference in viewpoints accounts for 80 percent of the difference in the two cost-benefit ratios.

With respect to measuring utilization rates, HCFA studied only those areas of the country which had a PSRO actually performing concurrent review in hospitals for at least half the study year (i.e., before July 1978). HCFA found that in the aggregate these areas had a decrease of 1.7 percent in the days of care provided to Medicare beneficairies. CBO based its estimates on a fully implemented PSRO program. CBO assumed that, if PSROs were operational in all areas of the country, they would have

the same costs and the same benefits as other PSROs currently operating in their geographic regions. This difference in methodology accounts for about 8 percent of the difference in the cost-benefit ratio.

With respect to the value of a day of care, HCFA assigned a monetary value to the decrease in utilization observed in the PSRO areas studied which reflected the hospital per diem charges for those areas. CBO, using average national charges, projected possible savings for a fully implemented nationwide program.

Also, in assigning values to days of care saved, HCFA assumed that the amount of money saved on ancillary services was equal to the average daily charges billed for such services. CBO reduced the HCFA assigned value because the first part of a hospital stay uses more ancillary services than the later days and PSROs affect utilization most by reducing lengths of stay rather than reducing admissions.

CBO reductions in the benefit-to-cost ratio to account for lower per diem costs and per diem ancillary charges, account for 9 and 3 percent of the total difference, respectively.

In commenting on the HCFA evaluations and in discussing its own estimate of PSRO cost savings, the Congressional Budget Office makes several comments which raise serious questions with respect to validity of assumptions made in both the HCFA and CBO evaluations.

For example, the January 1981 CBO evaluation states that, the evidence that PSROs reduce Medicare utilization is not firm. Considering the Nation as a whole, the program's apparent effect is sufficiently small and variable that it could be an artifact of chance variations in the data. Moreover, CBO pointed out that, in the South PSRO review seems to increase utilization, a pattern that is difficult to explain and throws all the results into some doubt. We are in basic agreement with this assessment.

PRIVATE PATIENT REVIEW BY PSROs

Some private (non-government) health insurers, and other third-party payors, contract with PSROs to conduct reviews of the health care services reimbursed by those organizations. Health care providers have also contracted with PSROs to review the services they provide to non-federal patients. The cost of such private reviews must be fully paid for by the users. The most recent information available indicates that at least 30 PSROs are associated with private review programs sponsored by third-party payors and health care providers. However, the full extent to which PSROs are involved in private review is unknown because complete data are not available.

In a November 1980 survey conducted by the American Association of PSROs (AAPSRO)--a non-government group organized to promote effective peer review in the health care system--26 PSROs indicated that they conduct private review programs for third-party payors and/or health care providers. An additional 4 PSROs indicated

that separate organizations associated with them conduct private reviews. We understand that the reason these "sister" organizations exist is in part due to a desire to provide separate accountability for privately and federally reimbursed activities. The PSROs and their sister organizations provide private review for hospitals, health maintenance organizations, insurance companies, and a variety of employers. For example, the Iowa Foundation for Medical Care, which available data indicates has the largest involvement in the private sector, is reported to have private review contracts with

--Blue Cross of Iowa,

--Blue Cross of Western Iowa and South Dakota,

--Bankers' Life,

--Dubuque Packing Company,

--Firestone Tire and Rubber Company, and

--Deere and Company.

Nationally, private patient review is reported for no less than 24 hospitals, 8 health maintenance organizations, 63 health insurers, 8 employers, and 11 other private entities. In a January 1980 AAPSRO survey, 29 PSROs reported that their private review programs involved an estimated 426,000 hospital discharges. The Iowa PSRO alone accounted for 100,000 of these.

Not enough information is available to provide a complete picture of the extent to which PSROs or their sister organizations are involved with private review. For example, 37 PSROs did not

respond to the most recent AAPSRO survey. Furthermore, private review data are not collected by HHS.

