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Report to the Secretary of Health and Human Services

August 1990

DISABILITY PROGRAMS

Use of Competitive Contracts for Consultative Medical Exams Can Save Millions

GAO/HRD-90-141

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

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August 17, 1990

The Honorable Louis W. Sullivan, M.D.
The Secretary of Health and Human Services

Dear Mr. Secretary:

We reviewed the procurement of medical examinations of claimants seeking benefits under the Social Security Administration's (SSA's) disability programs. These consultative examinations (CEs) are purchased when claimants' medical evidence is insufficient for disability determinations. State disability determination services (DDSs), who are reimbursed by SSA for 100 percent of their CE costs, select medical providers to perform these examinations and determine CE payment amounts.[1] New York and Oregon DDS data show substantial savings in CE costs through the use of competitively awarded contracts. We believe that SSA should work closely with other DDSs to identify areas where competitively awarded contracts are feasible and to require their use, where appropriate, because of the potential for annual savings of millions of dollars.

Background

Consultative medical examinations are purchased by state DDSs who make disability determinations on behalf of SSA for two national programs—Social Security Disability Insurance and Supplemental Security Income. In 1989, federal payments for the two disability programs were over $31 billion. As of September 1989, about 7.1 million disabled individuals and their families received benefits from the two programs.

As part of the adjudicative process for determining disability, DDSs obtain medical evidence from claimants' treating sources (attending physicians, hospitals, or other sources of record); but when the information is unavailable or insufficient, DDSs must purchase a consultative examination. CEs include physical and mental examinations, X rays and other diagnostic procedures, and laboratory tests. DDSs purchase CEs from three provider groups: (1) individual physicians and psychologists; (2) health care facilities, such as group practices, clinics, and hospitals; and (3) providers that specialize in performing CEs.

[1]SSA officials said that a proposed regulation clarifies the existing policy for DDSs to attempt to obtain all necessary medical evidence from claimants' treating physicians. Only when they cannot or will not provide sufficient medical evidence should the DDS purchase CEs from other medical sources, including those awarded competitive contracts. Only a small percentage of CEs are purchased from claimants' treating physicians, SSA officials said.

DDSs are responsible for informing their medical communities about disability program requirements and how to participate in providing CEs. They also must recruit and maintain a sufficient number of medical providers to meet their CE needs. DDSs select providers to perform CEs from a listing of these providers.[2] DDSs are also responsible for determining the amounts paid for CEs. In fiscal year 1989, SSA reimbursed DDSs about $121 million for their costs in purchasing CEs.

Most states use fee schedules in determining physicians' reimbursement, although some states reimburse based on physicians' usual and customary charges. The reasonableness of state-determined fee schedules was questioned in a 1988 report by the Department of Health and Human Services' (HHS's) Inspector General. Based on a comparison of DDS fees across the country, the Inspector General identified wide variations among states (see app. I). Some of the variation was due to medical market and cost-of-living differences. SSA suggested that state-imposed constraints on DDS fees and rate-methodology differences also accounted for some of the variation.

Objectives, Scope, and Methodology

The primary objective of this review was to determine the feasibility of using competitively awarded contracts to reduce CE expenditures.

We reviewed legislation, regulations, operating manuals, and other information pertaining to the purchase of CEs, as well as prior studies, such as a 1988 HHS Inspector General audit report and an SSA-contracted study. We visited the New York and Oregon DDSs who use competitively awarded contracts and discussed their cost savings, reasons for such contracting, and approaches to contracting. We obtained the cost-savings estimates of the two DDSs and discussed the methodology used, but did not verify the accuracy of the estimates.

We reviewed a "model" contract that SSA had sent to DDSs in January 1990 for their comment and use in contracting with volume providers for CEs.[3] SSA did not provide us the DDS comments until June 1990.[4] Consequently, during our review we contacted four DDSs that were not using

[2]The listing of medical providers from which DDSs make their CE selections is often referred to as a CE panel.