## GAO VIEWS ON THE ADMINISTRATION'S PROPOSAL TO ELIMINATE SOCIAL SECURITY ACT INSTITUTIONAL UTILIZATION REVIEW REQUIREMENT

The Administration proposes to phase out the PSRO program by the end of fiscal year 1983 and to repeal the requirement for facility utilization review committees in areas where PSROs are not active. We have not seen specific legislative proposals to accomplish these ends but we assume that the effect would be the elimination of legislative requirements for utilization review conducted at facilities at the time Medicare and Medicaid patients are being treated on an inpatient basis.

We assume States would be able to establish any type of utilization control program they wish for Medicaid (including no program) and that Medicare intermediaries would be responsible for some form of utilization review program for Medicare in connection with their determinations of whether the services were covered under the program. Apparently, the Administration believes the utilization control mechanisms which will arise in the marketplace from its forthcoming proposals to enhance competition in the health care industry will provide sufficient protection of Federal dollars from over or unnecessary utilization of institutional services.

We do not know what utilization control mechanisms must be substituted by the States for Medicaid or the intermediaries for

Medicare much less how effective these mechanisms would be or how much they would cost. Also, it must be remembered that the HCFA and CBO evaluations of PSRO effectiveness are made by comparing PSRO areas with areas that have title XVIII utilization review committees. With both of these mechanism gone, we cannot even speculate about the impact on Medicare utilization rates.

Based on 1980 costs, Federal payments under Medicare and Medicaid for inpatient hospital care were about $25.6 billion. The funding level for PSRO program was about $155 million or 0.6 percent of such costs, of which $97 million or 0.4 percent was assigned to the concurrent review activity and financed initially from the Medicare Trust funds. Thus, the cost of utilization review is but a small fraction of the cost of inpatient care.

Given that PSRO cost is such a small fraction of the cost of inpatient care, it seems to us that rather strong reasons can be offered for keeping the program in place. It is true that no one has a fully reliable measure of its effectiveness in holding down costs; but, conversely, no one is in a position to reliability predict whether and to what degree costs might increase if this and other utilization review requirements are discontinued.

Since the Congress, in enacting the PSRO legislation, acted in response to a determination that not only was utilization review warranted, but that the then-existing review mechanisms were not up to the job, and since considerable investment of time, energy,

and money has been made to bring the PSRO program to where it is, it could be well argued that this investment should not be scrapped until a better picture can be drawn of what the effects would be or some alternative is postulated which would clearly be more effective.

Accordingly, we cannot support repeal of the PSRO and utilization review committee provisions at this time.

## SUGGESTED ALTERNATIVES INCLUDING IMPROVED EFFECTIVENESS OF PSROs

In our September 1978 report on the problems in implementing the PSRO program, we recommended that when establishing new national programs similar to the PSRO program, the Congress should consider using the demonstration concept before authorizing or requiring full program implementation. We believe that such a suggestion is also appropriate when dismantling a program partially aimed at controlling costs especially when the short or long-term effects are uncertain.

As previously discusssed, both the 1978 and 1979 HCFA evaluations associated PSRO concurrent review in the South 1/ with increased utilization of 1.3 percent and 3.7 percent, respectively. Although there is some doubt as to the validity of these unexplained findings, we suggest that this might be an area where the Congress may want to test the hypothesis that the removal of

---

1/Includes the States of Delaware, Maryland, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, Kentucky, Texas, Tennessee, Alabama, Mississippi, Arkansas, Louisiana, Oklahoma, and the District of Columbia.

existing utilization control mechanisms will not result in a corresponding increase in unnecessary benefit payments. Although we recognize that given the difficulties in measuring or attributing the reasons for changes in utilization, such a demonstration might not be conclusive. On the other hand, if there are marked changes one way or the other, it is likely that the Congress will be in a better position to assess the advantages or risks of abandoning utilization review mechanisms nationwide. Further, before authorizing such a demonstration however, the Congress should be satisfied that the Department has designed the project in such a manner to provide the needed answers. We have not given this question sufficient study to determine just how this demonstration project should be designed.