[3]Providers who receive over $100,000 annually for performing CESs are generally referred to as volume providers.

[4]Our preliminary review of the DDS comments indicated that the concerns expressed by the DDSs would not alter our conclusions and recommendations.

competitive contracts to obtain their views on contracting in general and on SSA's model contract specifically. To determine providers' views on contracting, we talked to all providers in New York who had been awarded a competitive contract and a judgmental sample of such providers in Oregon.

Our work was performed at SSA's central office in Baltimore. We also contacted SSA regional offices in New York City, Philadelphia, and Seattle. We visited DDS locations in New York, Oregon, Maryland, Pennsylvania, and Ohio and contacted the Florida DDS. We chose the New York and Oregon DDSs because they were identified by SSA as realizing significant cost savings by using competitively awarded contracts for CE purchases. The other four DDSs were chosen based on their total CE costs. In fiscal year 1989, the DDSs contacted accounted for about 25 percent of total CE expenditures.

We discussed SSA's position on a draft of this report with agency officials and incorporated their comments where appropriate. We performed our audit work between September 1989 and March 1990 in accordance with generally accepted government auditing standards.

Cost Savings by Use of Competitively Awarded Contracts

The use of competitively awarded contracts for CE purchases by the New York and Oregon DDSs shows that substantial cost savings are possible. The New York DDS began competitive contracting for CEs in 1986 and expects a savings of about $8.3 million over the 3-year life of its contracts.[5] These savings represent about 26 percent of an estimated $32 million that would have been spent based on the DDS's fee-schedule amounts. (Examples of New York cost savings for specific types of CEs are shown in app. II.)

The Oregon DDS, which began using competitive contracts for CE purchases in 1984, expects to save about $1.6 million through 1993. These savings represent about 42 percent of an estimated $3.7 million that would have been spent in the absence of contracts.[6] Examples of

[5]Excluded from these savings is a 3-year statewide contract for laboratory services, which was extended for 2 years in September 1989. For the initial 3-year period, the New York DDS estimated that the contract resulted in annual cost savings of about $60,000 or a 50-percent reduction from the DDS's fee schedule for such services.

[6]Since the Oregon DDS does not use a fee schedule, the savings represent the difference between the contract prices and the average of physicians' usual and customary charges for the same services within the geographic areas of the contracts.

cost savings for specific types of CEs range from 11 percent for orthopedic examinations to 79 percent for pulmonary studies.

For the 3-year period ending September 30, 1989, the cost savings claimed by the Oregon and New York DDSs were about 14 and 15 percent, respectively, of their total CE expenditures. To obtain this level of cost savings, the two DDSs used competitive contracts for about 50 and 75 percent, respectively, of their total CE requirements. Since, nationwide, DDSs spent about $121 million for CEs in fiscal year 1989, the widespread use of competitively awarded contracts has the potential for substantial program savings.

Savings by other DDSs would depend on the portion of their CE purchases obtained by using competitive contracts. Such a portion could be affected by the extent to which DDSs are able to increase their use of medical evidence from claimants' treating sources and decrease their purchases of medical evidence from other providers. Another factor that could affect the amount of savings would be the extent to which DDSs can obtain reductions below their established fees.

The New York and Oregon DDSs told us that savings from competitive contracting were realized with minimal administrative costs. DDS expenditures included the costs of advertising, postage, and travel. The two DDSs relied on their existing staff for most of their contracting needs. Some assistance was also provided on legal and procurement matters by other branches of their state governments. DDS officials said that staff may need to be dedicated to the project initially because of the amount of work involved during the contract design and execution.

New York and Oregon DDSs' Reasons for Contracting

The New York and Oregon DDSs had different motivations for deciding to use competitively awarded contracts. The New York DDS contracted because it was faced with an increasing number of volume providers on its CE panel. The Oregon DDS was motivated by the need to gain control over escalating medical costs within the state.

Historically, the New York DDS has used volume providers for the majority of its CE referrals. Over time, DDS officials said the number of volume providers on the CE panel continued to grow. The growth was attributed to a policy of allowing all capable providers access to the panel. However, as the number of volume providers on the panel grew, the share of referrals available to each provider decreased resulting in some of the providers accusing the DDS of favoritism. Thus, the DDS

decided to use competitive contracts with volume providers in order to eliminate the appearance of favoritism, reduce costs, and improve provider monitoring.

The New York DDS selected seven volume providers to perform examinations in nine geographic areas. These areas included the New York City metropolitan area and surrounding counties, areas with concentrations of volume providers. Three of the providers were solely in the business of performing CEs, two were hospitals, and two were clinics. All had previously been on New York's CE panel. However, before the use of competitive contracts, they had charged the maximum fee-schedule amounts for the services provided, DDS officials said. (Information on the New York DDS's contract providers is shown in app. III.)

The primary reason the Oregon DDS decided to use competitive contracts was to save money. Because the Oregon DDS generally reimbursed based on physicians' usual and customary charges, DDS officials said there was little control over prices. Thus, to gain price stability and to better budget for medical costs, the Oregon DDS decided to contract competitively with providers. As shown in appendix IV, Oregon currently has 33 such contracts in six geographic areas of the state. These areas have a high need for specific medical services and a corresponding high concentration of specialists needed to perform the necessary CEs. Most of the Oregon DDS's competitive-contract providers are individual and group practices, although there are three hospitals and two clinics. Of the 33 contract providers, one was a volume provider.

Reasons Medical Providers Contract

CE providers gave us various reasons for wanting to enter into competitively awarded contracts with DDSs. The most important perhaps is the expectation of a steady number of CE referrals. These providers may range from those supplementing a new private practice to those supporting a million-dollar organization created solely for performing CEs. In exchange for a number of referrals, providers agree to perform CEs at a reduced fee. Further, regardless of provider size, the availability of existing staff, equipment, and facility necessary to support the contract are major considerations in the contracting decision. In particular, hospitals and clinics may have excess capacity and be eager to contract for CEs to utilize this excess.

Some of the New York and Oregon DDS competitive-contract providers said they were also providing medical services similar to CEs under competitive contract with other private and public sources. Thus, they were used to entering into such contracts with clients.

New York and Oregon DDSs' Approach to Contracting

SSA requires neither that DDSs use competitively awarded contracts nor that they follow federal acquisition regulations to purchase CEs. Thus, to contract for CEs, the New York and Oregon DDSs used the procurement policies and practices of their state governments. The DDS officials said they (1) asked their CE panel members if they were interested in contracting, (2) advertised in newspapers and professional journals, and (3) made mass distributions of information. The terms and conditions of their contracts were specified in bid proposals, which also required bidders to submit a unit price for each specified type of CE examination, procedure, or test listed. Included in the proposals was an estimate of the number of expected purchases for each type of CE. However, none of the estimates were guaranteed by the DDSs.

The DDSs established the relative importance to assign to quality and price in the selection of successful bidders. For example, the New York DDS evaluation approach called for excluding bidders that did not meet minimum qualifications and then ranking the remaining bidders by assigning relative weights to quality factors. From the highest ranked bidders, DDS officials said that final selections were made based on the lowest bid prices. Quality factors included physician and staff qualifications, facility and equipment specifications, and reporting standards.

Because the competitive-contract providers agreed to perform CEs at a reduced price, the DDSs established guidelines that gave these providers preference, after the claimants' treating sources, for CE referrals. Nevertheless, the guidelines allowed for continued CE referrals to other providers. The New York DDS, for example, established guidelines to give 80 percent of its CE referrals within the competitive-contract area to contract providers and 20 percent to other panel providers. Maintaining relationships with and continuing CE referrals to these other providers allows for flexibility and helps keep future options open.