The Administration proposes to phase out the PSRO program over the 1981-1983 period with all Federal support ending in 1984. During this period funding will be renewed for only those PSROs judged most effective in controlling health care costs and assuring a high quality of medical care.

In line with the Administration's proposal for funding the most effective PSROs, we believe one alternative to phasing out the program could be the consolidation of PSRO areas. There are presently 194 PSRO areas, of which 32 are single State and 162 involved 2 or more PSRO areas per State. California has 27 PSRO areas and New York 17. Other States with 10 or more are Florida, Michigan, Ohio, and Pennsylvania. Maryland with only 54 short-stay hospitals has 7 areas.

Because we have observed that PSROs have similar size administrative cadres to support their program operations irrespective of their workloads, we believe that at least administrative and overhead costs could be reduced through consolidation. 1/ Hopefully, less effective PSROs could be consolidated with more effective ones thereby increasing the overall cost effectiveness of the PSRO program.

Although we can support the principle of only funding the most effective PSROs, one problem with this approach may be identifying which are the most effective PSROs.

As previously discussed, the 1978 HCFA Program Evaluation ranked the 96 PSROs included in the study according to their relative impact on hospital utilization by aged Medicare beneficiaries. According to the CBO analysis, however, this ranking process was not valid and we note that it was not repeated in HCFA's 1979 evaluation.

In our prior work we looked at several mechanisms which the Department had designed to monitor the effectiveness of PSROs. The first mechanism was the Intermediary Post-Payment Monitoring Program which featured a review of a sample of claims related

---

1/Opportunities to Reduce Adminsitrative Cost of Professional Standards Review Organization, HRD-78-168, October 12, 1978.

to inpatient admissions reviewed by a PSRO to identify cases where intermediary physicians questioned the medical necessity of days approved by the PSRO. 1/ The second mechanism involved the monitoring of PSROs by the HCFA regional offices including (1) periodic assessments by teams composed of HCFA personnel and peers from other PSROs and (2) the day to day contact by HCFA project officers. 2/ We believe that both these mechanisms could be strengthened to support the Administration's objective of identifying and funding the most effective PSROs.

Regarding the use of the Post-Payment Monitoring Program, we concluded that the Department was not effectively using this program to monitor PSRO concurrent review activities or to assess individual PSROs. For example, at two PSROs we visited the intermediaries had questioned over 5 percent of the days sampled and the PSROs had agreed that they had inappropriately certified for payment about 2.6 percent and 4.2 percent of the total days.

We made several recommendaions aimed at making the Post-Payment Monitoring Program a more useful tool to PSRO and HHS management to improve the cost effectiveness of individual PSROs.

---

1/Need to Better Use he Professional Standards Review Organization Post-Payment Monitoring Program, HRD-80-27, December 6, 1979.

2/Department of Health and Human Services Should Improve Monitoring of Professional Standards Review Organizations, HRD-81-20, December 29, 1980.

With respect to the regional office monitoring of PSROs, we visited 13 PSROs and 39 hospitals and examined samples of adverse determinations--or cases where the PSRO had denied payment for part of the patient's stay. For the cases examined, the PSROs had denied 1,779 days, but we concluded that the PSROs should have denied 384 or 20 percent more.

The principal causes were (1) that PSROs were granting extensions of patient's stay which did not meet HHS coverage criteria and (2) delays in making the reviews which were inconsistent with HHS instructions. HHS officials were generally unaware of the incidence of the noncompliance with HHS coverage and procedural requirements and we made several recommendations to strengthen the HHS monitoring function which could then also help to identify the most effective PSROs.

- - - - -

This concludes our prepared statement and we would be pleased to respond to any questions this Subcommittee may have.