Other Benefits of Competitively Awarded Contracts

Besides cost savings, officials in both DDSs maintain that the use of competitively awarded contracts resulted in improving the overall quality of the CE services. They said that report quality and timeliness were better from competitive-contract providers. The competitive selection process

helps to ensure that better CE providers are awarded contracts. These contract providers generally have more knowledge of and experience with program requirements than panel members who perform CEs infrequently. Also, the contract providers should have a better idea of what is expected of them because expectations are formalized in the contract.

The officials also suggested that competitively awarded contracts better assure public accountability and provide for equity and openness in the selection process. Contracts can incorporate specific requirements for staff qualifications and standards for reporting and processing time.[7]

SSA Actions to Encourage Contracting

In May 1987, SSA solicited proposals for a study of DDS operations, including the use of volume providers. The study resulted in a January 1989 report, which suggested that SSA develop a model contract for DDS use in contracting with volume providers.[8] The use of contracts was shown to improve overall quality and result in substantial cost savings, the report stated. Except in unusual circumstances, it was suggested that contracts be competitively awarded. By obtaining discounts from existing volume providers, savings of from 10 to 25 percent below DDS fee schedules were possible, the report stated.

The study found that the DDS/volume provider relationships were "informal and non-contractual." Despite such providers receiving substantial payments for performing CEs, the DDSs obtained little or no financial advantage. In most situations that the study reviewed, the volume providers had a history of prior relationships with SSA, including several that involved physicians who had previously worked for SSA. The report suggested that these prior relationships gave the volume providers a better background on SSA requirements.

The report also suggested that substantial fee reductions obtained in the private sector from "preferred providers" offer a precedent for DDSs to obtain similar reductions when purchasing CEs. Many health insurance companies and self-insured corporations use contracts for purchasing medical services. In contrast to the traditional fee-for-service health plans, private companies contract with a network of physicians who

[7]To offset possible negative perceptions of volume providers, the New York DDS also contracted with a peer review organization to perform independent quality reviews of its contractors. For fiscal years 1988 and 1989, the cost of peer reviews was about $126,000.

[8]In a prior report SSA Consultative Medical Examination Process Improved: Some Problems Remain (GAO/HRD-86-23, Dec. 10, 1985), we determined that about one-half of the states used volume providers, who received about 26 percent of their CE expenditures.

typically agree to charge the company less than what they usually charge in exchange for an increased patient load and improved cash flow.

In January 1990, SSA sent a model contract to DDSs for their guidance and use and "urged" DDSs who use or plan to use volume providers to obtain financial concessions from them. SSA is in the process of developing guidelines for contracting and will review DDS replies on the use of the model contract as input to any policy changes.

The model contract (similar to the New York DDS volume-provider contracts) was written primarily to provide guidance to DDSs for contracts with large-volume providers who specialize in performing CEs. It contains an extensive list of "mandatory" medical services to be performed by the selected contractor. Included on the list are over 10 types of specialty examinations and a multitude of related procedures and tests. The model suggests that each proposal should include a fee for each medical service listed as well as documentation to support expected personnel, equipment, and facility costs and expected profit.

The four DDSs not using competitive contracts that we contacted were concerned about their ability to locate qualified providers who could meet all the requirements called for in SSA's model contract. One concern was that few medical markets would have providers capable of performing the number of mandatory examinations and other medical services listed in the model contract. Without an adequate number of providers willing to compete, it may not be possible to obtain the same discounts available in a competitive market. It was suggested that the model contract would most likely not apply to individual physicians and group practices because of the required multiple specialties. Also, use of the model contract may discourage some providers because of its extensive requirements and the amount of information to be submitted. In addition, one of the DDSs was concerned that emphasis on large volume, as suggested by SSA, may create an undesirable situation of over reliance on one or a few providers for most CE needs.

In contrast to the model contract approach, the DDSs suggested to us that the contract approach used by the Oregon DDS would probably be more suitable to the circumstances of many DDSs. The contracts used by the Oregon DDS contain fewer requirements and are generally based on a smaller number of CE referrals with individual physicians and group practices that offer one or a limited number of specialties.

Suggested Approach to Determine Feasibility for Competitive Contracts

To decide whether to contract competitively for CEs, DDSs need to evaluate their individual circumstances. Steps that DDSs could take include: (1) targeting geographic areas within the state with concentrations of claimants and providers, (2) determining CE needs in targeted areas, (3) matching CE needs with the types of specialists available in targeted areas, and (4) obtaining a preliminary indication of provider willingness to bid at a discounted price in exchange for some or most of the expected CE referrals in target areas. At this point, the DDS may wish to pilot test the concept by using competitive contracting only within a selected area. To encourage maximum competition, the DDS could contact existing panel members and other providers in the targeted areas as well as advertise in newspapers and professional journals.

Even if the overall state fee schedule is low, it may still be possible to obtain discounts from individual specialists in certain geographic areas. It may be possible to competitively contract below the DDS fee schedule in areas with high concentrations of one or more specialists. Hospitals and clinics were shown by the New York and Oregon DDSs to be good sources for competitive CE contracts because of underutilized test equipment and excess facility capacity.

Conclusions

Competitively awarded contracts can be effective in reducing the costs of CEs. Relying on marketplace forces provides better assurance of the reasonableness of prices. The competitive selection process can also help to ensure that the better CE providers are awarded contracts. Such contracts can further be used to better communicate expectations and to build in higher standards for quality, timeliness, and other requirements.

The contracting experience of the New York and Oregon DDSs demonstrates the benefits that can be derived from introducing greater competition into the provider selection process. Nevertheless, we realize that competitively awarded contracts may not always be applicable because of a low fee schedule or insufficient competition. Furthermore, some DDSs may experience higher administrative expenses for contracting than the New York and Oregon DDSs, especially if it is necessary to hire additional staff.

SSA's model contract is designed primarily for states that use large-volume providers. Some of these states may find it impractical to use competitive contracts with their volume providers. For such states and for states that do not use volume providers, we believe that SSA, in

developing guidelines for contracting, should incorporate provisions for the use of competitive contracts suitable for providers that offer one or a limited number of specialties. We believe such provisions would be more suitable for the individual and group-practice providers in DDS medical markets and lead to more widespread use of competitively awarded contracts.

Recommendations

We recommend that you direct the Commissioner of SSA to:

1. Require DDSs to periodically determine the feasibility of using competitively awarded contracts.

2. Require SSA's disability program managers to work closely with DDSs to determine contract feasibility and to provide assistance as needed. SSA should ensure that DDSs use competitively awarded contracts where feasible.

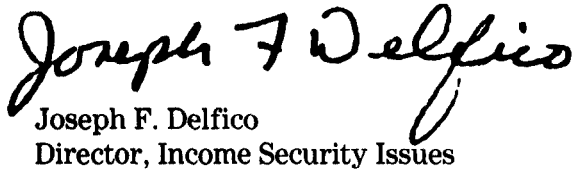
3. In developing guidelines for competitive contracting, include provisions suitable for contracts with individual and group practices.

As you know, 31 U.S.C. 720 requires the head of a federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Copies of this report are being sent to interested congressional committees and subcommittees; the Director, Office of Management and Budget; and other interested parties. Copies will also be made available to others on request.

Please contact me at (202) 275-6193 if you or your staff have any questions concerning this report. Other major contributors to this report are listed in appendix V.

Sincerely yours,



Joseph F. Delfico
Director, Income Security Issues

Contents

Abbreviations

CE	consultative examination
DDS	disability determination service
GAO	General Accounting Office
HHS	Department of Health and Human Services
SSA	Social Security Administration

Comparison of DDS Fees for Selected Types of Consultative Examinations

Selected CEs	DDS fees[a] High DDS	Low DDS	Average
Examinations			
Internal medicine	$120	$70	$85
Cardiology	120	70	86
Psychiatry	120	70	90
Orthopedic	120	70	86
Diagnostic procedures			
Chest X ray	100	22	45
EKG	103	25	42
Doppler (resting)	200	60	103
Doppler (exercise)	412	45	147
Stress test-treadmill	400	74	162
Laboratory tests			
Urinalysis	15	4	4
Blood sugar	28	4	10
Creatinine	29	5	11
Complete blood count	40	6	17
ANA	44	15	26
Sed rate	44	4	10
SMA 12	35	9	22

[a]In commenting on a draft of this report, SSA officials said that this comparison was based on a review of 12 of the 52 DDSs. SSA also provided a 1990 comparison based on the fees of all 52 DDSs that showed wider variations for some of the selected CEs.

Source: Disability Determination Services Medical Evidence Development Best Practices and Improvement Options, HHS Office of the Inspector General, August 1988.

New York DDS 1989 Cost Savings: Comparison of Fee Schedule and Contract Fees

Selected CEs	Fee schedule[a]	Contract fee	Percent savings
Examinations			
Comprehensive drug addition	$164	$106	35
Complete ear (with barany or caloric)	118	68	42
Complete neurological	82	53	35
Complete orthopedic	82	53	35
Complete psychiatric	82	53	35
Intelligence evaluation	67	45	33
Personality evaluation	107	70	35
Personality and organicity evaluation	134	80	40
Diagnostic procedure			
Ventilation tests	38	23	39
Electrocardiogram, resting	56	22	61
Electroencephalogram (EEG)	140	98	30
Electromyography (EMG) 2 extremities and related paraspinol area	253	114	55
Treadmill exercise electrocardiography	211	132	37
Speech discrimination test binaurel	42	16	62
X ray, skull, complete	135	81	40
X ray, ribs, both sides	113	44	61
X ray, chest, single PA	45	27	40
X ray, spine, cervical, minimum of 4 views	113	68	40
Doppler ultrasound flow meter test, bilateral, arterial only	71	43	39
Doppler utlrasound flow meter test after exercise, arterial only	91	53	42

[a]The New York DDS uses fees from the state workers' compensation program.

New York DDS Consultative Examination Contracts

Contractor[a]	Geographical area[b]	Estimated 1989 obligations
Diagnostic Health Services	Manhattan	$959,646
Health Disability Consulting Services, Inc.	Manhattan	1,008,210
Brooklyn Hospital	Brooklyn	1,595,947
K-MD Management Services, Inc.	Brooklyn	1,742,368
K-MD Management Services, Inc	Bronx	778,903
Union Hospital of the Bronx	Bronx	1,182,169
New York Diagnostic Centers	Queens	995,674
North Broadway Medical Associates	Nassau County	343,160
North Broadway Medical Associates	Suffolk County	558,108
Total		**$9,164,185**
Average		**$1,018,243**

[a]Each contractor performs several types of specialty examinations and diagnostic procedures.

[b]All of the contracts are within metropolitan New York City and the surrounding counties.

Oregon DDS Consultative Examination Contracts

Specialty type of CE[a]	Contract locations[b]	Number of contracts	Estimated 1989 obligations
Rheumatology	Portland	1	$42,000
Orthopedics	Portland	1	200,000
Pulmonary	Portland	1	20,000
	Springfield	1	15,000
	Medford	1	7,000
Cardiology	Portland	1	70,000
	Springfield	1	15,000
	Medford	1	18,000
Neurology	Portland	1	25,000
Mental	Albany	3	34,000
	Ashland	2	20,500
	Corvallis	2	9,500
	Eugene	3	70,500
	Medford	3	36,500
	Portland	7	141,500
	Salem	3	81,000
	Springfield	1	24,000
Totals		**33**	**$829,500**
Average			**$25,136**

[a]Includes both specialty examination and any necessary diagnostic procedure and laboratory test.

[b]Populations in geographic areas covered by contracts include: Portland, 1,092,000; Medford/Ashland, 141,700; Corvallis, 69,100; Salem/Kaiser, 255,000; Albany, 89,900; and Eugene/Springfield, 273,700.

Major Contributors to This Report

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